Division of Health Service Regulation

	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 NUMBER:	A. BUILDING: _		COMPL	EIED
		1141 00000	B WING		F	
		HAL080020			11/0	9/2018
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ANGELS A	AT HEART ASSISTED LIV	/ING	H MAIN STRE DVE, NC 2802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 000}	lnitial Comments		{D 000}			
	follow-up survey and November 8, 2018 the The complaint was in	sure Section conducted a a complaint investigation on rough November 9, 2018. itiated by the Rowan County Services on September 19,				
D 228	10A NCAC 13F .0702 Residents	? (d) Discharge Of	D 228			
	10A NCAC 13F .0702	P. Discharge Of Residents				
	following as applicable Paragraph (b) of this (1) documentation be assistant or nurse praparagraph (b) of this (2) the condition or of the health or safety of discharged or endangindividuals in the facilitaken to address the discharge of the reside (3) written notices of failure to pay the cost accommodations; or (4) the specific healt resident that the facilit met in the facility pursuand as disclosed in the	sident's record. Include one or more of the e to the reasons under Rule: y physician, physician ictitioner as required in Rule; circumstance that endangers of the resident being pers the health or safety of ity, and the facility's action problem prior to pursuing lent; warning of discharge for				
	facility failed to identif	as evidenced by: and record reviews, the by appropriate reasons for otice to 1 of 3 sampled				

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

TITLE (X6) DATE

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL080020	B. WING		11/09/2018	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS A	AT HEART ASSISTED LIV	/ING	H MAIN STRE			
0/0/15	SHIMMADV ST		OVE, NC 2802		1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 228	Continued From page	<u>:</u> 1	D 228			
	residents (Resident #	2) .				
	The findings are:					
	with peripheral vascul hypertension, latent e accident, and degene Review of a Notice of 10/15/18 for Resident -The reason for disch failed to pay the cost accommodations accommodations accontract" and "the resphysicians' order""The facility plans to checked. No name of was given as to where discharged to.	gnoses included diabetes lar disease, malignant lifects of cerebral vascular rative disk disease. Transfer/Discharge dated #2 revealed: large was "the resident has of services and ording to the resident with				
	Review of Resident # 11/08/18 revealed: -On 10/09/18, Reside purchase a cinnamon have enough money ther at that timeThere was no docum the physician had been	2's nurses notes on ent #2 went to the store to supplement, but did not to pay for it. She had \$6 with entation in the nurses notes en contacted about the to purchase cinnamon				
	Funds Ledger revealed balance was up to da	2's Resident Personal ed the resident's account te with a \$0 balance owed to ber 2018 and October				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
					F	₹
		HAL080020	B. WING		11/0	9/2018
NAME OF D		OTDEET AS	DDECC CITY CTA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
ANGELS	AT HEART ASSISTED LIV	VING 1114 SOL	JTH MAIN STRE	ET		
ANGLLO	AT TIEART AGGIGTED EN	CHINA G	ROVE, NC 2802	23		
(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		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 220	0	- 0	D 220			
D 228	Continued From page	e 2	D 228			
	Paviow of Pasidant #	2's Verbal Warning Form				
		_				
	dated 08/18/18 revea					
	•	e first warning for Resident				
	#2.					
	-The verbal warning v	was issued for the resident				
	being non-compliant	with physician's order as the				
	resident failed to supp					
		the resident was she did				
	not want to use the facility pharmacy and she					
	would get her own medications.					
	-The verbal warning was signed by the					
	_	was signed by the				
	Administrator.					
	-There were no verba	al warnings issued for unpaid				
	pharmacy bills in which	ch the facility had to pay for				
	medications.					
	Review of Resident #	2's Verbal Warning Form				
	dated 10/09/18 revea	_				
	-The warning was the					
	_	s second warning for				
	Resident #2.					
	_	was issued for the resident				
		with physician's order as the				
	resident failed to supp	ply her medications in a				
	timely manner.					
	-Explanation given by	the resident was she did				
	not want to spend he					
	=	d to sign the verbal warning.				
	-The verbal warning v					
	_	was signed by the				
	Administrator.					
		al warnings issued for unpaid				
	pharmacy bills in which	ch the facility had to pay for				
	medications.					
	Review of Resident #	2's Verbal Warning Form				
	dated 10/15/18 revea	_				
	-The warnings were o					
	10/09/18.	acca 10/01/10 and				
		was issued for				
	-The verbal warning v					
	non-compliance with	physician's order.				

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Division of Health Service Regulation

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF	
			A. BUILDING: _			
		HAL080020	B. WING		R 11/09/	2018
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ANGELO	AT LIEADT ACCIOTED LI	1114 SOU	ITH MAIN STRE	ET		
ANGELS	AT HEART ASSISTED LI	CHINA G	ROVE, NC 2802	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 228	Continued From page	e 3	D 228			
	-There was no explar and she walked away -The resident decline -The verbal warning was a resident first note attached 10/07/18 and was wrothe Administrator in was not in compliance that she was out of a using house stock an needed to purchase soften among as she did \$6. -The second note attached 10/15/18 and was wrothe second note attached 10/15/18 and was wrothe second note attached 10/15/18 and was wrother as a she did \$6. -The second note attached 10/15/18 and was wrother as a she did \$6. -The second note attached 10/15/18 and was wrother as a she did 10/15/18 and was wrother as a she did not she was given a ver 10/15/18 and would be she was not given a she did not know she decision. -She was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/18 and would be she was told "she confor 2 weeks after discontraction and 11/15/16 a	nation given by the resident y. Ind to sign the verbal warning. It was signed by the shote attached to it. It led to the form was dated itten by the Administrator. It formed Resident #2 that she is with her medications and cetaminophen and had been and out of cinnamon and some that day. It is seed acetaminophen but not not want to spend her last ached to the form was dated itten by the Executive in the facility in a timely store informed the resident of the facility in a timely store informed the resident of the store to the facility in a timely store informed the resident of the facility in a timely store informed the resident of the facility in a timely store informed the resident of the store to the facility in a timely store informed the resident of the store to the facility in a timely store informed the resident of the store on the leaving on 11/14/18. It is copy of the discharge. It is could appeal the facility's bould not appeal the decision				

