STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 SO /ILLE, NC 286			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
D 000	Initial Comments		D 000			
	conducted an annual investigation on Dece December 14, 2015. was initiated by the A Department of Social	partment of Social Services survey and complaint ember 7 - 11, 2015 and The complaint investigation lexander County Services on July 20, 2015.				
D 101	10A NCAC 13F .0309	0(b)(c) Plan For Evacuation	D 101			
	10A NCAC 13F .0309 Plan For Evacuation (b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official. (c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved. This Rule shall apply to new and existing facilities.					
	reviews the facility fai the fire plan were per shift in accordance wi	as evidenced by: ns, interviews, and record led to assure rehearsals of formed quarterly on each ith the requirement of the Code Enforcement Official.				
	The findings are:					
	revealed: -They had 13 fire rehe 12/7/15.	s Fire Drill Schedule forms earsals from 3/15/15 to s on the 6:00am to 6:00pm				

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

(X6) DATE TITLE

STATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		L-100004			10/4	4/0045
		hal002004	B. WING		12/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ALEVAND	NED ACCIOTED LIVING	3032 N C	HIGHWAY 16 S	ОИТН		
ALEXANL	DER ASSISTED LIVING	TAYLORS	SVILLE, NC 286	81		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETE DATE			
D 101	Continued From page	e 1	D 101			
	12/04/15 at 9:00a -One fire rehearsal or shift. 6/19/15 at 3:30pr Interviews with reside revealed: -One resident stated of for 2 years and remered another resident stated drills in December 20	am a				

Division of Health Service Regulation

December 2015.

on each shift."

since staff was hired.

Random interviews with staff during the survey

-There had only been 2 fire rehearsals in the past nine months, one in November 2015 and one in

-There had never been any fire rehearsals done

Interview with the Director on 12/14/15 at 4:07pm revealed "I try to have fire drills once per quarter

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	LIED
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SO ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 113	Continued From page	2	D 113			
D 113	10A NCAC 13F .0311	(d) Other Requirements	D 113			
	provide an adequate kitchen, bathrooms, la closets and soil utility temperature at all fixth be maintained at a mi (38 degrees C) and s	stem shall be of such size to supply of hot water to the aundry, housekeeping				
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure hot water temperatures were maintained at 1 tub and 2 sinks used by residents at a minimum of 100 degrees Fahrenheit. The findings are: A tour of the facility on 12/7/15 revealed: - At 10:32am, the water temperature in the sink of					
	was 80 degrees Fahr temperature of this sin temperature of 80 deg	n beside resident room #6 enheit. A recheck of the nk at 2:40pm revealed a grees Fahrenheit. er temperature in the sink of				
	degrees Fahrenheit.	nk at 2:35pm revealed a				
	- At 10:47am, the wat whirlpool tub was 80 or recheck of the temper					

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 3 of 67

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28881 SUMMARY STATEMENT OF DEPICIENCIES PREPIX SUMMARY STATEMENT OF DEPICIENCIES PREPIX REGULATORY OR I.SC IDENTIFYING NORMATION) D PROVIDER'S FLAN OF CORRECTION REGULATORY OR I.SC IDENTIFYING NORMATION) D PROVIDER'S FLAN OF CORRECTION REGULATORY OR I.SC IDENTIFYING NORMATION) D 113 A recheck of the water temperatures on 12/8/15 revealed: - At 8: 10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit At 8: 15am, the water temperature in the whitipool tub was 84 degrees Fahrenheit At 8: 15am, the water temperature in the whitipool tub was 84 degrees Fahrenheit. Confidential interview with a resident revealed: - The temperature of the whiripool tub was too cold, and had been that way for about 2 months The resident had arbritis, and the whiripool tub helped the arthritis pain The resident had toold the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: - He was unaware of the low water temperatures in those bathrooms The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater No resident had complained to him about hot water temperatures Interview with the facility Director on 12/7/15 at 2-47pm revealed no resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS.CITY, STATE. ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28881 INTERIOR SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CHOCATORY OF LISE DEFINITION OF PREPIX TAYLOR DEFINITION OF THE PREPIX				7 ti Boilebii (o			
ALEXANDER ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY D113 Continued From page 3 D 113 A recheck of the water temperature on 12/8/15 revealed: - At 8:10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit. - At 8:13am, the water temperature in the whiritpool tub was 82 degrees Fahrenheit. - At 8:13am, the water temperature in the whiritpool tub was 84 degrees Fahrenheit. - Confidential interview with a resident revealed: - The temperature of the whiritpool tub was too cold, and had been that way for about 2 months The resident had arthritis, and the whirlpool tub helped the arthritis pain. - The resident had told the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: - He was unaware of the low water temperatures in those bathrooms The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater No resident had complained to him about hot water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed no resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs			hal002004	B. WING		12/14	1/2015
TAYLORSVILLE, NC 28681 (CA) ID SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG D PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 113 Continued From page 3 A recheck of the water temperatures on 12/8/15 revealed: - At 8:10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit At 8:13am, the water temperature in the whirlpool tub was 82 degrees Fahrenheit At 8:16am, the water temperature in the whirlpool tub was 84 degrees Fahrenheit At 8:16am, the water temperature in the whirlpool tub was 84 degrees Fahrenheit The resident had arthritis, and the whirlpool tub helped the arthritis pain The resident had fold the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: - The twas unaware of the low water temperatures in those bathrooms The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater No resident had complained to him about hot water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed or resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
NATION D SUMMARY STATEMENT OF DEPCIENCIES D PROFIDE PROVIDER'S PLAN OF CORRECTION OXIO PREFIX TAG	ΔΙ ΕΧΔΝΩ	ER ASSISTED I IVING	3032 N C I	HIGHWAY 16 S	ОТН		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 113 Continued From page 3 A recheck of the water temperatures on 12/8/15 revealed: - At 8: 10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit. - At 8: 13am, the water temperature in the sink of the bath with the whirlipool tub was 82 degrees Fahrenheit. - At 8: 15am, the water temperature in the whirlipool tub was 82 degrees Fahrenheit. - Confidential interview with a resident revealed: - The temperature of the whirlipool tub was too cold, and had been that way for about 2 months. - The resident had arthritis, and the whirlipool tub helped the arthritis pain. - The resident had told the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: - He was unaware of the low water temperatures in those bathrooms. - The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater. - No resident had complained to him about hot water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed no resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs	TAYLORS			/ILLE, NC 286	81		
A recheck of the water temperatures on 12/8/15 revealed: At 8:10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit. At 8:13am, the water temperature in the sink of the bath with the whirlpool tub was 82 degrees Fahrenheit. At 8:16am, the water temperature in the whirlpool tub was 84 degrees Fahrenheit. Confidential interview with a resident revealed: The temperature of the whirlpool tub was too cold, and had been that way for about 2 months. The resident had arthritis, and the whirlpool tub helped the arthritis pain. The resident had told the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: He was unaware of the low water temperatures in those bathrooms. The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater. No resident had complained to him about hot water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed or resident had complained about the water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed no resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
revealed: - At 8:10am, the water temperature in the women's half bath sink was 82 degrees Fahrenheit. - At 8:13am, the water temperature in the sink of the bath with the whirlpool tub was 82 degrees Fahrenheit. - At 8:16am, the water temperature in the whirlpool tub was 82 degrees Fahrenheit. - At 8:16am, the water temperature in the whirlpool tub was 84 degrees Fahrenheit. Confidential interview with a resident revealed: - The temperature of the whirlpool tub was too cold, and had been that way for about 2 months. - The resident had arthritis, and the whirlpool tub helped the arthritis pain. - The resident had told the facility director but was not sure of the exact date. Interview with the facility Administrator on 12/7/15 at 2:45pm revealed: - He was unaware of the low water temperatures in those bathrooms. - The facility had 5 different hot water heaters and he believed those two affected bathrooms were on the same hot water heater. - No resident had complained to him about hot water temperatures. Interview with the facility Director on 12/7/15 at 2:47pm revealed no resident had complained about the water temperatures and a plumber would be called to correct the problem. Review of the facility's water temperature logs	D 113	Continued From page	e 3	D 113			
revealed: - On 8/19/15 at 4pm, the water temperatures in		revealed: - At 8:10am, the wate women's half bath sin Fahrenheit At 8:13am, the wate the bath with the whir Fahrenheit At 8:16am, the wate whirlpool tub was 84 c. Confidential interview - The temperature of cold, and had been the The resident had art helped the arthritis parange. The resident had too not sure of the exact cold. Interview with the fact at 2:45pm revealed: - He was unaware of in those bathrooms The facility had 5 diff he believed those two on the same hot water. No resident had con water temperatures. Interview with the fact 2:47pm revealed no resident had con water temperatures. Review of the facility's revealed:	r temperature in the sink of Ipool tub was 82 degrees or temperature in the sink of Ipool tub was 82 degrees or temperature in the degrees Fahrenheit. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was date. I with a resident revealed: the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the whirlpool tub was too hat way for about 2 months. Ithritis, and the way for about 2 months. Ithritis, and the way for about 2 months. I have a second a months and the way for				

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Fahrenheit.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		h = 1000004	B. WING		404	14/0045
		hal002004			12/1	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	ОИТН		
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
D 113	Continued From page	e 4	D 113			
	- On 9/9/15 at 6pm, th	ne water temperatures in the				
		were both 100 degrees				
	Fahrenheit.					
	- On 10/12/15 at 7:30	pm, the water temperatures				
	in the whirlpool tub ar					
	degrees Fahrenheit.					
	•	, the water temperatures in				
	-	sink were both 95 degrees				
	Fahrenheit.	· ·				
	- On 12/7/15 at 8pm, the water temperatures in					
	the whirlpool tub and sink were both 80 degrees					
	Fahrenheit, with a no	tation stating, "possible				
	heating element malf	unction, will recheck on				
	12/8/15."					
	Review the water tem	perature logs revealed the				
		ne women's half bath was				
	not monitored.					
	Confidential interview	with facility staff revealed:				
	- She assisted reside	nts with baths in the				
	whirlpool tub, and the	water temperatures did not				
	feel cool to the touch.					
		r complained about the				
	,	although 1 resident in				
	particular would like t					
		"a while to recover, about				
	·	another resident had just				
	taken a shower.					
	Intonvious with the plan	mbor on 12/0/15 at 0:20am				
	revealed:	mber on 12/9/15 at 9:30am				
		s not operating properly.				
		the affected water heater				
		and was replaced today.				
	saarj sorrousu u					
	A recheck of the water	er temperatures on 12/9/15				
	revealed:	•				
	- At 10:50am, the hot	water temperature in the				
		ub bath was 106 degrees				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDTEAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMI LETED	
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	/ILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 113	Continued From page	e 5	D 113			
	whirlpool tub was 108 - At 10:58am, the hot	water temperature in the degrees Fahrenheit. water temperature in the half bath was 104 degrees				
D 131	D 131 10A NCAC 13F .0406(a) Test For Tuberculosis		D 131			
	(a) Upon employment home, the administration any live-in non-reside tuberculosis disease in measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, In This Rule is not met Based on interviews a facility failed to assure 5 sampled staff (Staff tuberculosis disease)	and record reviews the e that upon employment 1 of				
		mployment record revealed:				
	Aide (MA)A "Record of Tubercontained documenta	12/26/14 as a Medication ulosis (TB) testing" form tion of a TB test being				
	administered on 5/28 documented results.	rio, dul there was no				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		hal002004	B. WING		12	2/14/2015
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N	ADDRESS, CITY, STATE C HIGHWAY 16 SOU RSVILLE, NC 28681	JTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 131	revealed: -Staff D had one TB employed at the faci never been documer -It was the responsit TB testing was perfor Review of facility's p -The 2 step process intra-dermal tubercut for persons who can negative TST within the first reading is no in 2-3 weeks, and re	o revealed: It on 5/28/15. It on 5/2	D 131			
D 176	(a) An adult care ho responsible for the to home and shall also Division of Health Se county department of and maintaining the The co-administrator share equal respons for the operation of the	1 (a) Management Of 1Management Of Facilites me administrator shall be otal operation of an adult care be responsible to the ervice Regulation and the f social services for meeting rules of this Subchapter. The when there is one, shall ibility with the administrator he home and for meeting rules of this Subchapter.	D 176			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
		hal002004	B. WING		12/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 176	Continued From page	2 7	D 176			
	The term administrator co-administrator when Subchapter.					
	This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, fire drills, water temperatures, tuberculosis testing of staff, resident assessments, personal care and supervision, activities, exploitation, controlled drug record keeping, reporting to the Health Care Personnel Registry (HCPR), and reporting to pharmacy.					
	The findings are:					
	revealed: -The Administrator wa about twice a weekThe Administrator wa careThe Administrator ro	ector on 12/14/15 at 4:07pm as present in the facility as not involved with resident utinely delegated and responsibilities to the				
	5:00pm revealed: -He was in the facility -"I oversee the total o	2 to 3 days per week. perations of the facility."				
	survey were:	nce identified during the				
	A. Based on observat	ions, interviews, and record				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		hal002004	B. WING		12	2/14/2015
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N C	DDRESS, CITY, STATE HIGHWAY 16 SOU			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 176	reviews the facility faithe fire plan were pershift in accordance w local Fire Prevention [Refer to D 101, 10A For Evacuation] B. Based on observarinterviews, the facility temperatures were m sinks used by resider degrees Fahrenheit. [I 13F .0311(d) Other R C. Based on interview facility failed to assure 5 sampled staff (Staff tuberculosis disease measures adopted by Services. [Refer to D .0406(a) Test For Tuber 14 residents (#1, #2, and #13) were compliadmission and at least an assessment instruction Department or an ins Department or an ins Department. [Refer to .0801(b) Resident As	led to assure rehearsals of formed quarterly on each ith the requirement of the Code Enforcement Official. NCAC 13F .0309(b)(c) Plan tions, record reviews, and a failed to assure hot water a intained at 1 tub and 2 ants at a minimum of 100 Refer to D 113, 10A NCAC requirements] I was and record reviews the each that upon employment 1 of a failed to a failed for in compliance with control of the Commission for Health 131, 10A NCAC 13F recording the eassessments for 9 out of #3, #4, #6, #9, #10, #12, eted within 30 days following stannually thereafter using the interest of the established by the trument approved by the required on the established D 254, 10A NCAC 13F	D 176	DEFICIENT	CY)	
	facility failed to provious sampled residents (R demonstrated sexual towards 2 residents (le supervision for 1 of 14				

