STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Service conducted an annual survey and a complaint investigation from 12/10/19 - 12/12/19 .	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) in accordance with her assessed needs and current symptoms. The findings are: Review of Resident #2's current FL-2 dated 09/18/19 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes mellitus, traumatic brain injury, atrial fibrillation, seizures, encephalopathy, and cirrhosis of the liver. -The resident was not ambulatory. -The resident had a history of seizures.	D 270		

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 270	Continued From page 1	D 270		

-The resident was incontinent of bladder and bowel.
-The resident could not verbally communicate needs.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 08/16/19 and readmitted on 09/18/19 after a hospitalization for aspiration pneumonia and acute respiratory failure with hypoxia.

Review of Resident #2's current assessment and care plan dated 08/16/19 revealed:
-The resident had Alzheimer's and due to her mental status change she was not able to complete her daily ADL's (activity of daily living).
-The resident was sometimes disoriented and forgetful.
-The resident required extensive assistance from staff with eating.
-The resident required total assistance from staff with toileting, ambulating, bathing, grooming, dressing, and transferring.

Review of Resident #2's Licensed Health Professional Support (LHPS) quarterly review dated 12/03/19 revealed:
-The resident required assistance with ambulation using assistive devices.
-The resident required assistance with transferring.
-The resident required assistance with physical restraints and/or alternatives to restraints.

Review of accident/injury reports from October 2019 - November 2019 for Resident #2 revealed Resident #2 fell or was found on the floor on four occasions from 10/10/19 - 11/27/19.

a. Review of an accident/injury report for

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D 270	Continued From page 2	D 270		

Resident #2's dated 10/10/19 revealed:
-The fall occurred on 10/10/19 at 4:22pm in the day room.
-The report documented the resident rolled off the couch.
-The hospice nurse came to the facility and checked the resident after the fall on 10/10/19.
-There were no documented injuries.
-There were no interventions or follow up orders documented on the incident/accident form.

Interview with a personal care aide (PCA) on 12/11/19 at 4:27pm revealed:
-Resident #2 had leaned over and rolled off the couch on 10/10/19.
-Resident #2 was on 15-minute checks when she rolled off the couch on 10/10/19.
-If a resident fell, they were put on 15-minute checks.
-The PCAs or other staff documented where the resident was on the 15-minute checks.

Review of Resident 2's 15-minute check documents dated 10/10/19 -10/12/19 revealed:
-The resident was on 15-minute checks beginning at 6:00am on 10/10/19.
-Resident #2 was in the TV room on 10/10/19 at 4:15pm - 4:45pm when she rolled off the couch at 4:22pm.
-The last documented time for the 15-minute checks was on 10/12/19 at 5:45am.

Interview with a supervisor on 12/12/19 at 12:20pm revealed:
-The fall on 10/10/19 at 4:22pm did not result with Resident #2 hitting her head.
-Resident #2 rolled off the couch in the TV room onto the fall mat.
-Resident #2's head was at the edge of the mat.
-Resident #2's head "kind of hung off the edge of

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 270	Continued From page 3	D 270		

the mat and touched the floor but did not hit the floor, not like a thud, but just like a bump".
-No injuries were noted.

Review of a physician's order for Resident #2 dated 10/21/19 revealed:
-There was an order for a lap buddy (a cushioned device that fits in a wheelchair and assists with positioning if a person tends to lean forward in his wheelchair and is in danger of falling out of the chair).
-The order was received by telephone by the RCC/SCUC on 10/21/19.
-The order was signed by the PCP and dated 10/24/19.

Interview with a personal care aide (PCA) on 12/11/19 at 4:27pm revealed Resident #2 did not use a lap buddy and she had never seen her use a lap buddy.