Division of Health Service Regulation

because she did not want to spend her last \$6 on

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
	HAL080020	B. WING		11	R I/ 09/2018	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
AT HEADT ASSISTED I IV	/ING 1114 SOL	UTH MAIN STREET				
AI HEART ASSISTED LIV	CHINA G	ROVE, NC 28023				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Continued From page	e 4	D 228				
-She asked the Admii if she did not find and Administrator said "sh	nistrator what would happen ther facility to go to and the ne will call the cops and					
11/09/18 at 11:55 am -The facility staff had was being discharged until 10/25/18She tried talking with Administrator would r information until she I the resident even afte okay to give the famil -She had filed an eme	revealed: told Resident #2 that she d, but she did not find out the Administrator, but the not listen or give her any had the power of attorney for er the resident said it was y member the information.					
-The family member hissueThe discharge form meeting with the Adm 11/09/18, to show tha	had been revised, during her ninistrator and the ED on It the family member					
4:10 pm revealed: -She gave Resident # notice when she infor be discharged from th -The discharge notice on 10/15/18 and the I (BOM) was a witness -The resident was be had not paid her phar non-compliant with ph cinnamon supplemen needed.	#2 a copy of the discharge med the resident she would he facility. #2 was given to Resident #2 #2 Business Office Manager #3. #4 ing discharged because she macy bills and was hysician's orders for the and acetaminophen as					
	Continued From page the cinnamon suppler. She asked the Admir if she did not find and Administrator said "shave her delivered to Interview with Reside 11/09/18 at 11:55 am. The facility staff had was being discharged until 10/25/18. She tried talking with Administrator would rinformation until she in the resident even after okay to give the famil She had filed an emethe resident. The family member issue. The discharge form meeting with the Administrator would rinformation until she in the resident even after okay to give the famil She had filed an emethe resident. The family member issue. The discharge form in meeting with the Administrator would rinformation until she in the resident. The family member issue. The discharge form in the resident was the information until she in the interview with the Administrator would rinformation until she in the resident.	AT HEART ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 the cinnamon supplement. -She asked the Administrator what would happen if she did not find another facility to go to and the Administrator said "she will call the cops and have her delivered to the nearest shelter". Interview with Resident #2's family member on 11/09/18 at 11:55 am revealed: -The facility staff had told Resident #2 that she was being discharged, but she did not find out until 10/25/18. -She tried talking with the Administrator, but the Administrator would not listen or give her any information until she had the power of attorney for the resident even after the resident said it was okay to give the family member the information. -She had filed an emergency appeal on behalf of the resident. -The family member had tried to resolve the issue. -The discharge form had been revised, during her meeting with the Administrator and the ED on 11/09/18, to show that the family member received a copy of the discharge notice. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She gave Resident #2 a copy of the discharge notice when she informed the resident she would be discharged from the facility. -The discharge notice was given to Resident #2 on 10/15/18 and the Business Office Manager (BOM) was a witness. -The resident was being discharged because she had not paid her pharmacy bills and was non-compliant with physician's orders for cinnamon supplements and acetaminophen as	A BUILDING: HALOBOO20 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE AT HEART ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 the cinnamon supplement. -She asked the Administrator what would happen if she did not find another facility to go to and the Administrator said "she will call the cops and have her delivered to the nearest shelter". Interview with Resident #2's family member on 11/09/18 at 11:55 am revealed: -The facility staff had told Resident #2 that she was being discharged, but she did not find out until 10/25/18She tried talking with the Administrator, but the Administrator would not listen or give her any information until she had the power of attorney for the resident even after the resident said it was okay to give the family member the informationShe had filed an emergency appeal on behalf of the residentThe family member had tried to resolve the issueThe discharge form had been revised, during her meeting with the Administrator and the ED on 11/09/18, to show that the family member received a copy of the discharge notice. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She gave Resident #2 a copy of the discharge notice when she informed the resident she would be discharged from the facilityThe discharge notice was given to Resident #2 on 10/15/18 and the Business Office Manager (BOM) was a witnessThe resident was being discharged because she had not paid her pharmacy bills and was non-compliant with physician's orders for cinnamon supplements and acetaminophen as needed.	A BUILDING: HAL080020 ROVIDER OR SUPPLIER AT HEART ASSISTED LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 4 the cinnamon supplement. -She asked the Administrator what would happen if she did not find another facility to go to and the Administrator said "she will call the cops and have her delivered to the nearest shelter". Interview with Resident #2's family member on 11/09/18 at 11:55 am revealed: -The facility staff had told Resident #2 that she was being discharged, but she did not find out until 10/25/18. -She tried talking with the Administrator, but the Administrator wall the power of attorney for the resident even after the resident said it was okay to give the family member the information. -She had filed an emergency appeal on behalf of the resident. -The family member had tried to resolve the issue. -The discharge form had been revised, during her meeting with the Administrator on 11/09/18 at 4:10 pm revealed: -She gave Resident #2 a copy of the discharge notice. Interview with the Administrator on 11/09/18 at 4:10 pm revealed: -She gave Resident #2 a copy of the discharge notice when she informed the resident she would be discharged from the facility. -The discharge from the facility. -The discharge from the facility. -The discharge from the susiness Office Manager (BOM) was a witness. -The resident was being discharged because she had not paid her pharmacy bills and was non-compliant with physician's orders for cinnamon supplements and acetaminophen as needed.	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 REACH DEPICIENCY SMUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CACHE COMPRECTIVE ACTION SHOULD BE CROSS REFERENCE ACTION TAGE CROSS REFERENCE ACTION TAGE CROSS REFERENCE ACTION TAGE PREFIX TAGE CROSS REFERENCE ACTION TAGE CROSS REFERENCE TAGE	