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PRINTED: 01/08/2016 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		hal002004	B. WING		12	2/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
AL EVAND	NED ASSISTED LIVING	3032 N C	HIGHWAY 16 SOU	ІТН		
ALEXANL	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 176	Continued From page	9	D 176			
	Personal Care and Su Violation.)]	upervision, (Type B				
	reviews, the facility fa 14 hours of planned gwere scheduled that i promote socialization accomplishment, creaknowledge and learni 317, 10A NCAC 13F. G. Based on observareviews, the facility faresident shall have thin at least one outing D 319, 10A NCAC 13 Program] H. Based on observation.	, physical interaction, group attive expression, increased ng of new skills [Refer to D .0905(d) Activities Program] tions, interviews, and record iled to assure that each e opportunity to participate every other month. [Refer to				
	exploitation by diversi medications by staff.	(Zolpidem 10mg and Norco 8, 10A NCAC 13F .0909				
	interviews, the facility accountability of control the failure to assure a receipt, administration controlled drugs for 4 sampled residents. [R	rolled drugs as evidenced by accurate records of the				
	interviews, the facility	ions, record reviews and failed to report suspected I drug medications by staff				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO			
	CLIMMADY CT		VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 176	Continued From page	: 10	D 176			
	to the dispensing pharmacy for 2 of 6 (#1 and #5) sampled residents. (Zolpidem 10mg and Norco 5/325.) [Refer to D 399, 10A NCAC 13F .1008(h) Controlled Substances]					
	interviews, the facility report 3 suspected sta Staff H) who had alled diversion to the Healt	ions, record reviews and failed to investigate and aff (Staff A, Staff G, and gations of controlled drug h Care Personnel Registry 138, 10A NCAC 13F .1205 el Registry, (Type B				
	A Plan of Protection was submitted by the facility on 12/14/15 that included: -The Administrator will take a more detailed involvement in the management of the facility. -The Administrator will work to correct the items that are out of compliance, to get them into compliance, and stay in compliance. -The Administrator will continue to monitor all areas to maintain and protect the residents from harm. -The Administrator will work with the Director to ensure the residents are kept safe at all times. DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2016.					
D 254	10A NCAC 13F .0801	(b) Resident Assessment	D 254			
		nd at least annually				

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PRINTED: 01/08/2016 FORM APPROVED

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
			B. WING			
		hal002004	D. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
	CUMMA DV CT				NI	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
D 254	Continued From page	. 11	D 254			
D 204	Continued From page	, 11	5 254			
		epartment or an instrument				
	approved by the Depa	artment based on it				
	containing at least the	e same information as				
	required on the estab	lished instrument. The				
	assessment to be cor	npleted within 30 days				
	following admission a	nd annually thereafter shall				
	be a functional asses	sment to determine a				
	resident's level of fun	ctioning to include				
	psychosocial well-bei	ng, cognitive status and				
	physical functioning in activities of daily living.					
	Activities of daily living are bathing, dressing,					
	personal hygiene, am	bulation or locomotion,				
	transferring, toileting	and eating. The				
	assessment shall indi	cate if the resident requires				
	referral to the residen	t's physician or other				
	licensed health care	professional, provider of				
	mental health, develo	pmental disabilities or				
	substance abuse serv	vices or community				
	resource.	•				
	This Rule is not met	as evidenced by:				
	Based on interviews a	and record reviews, the				
	facility failed to assure	e assessments for 9 out of				
	14 residents (#1, #2,	#3, #4, #6, #9, #10, #12,				
	-	eted within 30 days following				
	admission and at least	st annually thereafter using				
		ment established by the				
		trument approved by the				
	•	it containing at least the				
		required on the established				
	instrument.					
	The findings are:					
		at #1's current FL2 dated				
		ignoses which included:				
	neuropathy. osteopor	osis, and depressive				
	disorder.					
		41				
	Review of Resident #	T's record revealed:				1

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 12 of 67

Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
			B. WING			
		hal002004	D. WING		12/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
	OLIMANA DV OT		· ·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 254	O	- 40	D 254			
D 254	Continued From page	e 12	D 254			
	-There was no curren	nt Resident				
	Assessment/Care Pla	an.				
	-An admission date of	f 6/23/09.				
	Interview with Reside	ent #1 on 12/07/15 at				
	10:00am revealed she	e required the use of a				
	wheelchair for ambula					
	Refer to interview with	h Director on 12/14/15 at				
	10:45am.					
	B. Review of Residen	nt #2's current FL2 dated				
	10/27/15 revealed dia	agnoses which included:				
		post traumatic stress				
	disorder.	•				
	Review of Resident #	2's Resident Register				
	revealed an admissio	on date of 8/01/09.				
	Review of Resident #	2's assessment and care				
	plan dated 2/13/14 re	vealed:				
	-She was verbally and	d physically abusive.				
	-She was injurious to	self and property.				
	-She received mental					
	medications for menta	al illness.				
	-Required limited ass	istance with toileting,				
	ambulation and groor					
		assistance with bathing and				
	dressing.					
	Ü					
	Refer to interview with	h Director on 12/14/15 at				
	10:45am.					
	C. Review of Residen	nt #3's current FL2 dated				
	6/2/15 revealed diagr	noses which included: mild				
	_	npulse control disorder,				
		lux disease, hypothyroidism,				
	seizure disorder and					
	contact and		1			

Division of Health Service Regulation

Review of Resident #3's Resident Register

STATE FORM 6899 ORHZ11 If continuation sheet 13 of 67

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		hal002004	B. WING		12/14/2015	5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 S			
			ILLE, NC 286		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMF	(5) PLETE ATE
D 254	Continued From page	e 13	D 254			
	revealed an admissio	n date of 8/24/07.				
	Review of Resident # assessment and care	3's record revealed an plan dated 10/13/14.				
	Refer to interview with 10:45am.	n Director on 12/14/15 at				
	revealed: -Diagnoses of parano					
	hypertension, and obe -An admission date of					
		4's record revealed there ent Assessment/Care Plan.				
	Refer to interview with 10:45am.	n Director on 12/14/15 at				
	E. Review of Residen revealed:	t #6's FL2 dated 3/12/15				
	-Diagnoses of schizoa mental retardation.	affective disorder and mild				
	Review of Resident # revealed an admission					
		6's record revealed there ent Assessment/Care Plan.				
	Refer to interview with 10:45am.	n Director on 12/14/15 at				
	revealed:	t #9's FL2 dated 10/26/15 ohrenia, insulin dependent I seizure disorder.				

Division of Health Service Regulation

Review of Resident #9's Resident Register

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Division c	<u>of Health Service Regu</u>	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILA	JF GOINLOTION	IDENTIFICATION NO.IIDETA.	A. BUILDING: _		OOMI LETED
		hal002004	B. WING		12/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SC		
	I		SVILLE, NC 2868	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 254	Continued From page	e 14	D 254		
	revealed an admissio	n date of 5/20/14.			
	Review of Resident # assessment and care	#9's record revealed an e plan dated 5/26/14.			
	revealed he was inde	ent #9 on 12/7/15 at 9:45am ependent with activities of d only required assistance			
	Refer to interview with 10:45am.	th Director on 12/14/15 at			
	revealed:	nt #10's FL2 dated 10/24/15			
	-Diagnoses of diabete retardation, and chror disease.	es mellitus, mental nic obstructive pulmonary			
	Review of Resident # revealed an admission	#10's Resident Register on date of 10/01/08.			
		#10's record revealed there lent Assessment/Care Plan.			
	Refer to interview with 10:45am.	h Director on 12/14/15 at			
		nt #12's current FL2 dated gnoses which included: ardation and major			
	Review of Resident # revealed an admission	#12's Resident Register on date of 3/01/08.			
	plan dated 10/13/14 r	#12's assessment and care revealed: usive at times, resisted care,			

and had disruptive behavior.

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, , ,	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	hal002004	B. WING		12/14/2015	
NAME OF PROVIDER OR SUPPLIER ALEXANDER ASSISTED LIVING	3032 N C F	DRESS, CITY, STA HIGHWAY 16 SO VILLE, NC 286	DUTH		
(X4) ID SUMMARY STATEMEI PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 254 Continued From page 15 -She required supervision of the received mental healt medications for mental illner required supervision with dressing, and transferringRequired limited assistant groomingRequired extensive assistant required extensive assistant groomingRequired extensive assistant required diagnoses intellectual disabilities, anxional depression. Review of Resident #13's revealed an admission date. Review of Resident #13's aplan dated 9/30/14 revealed. She received mental healt medications for mental illnershe required the use of a sambulation, but can ambulation, bathing, dressist transferring. Interview with Resident #13'10:40am revealed: -She required help getting in the required help getting in the required help using the other daily activities.	th services and ess. eating, ambulation, be with toileting, and ance with bathing. ector on 12/14/15 at securrent FL2 dated swhich included: mild iety and major Resident Register e of 9/11/14. assessment and care ed: th services and ess. wheelchair for ate short distances with eating. t with toileting, ing, grooming, and as on 12/07/15 at in and out of bed. asfers in and out of	D 254			

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 16 of 67

Division C	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B WING		
		hal002004	B. WING		12/14/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
			HIGHWAY 16 S	•	
ALEXAND	ER ASSISTED LIVING				
		IAYLORS	VILLE, NC 286	81	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGOLATORI ORE	100 IDENTIFY THE INTORNATION	TAG	DEFICIENCY)	in i
				·	
D 254	Continued From page	e 16	D 254		
	Defeate intension with	h Diversion on 12/11/15 of			
		h Director on 12/14/15 at			
	10:45am.				
	1.6	10/44/45			
	Interview with the Dire	ector on 12/14/15 at			
	10:45am revealed:				
	-There were no other				
	-	lity to ensure assessments			
	and care plans were	completed on all residents.			
D 270	10A NCAC 13F .0901	(b) Personal Care and	D 270		
	Supervision				
	10A NCAC 13F .0901	Personal Care and			
	Supervision				
	(b) Staff shall provide	e supervision of residents in			
	accordance with each	n resident's assessed needs,			
	care plan and current	symptoms.			
	This Rule is not met	as evidenced by:			
	TYPE B VIOLATION				
	Based on interviews a	and record reviews, the			
	facility failed to provid	le supervision for 1 of 14			
	sampled residents (R	esident #7) who			
	demonstrated sexuall	y inappropriate behaviors			
		Resident #2 and Resident			
	#14).				
	•				
	The findings are:				
	-				
	Review of Resident #	7's current FL2 dated			
	6/24/2015 revealed:				
	-Diagnoses included a	autistic disorder, depression,			
		tuitary disorder, bipolar II			
		ficit hyperactivity disorder			

Division of Health Service Regulation

and sexual psychopathy.