Observation of Resident #2's room on 12/10/19 at 10:02am revealed no lap buddy was found.

b. Review of an accident/injury report for Resident #2 dated 10/26/19 revealed:
-The fall occurred on 10/26/19 at 12:45pm in the dining room.
-The report documented the resident had a fall/slip.
-The primary care provider (PCP) ordered to "keep an eye on resident" and if she began to complain of pain to call the PCP again.
-There were no injuries documented.
-The interventions and follow up orders documented on the incident/accident form included 15-minute checks continued, lap buddy had been ordered, staff were reminded to give the resident a baby doll or toy to hold.
-There was no documentation provided for any

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 270	Continued From page 4	D 270		

15-minute checks done on 10/26/19.

Review of Resident 2's 15-minute check documents dated 10/27/19 -10/29/19 revealed:
-The resident was on 15-minute checks beginning at 6:00am on 10/27/19.
-The last documented time for the 15-minute checks was on 10/29/19 at 5:45am.

c. Review of an accident/injury report for Resident #2's dated 11/18/19 revealed:
-The fall occurred on 11/18/19 at 7:30am in the resident's room.
-The report documented the resident was found on the floor in her room.
-There were no injuries documented.
-The primary care provider (PCP) ordered "to keep an eye" on resident for any sudden changes.
-The interventions documented on the incident/accident form included 15- minute checks continued and to lower the bed to the floor.

Review of Resident 2's 15-minute check documents dated 11/18/19-11/20/19 revealed:
-The resident was on 15-minute checks beginning at 6:00am on 11/18/19.
-It was documented Resident #2 was in her room at 6:00am-6:45am.
-It was documented Resident #2 was in the TV room from 7:00am-9:15am.
-The last documented time for the 15-minute checks was on 11/20/19 at 5:45am.

d. Review of an accident/injury report for Resident #2's dated 11/27/19 revealed:
-The fall occurred on 11/27/19 at 8:00pm in the day room.
-The report documented the resident rolled off the

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 270	Continued From page 5	D 270		

couch.
-There were no injuries documented.
-The PCP was notified, and no recommendations were given.
-The interventions documented on the incident/accident form included placed on 15-minute checks, staff reminded to use non-skid socks on the resident, and the resident should sleep in bed not on couch.

Review of Resident #2's 15-minute check documents dated 11/27/19-11/29/19 revealed:
-The resident was on 15-minute checks beginning at 6:00am on 11/27/19.
-It was documented Resident #2 was in her room at 6:00am on 11/27/19 -6:45am on 11/28/19.
-It was documented Resident #2 was in her room at 8:00pm on 11/27/19.
-The last documented time for the 15-minute checks was on 11/29/19 at 5:45am.

Observation of Resident #2 on 12/10/19 10:02am revealed:
-The resident was in her bed in her room.
-She was resting quietly on her right side facing the wall.
-There was a tri-fold fall mat which was the length of the bed and approximately 10" thick.
-The bottom of the bed met the top of the fall mat.
-There was a half bed rail in place on the left side of the top of the bed and in the raised position.

Interview with Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC) on 12/12/19 at 9:24am revealed:
-Residents were checked on every two hours.
-When a resident fell, the PCA first checked the resident for any injury.
-Vital signs were checked.
-Staff were not to move a resident after a fall and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 270	Continued From page 6	D 270		

were to get the supervisor.
-If needed, staff sent the resident out to emergency room if the resident hit their head or there was a suspected head injury.
-The supervisor completed an incident/accident form.
-The family and primary care provider were called.
-The on-call management person (the Administrator, transportation coordinator and/or the RCC/SCUC) was called if after hours or on weekends.
-There were 2 different lap buddies ordered for Resident #2.
-Neither of the 2 "worked" for Resident #2 and would not keep her from sliding out of the chair or toppling forward.
-On 12/11/19, the PCP had ordered the lap buddy to be discontinued and ordered a geri-chair with table top tray.
-Resident #2 was only on the 15-minute checks following a fall.