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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
		HAL080020	B. WING		R 11/09/2018
NAME OF D			ODESS CITY STA	TE ZID CODE	1
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA TH MAIN STRE		
ANGELS A	AT HEART ASSISTED LIV	/ING	OVE, NC 2802		
			1012, 110 2002		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 228	Continued From page	e 5	D 228		
D 228	facility had to buy the -She informed the resident the police if should have the facility are and and [expletive] if y. Interview with the BO revealed: -Currently Resident # -The facility had purely supplementsShe witnessed the Adischarge notice to the linterview with the Exercite at 7:00 pm revealed: -The facility had purely Resident #2 in the pastockThe resident was curboard chargesShe purchased cinnaresident on 10/09/18 back by the residentShe had issues in the buying her acetaminotake as neededThe resident kept he the bedside and had self-administrationShe thought the facility and purchased cinnaresident on 10/09/18 back by the resident.	Intually purchase her ook as needed but the cinnamon supplements. Sident that the facility only to had behaviors and would after her discharge. Immented "[expletive] if you ou don't" and walked off. IM on 11/09/18 at 6:36 pm. If 2 did not owe anything. The hased her cinnamon. In the discharge was a second or cinnamon and the discharge was a second or cinnamon supplement at the cinnamon	D 228		
	_	notified the physician of the non supplements or the			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
		HAL080020	B. WING		R 11/09	9/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELO	AT LIEADT ACCIOTED III	1114 SOU	TH MAIN STRE	ET		
ANGELS /	AT HEART ASSISTED LIV	CHINA GR	ROVE, NC 2802	3		
(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	(X5) COMPLETE DATE
D 228	Continued From page	e 6	D 228			
	Attempted telephone on 11/09/18 at 1:50 p Review of the facility revealed a resident of following reasons: -Charges for the residuence services had not been the date on which the -The resident require facility was unable to -The health, safety, of another resident requirements of the company of the health, safety who resides in the home.	interview with the physician m was unsuccessful. Transfer/Discharge Policy ould be discharged for the dent's accommodations and paid within 30 days after by came due. d a level of care that the provide. I welfare of the resident or irred discharge.				
{D 238}	Medical Examination 10A NCAC 13F .0703 Examination And Imm The results of the conin Paragraph (b) of the the FL-2, North Carol Term Care Services, Medicaid Program Mewhich shall comply with the information clear or is insufficient physician for clarificate the services of the facindividual's needs.	B Tuberculosis Test, Medical nunizations Inplete examination required is Rule are to be entered on ina Medicaid Program Long or MR-2, North Carolina ental Retardation Services, ith the following: on the FL-2 or MR-2 is not , the facility shall contact the tion in order to determine if cility can meet the	{D 238}			
	This Rule is not met	as evidenced by:				

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE COMPLETED	.Y
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED	
					R	
		HAL080020	B. WING		11/09/20	18
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS.	AT HEART ASSISTED LIV	JING 1114 SOUT	H MAIN STRE	ET		
ANGLEGA	TITLART AGGIGTED EN	CHINA GR	OVE, NC 2802	3		
(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 CO	(X5) DMPLETE DATE
{D 238}	Continued From page	÷ 7	{D 238}			
	facility failed to assure	and record reviews, the e medication orders were nt FL2s for 1 of 5 sampled (3).				
	The findings are:					
	The findings are: Review of Resident #3's FL2 dated 08/25/18 revealed: -Diagnoses included Alzheimer's Dementia, mental and developmental disabilities, depression with suicidal ideation, chronic obstructive pulmonary disease, emphysema, anemia, insulin dependent diabetes mellitus, and degenerative disk disease. -There were no medications listed on the FL2The medication section of the FL2 did not refer to an attached listThere was a medication list attached to the FL2 which had been printed on 09/11/18, but had not been signed.					
Review of 6 month physician's orders dated July 2018 revealed: -There was an order for lopressor (used to treat blood pressure) 75 mg two times a day. -There was an order for amlodipine (used to treat blood pressure) 10 mg daily. -There was an order for folic acid (used to treat vitamin B deficiency) 1 mg daily. -There was an order for Januvia (used to treat diabetes) 100 mg daily. -There was an order for ranitidine (used to treat gastric reflux) 150 mg daily. -There was an order for vitamin B12 (used to treat vitamin B deficiency) 1000mcg daily. -There was an order for vitamin D3 (used to treat vitamin D deficiency) 1000 units daily. -There was an order for venlafaxine (used to treat depression) 150 mg daily.						