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		hal002004	B. WING		12/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
41 = 3/41		3032 N C H	IGHWAY 16 S	ОИТН	
ALEXAND	ER ASSISTED LIVING	TAYLORSV	ILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 17	D 270		
	Review of Resident # revealed an admission Review of Resident # revealed there were meeds. Review of Nurse's Not revealed: -On 09/14/2015 "Resident From." -On 09/15/2015 "Resident From." -On 09/18/2015 "Resident From From On On One of the West From	7's resident register n date of 7/01/2015. 7's care plan dated 7/01/15 no assessed supervision otes for Resident #7 went into another res was told he couldn't be e." ident #7 was caught going a room during the snack stay out of everyone's room of upset and said everyone by took [named resident] on his room and was told not was caught 10 mins later in it in a stay of the share to the the share t			
		ation of any other sexually or. In the Director and			

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Interview with Resident #7 on 12/08/2015 at

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			7.1. 50.125.1.10.			
		hal002004	B. WING		12/14/20	15
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S			
	OUR MARY OF		ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CC	(X5) DMPLETE DATE
D 270	Continued From page	e 18	D 270			
	breakdown" because "picking on him and c -Since he returned fro	alling him names." om the hospital his behavior ad not been stealing things,				
	12/09/2015 at 12:00p -Resident #7 was living since 2002, but did has another assisted living -Resident #7 needed could not provide at has -The Director had call been a behavioral income.	ng at home most of the time have one failed placement at g facility. 24 hour care which she home. led her each time there had hident with Resident #7. hident had improved since his				
	been notified by the fa	y care provider had not acility about his behaviors. noident reports completed				
	10/27/2015 revealed: -Diagnoses included post-traumatic stress -She required limited and transfers.	nt #2's current FL2 dated major depression and disorder. assistance with ambulation dision with toileting, bathing,				
	Review of Resident # admission date of 8/0	2's record revealed an 1/09.				
	Interview with Reside	nt #2 on 12/8/2015 at				

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	,
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		hal002004	B. WING		12/14/201	5
NAME OF D	ROVIDER OR SUPPLIER	CTDEET A	DDRESS, CITY, STAT	E ZIR CODE	•	
NAME OF FI	NOVIDER OR SUFFLIER		HIGHWAY 16 SO			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 2868			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N ,	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE CON	MPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 270	Continued From page	e 19	D 270			
	11:45am revealed:					
		bbed her right breast and				
		her head around and kissed				
	her open mouthed.	Tion from a round and mood				
	•	ed on the porch at the				
	facility.	·				
	-She felt degraded ar	id angry.				
	-She notified the Adm	inistrator on Monday				
	morning (10/05/15) fo	llowing the incident.				
	-The Administrator an	d Director "did not do				
		olded Resident #7 and told				
	him to leave the wom					
		d not ask her about notifying				
	Law Enforcement.					
		local law enforcement.				
	the incident between	ent filled out papers about				
		alked to "by local law appropriate behaviors.				
		by local law enforcement if				
		he would be charged with				
	sexual harassment.	no weard be charged with				
	Interview with Reside	nt #7 on 12/08/15 at 2:56pm				
	revealed:					
	-"I kissed her on the f	orehead."				
		er and going too far with it,				
	too passionate"					
		e it into a relationship."				
	-"I am not supposed t	o get close to her"				
	Interview with Reside	nt #7's family member on				
	12/09/2015 at 12:00p					
	-	vas aware of an incident				
	between Resident #7					
		gave details of the incident,				
		esident #7 kissed Resident				

#2 without consent and touched her breast.

Interview with local law enforcement on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		hal002004	B. WING		12	2/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
ALEXANI	DER ASSISTED LIVING		HIGHWAY 16 SC SVILLE, NC 2868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Resident #2's leg and -Resident #7 stated have resident #7 said he put his hand on her k stopped. -The officer met with #7 and told them to k themselves and to average an	m revealed: ns that Resident #7 touched d kissed her. he had kissed her. tried to kiss Resident #2 and nee, but she said "no" and it Resident #2 and Resident heep their hands to hoid unwanted touching horid unwanted touching have of any incidents hers. Sident #2's record revealed hertation of the incident with have measures taken to keep The Director and her H2's record revealed hertation of the incident with her measures taken to keep The Director and her H2's at 3:50 pm. The H14 current FL2 dated The Director and her H14 current FL2 dat	D 270			

Division of Health Service Regulation

- Resident #14 had severe dementia and "would

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
ΑΙ ΕΧΑΝΠ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		TAYLORS	SVILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	21	D 270			
	-The incidents were wand the Director was Resident #7 was tryin #14.	I you if you would let her." vritten up in Nurse's Notes notified about the fact that ng to have sex with Resident				
	12/09/2015 at 12:00p -The family member v between Resident #7	was aware of an incident				
	found in bed with Res -The family member s the mind of a child an him that she loved hir					
	wayThe family member s	stated that Resident #14 is a everyone that she loves				
	that any harm occurred -The family member s	stated that she was upset ed to Resident #14. stated that Resident #7 did lent #14's diagnosis of				
	"that man" on the hea -The resident's roomr hug Resident #14.	evealed: ot recall any recent or touching. ating she had been hit by ad. mate had seen Resident #7				
	Refer to interview with Administrator on 12/0					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		hal002004	B. WING		12	2/14/2015
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N	ADDRESS, CITY, STATE C HIGHWAY 16 SOU RSVILLE, NC 28681	ITH		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	12/08/2015 at 3:50p -Resident #7 "sits in has the "mind of a c anybody." -Resident #7 "had to inappropriate behav after the incidents or -Resident #7 was m occurred, from one or so that staff could m -They denied that R residents hands or h -There were no other On 12/08/2015, the plan of protection: -Staff will monitor Rollocation and the safe -Resident #7 will be interactions with oth -Staff will do hourly -Resident #7 will no uninvitedThe Director will ho ensure each Reside -The Director will so staff from a mental h THE CORRECTION	irector and Administrator on m revealed: his room and masturbates"; hild"; and "never bothered be talked to about what ior is, and given examples" ccurred. oved, after the incidents end of the facility to the other, ionitor his actions at all times. esident #7 ever held any nugged any residents. er incidents reported. facility provided the following esident #7 to ensure his ety of other residents. given education on proper er residents. checks on Resident #7. It enter other resident rooms and monthly meetings to int's needs. hedule monthly training for	D 270			
D 317		05 (d) Activities Program 05 Activities Program	D 317			

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PRINTED: 01/08/2016 FORM APPROVED

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	or periornore		(VO) MULTIPLE	CONCEDUCTION	TWO DATE OUR VEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	5. 55.u.25.u.	152.11.11.15.	A. BUILDING: _		33
		hal002004	B. WING		12/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			HIGHWAY 16 SO	•	
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286		
	OUR MAR DV OT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	
				DEFICIENCY)	
D 317	Continued From page	23	D 317		
D 011	Continued From page	5.25	5017		
	` '	minimum of 14 hours of a			
	, ,	oup activities per week that			
		promote socialization,			
	' '	group accomplishment,			
		ncreased knowledge and			
	learning of new skills.				
	-	nts with HIV disease are			
		uirement as long as the			
	facility can demonstra	· ·			
		nt in a variety of activities.			
		ctivities are group singing,			
		cise classes, seasonal			
	council meetings, boo	oups, drama, resident			
	appreciation, review of				
	spelling bees.	or current events and			
	spenning bees.				
	This Rule is not met	as evidenced by:			
		ns, interviews, and record			
	reviews, the facility fa	iled to assure a minimum of			
	14 hours of planned of	group activities per week			
	were scheduled that i	nclude activities that			
	promote socialization	, physical interaction, group			
	accomplishment, crea	ative expression, increased			
	knowledge and learni	ng of new skills			
		residents during tour on			
	12/07/15 revealed:				
		watch football, but there			
	was "nothing to do he				
		ted, "there were no activities			
	here, and they haven calendar since I've be				
		een nere." ted "we don't have any			
	activities, we need so				
	-Another resident stat				
		ted, "sometimes we play			
		e singing and dancing."			
		ted "the activity board is			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14/2015	
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIR CODE	12/14/2013	
			HIGHWAY 16 SO			
ALEXANDER ASSISTED LIVING TAYLORS			SVILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 317	Continued From page	e 24	D 317			
	empty, there have be for the past 2 months -"We don't do anythin come anymore, it all s -"Sometimes we do p -The staff that was re had PCA duties and v transportation. Confidential interview -The facility was not p activities per weekThe activity director of activitiesThe activity director of activitiesThe activity director of activitiesThe activity director of scheduled on the activity play games such on some outings"They play games such on some outings"They just went to the "Birthday parties stop on 12/10/15 at 12:17p -There were no activity the hallway of the factor of the calendar was blated on the resident of the calendar was blated on the resident of the resident of the participant of the resident of the resident of the past of	en no activities or outings " g here, the churches don't stopped in August." uzzles." sponsible for activities now was responsible for s with staff revealed: providing 14 hours of was responsible for also worked as a personal ed transportation for tried to do what was vity calendar. ch as bingo, exercise and go se local Christmas parade." ber 2015 activity calendar om revealed: ties listed on the calendar in illity. ank. 1/15 at 10:00am revealed a pol group brought gifts and sidents. 201 12/10/15 at 12:30pm as were playing board games ving room.				
	Interview with the Dire	ector on 12/14/15 at 4:07pm				

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revealed:

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC SVILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 317	Continued From page	e 25	D 317			
	facilityActivities included: b local retail stores, cor-Recent activities incl	ovided transportation for the irthday parties, outings to				
D 319	10A NCAC 13F .0905	5 (f) Activities Program	D 319			
	10A NCAC 13F .0905	5 Activities Program				
	participate in at least					
	reviews, the facility fa	ns, interviews, and record illed to assure that each e opportunity to participate				
	12/07/15 revealed: -One resident stated, work, have to use the -Another resident stat store in 4 months."	"The lift on the van does not hand crank." ted, "I've not been to the taken to the Christmas				

the van.

Parade this year, but they only made one trip with

STATE FORM 6899 ORHZ11 If continuation sheet 26 of 67

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING			
		hal002004	B. WING		12/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			IIGHWAY 16 S			
ALEXAND	ER ASSISTED LIVING					
		IAYLURS	/ILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG REGULATORY OR		LOG IDENTIFICATION OF THE PROPERTY.	TAG	DEFICIENCY)		
				·		
D 319	Continued From page	e 26	D 319			
		its in wheelchairs "you can't				
	go" because the lift w					
		ted, "there were no activities				
	here, and they haven	•				
	calendar since I've be					
		ted "the activity board is				
		en no activities or outings				
	for the past 2 months."					
	-Another resident stated "we don't have any					
	activities, we need so	mething to do."				
	-Another resident stat	ted "the lift on the van is				
	broken, so residents t	that use wheelchairs cannot				
	go on outings."					
	-"We don't do anythin	ig here, the churches don't				
	come anymore, it all s	stopped in August."				
	-The staff that was re-	sponsible for activities also				
	worked as a personal	care aide (PCA) and was				
	also responsible for tr	ransportation.				
	•	·				
	Confidential interview	s with facility staff revealed:				
	-The activity director	was responsible for				
	activities.	•				
	-The activity director a	also worked as a PCA and				
	provided transportation					
	-The activity director t					
	scheduled on the acti					
		ch as bingo, exercise and go				
	on some outings.	on de omige, enercies and ge				
		on any outings in a long				
	time."					
		white transport van was				
	"totally broken now."	The danoport van was				
		e local Christmas parade."				
	They just went to the	c local Officialitàs parace.				
	Review of the Decem	ber 2015 activity calendar				
	on 12/10/15 at 12:17	<u> </u>				
	-	gs listed on the calendar in				
	-	=				
	the hallway of the fac	IIILY.	1			