Interview with the Administrator on 12/12/19 at 9:30am revealed:
-Resident #2 had two falls in October 2019 and November 2019.
-She had an order for increased supervision which meant 15-minute checks for a "couple of days".
-After a resident fell, 15-minute checks were performed for 72 hours and documented on the Personal Care Sheets (PCS) per the facility's policy.
-The 15-minute checks were documented on the PCS by the PCAs.
-These consisted of seeing the resident to make sure they were safe and had not fallen.
-Any of the staff could do the 15-minute checks but they were mostly performed by the PCAs.

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 7	D 270		

-She would ask the staff if they were performing the 15-minute checks.
-The RCC/SCUC collected the 15-minute check sheets daily.
-Her expectation of the staff was to notify the primary care provider (PCP), hospice if applicable, the on-call supervisor, and the power of attorney (POA) for all falls.
-The Administrator received notifications of falls if there were injuries or if the on-call person was called and she was on call.
-A lap buddy was ordered for Resident #2.
-She was unsure when the lap buddy was ordered or received.
-It was determined when the lap buddy was received by the staff that the lap buddy would not work for Resident #2, she was able to move out of it.
-The RCC/SCUC was trying to get a different type of lap buddy
-The RCC/SCUC tried to get a lap buddy from hospice but was unsuccessful.
-A lap tray was ordered and received before Thanksgiving (11/27/19) from a local durable medical equipment (DME) provider.
-On 12/09/19 or 12/10/19, it was determined the lap tray was not safe for Resident #2.
-Resident #2 could lift the tray up and slide under it.
-She was not sure why it took the facility so long to try the lap tray and determine that Resident #2 could not use it.
-A fall mattress was placed beside Resident #2's bed and couch.
-We have "tried" a little bit of everything.
-The RCC/SCUC sent orders for any equipment to the DME as soon as the order was received in the facility.
-A Fall Assessment was completed by the Administrator upon admission to the facility for

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 270	Continued From page 8	D 270		

residents and were never updated.
-Resident #2 had a fall assessment done when she was admitted on 08/16/19.
-There was no Fall Risk Program and no system used by the staff to identify residents who were at increased risk for falls.
-The residents who were identified by staff as being a "fall risk" were communicated between staff during shift change.
-Staff would receive one on one training on falls when they first started working at the facility.
-The plan was to notify the PCP to discuss additional orders or recommendations for Resident #2.

Interview with Resident #2's hospice Registered Nurse (RN) on 12/12/19 at 12:58pm revealed:
-Resident #2 was at high risk for falls due to her diagnoses and behaviors.
-She had visited in October 2019 and recommended they order a lap buddy for Resident #2.
-Resident #2 would "throw herself forward" while sitting in her wheelchair.
-The DME provider that hospice used did not have lap buddies.

Review of orders and receipts provided by the Administrator on 12/12/19 at 12:58pm revealed:
-There was documentation an inflatable lap buddy was ordered from an online vendor on 10/21/19 and was delivered on 11/25/19.
-There was documentation for an item ordered from a local DME provider on 11/18/19 but no description of the item was on the invoice.

Interview with a representative of the DME provider on 12/12/19 at 1:35pm revealed the invoice dated 11/18/19 was for a lap buddy which was delivered on 11/20/19.

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9 Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted interview with Resident #2's power of attorney on 12/12/19 at 9:12am was unsuccessful. Attempted telephone interview with Resident #2's PCP on 12/12/19 at 3:08pm was unsuccessful. _____ The facility failed to provide supervision and interventions (lap buddy, lap tray, geri-chair) as ordered for Resident #2 who had multiple falls. The facility's failure resulted in delays in implementation of interventions ordered for her safety which placed her at risk for more falls and was detrimental to her health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 12/12/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2020.	D 270		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 10	D 315		

against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
Based on observations, interviews and review of the facility's activity calendar, the facility failed to implement an activity program that promoted active involvement by the residents.

The findings are:

Observation on 12/10/19 at 9:50am during the initial tour of the facility revealed there was not an activity calendar posted in the assisted living (AL) hallways of the facility.

Observations on 12/10/19 at 10:00am-11:00am revealed there were no activities being conducted on the special care unit (SCU).

