	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			COMPL	ETED
		HAL075010	B. WING		05/2	4/2018
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
LAURELW	IOODS		ST MILLS STRE	ET		
			BUS, NC 28722	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department of	sure Section and the Polk of Social Services conducted 05/23/18 and 05/24/18.				
D 287	10A NCAC 13F .090 Service	4(b)(2) Nutrition And Food	D 287	See attached	\$	
	 (b) Food Preparation Homes: (2) Table service sha non-disposable place a knife, fork, spoon, 	ns may be made on an shall be based on				
	failed to assure table Unit (SCU) dining ro included a non-dispo	ns and interviews, the facility e service in the Special Care om and on room trays				
	The findings are:					
	dining room on 05/2 12:35pm revealed: -There were 18 resid room. -The place setting c cloth napkin. -The meal served to cooked green beam	unch meal service in the SCU 3/18 from 12:00pm to dents seated in the dining onsisted of a fork, spoon, and presidents included lasagna, s and carrots, a garlic				
Distator		y cobbler. ceived feeding assistance			Ô(,	Elio
Division of F LABORATOR	lealth Service Regulation Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE CM	pcon TITLE Executiv	e Dilecte	
			0			uation sheet 1 of 12

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STATEMENT	of Health Service Regu r of Deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMF	SURVEY
		HAL075010	B. WING		05/24/2018	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			12-112010
NAME OF PI	ROVIDER OR SUFFLIER		ST MILLS STREET			
LAURELW	VOODS		BUS, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 287	Continued From page	e 1	D 287			
		dining room who did not stance had no difficulty eating				
	lunch meal tray delive at 12:09pm revealed	ssisted living resident's ered to her room on 05/23/18 the place setting consisted only; there was no knife.				
	tray delivered to the 12:12pm revealed the	CU resident's lunch meal room on 05/23/18 at ere was a disposable foam e resident's beverage.				
	05/23/18 at 12:25pm -"We are running low -"Sometimes the glas and they can't lift the	/ on regular glasses." sses are too heavy for them m." yout out knives in the place				
		the SCU dining room staff pm revealed "We don't put ."				
	breakfast meal tray of 05/24/18 at 7:56am r	isted living resident's delivered to her room on revealed the place setting c fork and spoon; there was				
	SCU dining room on 8:40am revealed: -There were 12 resid room.	reakfast meal service in the 05/24/18 from 7:45am to dents seated in the dining onsisted of a fork, spoon, and				
	- The place setting co cloth napkin. ealth Service Regulation	onsisted of a fork, spoon, and				

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If continuation sheet 2 of 12

STATEMENT	f Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	ONSTRUCTION	(X3) DATE COMF	SURVEY
			B. WING		05/24/2018	
		HAL075010			<u>_</u>	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
LAURELW	IOODS		ST MILLS STREET			
			BUS, NC 28722	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
D 287	Continued From pag	e 2	D 287			
	The meet converte	residents included choice of				
	- The meal served to	ambled eggs, bacon, grits,				
	and a slice of french	toast with svrup.				
	-One resident receiv	ed feeding assistance from				
	staff.	C				
	-The residents in the	e dining room who did not				
	receive feeding assis	stance had no difficulty eating				
	the meal.					
	Observation in the S	CU kitchen on 05/24/18 at				
	8.15am revealed the	ere was one knife available in				
	the silverware tray.					
	Interview with one o	f the SCU dining room staff				
	on 05/24/18 at 8:16a	am revealed:				
	-"We only bring out	a limited number of				
	silverware" from the	main kitchen.				
	the kitchen."	ware being washed now in				
	The Kitchen.	tional supply of all silverware				
	available in the main					
	Observation in the r	nain facility kitchen on				
	05/24/18 at 8:45am	and 9:15am revealed there				
	were 87 knives ava	ilable for place settings.				
		ok on 05/24/18 at 7:45am				
	revealed:	ut out at the tables in the "back				
	dining room" (SCU)	so "residents don't hurt				
	themselves".					
	-He had worked at	the facility for under one year				
	and "it (no knives) h	nas always been that way".				
	-There are knives k	ept in the SCU kitchen area				
	that staff can use to	assist residents, as needed.				
	-They cooked the v	regtables until they were "soft				
	so a knife was not	needed". products into pieces for the				
	SCU residents.	products into pieces for the				
	SUD residents.					