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-The calendar was blank.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ΓE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 319	Continued From page	: 27	D 319			
	revealed: -A PCA was responsil provided transportation -Activities included: but local retail stores, cornor - "Whoever wants to go have 2 vans." - "Both vans are availated on the van works." - Residents requiring various go on outings There is only one results of the lift on the vance of the	arthday parties, outings to supply the state of the continuous parties, and the lift wheelchairs are allowed to sident that would require the an for outings. Suded a trip to the Christmas many [residents] wanted to supply the continuous parties of the				
D 338	know." -"I will send it to the s -There is only one resuse of the lift on the v -"Some people [staff] van [large van with lift -The Administrator wathe van. 10A NCAC 13F .0909 An adult care home s all residents guarante	ident that would require the an for outings. don't like to drive the white i.j." as responsible for repairs on Resident Rights Resident Rights hall assure that the rights of ed under G.S. 131D-21, nts' Rights, are maintained	D 338			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14/2015
ALEXANDER ASSISTED LIVING 3032 N C			DRESS, CITY, STA	DUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	This Rule is not met TYPE B VIOLATION Based on observation interviews, the facility sampled residents (# exploitation by diversimedications by staff. 5/325.) The findings are: A. Review of Residen 7/14/15 revealed: -Diagnoses included depression, congestive fibrillationA medication order for tablets every 6 hours (Acetaminophen is armild to moderate pain -An admission date on Review of Resident #-A medication order of 5/325 (Hydrocodone tablets, 1 tablet every (Norco is a controlled moderate to severe p-Standing orders date Acetaminophen 325m as needed for pain, h Observation of Resident -No Hydrocodone 5/3 administer to Resident -No Hydrocodone 5/3 administer to Resident -No Re	as evidenced by: as, record reviews and failed to assure 2 of 6 1 and #5) were free from ion of their controlled (Zolpidem 10mg and Norco at #5's current FL2 dated dementia, anxiety, we heart failure, and atrial or Acetaminophen 500mg, 2 as needed for pain. analgesic used to treat a.) f 2/27/15. 5's record revealed: ated 10/1/15 for Norco //Acetaminophen 5/325) 180 4 hours as needed for pain. drug used to treat ain.) dd 10/21/15 for ng, 2 tablets every 4 hours eadache, or fever. ent #5's medications on 10:10am revealed: 25mg tablets available to	D 338		

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	or riealth Service Regu		T 0.21 1 11 11 21 21 2			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COWIFE	ETED
		hal002004	B. WING		12/1	4/2015
		1101002004			1 12/1	4/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C I	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS	/ILLE, NC 286	81		
	CLIMMA DV CT				.1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 000	0 " 15	00	D 000			
D 338	Continued From page	29	D 338			
	Interview with the pha	armacist at the pharmacy				
	provider on 12/10/15					
	-They had sent all 180					
	-	ninophen 5/325 to the facility				
	in October 2015.	intoprien 5/323 to the facility				
		during account also ata fair				
		drug count sheets for				
		odone/Acetaminophen				
	5/325.					
	-The facility had not returned any Hydrocodone/Acetaminophen 5/325 to the					
	pharmacy for Resider	nt #5.				
		5's electronic Medication				
		d (eMAR) for October,				
	November, and Dece	mber 2015 revealed 25				
	tablets of Hydrocodor	ne/Acetaminophen 5/325				
	documented as admir	nistered.				
	Review of Resident #	5's electronic Medication				
	Administration Record	d (eMAR) for December				
	2015 revealed the Hy	drocodone/Acetaminophen				
	5/325mg was docume	ented as administered on				
	_	and 12/10/15 at 2:10am.				
	Review of Resident #	5's electronic Medication				
	Administration Record	d (eMAR) for November				
		drocodone/Acetaminophen				
	-	ented as administered on				
	•	1/10/15 at 11:51am, 11/12/15				
	at 11:55am, and 11/20					
	Review of Resident #	5's electronic Medication				
		d (eMAR) for October 2015				
	revealed:	a (CIVIAIT) IOI OCIODEI 2013				
		cetaminophen 5/325mg was				
		-				
		nistered on 10/2/15 at				
		1:46am, 10/4/15 at 7:33pm,				
		0/6/15 at 1:53pm, 10/7/15 at				
	•	42pm, 10/10/15 at 11:39am,				
	10/10/15 at 9:59pm, 1	10/11/15 at 4:39pm,				

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DIVISION	of Health Service Regu	lation	_		,		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		h - 1000004	B. WING		1 404	4/004=	
		hal002004	B. WING		12/14	4/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
			HIGHWAY 16 SO				
ALEXAND	ER ASSISTED LIVING						
		IATLORS	VILLE, NC 286	81			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE	
TAG	NEODEATORT OR I	100 IDENTIL TING IN GRAMATION)	TAG	DEFICIENCY)	WATE		
D 338	Continued From page	e 30	D 338				
	404045 4004	10/10/15					
	10/12/15 at 2:04pm, 1	•					
	10/16/15 at 9:45pm, 1	•					
	10/18/15 at 11:47am,	• •					
	10/29/15 at 3:27pm, 1	10/30/15 at 9:25am, and					
	10/30/15 at 3:28pm.						
	Review of Resident #	5's controlled drug count					
	sheet for the Hydroco	done/Acetaminophen 5/325					
	revealed:	•					
		g sheet available from					
		10/15 in the facility, with 15					
	tablets noted as deliv	•					
		count sheet was handwritten					
	by medication aide st						
	-Fifteen tablets of Hyd						
		nistered on the following					
	dates; 2 tablets on 10						
	10/17/15, 1 tablet on						
		10/30/15, 1 tablet on					
		1/6/15, 1 tablet on 11/10/15,					
	1 tablet on 11/12/15,	1 tablet on 11/26/15, 1 tablet					
	on 12/3/15, and 1 tab	let on 12/10/15.					
	Interview with the Me	dication Aide (MA) on					
	12/10/15 at 10:15am	revealed:					
	-She was not aware o	of any other					
		ninophen 5/325 tablets					
	available in the facility	•					
	-	nat happened to Resident					
	#5's other tablets of	P.P					
	Hydrocodone/Acetam	ninophen 5/325					
	•	nat happened to the other					
		sheets for Resident #5's					
	Hydrocodone/Acetam						
		count sheets are placed in a					
	•	•					
	wire basket just outsi	de the facility office for filing.					
	Interview with Reside	nt #5 on 12/10/15 at					

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11:28am revealed:

-He was not sure what pain medications he took.

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			D WING			
		hal002004	B. WING		12/14/	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	NOVIBER OR OUT FEET					
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	VILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DAIL
D 338	Continued From page	e 31	D 338			
	Lle equid pet recall e	ny inaidanasa of unraliayad				
		ny incidences of unrelieved				
	pain.					
	-	nedications when he asked				
	for them.					
		ne MA on 12/10/15 at				
	3:40pm revealed:					
	-She understood Res	ident #5's pain medications				
	based on how he ask	ed for them.				
	-"When Resident #5 a	asked for two little white				
	pills, he wanted Tylen	ol."				
	-"When he asked for	a little white pill, (MA				
		of two fingers showing the				
		meant the Hydrocodone."				
	0120 01 110 1001017, 110	mount the right occurre.				
	Interview with the faci	ility Director on 12/10/15 at				
		was unaware of Resident				
	#5's missing tablets o					
	<u> </u>					
	Hydrocodone/Acetam	iinophen 5/325.				
	Interview with the san	no MA on 12/10/15 of				
	5:10pm revealed:	THE WIA OIT 12/10/13 at				
	•	the only available controlled				
		Resident #5's Hydrocodone				
	•	•				
	at the request of the I					
		atrolled drug count sheets				
		sident #5's Hydrocodone.				
		ne controlled drug count				
		ere was only one cassette				
	of 15 Hydrocodone ta	blets available for Resident				
	#5.					
		delivery sheets faxed to the				
	facility on 12/10/15 re					
	-60 tablets of Hydroco	odone/Acetaminophen 5/325				
	for Resident #5 were	sent to the facility on				
	10/1/15 and signed for	or by Staff B, a Personal				
	Care Aide (PCA) at 2:	-				
		codone/Acetaminophen				

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5/325 for Resident #5 were sent to the facility on

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NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TATALORS/LILE, NC 28881 NAME OF PROVIDER'S PLAN OF COMPRECTION NAME OF PROVIDER'S PLAN OF COMPRECTION (PACH DESCRIPTION OF MUST SEE PRECEDED BY FULL TATALORS/LILE, NC 28881 D PROVIDER'S PLAN OF COMPRECTION OF DEPOSITENCES (PACH DEPOSITED BY TALL TATALORS/LILE, NC 28881 D PROVIDER'S PLAN OF COMPRECTION OF DEPOSITENCES (PACH DEPOSITED BY TALL TATALORS/LILE, NC 28881 D PROVIDER'S PLAN OF COMPRECTION OF DEPOSITENCES (PACH DEPOSITENCE ACTION SPOULD BY TAKE OF	Division of	<u>of Health Service Regu</u>	lation			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 72P CODE 3022 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681 SUMMAY STATEMENT OF DEPTICIENCES 102 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681 SUMMAY STATEMENT OF DEPTICIENCES BY PULL PREFER CROSS REFERENCES TO THE APPROPRIATE TAG D 338 CONTINUED FROM page 32 D 338 Continued From page 32 D 338 Continued From page 32 D 338 Continued From page 32 D 338 Continued From page 32 D 338 Continued From page 32 D 338 The Statement had details about medications sent. Including the name of the drug and the number of lablets sent. Interview with Staff B on 12/11/15 at 11/45pm revealed: The Hydrocodone/Acetaminophen 5/325 was here in the facility when she checked them in on 10/1/15 and 10/2/15. Some typed controlled drug count sheets from the pharmacy came in with the Hydrocodone/Acetaminophen 5/325, but she was not sure how many. After she checked in the controlled drugs on the morring of 10/1/15 and 10/2/15 she placed the plastic bags containing the controlled drugs in the locked medication room. Then were a bunch of cassettes* of Resident #55 Hydrocodone/Acetaminophen 5/325. After she placed them in the medication room. Staff B was not sure what happened to Resident #55 Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication room. Staff B was not sure what happened to Resident #55 Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: Each cassette of medications can hold up to 16 tablets. 180 tablets of Hydrocodone/Acetaminophen 5/325.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JP CODE 332 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28881 PROVIDER'S LAND CORRECTION PREPRINT OF DEPICIENCES PART OF DEPICE PART OF DEPACE P	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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Hydrocodone/Acetaminophen 5/325, but she was not sure how many. -After she checked in the controlled drugs on the morning of 10/1/15 and 10/2/15 she placed the plastic bags containing the controlled drugs in the locked medication room. -The MAs and Director had keys to the medication room. -There were a "bunch of cassettes" of Resident #5's Hydrocodone/Acetaminophen 5/325. -After she placed them in the medication room, Staff B was not sure what happened to Resident #5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets. -180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		-Some typed controlle	ed drug count sheets from			
not sure how many. -After she checked in the controlled drugs on the morning of 10/1/15 and 10/2/15 she placed the plastic bags containing the controlled drugs in the locked medication room. -The MAs and Director had keys to the medication room. -There were a "bunch of cassettes" of Resident #5's Hydrocodone/Acetaminophen 5/325. -After she placed them in the medication room, Staff B was not sure what happened to Resident #5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets. -180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		the pharmacy came in	n with the			
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morning of 10/1/15 and 10/2/15 she placed the plastic bags containing the controlled drugs in the locked medication room. -The MAs and Director had keys to the medication room. -There were a "bunch of cassettes" of Resident #5's Hydrocodone/Acetaminophen 5/325. -After she placed them in the medication room, Staff B was not sure what happened to Resident #5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets. -180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		not sure how many.				
plastic bags containing the controlled drugs in the locked medication room. -The MAs and Director had keys to the medication room. -There were a "bunch of cassettes" of Resident #5's Hydrocodone/Acetaminophen 5/325. -After she placed them in the medication room, Staff B was not sure what happened to Resident #5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets. -180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12						
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#5's Hydrocodone/Acetaminophen 5/325. -After she placed them in the medication room, Staff B was not sure what happened to Resident #5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12						
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#5's Hydrocodone/Acetaminophen 5/325. Observation of the facility's medication delivery system revealed: -Each cassette of medications can hold up to 16 tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12						
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system revealed: -Each cassette of medications can hold up to 16 tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		#5's Hydrocodone/Ac	etaminophen 5/325.			
system revealed: -Each cassette of medications can hold up to 16 tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		Observation of the for	cility's medication delivery			
-Each cassette of medications can hold up to 16 tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12			cinty 3 medication delivery			
tablets180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12		,	dications can hold up to 16			
-180 tablets of Hydrocodone/Acetaminophen 5/325 would require 11.25 cassettes of 16, or 12			dications can note up to 10			
5/325 would require 11.25 cassettes of 16, or 12			rodone/Acetaminonhen			
Loasselles of to labels each		cassettes of 15 tablet				