Observations on 12/10/19 at 2:30pm revealed there were no activities being conducted on the SCU.

Observation on 12/11/17 at 2:20pm revealed a staff member walking thru the SCU door carrying an activity calendar.

Review of the December 2019 Activity Calendar on 12/11/19 at 4:27pm posted on a bulletin board in AL hallway revealed:
-There were at least fourteen hours of activities scheduled weekly on the calendar.
-There was documentation all activities were subject to change and all activities 1 hour unless specified.
-The activity of "puzzles" was scheduled on 12/12/19 at 9:30-10:00am.

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 315	Continued From page 11 Observations on 12/12/19 at 9:30am revealed: -There was no activity being conducted on AL. -There was no staff member or residents in the activity room. Interview with a resident on 12/10/19 at 9:49am revealed: -The facility did not have no activities. -The facility did not have an activities director. -The transporter will take us shopping occasionally. -We are supposed to go shopping this Friday (12/13/19). Interview with a second resident on 12/10/19 at 9:54 revealed: -The facility did not have an activity director. -The facility did not do activities with residents. Interview with a third resident on 12/10/19 at 10:32am revealed: -She has not been on an outing in 2 months. -The facility used to have activities. -The facility did not have any activities. Interview with a personal care aide (PCA) on 12/11/19 at 4:27pm revealed: -She worked in the special care unit (SCU). -She had not seen any activities in the SCU in several months. -Bingo had been played in AL assisted living 1 or 2 times in several months. Interview with a nursing aide (NA) on 12/11/19 at 4:40pm revealed: -There was not an activity director. - "We tried to do activities" with the residents, for example, played ball, coloring, reading, and playing cards.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 12 -"Whatever" held their attention. Interview with a medication aide/supervisor (MA/S) on 12/11/19 at 4:30pm revealed there was no activity director at the facility. Interview with a second PCA on 12/11/19 on 12/11/19 on 4:44pm revealed: -There was not an activity director working at the facility. -There has not been an activity director since the facility re-opened in June 2019. Interview with a second NA on 12/11/19 at 4:50pm revealed: -There was not an activity director working at the facility. -The only activity she had observed was the distribution of snacks to the residents. Interview with the Administrator on 12/11/19 at 5:30pm revealed: -There was not a current activity director; there were a few staff members who assisted with the facility's activity program. -The staff members who assisted with resident activities in the absence of an activity director were the Resident Care Coordinator (RCC)/Special Care Unit Coordinator (SCUC), a personal care aide (PCA), and the transporter.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 13 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the facility failed to protect 2 of 2 sampled residents (#3 and #7) from physical abuse by Staff B. The findings are: Interview with a medication aide/supervisor (MA/S) on 12/12/19 at 9:15am revealed: -She completed resident rights training during orientation upon hire and again recently with the Ombudsman. (no dates provided). -She was trained to immediately report to the Administrator any resident abuse that she may have witnessed, or any abuse reported to her. -If the Administrator was not in the building, she would call the Administrator on her cell phone. Interview with another MA/S on 12/12/19 at 10:05am revealed: -She had completed resident rights training upon hire and at other times since then (no dates provided). -She was trained that residents had the right to refuse, had the right to privacy, to be treated with respect, and free from abuse. -Abuse could be verbal, or physical. -She had not seen or heard of any abuse of any resident by any staff. -If she had seen or heard of abuse, she would immediately report it to the Resident Care Coordinator (RCC) or Administrator. -If she saw the abuse, she would immediately pull the staff away from the situation and take them to the office. -She would get another staff to check on the resident.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 14 Interview with a personal care aide (PCA) on 12/12/19 at 9:30am revealed: -She had completed resident rights training when she was hired in June 2019. -During that training she was instructed that residents were to be treated with respect and should not be abused in any way. -Abuse could be pushing or pulling on a resident, confining a resident to their room, fussing or yelling at a resident, or withholding food. -She was instructed that any abuse seen or heard of should be immediately reported to the supervisor. -If the supervisor did not handle the situation, then she would report the abuse to the Administrator. -She had not seen any abuse of any resident. Interview with a second PCA on 12/12/19 at 9:45am revealed: -She had completed resident rights training upon hire and several times since then (no dates provided). -She had not seen or heard of any resident abuse. -If she had seen resident abuse, she would immediately report it to the supervisor. 1. Review of Resident #3's current FL-2 dated 06/26/19 revealed: -Diagnoses included Alzheimer's disease, tremors, major depressive disorder, and mixed hyperlipidemia. -She was intermittently disoriented and ambulatory. -She was a resident on the special care unit (SCU). Review of Resident #3's Resident Register	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 338	Continued From page 15	D 338		