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Division C	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	≣TED
					R	,
		HAL080020	B. WING		1	9/2018
					1 11/0	3/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS A	AT HEART ASSISTED LIV	VING 1114 SOU	TH MAIN STRE	ET		
ANGLLO	TILART AGGIGTED EN	CHINA GF	ROVE, NC 2802	3		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 238}	Continued From page 8		{D 238}			
	was no documentation contacted for clarifical Interview with a medicat 9:23 am revealed: -She had noticed some any medications listed -The Resident Care Exaministrator filled outshe did not know if a record (MAR) could be the FL2 or notShe did not think a Mattached to the FL2 are -She had faxed physician on 11/01/18	cation of medication orders. cation aide (MA) on 11/09/18 ne of the FL2s did not have don them. Director (RCD) or the latt the FL2s. a medication administration be printed and attached to MAR could be printed and lifter it had been signed.				
	-She had only filled or - The RCD or the Adn the FL2s. -The medications sho -If medications were r should say "see attac -She had seen an FL2	ministrator usually filled out ould be listed on the FL2. not listed on the FL2, it				
	the contracted pharm revealed: -Orders were filled by	macy representative from lacy on 11/09/18 at 9:15 am whatever was sent to them. sician orders they received and were 6 month				

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Interview with the Administrator on 11/09/18 at

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL080020	B. WING		R 11/09/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1114 SOU	TH MAIN STRE	ET		
ANGELS	AT HEART ASSISTED LIV	CHINA GF	ROVE, NC 2802	3		
(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 238}	Continued From page	9	{D 238}			
	4:10 pm revealed: -The FL2s were filled -She had never filled -Medications were su FL2She double checked inShe did not know wh medications listed on -She did not know wh had been printed on 0 MAR a few weeks aft -Current orders were physician when a resi -She removed the pri attachment from the F -She and the Execution on a weekly basis. Interview with the Exe at 7:00 pm revealed: -The RCD and the Ad for completing the FL	out by the MAs. out an FL2. pposed to be listed on the all orders when they came y the FL2 did not have it. y a copy of current orders 19/11/18 and attached to the er the FL2 had been signed. printed and sent to the ident had an appointment. Inted current orders FL2. Ive Director audited records ecutive Director on 11/09/18 ministrator were responsible				
	-She did not know wh medications listed on -She did not know wh	y the FL2 did not have it. y a copy of the current ed and attached to the				
	signed FL2 a few wee	eks later. trator were responsible for				
D 310	10A NCAC 13F .0904 Service	e(e)(4) Nutrition and Food	D 310			
	(e) Therapeutic Diets	Nutrition and Food Service in Adult Care Homes: ets, including nutritional				