Based on review of controlled drug logs,

STATE FORM 6899 ORHZ11 If continuation sheet 33 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12	2/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE		
ALEXAND	DER ASSISTED LIVING		HIGHWAY 16 SC SVILLE, NC 2868			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	receipt and disposition observation of medical interviews, the facility tablets of Hydrocodor Refer to interview with 12/10/15 at 4:00pm. Refer to interview with at 5:10pm. Refer to interview with 12/10/15 at 5:45pm. B. Review of Resider 11/17/15 revealed: -Diagnoses included neuropathy, and osteration order for four guided to treat insubedtime as needed for the American date of Zolpidem 10mg with 11/24/15 and 16 tables. Review of Resident # Administration Record 2015 revealed Zolpid documented as admin 12/07/15. Review of Resident # 2015 revealed Zolpid.	ation records, records for the n of medications, ations on hand and could not account for 155 ne/Acetaminophen 5/325. In facility Director on the facility Administrator on Zolpidem (a controlled domnia) 10mg, 1 tablet at the facility and f	D 338			
	documented as admit 11/30/15.	nistered from 11/01/15 to				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC VILLE, NC 2868			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	: 34	D 338			
		1's eMAR for October 2015 lmg had been documented , 10/03/15.				
	2015 revealed Zolpide	1's eMAR for September em 10mg had not been nistered from 09/01/15 to				
	revealed two tablets of	1's eMAR for August 2015 of Zolpidem 10mg had been nistered on 08/28/15 and				
	sheet dated 4/17/15 frevealed: -Sixteen tablets noted-Eight tablets of Zolpidocumented as admirdates; 7/26/15, 8/28/1-Four tablets of Zolpidadministered on the con 9/11/15, 9/14/15, 9 were not documented as taken home on the 8/30/15, 2 on 10/07/1 an undated entryOne tablet of Zolpidas wasted on 11/19/1-One tablet of Zolpidathe controlled drug codocumentation was a signature of the MA, at the eMAR.	nistered on the following 15, 8/29/15, and 10/03/15. Idem were documented as controlled drug count sheet 10/27/15, and 10/16/15, but If on the eMAR. Idem 10mg were documented in following dates; 7/26/15, 10/15/15, and 1 tablet on 10mg was documented 15. Idem 10mg was deducted from 10mg was deducted from 10mg was deducted from 10mg was not documented on 10/18/15, but besent for the quantity given, and was not documented on				
		ffing schedule on 12/10/15 was working on 10/18/15.				

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 35 of 67

	or Regulation		0/0) 1/1/1/ 7/5/ 5	CONCERNATION	Taran Barrer	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		OOM! L	LILD
		hal002004	B. WING		12/1	14/2015
NAME OF B	20,4252 02 0422452	070557.40		TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		TAYLORS	VILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGULATORT ORT	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	NAIL	5,112
D 338	Continued From page	e 35	D 338			
	Review of Resident #	1's controlled drug count				
	sheet dated 10/07/14	for the Zolpidem 10mg				
	revealed:					
	-Sixteen tablets noted	d as delivered on 10/07/14.				
	-Nine tablets of Zolpid	dem 10mg were				
	documented as admir	nistered on the following				
	dates; 5/14/15, 5/22/1					
		1/15, 7/05/15, and 7/06/15.				
	T	lem 10mg were documented				
	as taken home on 6/08/15.					
		pidem 10mg tablets were				
	documented as "quar					
		documentation of the				
	administration of the	five remaining tablets.				
	Review of Resident #	1's record revealed:				
	-A Medication Releas	e Form dated 6/08/15 with 2				
	Zolpidem tablets doci	umented as sent home with				
	Resident #1.					
	-A Medication Releas	e Form dated 11/19/15 with				
		cumented as sent home with				
	Resident #1.					
		cation Release Forms for				
	_	home with Resident #1 on				
	7/26/15, 8/30/15, 10/0					
		Medication Release Forms				
	in the record.					
	Interview with Reside	nt #1 on 12/07/15 at				
		e resident's Zolpidem 10mg				
	had been "coming up	· · · · · · · · · · · · · · · · · · ·				
	Doon bonning up					
	Interview with a first s	shift Medication Aide (MA) on				
		evealed that Resident #1				
		Zolpidem 10mg in the past.				
	-	armacist at the pharmacy				
	provider on 12/09/15					
		of absence Zolpidem 10mg				
	for Resident #1 as fol	lows: quantity of 4 on				

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 36 of 67

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 SO	ОИТН		
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 286			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT ORT	100 IDENTIL PINO INI GRAVIATION)	IAG	DEFICIENCY)	MAIL	
D 338	Continued From page	26	D 338			
D 330	. •		D 550			
		3 on 10/29/15, and quantity				
	2 on 11/04/15.	the medication cost was				
		the medication cart were tity 16 and 11/24/15 quantity				
	16.	ity to and 11/24/15 quantity				
	10.					
	Interview with the faci	ility Director on 12/10/15 at				
	3:45pm revealed:	•				
		Resident #1's missing				
	doses of Zolpidem.					
		nat happened to Resident				
	_	ets of Zolpidem that were				
	count sheet, and the	0/07/14 controlled drug				
		macy for leave of absences				
	on 10/19/15, 10/29/15					
		nd Resident #1's Medication				
	Release Forms for the	e leave of absences on				
	10/19/15, 10/29/15, a	nd 11/04/15.				
		one of the MA staff (Staff A)				
	•	ons, and stated "I believe				
	(Staff A) took them, sl					
	(between September	,				
	-She did not report St	HCPR), and stated, "I started				
		olled drug count sheets) and				
	gather evidence, but	,				
	_					
		t shift MA on 12/10/15 at				
	4:45pm revealed:					
		of any other Zolpidem 10mg				
		e facility for Resident #1.				
		nat happened to Resident ets of Zolpidem 10mg that				
	•	the 10/07/14 controlled drug				
	count sheet.	and the second control and				
		controlled drug count				
		Resident #1's Zolpidem				

10mg.

-The undated entry on the 4/17/15 controlled drug

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			B. WING			
		hal002004	B. WING		12/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE. ZIP CODE		
			HIGHWAY 16 S			
ALEXAND	ER ASSISTED LIVING		/ILLE, NC 286			
		IATLORS	TILLE, NC 200	7		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)	0	
			+			
D 338	Continued From page	e 37	D 338			
	count choot was cont	home with Resident #1 on				
		nome with Resident #1 on				
	11/20/15.					
	D	tlld-dwl				
	Based on review of co					
		ation records, records for the				
	receipt and dispositio					
	observation of medica					
	_	could not account for 14				
	tablets of Zolpidem 10	0mg.				
	Refer to interview with	h facility Director on				
	12/10/15 at 4:00pm.					
	Refer to interview with	h a first shift MA on 12/10/15				
	at 5:10pm.					
	Refer to interview with	h the facility Administrator on				
	12/10/15 at 5:45pm.					
	•					
	Interview with facility	Director on 12/10/15 at				
	4:00pm revealed:					
	•	the MA staff (Staff A, Staff G,				
	•	MA in particular (Staff A),				
	·	k the controlled drugs,				
	•	sheets, and pharmacy				
	delivery sheets.	silects, and pharmacy				
	-No residents had cor	mplained of missing				
	medications.	ilplained of fillssing				
		onally "trash" a controlled				
		•				
		d without a witness, against				
	facility policy.	nament han averiete - ()				
		report her suspicions to the				
	pharmacy.	101 ((A) 11 11 2				
		report Staff A to Health Care				
		HCPR) because she "could				
	not prove anything."					
		ncidents happened in late				
	September or early O	october.				

Division of Health Service Regulation

-When Staff A worked, she acted weird (no

STATE FORM 6899 ORHZ11 If continuation sheet 38 of 67

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		hal002004	B. WING		12/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
AI EYAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	OUTH	
ALEXANL	ER ASSISTED LIVING	TAYLORS	SVILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 338	Continued From page	e 38	D 338		
	different, "like they we medicines." -All 3 of the suspect N around the end of Oc-Residents were actir MA were fired. Interview with a first s 5:10pm revealed: -When controlled drup pharmacy, we (the M medications with the -If there was a discrecontrolled drugs in the packing slip, "we sent to the pharmacy." Interview with the fac 12/10/15 at 5:45pm re-Staff A's last pay che her last day of employer.	MAs, were eventually fired stober. In a much better since those 3 shift MA on 12/10/15 at a g orders came in from the A) had to count the pharmacy driver. I pancy between the e pharmacy tote and the d the whole thing (tote) back sility Administrator on evealed eck was dated 11/3/15 with			
	plan of protection: -The facility will continuous and inservices regard care, and supervisionThe facility will ensure and maintained cand controlled drugsThe Director and the	re that all resident rights are concerning all medications MAs will oversee and ontrolled drug count sheets			
	THE DATE OF CORF	RECTION FOR THIS TYPE			

Division of Health Service Regulation

B VIOLATION SHALL NOT EXCEED JANUARY

STATE FORM 6899 ORHZ11 If continuation sheet 39 of 67

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	ОИТН		
ALLXAND	EN AGGIGTED EIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(* /	
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
			+	DEFICIENCY)		
D 338	Continued From page	e 39	D 338			
	28, 2016.					
D 392	10A NCAC 13F .1008	8(a) Controlled Substances	D 392			
	10A NCAC 13F .1008	3 Controlled Substances				
		ne shall assure a readily				
		controlled substances by				
	documenting the receipt, administration and disposition of controlled substances. These					
	records shall be maintained with the resident's					
		order that there can be				
	accurate reconciliatio	n.				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
		ns, record reviews, and				
	interviews, the facility	rolled to assure rolled drugs as evidenced by				
	•	accurate records of the				
	receipt, administration	•				
	controlled drugs for 4 sampled residents.	of 6 (#1, #4, #5, and #11)				
	sampled residents.					
	The findings are:					
	A. Review of Resider	nt #5's current FL2 dated				
	7/14/15 revealed:	damantia, anviato				
	-Diagnoses included depression congestiv	dementia, anxiety, /e heart failure, and atrial				
	fibrillation.	To Hoart Idilato, and athar				
	-An admission date o	f 2/27/15.				
	Review of Resident #	5's record revealed:				
	-A medication order d	lated 10/1/15 for Norco				
	5/325 (Hydrocodone	/Acetaminophen 5/325) 180				

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tablets, 1 tablet every 4 hours as needed for pain.

(Norco is a controlled drug used to treat

moderate to severe pain.)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		hal002004	B. WING		12/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		3032 N C I	HIGHWAY 16 S	оитн	
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286		
	OUR MAR DV OT		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 392	Continued From page	2 40	D 392		
	hand on 12/10/15 at 1 Hydrocodone 5/325m administer to Resider Interview with the pha provider on 12/10/15 -They had sent all 18/ Hydrocodone/Acetam in October 2015They provide controlled -The facility had not re Hydrocodone/Acetam pharmacy for Resident # Administration Record	g tablets available to ht #5. armacist at the pharmacy at 3:05pm revealed: 0 tablets of hinophen 5/325 to the facility led drug count sheets for drugs. eturned any hinophen 5/325 to the			
	tablets of Hydrocodor were documented as	ne/Acetaminophen 5/325 administered.			
	count sheet from 10/1 the Hydrocodone/Ace -Only 1 controlled dru	5's only controlled drug 14/15 through 12/10/15 for staminophen 5/325 revealed: ig sheet available in the s noted as delivered on			
	-The controlled drug of by medication aide structure. Fifteen tablets of Hyddocumented as admir dates; 2 tablets on 10/17/15, 1 tablet on 10/29/15, 2 tablets on 11/5/15, 1 tablet on 11	drocodone were nistered on the following 1/16/15, 2 tablets on 10/18/15, 1 tablet on 10/30/15, 1 tablet on 1/6/15, 1 tablet on 11/10/15, 1 tablet on 11/26/15, 1 tablet			