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STATEMENT	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		SURVEY PLETED
		HAL075010	HAL075010 B. WNG		05	/24/2018
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	NOVIDER OR GOLF EIER		ST MILLS STREET			
AURELW	VOODS	COLUME	BUS, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 287	Continued From pag	e 3	D 287			
	Interview with the As Manager on 05/24/1 -She had worked at -"There haven't beer don't hurt themselve setting at the SCU ta Interview with the Ac 8:47am revealed: -All the food in the S -Residents have a p to cut up food. -Staff "monitor" the S food for residents ba asks for help or whe help." -"All meat is cut up f Interview with one S 9:40am revealed: -The place setting w fork." -Residents could ge -"It doesn't really ma -"You can ask some cutting up your food you."	esistant Dining Room 8 at 7:50am revealed: the facility for one year. h knives so the residents s" (as a part of the place ables). Iministrator on 05/24/18 at CU was "cut up" by staff. roblem with having "strength" SCU dining room and "cut up ack there when a resident in staff sees a resident needs for the residents" in the SCU. GCU resident on 05/24/18 at vas "usually just a spoon and it a knife "if you ask for one." atter to me." oone" for assistance with and "somebody will do it for .		·		
	-She denied ever ha food, however was she needed help.	aving trouble cutting up her "sure" staff would help her if				
	Interview with a per 10:00am revealed: -The place setting i	sonal care aide on 05/24/18 at n the SCU dining room ı fork, spoon, and cloth napkin.				

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TATEMENT	f Health Service Regu of DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
ND FLAN U	GONNEOTION	HAL075010	B. WING		05/24/2018	
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AME OF PF	CONDER ON SOM LIEN		ST MILLS STREET			
AURELW	OODS	COLUM	BUS, NC 28722			
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT 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) COMPLET DATE
D 287	 Continued From page 4 -"All their food comes cut up back here." -The residents "very rarely need help." -"It depends on the food." -If something was served that required cutting and it did not come out cut from the kitchen, the staff would "go around and cut up everybody's food." Interview with the Special Care Coordinator (SCC) on 05/24/2018 at 1:30pm revealed: -The SCC was hired "about two weeks ago." 		D 287			
	-The SCC was hired -The SCC was not a SCU did not have ki	l "about two weeks ago." ware the residents in the				
	05/24/18 at 1:40pm -The place setting th a fork, spoon, and c -"We cut up everyth -"Some of the residu	revealed: ne SCU dining room included doth napkin. ing for them." ents take utensils." ave had residents who "poke				
	(RCC) on 05/24/20 -The RCC had been "about two years".	tesident Care Coordinator 18 at 1:45pm revealed: n employed at the facility for en removed from the SCU tt two years ago."				
	3:00pm revealed: -"I asked the kitche put out knives" in th -"They cut their foo -They weren't puttin reasons."	administrator on 05/24/18 at en staff and they have never ne SCU. d before it goes over." ng out knives for "safety have always done it."				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO IDENTIFICATION NUMBER: A. BUILDING:		CONSTRUCTION		SURVEY
ND PLAN OI	FCORRECTION	IDENTIFICATION NOMBER	A. BUILDING:			
		HAL075010	B. WING		05/24/2018	
AME OF PR	OVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
	0005		ST MILLS STRE	ET		
AURELW	0003	COLUME	BUS, NC 28722	1		(УЕ)
(X4) ID PREFIX TAG	(FACH 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) COMPLET DATE
D 464	Continued From page	e 5	D 464			
	D 464 10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan		D 464	see attac	hed	
	Profile & Care Plan In addition to the required. 0801 and 13F .0802 facility shall assure the (1) Within 30 days of care unit and quarter develop a written ress assessment data that behavioral patterns, daily living skills, spe physical abilities and cognitive impairment (2) The resident care 13F .0802 of this Sul or revised based on specify programming social and health call resident attain or material	admission to the special ly thereafter, the facility shall ident profile containing t describes the resident's self-help abilities, level of icial management needs, disabilities, and degree of				
	facility failed to com profiles for 3 of 3 sa	t as evidenced by: and record reviews the plete quarterly resident mpled residents (#1, #2, and the Special Care Unit (SCU).				
	The findings are:					
	02/27/18 revealed: -Diagnoses included disturbance, hyperto neuralgia.	ent #2's current FL2 dated d dementia with behavioral ension, depression, and onstantly disoriented.				