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Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL080020	B. WING		R 11/09/2018
	ROVIDER OR SUPPLIER	/ING	DRESS, CITY, STA TH MAIN STRE OVE, NC 2802	ET	
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 310		e 10 kened liquids, shall be the resident's physician.	D 310		
	reviews, the facility fa diets were served as resident (Resident #2 a no concentrated sw calcium.	as evidenced by: ns, interviews and record iled to ensure therapeutic ordered for 1 of 1 sampled b) with a physician's order for reets (NCS) diet with no			
	vascular disease, ma effects of cerebral vas degenerative disk dis -There was a physicia fingerstick blood sugarthere was a physicia concentrated sweets Review of Resident # revealed: -There was an order of discontinue any calciu and multivitamins.	diabetes with peripheral lignant hypertension, latent scular accident, and ease. an's order for weekly ars once on Wednesdays. an's order for a no diet with no calcium. 2's physician's orders dated 09/17/18 to um containing medications er dated 10/3/18 for a low			
	Review of Resident #	2's record revealed no			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL080020	B. WING		11/09/	2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS	AT HEART ASSISTED LIV	/ING	H MAIN STRE			
	CLIMMADY CT.	ATEMENT OF DEFICIENCIES	OVE, NC 2802	PROVIDER'S PLAN OF CORRECTION	N.	0.5
(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 310	Continued From page	e 11	D 310			
	documentation the ph clarification of the die	nysician was contacted for torder.				
	kitchen revealed Resi	eutic diet list posted in the ident #2 was to be served a sets diet (a regular diet with ne-half portion).				
		eutic diet menus revealed menu used for all diabetic				
	Review of Resident # administration record revealed a blood suga	(MAR) for September 2018				
	Review of Resident # revealed a blood suga	2's MAR for October 2018 ar range of 140 - 245.				
	Review of Resident # revealed a blood suga	2's MAR for November 2018 ar of 179.				
	sandwich, cucumber	revealed: ved water, a grilled cheese and tomato salad with Italian ed sugar vanilla ice cream.				
	package revealed tha	ents label on the cheese It one slice of cheese alue of calcium based on a				
	sugar ice cream reve	ents label on the no added aled that one serving ue of calcium based on a				
	Interview with Reside	nt #2 on 11/08/18 at				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL080020	B. WING		11/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ANGELS A	AT HEART ASSISTED LIV	/ING	H MAIN STRE		
0/0.15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	OVE, NC 2802	PROVIDER'S PLAN OF CORRECTION	l over
(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 APPROPR DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 12	D 310		
D 310	12:30pm revealed: -She was a diabetic a control her diabetesShe had her blood so on Wednesdays by statesTo her knowledge, states diet, but was not supperfect the facility had LCS for all diabetics, but the provided and the facility had LCS for all diabetics, but the facility had LCS for all diabetics, but the menusDesserts in white borresidents and dessert residents on a regular linterview with the Adra 4:10 pm revealed: -She knew Resident acalciumShe double checked came inThe facility only used.	and took medications to agar checked once a week saff. The should be on a diabetic cosed to have calcium. Idents got the same dessert, Tent colored bowls. The served at meals were always atary Manager (DM) on The evealed: #2 was on a LCS diet. Ider changed, management Thim with a new diet order. Idiet menus that were used The facility did not have NCS was were used for diabetic Tes in red bowls were used for	D 310		
	preparing meals.	interview with the physician			
D 344	10A NCAC 13F .1002	2(a) Medication Orders	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL080020	B. WING		11	R I/ 09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	•	
ANGELS	AT HEART ASSISTED L	IVING 1114 SO	UTH MAIN STREET	Г		
ANGLES	AT TIEART ASSISTED E	CHINA (SROVE, NC 28023			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 344	10A NCAC 13F .100 (a) An adult care ho the resident's physic for verification or cla medications and treat (1) if orders for admiresident are not date of admission or read (2) if orders are not (3) if multiple admission or readmiforms are not the sa The facility shall ens	22 Medication Orders ome shall ensure contact with cian or prescribing practitioner rification of orders for atments: ssion or readmission of the ed and signed within 24 hours lmission to the facility; clear or complete; or sion forms are received upon ssion and orders on the	D 344			
	interviews, the facilit of medication orders (Resident #1 and #2 (#1) and a diuretic a The findings are: 1. Review of Reside 08/21/18 revealed dipre-diabetes, atrial file.	ons, record reviews, and y failed to assure clarification of for 2 of 4 sampled residents of including refresh gel drops and a laxative (#2).				
	form dated 10/04/18 -Documentation on t severe dry eye with	#1's medication clarification revealed: he form included "Pt. has erosion OS (left eye)." ian's order to start refresh gel				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII ELTED
		HAL080020	B. WING		R 11/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ANGELS A	AT HEART ASSISTED LIV	/ING	H MAIN STRE OVE, NC 2802		
(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 344	Continued From page	e 14	D 344		
	drops (treat dry eyes)	four times daily OS.			
	Administration Record	1's electronic Medication ds (MARs) for October and aled no entry for refresh gel			
	#1 on 11/08/18 at 5:2	ations on hand for Resident 2pm revealed refresh gel ble for administration.			
	at 5:26pm revealed: -She did not recall se dropsResident #1 had a property of the property of the order in the the orders and making sent to the pharmacyWhen the medication pharmacy the MA on label with the order to filled and dispensed a instructionsThere was no documerers begel drops and refresh gel drops got	eceived the MA on duty was medication tracking book. as responsible for reviewing g sure they were clear and an was received from the duty checked the pharmacy ensure the medication was according to the physician's mentation regarding the she did not know how the missed.			
	Interview with Reside 11:11am revealed: -Currently, she had us because her right eye -Sometimes she had something for her left	se of her left eye only was artificial. very dry eyes and needed			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			_			R
		HAL080020	B. WING		11	/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
ANGELS A	AT HEART ASSISTED LIV	/ING	JTH MAIN STREET			
	QUILITATE VAT		ROVE, NC 28023	DD0///DED/0 DLAN 05 0		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 344	Continued From page	e 15	D 344			
	was very thick and she the medication was a administered the medication was a administered the medication. Currently, she had a in her room at her beson and the she will be administered four time. Interview with the Exact 11:15am revealed: -When medication or on duty should log the prescription to the pholif the physician did not the refresh gel drops considered the refress.	dication at bedtime. rtificial tears, which she kept dside and used as needed. tting an eye gel es daily. ecutive Director on 11/09/18 ders were received the MA e order and send the armacy. tot send a prescription for the MA may not have h an order. e contacted the physician in				
	8:10pm revealed: -When orders were re or missing information should follow-up with (PCP) to clarify the or -She reviewed medic ensure medications v orderedShe had reviewed th four times daily for Re consider the refresh or because the physicial prescriptionShe knew the facility medications even as medications.	ation orders after the MA to were administered as e order for refresh gel drops esident #1, but did not gel drops to be an order in did not hand write a reeded an order for all needed (recommended) e refresh gel drops four				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL080020	B. WING		11	R / 09/2018
NAME OF PRO	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	E, ZIP CODE		
ANGELS A	T HEART ASSISTED LIV	/ING	ITH MAIN STREE [®] ROVE, NC 28023	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	Resident #1's PCP's e-Due to Resident #1's eyes. -The physician wrote four times daily, but do the medication because purchased over-the-ce-Since there was no wrefresh gel drops, the contacted the PCP's econtacted the econtacted the PCP's econtacted the econtacted the PCP's econtacted the econtacted the econtacted the PCP's econtacted the econtacted the PCP's econtacted the econtacted the PCP's econtacted the econtacted the econtacted the PCP's econtacted the econtacted the econtacted the PCP's econtacted the econtacted the PCP's econtacted the PCP	at 1:50 pm with the nurse at office revealed: age she had chronic dry to start refresh gel drops id not write a prescription for se the medication could be ounter. written prescription for the facility should have office to clarify the order. It #2's current FL2 dated agnoses included diabetes lar disease, malignant affects of cerebral vascular varietive disk disease. In sorder for furosemide (allow morning) (no dosage or sheet dated 10/15/18 station aide (MA) asked the ethylene glycol powder 17 the medication administration. It is physician's orders medication order dated there are glycol 3350 powder 1. It is physician to clarify the de glycol and furosemide.	D 344			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		D
			B 14/11/0		R	
		HAL080020	B. WING		11/09/2	018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS	AT HEART ASSISTED LIV	/ING	H MAIN STRE			
		CHINA GR	OVE, NC 2802	3		
(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 C	(X5) COMPLETE DATE
D 344	Continued From page	e 17	D 344			
	orders dated 09/19/18 -There was a physicia mg every morningThere was no physic glycol 3350 powder. Review of Resident # Medication Administrate revealed: -There was an entry f daily which had been administeredThere was no entry f daily which had been administeredThere was an entry f daily which had been administeredThere was an entry f daily which had been administeredThere was an entry f powder 17 grams one documented as administered. Review of Resident # revealed: -There was an entry f daily which had not been dadministered. Review of Resident # revealed: -There was an entry f daily which had been administeredThere was an entry f daily which had been administeredThere was an entry f powder 17 grams once	an's order for furosemide 40 ian's order for polyethylene 2's September 2018 ation Record (MAR) or furosemide 40 mg once documented as or polyethylene glycol. 2's October 2018 MAR or furosemide 40 mg once documented as or polyethylene glycol be daily which had been nistered. entry for polyethylene glycol needed for constipation ocumented as being 2's November 2018 MAR or furosemide 40 mg once documented as or polyethylene glycol needed for constipation ocumented as being				
	powder 17 grams as	entry for polyethylene glycol needed for constipation ocumented as administered.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETED
		HAL080020	B. WING		R 11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	AT HEART ASSISTED LIV	/ING	TH MAIN STRE		
	I	CHINA GF	OVE, NC 2802	23	
(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 344	Continued From page	e 18	D 344		
	pm revealed: -She used a mail order prescriptions filledStaff gave her a fluid -She only used the porneeded, but she used Interview with a mediat 9:23 am revealed: -She did not know Renot been clarified on the Resident Care Expedient #2 used a pher prescriptions filled get the medications a -The RCD was no longer the state of the prescription of the RCD was no longer the state of the prescription of the RCD was no longer the state of the prescription of the RCD was no longer t	cation aide (MA) on 11/09/18 esident #2's medication had the FL2. Director (RCD) usually from the physician. mail order pharmacy to get d but it took 7 - 10 days to			
	4:10 pm revealed: -She double checked inThe FL2 was usually -She had never filled -The FL2 should had				
	Resident #2's pharma revealed: -The pharmacy filled #2. -The pharmacy did no fill prescriptions.	macy representative from acy on 11/09/18 at 4:20 pm prescriptions for Resident of use Resident #2's FL2 to prescriptions directly to the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING		R	
		HAL080020	B. WING		11/09/201	8
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS A	AT HEART ASSISTED LIV	/ING	H MAIN STRE			
	OLIMANA DV. OT		OVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
D 344	Continued From page	19	D 344			
	was for 40 mg daily. -The last order for pol grams daily. -The prescriptions we supply.					
	Attempted telephone on 11/09/18 at 1:50 pt	interview with the physician m was unsuccessful.				
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358			
	(a) An adult care hon preparation and admi prescription and non-lby staff are in accorda (1) orders by a licens which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: ed prescribing practitioner in the resident's record; and on and the facility's policies				
	reviews, the facility fa were administered as practicing practitioner	s, interviews and record iled to assure medications ordered by a licensed				