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DIVISION	of Health Service Regu	lation			
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
		hal002004	B. WING		12/14/2015
		070557.40	DDE00 0171/ 074	TE 710 000E	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	I E, ZIP CODE	
AL EYAND	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH	
ALLXAND	LIVASSISTED LIVING	TAYLORS	VILLE, NC 286	81	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI	(- /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE DATE
				DEFICIENCY)	
D 000			D 000		
D 392	Continued From page	2 41	D 392		
	Review of facility's ph	armacy delivery sheets			
	revealed no record fo				
	Hydrocodone/Acetam	inophen 5/325 tablets.			
		dication Aide (MA) on			
	12/10/15 at 10:15am	revealed:			
	-She was not aware of	of any other			
	Hydrocodone/Acetam	ninophen 5/325 tablets			
	available in the facility				
	_	nat happened to Resident			
	#5's missing tablets of				
	Hydrocodone/Acetam				
	_				
		nat happened to the other			
	_	sheets for Resident #5's			
	Hydrocodone/Acetam	inophen 5/325.			
	Interview with the fact	ility Director on 12/10/15 at			
	4:00pm revealed:				
	-She was unaware of	Resident #5's missing			
		e/Acetaminophen 5/325.			
	_	he MA staff, and 1 MA in			
	•	nd believed they took the			
		trolled drug count sheets,			
	and pharmacy deliver				
		~			
		when she worked," (no			
		refused to take a drug test			
	when requested by th				
		ncidents happened in late			
	September or early O	ctober 2015.			
	Interview with the san	ne MA on 12/10/15 at			
	5:10pm revealed:				
		the only available controlled			
		Resident #5's Hydrocodone			
	at the request of the I				
	T				
		drug count sheet was not			
	available for Resident				
		ne controlled drug count			
	sheet was created, th	ere was only one cassette			

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of 15 Hydrocodone tablets available for Resident

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			P WING			
		hal002004	B. WING		<u> </u>	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
		IATLURS	VILLE, NC 200			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 392	Continued From page	2 42	D 392			
	# 5.					
	#5.					
	Review of pharmacy	delivery sheets faxed to the				
	facility on 12/10/15 re					
	•	odone/Acetaminophen 5/325				
	for Resident #5 were					
		or by Staff B, Personal Care				
	Aide (PCA) at 2:14am	-				
		odone/Acetaminophen				
		were sent to the facility on				
	10/2/15 and signed to	or by Staff B at 1:46am.				
	Interview with Ctoff D	on 12/11/15 of 11:45nm				
		on 12/11/15 at 11:45pm				
	revealed:	natarainanhan 5/225 was				
		cetaminophen 5/325 was				
		en she checked them in on				
	10/1/15 and 10/2/15.					
		g count sheets from the				
	pharmacy came in wi					
	•	inophen 5/325 tablets, but				
	she was not sure how	/ many.				
	Based on review of co	5 5 .				
		ation records, records for the				
	receipt and disposition	•				
	observation of medica					
	interviews, the facility	could not account for 155				
	tablets of Hydrocodor	ne/Acetaminophen 5/325.				
	Refer to review of the	facility's policy on				
	medication administra	ation and controlled drugs.				
		n a first shift MA on 12/10/15				
	at 5:10pm.					
	Refer to interview with	n facility Director on				
	12/10/15 at 4:00pm.					
	B. Review of Residen	t #4's FL2 dated 10/6/15				

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revealed:

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	12/14/2010	
ΔΙ ΕΧΔΝΩ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	DUTH		
ALLAAND			SVILLE, NC 286			_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	Έ
D 392	Continued From page	2 43	D 392			
D 392	-Diagnoses included hypertension, and obe-A medication order for bedtime as needed for controlled drug used to-An admission date of the controlled drug used to-An admission date of the controlled drug used to-An admission date of the controlled drug to	paranoid schizophrenia, esity. or Ambien 5mg, 1 tablet at or sleep. (Ambien is a to induce sleep.) of 7/9/10. ords revealed: drug count sheets for sm 5mg (generic Ambien), count sheet was started on a 5mg documented as ay from 11/6/15 through s documented as remaining. drug sheet was started on m 5mg documented as 11/22/15 through 12/6/15, and 2 tablets remained on of 12/8/15 revealed 2 mg remained in the cassette ed drug count sheet. 4's electronic Medication ds (eMARs) for October locumented as administered th, 8th, 9th, 10th, 14th, 16th, 26th, 27th, 29th, and 31st is.	D 392			
	Review of Resident #	4's eMARs for November				

Division of Health Service Regulation

2015 revealed:

STATE FORM 6899 ORHZ11 If continuation sheet 44 of 67

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
			74. BOILBING.			
		hal002004	B. WING		12/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SC			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	VILLE, NC 286	PROVIDER'S PLAN OF CORRE	CTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 392	Continued From page	2 44	D 392			
	on the 1st, 3rd, 7th, 8 21st, 22nd, 24th, 25th November 2015 for a No controlled drug sh reconcile the doses a	eet was available to dministered on the 1st and				
	Administration Record 2015 revealed: -Zolpidem 5mg was d	5. 4's electronic Medication ds (eMARs) for December locumented as administered and 6th of December 2015				
	5mg documented as	0/15, 13 doses of Zolpidem given on Resident #4's are signed out on the sheet.				
		n 12/7/15, 4 doses of nented as given on the nigned out on the controlled				
	12/9/15 at 10:25am re -She always recorded when she gives them -Resident #4 did not a 2 nightsShe could not explain	If medications on the eMAR ask for his Zolpidem the past the discrepancy in the sheet and the eMAR counts				
	revealed:	nt #4 on 12/9/15 at 2:35pm every night, and it helps him				

sleep.

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STATE FORM 6899 ORHZ11 If continuation sheet 45 of 67

Division of	Division of Health Service Regulation				1 Ordivi	ALLINOVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO VILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 45	D 392			
	-He was aware of what looked like.	at his generic Ambien				
	12/9/15 at 3:10pm rev-16 tablets of Zolpider Resident #4 on 9/18/1-15 tablets of Zolpider Resident #4 on 10/1/1-15 tablets of Zolpider Resident #4 on 10/19-16 tablets of Zolpider Resident #4 on 11/4/1-16 tablets of Zolpider Resident #4 on 11/21.	m 5mg were dispensed for 15. m 5mg were dispensed for 15. m 5mg were dispensed for 17. m 5mg were dispensed for 18. m 5mg were dispensed for 18. m 5mg were dispensed for 17. m 5mg were dispensed for 18. m 5mg were dispensed for 19. m 5mg were dispe				
	drug count sheets for	ords revealed no controlled Resident #4's Zolpidem , 10/1/15, and 10/19/15.				
	Refer to review of the medication administra	facility's policy on attion and controlled drugs.				
	Refer to interview with 12/10/15 at 4:00pm.	n facility Director on				
	Refer to interview with at 5:10pm.	n a first shift MA on 12/10/15				

11/17/15 revealed:

C. Review of Resident #1's current FL2 dated

-A medication order for Zolpidem (a controlled drug used to treat insomnia) 10mg, 1 tablet at

-Diagnoses included depression, asthma,

neuropathy, and osteoporosis.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SI		
			A. BUILDING: _			
		hal002004	B. WING		12/1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S /ILLE, NC 286			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	hand on 12/08/15 at 2 of Zolpidem 10mg wit 11/24/15 and 16 table Review of Resident # Administration Record 2015 revealed Zolpide documented as admin 12/07/15. Review of Resident # 2015 revealed Zolpide documented as admin 11/30/15. Review of Resident # revealed Zolpidem 10 as administered once Review of Resident # 2015 revealed Zolpidem 10 as administered as admin 09/30/15. Review of Resident # revealed Zolpide documented as admin 09/30/15. Review of Resident # revealed 2 tablets of 2 documented as admin 08/29/15. Review of Resident # Review of Revie	ent #1's medications on 2:30pm revealed a cassette th a dispensing date of ets in the cassette. 1's electronic Medication d (eMAR) for December em 10mg had not been nistered from 12/01/15 to 1's eMAR for November em 10mg had not been nistered from 11/01/15 to 1's eMAR for October 2015 omg had been documented	D 392	DEFICIENCY)		
	-Eight tablets of Zolpidocumented as admir	d as delivered on 04/17/15. dem 10mg were nistered on the following 15, 8/29/15, and 10/03/15.				

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			D WING			
		hal002004	B. WING		12/1	14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		3032 N C F	IIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		/ILLE, NC 286			
	OUR MAR DV OT		<u> </u>			T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
iAO		,	IAG	DEFICIENCY)		
D 392	Continued From page	e 47	D 392			
	-Four tablets of Zolpic	dem were documented as				
	•	controlled drug count sheet				
		9/27/15, and 10/16/15, but				
	were not documented					
		em 10mg were documented				
		e following dates; 7/26/15,				
		5, 10/15/15, and 1 tablet on				
	an undated entry.					
	-	em 10mg was documented				
	as wasted on 11/19/1					
		em 10mg was deducted from				
	the controlled drug co	ount sheet on 10/18/15, but				
	documentation was a	bsent for the quantity given,				
	signature of the MA, a	and was not documented on				
	the eMAR.					
	Review of the MA sta	ffing schedule on 12/10/15				
	revealed that Staff A	was working on 10/18/15.				
	Review of Resident #	1's controlled drug count				
	sheet dated 10/07/14	for the Zolpidem 10mg				
	revealed:					
	-Sixteen tablets noted	d as delivered on 10/07/14.				
	-Nine tablets of Zolpic	dem 10mg were				
	•	nistered on the following				
	dates; 5/14/15, 5/22/1	· ·				
		1/15, 7/05/15, and 7/06/15.				
		lem 10mg were documented				
	as taken home on 6/0	_				
		pidem 10mg tablets were				
	•	ntity left" on the sheet.				
		documentation of the				
	administration of the f	five remaining tablets.				
	Deview of Deside 17	41e we could not to all = -1-				
	Review of Resident #					
		e Form dated 6/08/15 with 2				
	•	umented as sent home with				
	Resident #1.					
	-A Medication Releas	e Form dated 11/19/15 with				

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1 Zolpidem tablet documented as sent home with

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		hal002004	B. WING	B. WING		2/14/2015
	ROVIDER OR SUPPLIER DER ASSISTED LIVING	3032 N C	DDRESS, CITY, STATE HIGHWAY 16 SOU	ІТН		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Resident #1. -There were no Medic Zolpidem 10mg sent 7/26/15, 8/30/15, 10/0 -There were no other in the record. Interview with the phaprovider on 12/09/15 -They had sent leave for Resident #1 as fol 10/19/15, quantity of 2 on 11/04/15. -Cassettes for use on sent on 4/17/15 quan 16. Interview with the fac 3:45pm revealed: -She was unaware of doses of Zolpidem. -She was not sure wh #1's remaining 5 table documented on the 1 count sheet, and the prepared by the phanon 10/19/15, 10/29/15 -She was unable to fi Release Forms for th 10/19/15, 10/29/15, a-She had suspected of taking the medicati (Staff A) took them, s (between September Interview with the firs 4:45pm revealed: -She was not sure wh #1's remaining 5 table was not sure wh #1's remaining 5 table she was not sure wh #1's remaining 5 table she was not sure wh #1's remaining 5 table she was not sure wh #1's remaining 5 table she was not sure wh #1's remaining 5 tables.	cation Release Forms for home with Resident #1 on 07/15 and 10/15/15. Medication Release Forms armacist at the pharmacy at 3:20pm revealed: of absence Zolpidem 10mg lows: quantity of 4 on 3 on 10/29/15, and quantity the medication cart were tity 16 and 11/24/15 quantity lity Director on 12/10/15 at Resident #1's missing at happened to Resident ets of Zolpidem that were 0/07/14 controlled drug 9 Zolpidem that were macy for leave of absences 5, and 11/04/15. In the Resident #1's Medication at leave of absences on 11/04/15. One of the MA staff (Staff A) ons, and stated "I believe the was working then	D 392			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				_	
		hal002004	B. WING		12/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
AI EVAND	ER ASSISTED LIVING	3032 N C I	HIGHWAY 16 SC	DUTH	
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 392	Continued From page	e 49	D 392		
	count sheetThere were no other sheets available for R 10mgThe undated entry or count sheet was sent 11/20/15. Based on review of comedication administrative receipt and disposition observation of medical	controlled drug count Resident #1's Zolpidem In the 4/17/15 controlled drug Ihome with Resident #1 on Controlled drug logs, Pation records, records for the In of medications, Pations on hand and In could not account for 14			
	Refer to review of the facility's policy on medication administration and controlled drugs. Refer to interview with a first shift MA on 12/10/15				
	at 5:10pm. Refer to interview witl 12/10/15 at 4:00pm.	h facility Director on			
	D. Review of Resident #11's current FL2 dated 4/13/15 revealed: -Diagnoses included degenerative disc disease of the lumbar and sacral spine, seizure disorder, hypertension, chronic pain, and chronic anxiety. -A medication order for Fentanyl (a controlled medication used to treat severe pain) 50mcg/hour patch, apply 1 patch topically to skin every 72 hours. -An admission date of 4/29/15. Observation of Resident #11's medications on hand on 12/10/15 at 10:00am revealed a plastic bag of Fentanyl 50mcg/hour patches with a dispensing date of 11/23/15 and 4 patches in the				

bag.