revealed she was admitted to the facility on 07/18/19.

Review of Resident #3's care plan dated 07/22/19 revealed:
-She was always disoriented and had significant memory loss.
-She required total assistance from staff with bathing, dressing, and toileting.
-She required limited assistance from staff with feeding, ambulation and transferring.

Review of a Health Care Personnel Registry (HCPR) 24-hour initial report dated 09/24/19 revealed:
-The allegation was documented as resident abuse.
-The description of the allegation was Staff B, (medication aide/supervisor (MA/S) held Resident #3 by the tops of her arms and forcefully sat her down and told her, "I told you to sit down."
-There were no injuries noted to the resident.
-The incident date was documented as 09/20/19.
-The date the facility became aware of the incident was documented as 09/20/19 at 10:00pm.
-The report was signed by the Management Liaison and dated 09/24/19.
-The fax cover sheet was dated 09/24/19.

Review of an HCPR 5-day investigation report dated 10/01/19 revealed:
-The allegation was documented as resident abuse.
-The incident date was documented as 09/20/19.
-The location of the incident was documented as the day room in the SCU.
-It was documented Resident #3 had dementia and resided in a SCU.
-It was documented Staff B was trying to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 338	Continued From page 16	D 338		

Resident #3 to sit down.
-The resident "did not sit down" when told to do so.
-Staff B "grabbed" Resident #3 by the top part of both of her arms and started making the resident walk backwards towards the chair.
-Once Resident #3 was at the chair, Staff B "forcefully pushed" the resident while still holding onto the resident's arms, into a sitting position in the chair.
-The report was signed by the Management Liaison and dated 10/01/19.
-The fax cover sheet was dated 10/01/19.

Review of an incident / investigation report from local law enforcement dated 10/01/19 revealed:
-It was documented that local law enforcement received a report of elder abuse on 10/01/19.
-It was documented on the report the incident occurred on 09/20/19.
-The victim documented on the report was Resident #3.
-There was no reported injury to Resident #3.
-The suspect documented on the report was Staff B.
-It was documented that the suspect "forced" the victim to sit down in a chair.
-It was documented the weapon used was the suspects hands.
-The victim had dementia and was unaware of the incident.

Interview with a PCA on 12/11/19 at 4:27pm revealed:
-She witnessed Resident #3 being "pushed down into a chair" by Staff B, who was the MA/S for the shift.
-The incident took place on a Friday; she couldn't remember the date.
-She reported Staff B the same night to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 338	Continued From page 17	D 338		

oncoming MA/S.
-The MA/S told her to report the incident to the Administrator.
-She reported the incident to the Administrator on Monday by phone (no date provided), because the Administrator was off the weekend.

Interview with a MA/S on 12/12/19 at 9:15am revealed:
-She had received a report of abuse to Resident #3 from a PCA, but she did not recall the exact date she received the report.
-The PCA reported she had observed Staff B push Resident #3 down into a chair.
-The PCA reported the incident to her the same day it occurred, after she and Staff B changed shifts.
-When she received the report from the PCA, Staff B had already ended her shift and she was out of the building.
-This incident occurred towards the end of the week.
-She immediately sent a text message to the Administrator to notify her of what the PCA had reported.
-She did not receive any response from the Administrator in response to her text.
-She did not call anyone else.
-She was not aware of any other resident being abused by any other staff.