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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	
		HAL080020	B. WING		R 11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
ANGELS	AT HEART ASSISTED LIV	/ING	TH MAIN STRE		
		CHINA GF	ROVE, NC 2802		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	20	D 358		
	The findings are:				
	· · · ·				
	form dated 10/04/18 r -Documentation on th severe dry eye with e	e form included "Pt. has rosion OS (left eye)." an's order to start refresh gel			
	Administration Record	1's electronic Medication ds (MARs) for October and aled no entry for refresh gel			
	#1 on 11/08/18 at 5:2	ations on hand for Resident 2 pm revealed refresh gel ble for administration.			
	at 5:26 pm revealed: -She did not recall sedoropsResident #1 had a property of the previously put on did not recall seeing the was previously put on did not recall seeing the was previously put on did not recall seeing the was did not recall seeing the orders were retained to the order of the pharmacyThere was no docume refresh gel drops were	roblem with dry eyes and an eye lubricant, but she he gel drops. eceived the MA on duty was medication tracking book. as responsible for reviewing g sure they were clear and entation regarding the e received or administered.			
	Interview with Reside	nt #1 on 11/09/18 at 11:11	1		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
			B WING		R
		HAL080020	B. WiiNO		11/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS A	AT HEART ASSISTED LIV	VING	TH MAIN STRE		
	Г		OVE, NC 2802		
(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 358	because her right eyes-Sometimes she had something for her left -She was previously of was very thick and she the medication was a administered the medication was a administered the medication at her room at her besome of the control of the contr	se of her left eye only e was artificial. very dry eyes and needed eye. ordered an eye lubricant that ne was unable to see after dministered, so staff dication at bedtime. rtificial tears, which she kept dside and used as needed. etting an eye gel es daily. ecutive Director on 11/09/18 : ald be administered as ders were received the on duty should log the order oftion to the pharmacy. not send a prescription for the MA may not have the an order. e contacted the physician in fy the order. ministrator on 11/09/18 at ere not currently being dent #1. ation orders after the MA to	D 358	DEFICIENCY)	
	prescription.	n did not hand write a s were never administered.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		R 11/09/2018
	ROVIDER OR SUPPLIER	/ING 1114 SOU	DRESS, CITY, STATE TH MAIN STREIN ROVE, NC 2802	ET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETE
D 358	medications even as medications. Interview on 11/09/18 Resident #1's PCP's c-Due to Resident #1's eyesThe physician wrote four times daily, but d the medication becaupurchased over-the-c-Since there was no verfresh gel drops, the	needed an order for all needed (recommended) at 1:50 pm with the nurse at office revealed: age she had chronic dry to start refresh gel drops id not write a prescription for se the medication could be ounter. written prescription for the	D 358		
D 421	Personal Funds (c) A record of each to of the resident's personal funds. Paragraph (b) of this resident, legal represents the resident, if not with two witnesses' si verifying the accuracy personal funds. The in the home. This Rule is not met abased on record reviet facility failed to assure signatures on the Resident to verify the adisbursement of personal funds.	Accounting For Resident's ransaction involving the use onal funds according to Rule shall be signed by the entative or payee or marked adjudicated incompetent, gnatures at least monthly of the disbursement of record shall be maintained as evidenced by: ews and interviews, the ethere were two witness sident Personal Funds ccuracy of transactions and	D 421		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.12510		R	
		HAL080020	B. WING		11/09/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS	AT HEART ASSISTED LIV	/ING	H MAIN STRE			
	I	CHINA GR	OVE, NC 2802			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 421	Continued From page	23	D 421			
	The findings are:					
	08/21/18 revealed dia pre-diabetes, atrial fib	t #1's current FL2 dated agnoses included orillation, anemia, cardiac idney disease three and				
	-The begining balance \$80.00. -Resident #1 had 1 tr 2018 for receipt of \$2 -There was 1 signatur staff to sign. -The ending balance \$60.00. -Resident #1 signed of \$20.00 in September	er for Resident #1 revealed: e for September 2018 was ansaction in September 0.00 in personal funds. re line for Resident #1 and for September 2018 was confirming she received				
	Fund Ledger for Resi The begining balance \$60.00Resident #1 had 1 tra for receipt of \$20.00 i -There was 1 signatur staff to signThe ending balance \$40.00Resident #1 signed of \$20.00 in October 20	e for October 2018 was ansaction in October 2018 n personal funds. re line for t Resident #1 and for October 2018 was confirming she received				
	Interview with Reside pm revealed:	nt #1 on 11/09/18 at 8:08				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION) DATE SURVEY COMPLETED		
and Plan of Correction IDENTIFICATION NUMBER		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED			
HAL080020		B. WING		R 11/09/2018				
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
ANGELS AT HEART ASSISTED LIVING			TH MAIN STRE OVE, NC 2802					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE		
D 421	Continued From page	24	D 421					
D 421	-She paid for her cost fundsHer family member be each month for her to -She could get money wanted toThe Business Office Executive Director (E she requested it and switness her signature Resident Personal Led Attempted telephone 11/09/18 at 5:06 pm volume 11	to force from personal brought money to the facility use as needed. If from the facility when she Manager (BOM) or the D) gave her money when she had not seen anyone when she signed the deger. Interview with the BOM on was unsuccessful. Ecutive Director on 10/09/18 Fate pay and paid for her to #1 did not receive Special Office Manager were g and had signed as a stions were made for private kay for the resident and 1 the Resident Personal Fund vitness signatures were ons. by there was not a witness dent Fund Ledger when Resident #1. It #2's current FL2 dated Ignoses included diabetes lar disease, malignant effects of cerebral vascular	D 421					
	Review of the September 2018 Resident							