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		1	B. WING			
		hal002004	B. WC		12/14/201	5
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING	TAYLOR	SVILLE, NC 286	81		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN OF CORRECTIO	d /	VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	,	(X5) IPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE D.	ATE
				DEFICIENCY)		
D 392	Continued From page	50	D 392			
D 002	Continued From page	5 50	5 002			
		11's electronic Medication				
	Administration Record	d (eMAR) for November				
	2015 revealed:					
	-An order for Fentany	l 50mcg/hour, apply 1 patch				
	every 72 hours.					
	-Six patches docume	nted as administered on				
	11/3/15, 11/6/15, 11/9/15, 11/12/15, 11/15/15, and 11/18/15Documentation that the medication was "not on					
	the cart" on 11/21/15.					
	-Documentation that t	the medication was "not				
	required" on 11/26/15	and 11/29/15.				
	-There was no further	documentation that				
	Fentanyl 50 mcg/hou	r was administered on any				
	other dates.					
	Review of Resident #	11's controlled drug count				
	sheet dated 11/23/15	for the Fentanyl				
	50mcg/hour revealed	:				
	-Ten patches noted a	s delivered on 11/23/15.				
	-Three patches of Fei	ntanyl 50 mcg/hour were				
	documented as admir	nistered on the controlled				
	drug count sheet on t	he following dates: 11/24/15,				
	11/27/15 and 11/30/1	5, but were not documented				
	as administered on th	e November 2015 eMAR.				
		armacist at the pharmacy				
		at 3:20pm revealed they had				
	sent Fentanyl 50 mcg					
	Resident #11 on 11/2	3/15.				
	Interview with the fire	t shift MA on 12/10/15 at				
	4:45pm revealed:	t Shift WA OH 12/10/13 at				
		t of Fentanyl 50 mcg/hr on				
	11/21/15.	or remanyr 50 mog/m on				
	_	nessed up" when we wait for				
	a new prescription.	nessed up when we wait iof				

due dates.

-The pharmacy had been contacted to correct the

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			P WING			
		hal002004	B. WING		12/1	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		3032 N C	HIGHWAY 16 S	OUTH		
ALEXAND	ER ASSISTED LIVING		VILLE, NC 286			
		IATLURS	VILLE, NC 200	100 I		_
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	NEODEMONT ON	100 IDENTIFICATION OF THE ONLY	IAG	DEFICIENCY)	110112	
D 392	Continued From page	e 51	D 392			
		nt #11 on 12/10/15 at				
	11:00am revealed:					
	-"I do run short some					
	-The due dates on the	e eMAR are incorrect.				
	-She kept a calendar	in her room of all dates she				
	received the Fentany	l patch.				
	-She "got out of pain	patch" one time on				
	November 21, 2015.					
	-"It (Fentanyl) has run out other times, but they (facility) say it's the doctor's fault, but I think it's					
	the pharmacy."					
	are priarriacy.					
	Interview with the faci	ility Director on 12/14/15 at				
	4:07pm revealed:	inty Director on 12/14/10 at				
		e Fentanyl patch were				
	-	and that resulted in the				
	eMARs showing the r	nedication was "not				
	required".					
		time a new prescription is				
	filled."					
	Refer to review of the	facility's policy on				
	medication administra	ation and controlled drugs.				
	-					
	Interview with the faci	ility Director on 12/10/15 at				
	4:00pm revealed:					
	-She suspected 3 of t	the MA staff (Staff A, Staff G,				
		MA in particular (Staff A),				
		k the controlled drugs,				
		sheets, and pharmacy				
	delivery sheets.					
	-	ncidents happened in late				
	September or early O					
	September of early O	CLUDEL ZU ID.				
	Dovious of the feetitest	a policy on modication				
	_	s policy on medication				
		introlled drugs revealed:				
	-The MAR will include	e the date and time of				

Division of Health Service Regulation

medication administation with the name and

STATE FORM 6899 ORHZ11 If continuation sheet 52 of 67

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		hal002004	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	. ZIP CODE		2/14/2015
			HIGHWAY 16 SOL			
ALEXAND	DER ASSISTED LIVING	TAYLOR	SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	2 52	D 392			
	reviewThe record of docume drugs) will be kept in MAR or controlled drugh in the review with a first some state of the review with a first some state of the review with a first some state of the revealed: -When controlled drugh in the state of the rewas a discreption of the rewas a discr	introlled drugs will be illity and will be available for sentation (of controlled the resident's record, ex. ag sign-out record. whift MA on 12/10/15 at the gs came in from the A) had to count the pharmacy driver.				
	On 12/11/15, the facility provided the following plan of protection: -The facility will continue to count all controlled drugs at the beginning and end of each shift. -The Director will monitor all control sheets to ensure that the MARs and controlled drug counts are accurate. -The director will perform random controlled drug count checks to verify amounts of controlled drugs weekly. -The pharmacy will provide an inservice for all Medication Aides on all aspects of controlled drug record keeping, to ensure that all medications are accounted for. -The pharmacy will perform medication cart audits as part of the quarterly pharmacy reviews. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 28, 2016.					

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PRINTED: 01/08/2016 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		hal002004	B. WING		12	2/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ALEXAND	DER ASSISTED LIVING		C HIGHWAY 16 SOL RSVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 399	(h) The facility shall diversions are reportenforcement agency Registry as required suspected drug diver	3 (h) Controlled Substance 3 Controlled Substance ensure that all known drug ed to the pharmacy, local law and Health Care Personnel by state law, and that all sions are reported to the all be documentation of the ken.	D 399			
	interviews, the facility diversion of controlle to the dispensing pha sampled residents. (2 5/325.)	as evidenced by: ns, record reviews and refailed to report suspected d drug medications by staff armacy for 2 of 6 (#1 and #5) Zolpidem 10mg and Norco				
	7/14/15 revealed: -Diagnoses included	ve heart failure, and atrial				
	5/325 (Hydrocodone tablets, 1 tablet every (Norco is a controlled moderate to severe p	dated 10/1/15 for Norco /Acetaminophen 5/325) 180 / 4 hours as needed for pain. I drug used to treat pain.)				
	Review of Resident #	5's medications on hand on				

Division of Health Service Regulation

STATE FORM 6899 ORHZ11 If continuation sheet 54 of 67

DIVISION	or riealin Service Regu	ialion				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1			
			P WING		l	
		hal002004	B. WING		12/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
			, ,	,		
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 S			
		IAYLURS	VILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	130 IDENTIF TING IN ONWATION)	TAG	DEFICIENCY)	MAIL	57.11.2
			+	,		
D 399	Continued From page	e 54	D 399			
		revealed no Hydrocodone			ļ	
	5/325mg tablets avail	able to administer to			ļ	
	Resident #5.					
		armacist at the pharmacy				
	provider on 12/10/15					
	-They had sent all 18					
	Hydrocodone/Acetaminophen 5/325 to the facility					
	in October 2015.					
-The facility had not returned any						
	Hydrocodone/Acetam	inophen 5/325 to the				
	pharmacy for Resider	nt #5.				
	-The facility had not re	eported any missing				
	controlled drugs or sta	aff suspected of diverting				
	medications.					
	Review of Resident #	5's electronic Medication				
	Administration Record	d (eMAR) for October,				
		mber 2015 revealed 25				
	The state of the s	ne/Acetaminophen 5/325				
	had been documente	·				
	naa boon accamento	a do danimiotoroa.				
	Review of Resident #	5's controlled drug count				
		done/Acetaminophen 5/325				
	revealed:	4011077 (00ta1111110p11011 07020				
		g sheet available in the				
		through 12/10/15, with 15				
	tablets noted as deliv	-				
		count sheet was handwritten				
	_					
	by medication aide st					
	-Fifteen tablets of Hyd					
		nistered on the following				
	dates; 2 tablets on 10					
	10/17/15, 1 tablet on					
		10/30/15, 1 tablet on				
	· ·	1/6/15, 1 tablet on 11/10/15,				
	1 tablet on 11/12/15,	1 tablet on 11/26/15, 1 tablet				
	on 12/3/15, and 1 tab	let on 12/10/15.				

Division of Health Service Regulation

Interview with the Medication Aide (MA) on

STATE FORM 6899 ORHZ11 If continuation sheet 55 of 67

Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		hal002004	B. WING		12/1	4/2015
			1		1 12/1	4/2010
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΟ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH		
TAYLORS		VILLE, NC 286	81			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	REGOLATORY OF		TAG	DEFICIENCY)	W (1 L	
D 399	Continued From page	e 55	D 399			
	12/10/15 at 10:15am	revealed:				
	-She was not aware o					
		ninophen 5/325 tablets				
	available in the facility					
		nat happened to Resident				
	#5's other tablets of					
	Hydrocodone/Acetam	ninophen 5/325.				
	-She was not sure what happened to the other controlled drug count sheets for Resident #5's Hydrocodone/Acetaminophen 5/325.					
	Interview with Reside	ent #5 on 12/10/15 at				
	11:28am revealed:					
		at pain medications he took.				
		ny incidences of unrelieved				
	pain.					
	-	medications when he asked				
	for them.					
	Interview with the fac	ility Director on 12/10/15 at				
		was unaware of Resident				
	#5's missing doses of					
	Hydrocodone/Acetam					
	Trydrocodone// toctair	miopriem 5/525.				
	Interview with a MA o	on 12/10/15 at 5:10pm				
	revealed:					
	-She had handwritten	the only available controlled				
		Resident #5's Hydrocodone				
	at the request of the I					
		o controlled drug count				
	sheet for Resident #5	5's Hydrocodone.				
	-On 10/14/15 when th	ne controlled drug count				
	sheet was created, th	ere was only one cassette				
	of 15 Hydrocodone ta	ablets available for Resident				
	#5.					
		delivery sheets faxed to the				
	facility on 12/10/15 re	evealed:				

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-Sixty tablets of Hydrocodone/Acetaminophen 5/325 for Resident #5 were sent to the facility on

STATE FORM 6899 ORHZ11 If continuation sheet 56 of 67

DIVISION	n Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		hal002004	B. WING		12/1	4/2015
		1101002004			12/14	4/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
AI EVAND	ALEXANDER ASSISTED LIVING 3032 N C			OUTH		
ALEXAND	ER ASSISTED LIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIAIE	DAIL
D 399	Continued From page	e 56	D 399			
	10/1/15 and 120 table	ets of				
	Hydrocodone/Acetam	ninophen 5/325 for Resident				
	#5 were sent to the fa					
	Review of facility reco	ords revealed:				
	-The Director received					
		idents, including Resident				
	# 5.					
	-The statement had details about medications					
	sent, including the name of the drug and the					
	number of tablets sen	nt.				
	Refer to review of the					
	medication administra	ation and controlled drugs.				
	Refer to interview with	h the facility Director on				
	12/10/15 at 4:00pm.	, ,				
	Defeate intendenced	finat - bift MA 40/40/45				
		h a first shift MA on 12/10/15				
	at 5:10pm.					
	Refer to interview with	h the facility Administrator on				
	12/10/15 at 5:45pm.	in the lacinty / tarminetrator on				
	12/10/10 at 0.10pm.					
	B. Review of Residen	t #1's current FL2 dated				
	11/17/15 revealed:					
	-Diagnoses included	depression, asthma,				
	neuropathy, and oste	oporosis.				
		or Zolpidem (a controlled				
	~	omnia) 10mg, 1 tablet at				
	bedtime as needed for					
	-An admission date of	f 06/23/09.				
	Observation of Reside	ent #1's medications on				
		30pm revealed a cassette of				
	Zolpidem 10mg with a	· ·				
	11/24/15 and 16 table	· · · · · · · · · · · · · · · · · · ·				
	2 ii 10 dila 10 table					
	Review of Resident #	1's electronic Medication				

Division of Health Service Regulation

Administration Record (eMAR) for December

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		hal002004	B. WING		12	/14/2015
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ALEXAND	ER ASSISTED LIVING		SVILLE, NC 28681			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 399	Continued From page	e 57	D 399			
	2015 revealed Zolpidem 10mg had not been documented as administered from 12/1/15 to 12/7/15. Review of Resident #1's eMAR for November 2015 revealed Zolpidem 10mg had not been documented as administered from 11/1/15 to 11/30/15. Review of Resident #1's eMAR for October 2015 revealed Zolpidem 10mg had been documented as administered once, 10/3/15.					
	Review of Resident #1's eMAR for September 2015 revealed Zolpidem 10mg had not been documented as administered from 9/1/15 to 9/30/15.					
	revealed 2 tablets of 2	1's eMAR for August 2015 Zolpidem 10mg had been nistered on 8/28/15 and				
	sheet dated 4/17/15 frevealed: -Sixteen tablets noted -Eight tablets of Zolpi documented as admin dates; 7/26/15, 8/28/1 -Four tablets of Zolpi administered on the con 9/11/15, 9/14/15, 9 were not documented -Six tablets of Zolpide as taken home on the 8/30/15, 2 on 10/7/15 an undated entry.	nistered on the following 15, 8/29/15, and 10/3/15. dem were documented as controlled drug count sheet 0/27/15, and 10/16/15, but I on the eMAR. em 10mg were documented e following dates; 7/26/15, , 10/15/15, and 1 tablet on				