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If continuation sheet 6 of 12

STATEMENT	Health Service Regu of Deficiencies F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	JNSTRUCTION .	B) DATE SURVEY COMPLETED	
IND PLAN OI	GONNEOTION	HAL075010	B. WING		05/24/2018	
			DDRESS, CITY, STATE	ZIP CODE		
IAME OF PR	OVIDER OR SUPPLIER		ST MILLS STREET			
AURELW	OODS		BUS, NC 28722			
(X4) ID PREFIX TAG	(EACH DEFICIEN(TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
D 464	Continued From pag	e 6	D 464			
		level of care was a SCU.				
	Review of Resident revealed an admissi	#2's Resident Register on date of 01/03/11.				
	-There were residen 06/26/17 and 12/07/ -There were residen 06/26/17 and 12/07/	it care plans completed				
	Refer to the intervie 05/23/18 at 3:20pm	w with the Administrator on				
	Refer to the intervie Coordinator (SCC)	w with the Special Care on 05/24/18 at 8:15am.				
	01/25/18 revealed: -Diagnoses include depression, and all -Resident #1 was in wanderer.	ent #1's current FL2 dated d dementia, osteoarthritis, ergic rhinitis. htermittently disoriented and a d level of care was a SCU.				
	Review of Residen revealed an admiss	t #1's Resident Register sion date of 01/10/18.				
	-There was a resid	t #1's record revealed: ent care plan completed arterly update to Resident #1's				
	Refer to the intervi 05/23/18 at 3:20pr	iew with the Administrator on n.				
	Refer to the interv lealth Service Regulation	iew with the Special Care				

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE COMI	PLETED
- CORRECTION		B. WNG		05	/24/2018
OVIDER OR SUPPLIER					
2008			I		
			PROVIDER'S PLAN O	CORRECTION	(X5)
(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
Continued From pag	je 7	D 464			
Coordinator (SCC) o	on 05/24/18 at 8:15am.				
11/09/17 revealed: -Diagnoses included dementia/hallucinati -Resident #5 was do	d Alzheimer's lons, anxiety and depression. ocumented as a wanderer.				
Review of Resident revealed an admiss	#5's Resident Register ion date of 01/10/18.				
-There was a reside	ent care plan completed				
Refer to the intervie Coordinator (SCC)	ew with the Special Care on 05/24/18 at 8:15am.				
3:20pm revealed: -"We have been do residents' (in SCU -We changed from "about a year ago. -"We can update c	bing updates to all the) care plans every 6 months." a 3 month to 6 month updates " pur system to trigger quarterly				
(SCU) on 05/24/18 -The SCC had be two weeks ago". -"Care plans and	8 at 8:15am revealed: en hired for the position "about assessments are done every six				
	DF DEFICIENCIES = CORRECTION OVIDER OR SUPPLIER OODS SUMMARY S (EACH DEFICIENC REGULATORY OR Continued From page Coordinator (SCC) of 3. Review of Resider 11/09/17 revealed: -Diagnoses included dementia/hallucinati -Resident #5 was do -The recommended Review of Resident revealed an admiss Review of Resident revealed an admiss Review of Resident -There was a reside 12/24/17. -There was no qual care plan. Refer to the intervie 05/23/18 at 3:20pm Refer to the intervie 0	IDENTIFICATION NUMBER: OODS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 Coordinator (SCC) on 05/24/18 at 8:15am. 3. Review of Resident #5's current FL2 dated 1/09/17 revealed: - The recommended level of care was a SCU. Review of Resident #5's Resident Register revealed an admission date of 01/10/18. Review of Resident #5's record revealed: - There was a resident care plan completed 1/2/24/17. - There was no quarterly update to Resident #1's	OF DEFICIENCIES (*1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (x) MOLLIFEE G A BUILDING: HAL075010 B. WNG OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 1062 WEST MILLS STREET COLUMBUS, NC 28722 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 7 D 464 Coordinator (SCC) on 05/24/18 at 8:15am. D 464 3. Review of Resident #5's current FL2 dated 11/09/17 revealed: -Diagnoses included Alzheimer's dementia/hallucinations, anxiety and depression. -Resident #5 was documented as a wanderer. -The recommended level of care was a SCU. Review of Resident #5's record revealed: -There was a resident care plan completed 12/24/17. -There was no quarterly update to Resident #1's care plan. Refer to the interview with the Administrator on 05/23/18 at 3:20pm. Refer to the interview with the Special Care Coordinator (SCC) on 05/24/18 at 8:15am.	CM1 PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: LD2 MALLINC. HAL075010 B. WING OWDER OR SUPPLIER STREET ADDRESS, GTV, STATE, ZP CODE 1062 WEST MILLS STREET CODB STREET ADDRESS, GTV, STATE, ZP CODE 1062 WEST MILLS STREET CODB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OL SC DENTIFYING INFORMATION) PD PREVIDER'S CARECTIVE AC COROSS-REFERENCED TO DEFICIENCY OL SC DENTIFYING INFORMATION) Continued From page 7 D. 464 Condinator (SCC) on 05/24/18 at 8:15am.	OPERAGENCIES (M) PROVIDERSUPPLEADA IDENTIFICATION NUMBER LA JUNCTUCE Control NUMBER COMMINICATION NUMBER 00 OWDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE 02 OUNDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE 02 SUBMARY STATEMENT OF DEFICIENCES COLUMBUS, NC 28722 PROVIDERED TO THE SUBMARY STATEMENT OF DEFICIENCES SUBMARY STATEMENT OF DEFICIENCES COLUMBUS, NC 28722 REGULATORY ON LSS DEPARTY NO. D Continued From Page 7 D 464 Coordinator (SCC) on 05/24/18 at 8:156an. S. Review of Resident #5's current FL2 dated 11/09/17 revealed:

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STATEMENT	Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ND PLAN OI	CORRECTION		B. WING		05/24/2018
		HAL075010			
AME OF PR	OVIDER OR SUPPLIER		DRESS, CITY, STA		
			T MILLS STREE	ET	
AURELW	OODS	COLUMBL	JS, NC 28722		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN(TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
D 464	Continued From pag	je 8	D 464		
	-The SCC had been profiles were to be c -"The computer is se done every six mont -The SCC would "m	unaware quarterly resident ompleted. et up for assessments to be			
D935	G.S.§ 131D-4.5B(b) Training and Compe	ACH Medication Aides; etency	D935	see attache	d
P	G.S. § 131D-4.5B (I Medication Aides; T Evaluation Required	raining and Competency		3	
	home is prohibited any unsupervised n that individual has p medication aide du an adult care home of the following: (1) A five-hour train Department that in- in all of the followin a. The key principle administration. b. The federal Cen Prevention guidelin applicable, safe inj procedures for mo	ber 1, 2013, an adult care from allowing staff to perform nedication aide duties unless previously worked as a ring the previous 24 months in a or successfully completed all hing program developed by the cludes training and instruction ng: es of medication hters for Disease Control and nes on infection control and, if jection practices and nitoring or testing in which the potential for bleeding			
	 (2) A clinical skills NCAC 13F .0503 (3) Within 60 days individual must ha a. An additional 10 developed by the 	evaluation consistent with 10A and 10A NCAC 13G .0503. From the date of hire, the twe completed the following: 0-hour training program Department that includes action in all of the following:			

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TATEMENT	Health Service Reg OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY
ND PLAN O		HAL075010	B. WING		05	/24/2018
			ADDRESS, CITY, STATE	ZIP CODE		
AME OF PF	OVIDER OR SUPPLIER		EST MILLS STREET			
AURELW	OODS		BUS, NC 28722			
		المربع المراجع ا	ID	PROVIDER'S PLAN	F CORRECTION	(X5) COMPLET
(X4) ID PREFIX TAG		STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	DATE
D935	Continued From page	ge 9	D935			
	 The key principles of medication administration. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. An examination developed and administered 					
	b. An examination of h	lealth Service Regulation in				
	accordance with SL	ibsection (c) of this section.				
	This Dula is not m	et as evidenced by:				
	This Rule is not in	vs and record reviews, the	1			
	facility failed to as	sure 2 of 3 sampled medication				
	aides (Staff D and	F) who administered				
	medications had a	Medication Clinical Skills				
	Competency chec	klist completed prior to				
	administering med	lications.				
	The findings are:					
	1 Review of Staff	D's personnel file revealed:				
	-She was hired or	09/30/16 as a Personal Care				
	Aide (PCA).					
	-There was no do	cumentation of when Staff D's				
	job description ch	anged to Medication Aide (MA).				
	-She completed t	he 15 hour medication aide				
	training on 03/22/	17. passed the medication				
	-She successfully administration ex	am on $05/23/17$.				
	There was no do	ocumentation of a medication				
	clinical skills valid	lation.				
	Observation on C	5/23/18 from 11:55am to				
	Upservation on C	he medication pass revealed				
1	Health Service Regulation					