Interview with Resident #3's power of attorney (POA) on 12/12/19 at 3:30pm revealed:
-The Administrator called the POA to make her aware that a staff person had "held Resident #3 down in a chair."
-She did not recall the date, but it was "a few months ago."

Interview with the Administrator on 12/12/19 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 338	Continued From page 18	D 338		

9:30am revealed:
-The facility's policy was to report abuse immediately.
-She could not recall being notified by staff of the allegation on 09/20/19.
-She could not remember doing any investigation into the allegation.
-The Human Resource staff or Management Liaison did the investigation.

Interview with the Management Liaison on 12/12/19 at 10:38am revealed she was aware of the allegation of Staff B abusing Resident #3 was reported but could not remember when it was reported to her.

Telephone interview with Staff B on 12/12/19 at 4:30pm revealed:
-She was employed at the facility from June 2019-September 2019.
-One of the PCAs called her to the SCU saying Resident #3 was "out of control and was combative."
-She went over to the SCU and asked Resident #3 what was wrong.
-She took Resident #3 by the hand, but she did not abuse her in any way.
-She believed that was on a Friday and she continued to work her schedule.
-The incident was not mentioned again until later than next week (no dates provided).
-She was never questioned regarding any allegations of abuse of Resident #3.
-She had never abused any resident.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interview able.

Refer to the interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 338	Continued From page 19 12/12/19 at 9:30am. 2. Review of Resident #7's current FL-2 dated 06/20/19 revealed: -Diagnoses included dementia, schizophrenia, diabetes, hypertension, and hyperlipidemia. -He was intermittently disoriented and ambulatory. -He was a resident on the special care unit (SCU). Review of Resident #7's Resident Register revealed he was admitted to the facility on 06/20/19. Review of the HCPR Initial Allegation Report dated 10/03/19 revealed: -Staff B, medication aide/supervisor (MA/S) told Resident #7 to sit down but he did not sit. -Staff G, personal care aide (PCA) witnessed Staff B, grab Resident #7 by the arm and "forcefully sit him down in a chair." -There was documentation Staff G failed to report the incident at the time she witnessed it. -There was documentation Staff G reported the incident between Staff B and Resident #7 when she was being questioned about another incident in which Staff B had allegedly abused another resident. -It was documented the facility first became aware of the incident on 09/26/19. Review of the HCPR Investigation Report dated 10/09/19 revealed there was documentation Staff G had knowledge of an incident in which Resident #7 had been "handled aggressively by Staff B" but failed to report it immediately to her supervisor per company policy. Review of documentation identified by the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 20	D 338		

Administrator as the investigation of Staff B interview notes dated 09/26/19 revealed:
-It was documented the interview took place between Staff G and the Administrator.
-It was documented Staff G witnessed Staff B grab Resident #7 by his arm and, "slammed him down in a chair when he would not sit down in a chair" after Staff B told him to.

Review of documentation identified by the Director of Human Resources (HR) as the investigation of Staff B interview notes dated 10/04/19 revealed:
-Staff G witnessed Staff B ask Resident #7 to sit down.
-The incident occurred about one week prior to 09/18/19,
-Staff B grabbed Resident #7 on both of his upper arms and "jerked him down forcefully" onto the couch.
-Resident #7 lost his balance and "slammed down" on the couch.
-There was documentation Staff G did not report the incident because she felt her name would be mentioned to Staff B and there would be "issues."