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 421 Continued From page 25 A. BUILDING: A. BUILD	STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION	` '	1 ' '			(3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING			A. BUILDING:	A. BUILDING.		_	
ANGELS AT HEART ASSISTED LIVING 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID PREFIX PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	HAL080020		B. WING	B. WING			
ANGELS AT HEART ASSISTED LIVING CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CHINA GROVE, NC 28023 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	NAME OF PROVIDER OR SU	DER OR SUPPLIER STREE	ET ADDRESS, CITY, STATE	E, ZIP CODE			
CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CHINA GROVE, NC 28023 ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	ANGELS AT HEART AS	EART ASSISTED LIVING					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		CHIN	IA GROVE, NC 28023			_	
D 421 Continued From page 25 D 421	PREFIX (EACH	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE	
	D 421 Continued F	1 Continued From page 25					
Personal Fund Ledger for Resident #2 revealed: -The begining balance for September 2018 was \$1436.00Resident #2 had 3 transactions in September 2018 for payment of \$120.00 for cost of care, a payment of \$40.00 for medication costs, and receipt of \$200.00Resident #2 should have received \$196.00, but an extra \$4.00 was given to Resident #2 in errorThere was 1 signature line for Resident #2 and staff to sign for the September 2018 transactionsResident #2 signed confirming payment of \$1200.00, \$40,00 and receipt of \$200.00 on 09/26/18, but there were no witness signatures. Review of the October 2018 Resident Personal Fund Ledger for Resident #2 revealed: The begining balance for October 2018 was \$1436.00Resident #2 had 3 transactions in October 2018 for payment of \$117.77 and \$61.80 for medication chargesThere was 1 signature line for Resident #2 and staff to sign for both September and October 2018 was \$36.43Resident #2 signature line for Resident #2 and staff to sign for both September and October 2018 was \$36.43Resident #2 signature line for Resident #2 and staff to sign for both September and October 2018 was \$36.43Resident #2 signature line for Resident #2 and staff to sign for both September and October 2018 was \$36.43Resident #2 signature line for Resident #2 and \$361.80 on 10/26/18, but she did not sign confirming medication payments of \$117.77 and \$61.80 on 10/26/18There were no witness signatures on the Resident Personal Ledger. Review of the Resident Personal Fund Ledger notebook of Resident #2 revealed: -There was a signed letter written by the Business Office Manager to Resident #2.	Personal Fu-The beginin \$1436.00Resident # 2018 for pare payment of receipt of \$3Resident # an extra \$4There was staff to sign resident # \$1200.00, \$09/26/18, but receipt of \$3Resident # \$1200.00, \$09/26/18, but receipt of \$3Resident # for payment of chargesThere was staff to sign 2018 transariant receipt r	rsonal Fund Ledger for Resident #2 revealed: the begining balance for September 2018 was 436.00. The sident #2 had 3 transactions in September 18 for payment of \$1200.00 for cost of care, a tyment of \$40.00 for medication costs, and the eight of \$200.00. The sident #2 should have received \$196.00, but the extra \$4.00 was given to Resident #2 in error. The ere was 1 signature line for Resident #2 and the to sign for the September 2018 transactions. The exident #2 signed confirming payment of 200.00, \$40.00 and receipt of \$200.00 on 26/18, but there were no witness signatures. The eventual exident #2 revealed: The begining balance for October 2018 was 436.00. The exident #2 had 3 transactions in October 2018 The payment of \$1200.00 for cost of care, Tyment of \$117.77 and \$61.80 for medication the exident #2 signature line for Resident #2 and the to sign for both September and October 18 transactions. The ending balance for October 2018 was 6.43. The exident #2 signed confirming payment of 200.00, on 10/26/18, but she did not sign The ending balance for October 2018 was 6.43. The event on witness signatures on the Sident Personal Ledger. The wiew of the Resident Personal Fund Ledger The ebook of Resident #2 revealed: The event was a signed letter written by the Business The event was a signed letter written by the Business					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080020			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING			R 11/09/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		1114 SO	UTH MAIN STREET	•			
ANGELS A	AT HEART ASSISTED LI	VING CHINA G	ROVE, NC 28023				
(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 T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 421	Continued From pag	e 26	D 421				
	medication (\$117.77 and \$61.80) which Resident #2 agreed to payResident #2 signed the letter confirming she received \$56.43 on 11/01/18The Business Office Manager signed confirming she gave Resident #2 \$56.43 on 11/01/18, but there were no witness signatures.						
	pm revealed: -She received money after her medication -She usually had \$23 cost of care and before -She signed the Res when she paid for her received moneyUsually there was 1	y from the facility monthly costs were paid. 36 left after paying for her pre paying for her medication. ident Personal Fund Ledger er cost of care and when she signature on the Resident er besides hers and not 2					
		interview with the Business 1/09/18 at 5:06 pm was					
	at 5:28 pm revealed: -Resident #2 was pri cost of care. Resider Assistance fundsShe or the Business responsible for signir witness when transa pay residentsShe thought it was of witness to sign off or LedgerShe did not know 2 required for transacti	vate pay and paid for her nt #2 did not receive Special s Office Manager were ng and had signed as a ctions were made for private okay for the resident and 1 n the Resident Personal Fund witness signatures were					