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STATE FORM 6899 ORHZ11 If continuation sheet 58 of 67

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		hal002004	B. WING		12/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΧΔΝΓ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH		
ALLXAND	ERAGGIOTED EIVING	TAYLORS	VILLE, NC 286	81		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 399	Continued From page	e 58	D 399			
	-One tablet of Zolpide the controlled drug codocumentation was a	em 10mg was deducted from bunt sheet on 10/18/15, but bsent for the quantity given, and was not documented on				
		ffing schedule on 12/10/15 was working on 10/18/15.				
	sheet dated 10/7/14 frevealed: -Sixteen tablets noted -Nine tablets of Zolpid documented as admit dates; 5/14/15, 5/22/16/28/15, 7/1/15, 7/5/1 -Two tablets of Zolpid as taken home on 6/8 -A quantity of five Zolpid documented as "quantity of the statement of the	nistered on the following 15, 6/1/15, 6/24/15, 6/27/15, 5, and 7/6/15. lem 10mg were documented 8/15.				
	Zolpidem tablets doct Resident #1. -A Medication Releas 1 Zolpidem tablet doc Resident #1. -There were no Medic Zolpidem 10mg sent 1 7/26/15, 8/30/15, 10/7	e Form dated 6/8/15 with 2 cumented as sent home with e Form dated 11/19/15 with cumented as sent home with cation Release Forms for home with Resident #1 on				
	provider on 12/9/15 a	armacist at the pharmacy t 3:20pm revealed: of absence Zolpidem 10mg				

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STATE FORM 6899 ORHZ11 If continuation sheet 59 of 67

Division of	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		hal002004	B. WING		12/1	4/2015
		1101002004			1 12/1	4/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ΔΙ ΕΥΔΝΠ	ER ASSISTED LIVING	3032 N C	HIGHWAY 16 S	OUTH		
ALLXAND	ER AGGIGTED LIVING	TAYLORS	SVILLE, NC 286	81		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR I	230 IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	NAIL	5,2
			-			
D 399	Continued From page	∍ 59	D 399			
	for Resident #1 as fol	llows: quantity of 4 on				
		3 on 10/29/15, and quantity				
	2 on 11/4/15.					
	-Cassettes for use on	the medication cart were				
	sent on 4/17/15 quan	tity 16 and 11/24/15 quantity				
	16.	, ,				
	Interview with the fac	ility Director on 12/10/15 at				
	3:45pm revealed:					
	-She was unaware of	f Resident #1's missing				
	doses of Zolpidem.					
		nat happened to Resident				
		ets of Zolpidem that were				
		0/7/14 controlled drug count				
	· ·	idem that were prepared by				
	the pharmacy for leave 10/29/15, and 11/4/15	ve of absences on 10/19/15, 5.				
	-She was unable to fi	nd Resident #1's Medication				
		e leave of absences on				
	10/19/15, 10/29/15, a					
		one of the MA staff (Staff A)				
	(Staff A) took them, s	ions, and stated "I believe				
	(between September	<u> </u>				
	(between September	and October 2015).				
	Interview with the first	t shift MA on 12/10/15 at				
	4:45pm revealed:	12/10/10 40				
	•	nat happened to Resident				
		ets of Zolpidem 10mg that				
		the 10/07/14 controlled drug				
	count sheet.	J				
	-There were no other	controlled drug count				
		Resident #1's Zolpidem				
	10mg.	•				
		n the 4/17/15 controlled drug				
	count sheet was sent	home with Resident #1 on				
	11/20/15.					
	Refer to review of the					
	medication administra	ation and controlled drugs.				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMP	LETED		
	hal002004		B. WING		42	12/14/2015	
					12	14/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
ALEXAND	ER ASSISTED LIVING		HIGHWAY 16 SO				
			SVILLE, NC 286				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 399	Continued From page	e 60	D 399				
	Refer to interview witl 12/10/15 at 4:00pm.	h the facility Director on					
	Refer to interview with at 5:10pm.	h a first shift MA on 12/10/15					
	Refer to interview with 12/10/15 at 5:45pm.	h the facility Administrator on					
	administration and co -The MAR will include medication administa initials of the person a medicationDocumentation of co maintained by the fac reviewThe record of docum	tion with the name and administering the entrolled drugs will be cility and will be available for entation (of controlled the resident's record, ex.					
	4:00pm revealed: -She suspected 3 of tand Staff H), and one and believed they too drugs, controlled drug pharmacy delivery sh-"When Staff A worke specifics), and the redifferent, like they we medicines." -Staff A would occasion drug she had dropped facility policyThe Director asked S	eets. d, she acted weird (no sidents acted weird or					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ALEXAND	ER ASSISTED LIVING		IGHWAY 16 SO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	before she was fired, (in the facility), (name door." -The Director stated to cup containing control locker of Staff H. -All 3 of the suspected around the end of Octare action. MAs were fired. -No residents had commedications.	to interview Staff A just but "as soon as she saw me ed staff) ran out the front that she found a medication lled medications in the d MAs, were eventually fired tober. g much better since those 3				
	pharmacyThe Director did not Personnel Registry (Foundation of Personne	report Staff A to Health Care HCPR) because she "could nicidents happened in late ctober 2015. Thiff MA on 12/10/15 at g orders came in from the A) have to count the pharmacy driver.				
	Interview with the faci 12/10/15 at 5:45pm re -Staff A's last pay che her last day of employ	evealed: ck was dated 11/3/15 with				

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Division	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		hal002004	B. WING		12/1	4/2015
		1101002004			12/1	4/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
AL EVAND	ED ASSISTED LIVING	3032 N C	HIGHWAY 16 SO	UTH		
ALEXAND	ER ASSISTED LIVING	TAYLOR	SVILLE, NC 2868	1		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				22. 10.2.10		
D 438	Continued From page	e 62	D 438			
D 420	10 A NCAC 12E 120E	Licetth Care Derespond	D 438			
D 430		Health Care Personnel	D 436			
	Registry					
	104 NCAC 13E 120E	Health Care Personnel				
	Registry	Treatti Care i cisonilei				
	• ,	ply with G.S. 131E-256 and				
		NCAC 130 .0101 and				
	.0102.	110710 100 1010 1 dila				
	.0102.					
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	·				
	Based on observation	ns, record reviews and				
	interviews, the facility	failed to investigate and				
	report 3 suspected sta	aff (Staff A, Staff G, and				
	Staff H), who had alle	gations of controlled drug				
	diversion to the Healt	h Care Personnel Registry				
	(HCPR).					
	The findings are:					
		ility Director on 12/10/15 at				
	3:45pm revealed:	6 H . A . H . H				
		one of the Medication Aide				
	. , , , , , , , , , , , , , , , , , , ,	taking controlled drugs that				
		s, and stated "I believe (Staff				
		s working then (between				
	=					
	•	,				
	gather evidence, but	i never reported her."				
	Cubooguont internii	with the facility Director or				
	-	<u>-</u>				
	•					
	to look at stuff (contro gather evidence, but Subsequent interview 12/10/15 at 4:00pm re	aff A to Health Care HCPR), and stated, "I started billed drug count sheets) and I never reported her."				

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and Staff H), and one MA in particular (Staff A), and believed they took the controlled drugs,

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Division (of Health Service Regu	ulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/1	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
AI EYANE	DER ASSISTED LIVING	3032 N C	HIGHWAY 16 SC	ЭИТН		
ALEXAME	PER ASSISTED LIVING	TAYLORS	SVILLE, NC 2868	81		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	÷ 63	D 438			
	delivery sheetsWhen Staff A worked specifics), and the res different, "like they we medicines." -Staff A would occasion drug she had dropped facility policyThe Director asked Stand she refused, (spearound the time of the The Director sought before she was fired, (in the facility), (named door." -The Director stated to cup containing control locker of Staff HAll 3 of the suspected around the end of Occaresidents were acting MAs were firedNo residents had commedicationsThe Director did not pharmacyThe Director did not personnel Registry (Finot prove anything."	onally "trash" a controlled d without a witness, against Staff A to take a drug test ecific time not given, but ese events.) to interview Staff A just but "as soon as she saw me ed staff) ran out the front that she found a medication olled medications in the d MAs, were eventually fired etober. In g much better since those 3				

HCPR.

-She believed these incidents happened in late

-Staff A's last pay check was dated 11/3/15 with her last day of employment of 10/18/15. -He was not aware of the missing controlled

Interview with the facility Administrator on

September or early October 2015.

12/10/15 at 5:45pm revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		hal002004	B. WING		12/14	4/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	<u> </u>	
ALEXAND	ER ASSISTED LIVING		IIGHWAY 16 S			
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	/ILLE, NC 286	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 64	D 438			
	drugs.					
	reviews and interview 2 residents (#1 and # exploitation by diversi	sed on observations, record rs, the facility failed to assure 5) were free from				
	plan of protection: -Facility will monitor a orders for amounts re -Facility will monitor of for all errors and miss -All Medication Aides disappearing will be re Department of Social law enforcementThe Medication Aide THE DATE OF CORF	ontrolled drug count sheets sing medications. involved in medications eported to the HCPR, Services, Pharmacy, and				
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	laration of Residents' Rights ration of Residents' Rights have the following rights: and services which are e, and in compliance with state laws and rules and	D912			
	This Rule is not met	as evidenced by:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		hal002004	B. WING		12/14/2015	
ALEXANDER ASSISTED LIVING 3032 N C HI			RESS, CITY, STA	ОИТН		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	=
D912	reviews, the facility fareceived care and ser appropriate, and in confederal and state laws in the areas of control keeping and reporting Personnel Registry (Formal The findings are: A. Based on observating accountability of control the failure to assure a receipt, administration controlled drugs for 4 sampled residents. [Refer to D 392, 10A Controlled Substance B. Based on observatinterviews, the facility report 3 suspected states of the sampled residents. Staff H) who had alleg diversion to the Health	is, interviews, and record iled to assure residents vices which were adequate, impliance with relevant and rules and regulations led substances record to the Health Care HCPR). itions, record reviews, and failed to assure rolled drugs as evidenced by accurate records of the and disposition of of 6 (#1, #4, #5, and #11) NCAC 13F .1008(a) as, (Type B Violation.)] itions, record reviews and failed to investigate and aff (Staff A, Staff G, and gations of controlled drug th Care Personnel Registry 138, 10A NCAC 13F .1205	D912			
D914	G.S. 131D-21 Declar Every resident shall h 4. To be free of menta neglect, and exploitat This Rule is not met		D914			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED
hal002004 B. WING	12/14/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ALEXANDER ASSISTED LIVING 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION STAGE PROVIDER'S PLAN OF CORRECTIVE P	SHOULD BE COMPLETE
Deficiency) Dottinued From page 66 interviews, the facility failed to assure residents were free from abuse, neglect, and exploitation in the areas of supervision to prevent sexual assault, diversion of controlled medications, and management of facilities. The findings are: A. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 14 sampled residents (Resident #7) who demonstrated sexually inappropriate behaviors towards 2 residents (Resident #2 and Resident #14). [Refer to D 270, 10A NCAC 13F .0901(b) Personal Care and Supervision, (Type B Violation.)] B. Based on observations, record reviews and interviews, the facility failed to assure 2 of 6 sampled residents (#1 and #5) were free from exploitation by diversion of their controlled medications by staff. (Zolpidem 10mg and Norco 5/325.) [Refer to D 338, 10A NCAC 13F .0909 Resident Rights, (Type B Violation.)] C. Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility met and maintained rules related to management of the facility, fire drills, water temperatures, tuberculosis testing of staff, resident assessments, personal care and supervision, activities, exploitation, controlled drug record keeping, reporting to the Health Care Personnel Registry (HCPR), and reporting to pharmacy. [Refer to D 176, 10A NCAC 13F .0601(a) Management of Facilities, (Type B Violation.)]	

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