Telephone interview with Staff G on 12/12/19 at 12:07pm:
-She worked at the facility as a nursing assistant (NA) for a couple of months.
-She worked second (2:00pm-10:00pm) and third (10:00pm-6:00am) shifts.
-She had never witnessed any physical or verbal abuse of any resident at the facility.
-She did not witness an incident between Staff B and Resident #7 on 09/18/19.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interview able.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D 338	Continued From page 21 Refer to the interview with the Administrator on 12/12/19 at 9:30am. _____ Interview with the Administrator on 12/12/19 at 9:30am revealed: -The facility policy was for staff to report any abuse immediately. -If the staff were not comfortable reporting something to the Supervisor then they were to report to the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC). -If something happened at night or on the weekend that needed reporting there was an on-call management person that could be reached. -The staff would be suspended immediately upon the Administrator hearing of an abuse allegation. -She would report allegations of abuse to corporate as soon as she found out. _____ The facility failed to assure residents were free from physical abuse resulting in witnessed physical abuse to Resident #3 and Resident #7 who were intermittently disoriented and resided in the Special Care Unit. Staff G witnessed Resident #7 being grabbed by the arm and forced into the chair by Staff B but did not report it which deviated from the facility's policy to report abuse immediately. Resident #3 was "pushed down into a chair" by Staff B. The facility's failure resulted in substantial risk for continued physical abuse and serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 12, 2019 for this violation.	D 338		

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 22 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 11, 2020.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to report allegations of physical abuse to the North Carolina Personnel Registry (HCPR) within 24 hours of the allegation for 1 of 1 sampled staff (B). The findings are: Review of Resident #3's current FL-2 dated 06/26/19 revealed: -Diagnoses included Alzheimer's disease, tremors, major depressive disorder, and mixed hyperlipidemia. -She was intermittently disoriented and ambulatory. -She was a resident on the special care unit (SCU). Review of Resident #3's care plan dated 07/22/19	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 23	D 438		

revealed:
-She was always disoriented and had significant memory loss.
-She required total assistance with bathing, dressing, and toileting.
-She required limited assistance with feeding, ambulation and transferring.

Review of a Health Care Personnel Registry (HCPR) 24-hour initial report dated 09/24/19 revealed:
-The allegation was documented as resident abuse.
-There description of the allegation was Staff B held Resident #3 by the tops of her arms and forcefully sat her down and told her, "I told you to sit down."
-There were no injuries noted to resident.
-The incident date was documented as 09/20/19.
-The date the facility became aware of the incident was documented as 09/20/19 at 10:00pm.
-The report was signed by the Management Liaison and dated 09/24/19.
-The fax cover sheet was dated 09/24/19.

Review of an HCPR 5-day investigation report dated 10/01/19 revealed:
-The allegation was documented as resident abuse.
-The incident date was documented as 09/20/19.
-The location of the incident was documented as the day room in the Special Care Unit (SCU).
-It was documented Resident #3 had dementia and resided in a SCU.
-It was documented Staff B, medication aide/supervisor (MA/S), was trying to get Resident #3 to sit down.
-The resident "did not sit down" when told to do so.

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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D 438	Continued From page 24	D 438		

-Staff B "grabbed" the resident by the top part of both of her arms and started making the resident walk backwards towards the chair.
-Once Resident #3 was at the chair, Staff B "forcefully pushed" the resident while still holding onto the resident's arms, into a sitting position in the chair.
-The investigative action section of the report documented the allegations were substantiated for resident abuse.

Interview with a personal care aide (PCA) on 12/11/19 at 4:27pm revealed:
-She witnessed Resident #3 being "pushed down into a chair" by Staff B, who was the MA/S for the shift.
-The incident took place on a Friday; she couldn't remember the date.
-She reported Staff B the same night to the oncoming MA/S.
-The MA/S told her to report the incident to the Administrator.
-She reported the incident to the Administrator on Monday by phone (no date provided), because the Administrator was off the weekend.

Interview with a MA/S on 12/12/19 at 9:15am revealed:
-She had received a report of abuse to Resident #3 from a PCA, but she did not recall the exact date she received the report.
-The PCA reported she had observed Staff B push Resident #3 down into a chair.
-The PCA reported the incident to her the same day it occurred, after she and Staff B changed shifts.
-When she received the report from the PCA, Staff B had already ended her shift and she was out of the building.
-This incident occurred towards the end of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 25	D 438		

week.
-She was not sure if Staff B worked any after this incident.
-She immediately sent a text message to the Administrator to notify her of what the PCA had reported.
-She did not receive any response from the Administrator in response to her text.
-She did not call anyone else.