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ווטופועום	or riealiti Service Regu	ilation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	COMPLETED	
		1				
				F	₹	
		HAL080020	B. WING	······································	11/0	9/2018
NAME OF D	DOVIDED OD CUDDUED	OTDEET AS	NDDECC CITY CTA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS	AT HEART ASSISTED LIV	VING	ITH MAIN STRE			
		CHINA GI	ROVE, NC 2802	23		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE
				DEFICIENCY	<u> </u>	
D 421	Continued From page	e 27	D 421			
	Communication page					
	witness on 10/26/18 f	for \$117.77 for medication or				
	\$56.43 cash on the R	Resident Personal Fund				
	Register, because Re	esident #2 did not receive				
		to her wanting a money				
	order to pay an aparti					
		provide the information for				
		he apartment complex, but				
	,	and was given \$56.43 in				
	cash on 11/01/18.	and was given \$50.45 in				
	Casir on 11/01/10.					
	2 Poviou of Posidon	it #4's current FL2 dated				
	08/25/18 revealed dia	•				
schizoaffective disorder, depression, insulin						
	· -	gastroesophageal refulux				
	disease, and thrombo	ocytopenia.				
	Review of the Septen					
		er for Resident #4 revealed:				
		d Special Assistance funds.				
	-The begining balanc	e for September 2018 was				
	\$66.00. and -Resident #4 was given \$38.11 after having an					
	advance of \$2.00 deb	pited for cigaretts and paying				
a pharmacy bill of \$25.89 in September 2018						
		for September 2018 was \$0.				
	-There was a signature line for Resident #4, the					
	T =					
	Administrator, and a staff/witnessThe Resident Personal Fund Ledger for					
		•				
		ned by Resident #4 and the				
	Business Office Mana	_				
	- There was not a sec	ond witness signature.				
	Deview of the Oct 1	on 2040 Decident Decree				
		er 2018 Resident Personal				
	Fund Ledger for Resi					
		e for October 2018 was				
	\$66.00.					
	-There were no trans	actions.				
	-Resident #4 was give	en \$66 in October 2018.				
		for October 2018 was \$0.				
-There was a signature line for the Resident #4,						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080020			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			R 11/09/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ANGELS	AT HEART ASSISTED LI	VING 1114 SO	UTH MAIN STREET	-		
ANGLES	AT TIEART ASSISTED ET	CHINA G	ROVE, NC 28023			
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 421	Continued From page	e 28	D 421			
	Business Office Mana	nal Fund Ledger for ned by Resident #4 and the				
	Review of the November 2018 Resident Personal Fund Ledger for Resident #4 revealed: -The beginning balance for November 2018 was \$66.					
	-Resident #4 was given \$66 in November 2018The ending balance for November 2018 was \$0There was a signature line for the Resident #4, the Administrator, and a staff/witness.					
	-The Resident Personal Fund Ledger for Resident #4 was signed by Resident #4 and the Business Office Manager on 11/06/18.					
	-There was not a second witness signature.					
	Interview with Resident #4 on 10/08/18 at 11:58 am revealed:					
	every month.	costs, he received what				
	was left over after pa					
	Interview with the Resident #4 on 10/09/18 at 8:11 pm revealed: -He signed the Resident Personal Fund Ledger					
	when he received mo -There was only one	oney every month. other person who signed				
	when he signed and or the Business Office	that was either the Director e Manager.				
		interview with the Business /09/18 at 5:06 pm was				
	Interview with the Exc at 10:03 am revealed	ecutive Director on 10/08/18				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL080020		B. WING		R 11/09/2018	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	AT HEART ASSISTED LIV	/ING	ITH MAIN STRE ROVE, NC 2802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 421	-Resident #4 received each month. Interview with the Exe at 5:28 pm revealed: -She and the Business responsible for signin was given to resident: -She or the Business as a witness when reach Assistance personal refundsShe thought it was of witness to sign off on LedgerShe did not know 2 versions.	d Special Assistance funds. d \$66 in personal allowance ecutive Director on 10/09/18 s Office Manager were g as a witness when money s. Office Manager had signed sidents received the Special needs allowance or personal kay for the resident and 1 the Resident Personal Fund witness signatures were al Assistance personal needs	D 421		

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