If continuation sheet 10 of 12

STATEMENT	f Health Service Regu of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND PLAN O	FORRECTION		B. WNG		05/24/2018	
		HAL075010				
NAME OF PF	OVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
	0000		EST MILLS STREET	ſ		
LAURELW	0005	COLUM	BUS, NC 28722		TION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIEN(TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE	
D935	Continued From page	ge 10	D935			
	Staff D administered	I medications to five				
	residents.					
	Interview with the B	usiness Director on 05/24/18				
	at 11:10am revealed	d:				
		e filing for the personnel files				
	for employees. -She was unable to find a medication clinical				•	
	skills validation che	cklist for Staff D in the				
	personnel file.					
	-She was unaware	of the requirement for a	1			
	medication aide to r	nave a medication clinical cklist signed off by a				
	Registered Nurse (RN) before administering				
	medications.					
	-She had never see	en nor knew where to get a				
	medication clinical	skills validation form to use.				
	- The previous facility	ty RN's had performed tration training with new				
	medication aides, h	nowever she did not know if the				
	content of the traini	ing was the same as the				
	content on the med checklist.	lication clinical skills validation				
	Refer to interview v	with the Administrator on				
	05/24/18 at 11:15a	m.				
	2. Review of Staff I	F's personnel file revealed:				
	-She was hired on	06/19/17 as a MA. ployment verification dated				
	08/30/2017 in her 1	file verifying past employment				
	as a MA.	passed the medication				
	administration exa	m on 07/02/13.				
	-There was no doo clinical skills valida	cumentation of a medication				
		Business Director on 05/24/18				
	at 11:10am reveal	ed:				
	-She maintained the service Regulation	he filing for the personnel files				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		05	05/24/2018	
		HAL075010			105	124/2018	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE EST MILLS STREET				
AURELN	IOODS		BUS, NC 28722				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
D935		ge 11	D935				
	 D935 Continued From page 11 for employees. She was unable to find a medication clinic skills validation checklist for Staff F in the personnel file. She was unaware of the requirement for a medication aide to have a medication clinic skills validation checklist signed off by a Registered Nurse (RN) before administerir medications. She had never seen nor knew where to ge medication clinical skills validation form to -The previous facility RN's had performed medication aides, however she did not know content of the training was the same as the content on the medication clinical skills validation form to the content on the medication clinical skills validation form to -The previous facility RN's had performed medication aides, however she did not know content of the training was the same as the content on the medication clinical skills validation clinical skills validation. 						
	11:15am revealed: -She had started w 2017 as the Admini -She became the A January 2018. -An audit had been records shortly afte facility and it was d required staff qualif missing out of the p -She had been una medication aide to	dministrator in the facility in performed of personnel r she had come to work in the iscovered some of the fication documents were					

D 287 10A NCAC 13F .0904(b)(2) Nutrition and Food Service

- 1. Staff has been trained to provide resident, unless there is a physician order to the contrary, a full plate setting.
- 2. To prevent this alleged deficiency from reoccurring trays and place settings will be audited.
- 3. The Dietary Director or designee will conduct audits trays and place settings.
- 4. The trays and place setting will be audited daily.
- 5. Completion date: 5/25/18

D464 10A NCAC 13F .1307 Special Care Unit Res. Profile and Care Plan

- 1. Wellness Director is conducting an audit of SCU resident care plans during the month of June. Any residents who have not have a quarterly assessment will have a new assessment conducted.
- 2. To prevent this alleged deficiency from reoccurring, Wellness Director will utilize a spreadsheet with quarterly due dates for all SCU residents.
- 3. The Wellness Director and Executive Director will ensure compliance.
- 4. The monitoring will occur monthly.
- 5. Completion date: 7/1/18

D935 G.S. 131D-4.5B(b) ACH Medication Aides; Training and Competency

- 1. Clinical Skills Competency Checklist has been obtained from the state website. Wellness Director is performing an audit of all current Med Techs to ensure the Checklist has been completed. Wellness Director will perform Competency evaluation on any Med Techs who do not previously have one.
- 2. To prevent this alleged deficiency from reoccurring, Wellness Director will perform Competency evaluations using the Clinical Competency Checklist on all new Med Techs, and will provide the Executive Director with a copy of the Checklist prior to assigning Med Tech to a Med Cart.
- 3. The Wellness Director and Executive Director will monitor the situation going forward.
- 4. Monitoring will occur upon hire/training of each Med Tech and during random employee file audits.
- 5. Completion date: 7/1/18

POC DISCLAIMER

"This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Laurelwoods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to Community's policies and the procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."