Interview with the Administrator on 12/12/19 at 9:30am revealed:
-She could not recall being notified by staff of the allegation on 09/20/19.
-The facility policy was for staff to report any abuse immediately.
-If the staff were not comfortable reporting something to the Supervisor then they were to report to the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC).
-If something happened at night or on the weekend, that needed reporting, there was an on-call management person that could be reached.
-The employee would be suspended immediately upon the Administrator hearing of an abuse allegation.
-She would report allegations of abuse to corporate as soon as she found out.
-HCPR would be notified within 24 hours of her finding out about the allegation.
-The Management Liaison sent the 24-hour HCPR report after finding out about the allegation, but she could not remember the date.
-Upon review of the Initial HCPR report dated 09/24/19 with the documentation the facility first became aware of the incident on 09/20/19, she acknowledged she did not remember "it happening that way."
-She was unsure of how many incidents had

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	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 26	D 438		

occurred, it was all "bunched together", she was not sure of the dates.

Interview with the Management Liaison on 12/12/19 at 10:38am revealed:
-She was aware the allegation of abuse by Staff B was reported but could not remember when it was reported.
-Any allegations of abuse should be reported to the MA/S at the time it happened or by the end of the shift.
-If staff could not report the allegation to the Supervisor for some reason then they were to report it to the Resident Care Coordinator/Special Care Unit Coordinator (RCC/SCUC).
-At night and on the weekends, there was someone on call that it could be reported to.
-As soon as the Administrator knew about an allegation, she was supposed to notify the corporate office.
-Allegations of abuse were to be reported to HCPR within 24 hours.

Telephone interview with Staff B on 12/12/19 at 4:30pm revealed:
-She was employed at the facility from June 2019-September 2019.
-One of the PCAs called her to the SCU saying Resident #3 was "out of control and was combative."
-She went over to the SCU and asked Resident #3 what was wrong.
-She took Resident #3 by the hand, but she did not abuse her in any way.
-She believed that was on a Friday and she continued to work her schedule.
-The incident was not mentioned again until later the next week (no dates provided).
-Later the next week, (she did not remember the date), she was called by the Administrator to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 27 come to the office and told she had a phone call (no dates provided). -She got on the phone in which a lady from corporate told her to turn in all her keys and exit the building; she was suspended for allegations of abuse. Review of time clock records for Staff B revealed: -She was clocked in on Friday, 09/20/19 from 5:57am - 6:04pm -She was clocked in on Saturday, 09/21/19 from 5:49am - 6:01pm. -She was clocked in on Monday, 09/23/19 from 5:44am - 6:00pm -She was clocked in on Tuesday, 09/24/19 from 5:51am - 5:03pm. The facility failed to report allegations of physical abuse to North Carolina Healthcare Personnel Registry (HCPR) within 24 hours of notification and failed to suspend Staff B in accordance with their established policies. The facility's failure resulted in a delay in reporting the allegations of abuse to HCPR and Staff B being allowed to continue to work until 09/24/19 which placed the residents at risk for continued physical abuse and substantial risk serious of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on December 12, 2019 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 11, 2020.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D912	Continued From page 28 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) in accordance with her assessed needs and current symptoms. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	12/12/2019

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D914	Continued From page 29 This Rule is not met as evidenced by: Based on observations, interviews, and review of documentation, the facility failed to assure residents were protected from abuse and neglect as related to resident rights and health care personnel registry. The findings are: 1. Based on observations, interviews, and record review, the facility failed to protect 2 of 2 sampled residents (#3 and #7) from physical abuse by Staff B. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 2. Based on interviews and record reviews the facility failed to report allegations of physical abuse to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours of the allegation for 1 of 1 sampled staff (B). [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].	D914		