NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 350 SCHOOL DRIVE TAYLORSVILLE HOUSE 350 SCHOOL DRIVE TAYLORSVILLE, NC 28681 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 09/09/20 and a desk review survey on 09/10/20 to 09/11/20 and 09/14/20 to 09/17/20 and a telephone exit on 09/17/20. D 438 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Corrective Action Report; reporting sole yas a matter of compliance with State law." 10A NCAC 13F .1205 Health Care Personnel Registry NA NCAC 13F .1205—Health Care Personnel Registry This Rule is not met as evidenced by: Based on interviews and record re	ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
CX41/DC SUMMARY STATEMENT OF DEFICIENCIEs TAYLORSVILLE, NC D (X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST DE PERCECTED BOY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDERS PLAN OF CORRECTIVE (EACH DEFICIENCY WIST DE PRECECTED BOY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDERS PLAN OF CORRECTIVE (EACH DEFICIENCY) D 000 Initial Comments D 000 Initial Comments D 000 The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 09/09/20 and a desk review survey on 09/10/20 to 09/11/20 and 09/14/20 to 09/17/20 and a telephone exit on 09/17/20. D 438 Responses to the cited deficiencies or oncostitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law." 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 130.0101 and .0102. D 438 10A NCAC 13F .1205 Health Care Personnel Registry This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge of the injury for 1 of 1 sampled residents (Resident #3) who had an addition, an investigation will be completed and		HAL002003	B. WING		09/17	7/2020
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 (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 000 Initial Comments D 000 D 000 Initial Comments D 000 The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 09/09/20 and a desk review survey on 09/10/20 to 09/11/20 to 09/17/20 and a telephone exit on 09/11/20. D 438 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law." 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 130 .0101 and .0102. D 438 D 438 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge of the injury for 1 of 1 sampled residents (Resident #3) who had an information and fraud will be completed and All allegation will be completed and		350 SCH	HOOL DRIVE			
 The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 09/09/20 and a desk review survey on 09/10/20 to 09/11/20 and 09/14/20 to 09/17/20. D 438 10A NCAC 13F .1205 Health Care Personnel Registry 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: Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge of the injury for 1 of 1 sampled residents (Resident #3) who had an 	PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLE DATE
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Injury of diriktiown origin in the form of braising on both arms.the Investigation report will be submitted within 5 working days.The findings are:Staff were re-trained on August 12th, 2020 by ALG Senior Divisional Director of Clinical Services, on Resident Rights, and Reporting requirements of Abuse, Neglect, Injury of Unknown Origin, Exploitation and Fraud. In addition,re-training was completed on Managing and De-escalating Aggressive Behaviors.	Alexander County De conducted a complai COVID-19 focused II an onsite visit on 09/ survey on 09/10/20 t 09/17/20 and a telep D 438 10A NCAC 13F .120 Registry 10A NCAC 13F .120 Registry The facility shall corr supporting Rules 10/ .0102. This Rule is not met Based on interviews facility failed to comp Registry (HCPR) init hours of knowledge sampled residents (F injury of unknown or both arms. The findings are: Review of Resident a 07/06/20 revealed: -Diagnoses included chronic kidney disea	partment of Social Services at investigation and a fection Control survey with 09/20 and a desk review 0 09/11/20 and 09/14/20 to none exit on 09/17/20. Health Care Personnel Health Care Personnel oly with G.S. 131E-256 and NCAC 13O .0101 and as evidenced by: and record reviews, the ete Health Care Personnel al allegation report within 24 f the injury for 1 of 1 esident #3) who had an gin in the form of bruising on 3's current FL2 dated Alzheimer's dementia, se stage 3, cirrhosis of liver,	D 438	 do not constitute an admission or agreement by the facility of the tru of the facts alleged or conclusions forth in the Statement of Deficience or Corrective Action Report; the Pl of Correction is prepared solely as matter of compliance with State Ia 10A NCAC 13F.1205—Health Care P Registry All allegations related to abuse, negle of unknown origin, exploitation and fra promptly reported to the HCPR using Allegation reporting form, within the 2- timeframe, as set forth by this rule are addition, an investigation will be comp the Investigation report will be submitted within 5 working days. Staff were re-trained on August 12th, ALG Senior Divisional Director of Clinical Services, on Resident Righ Reporting requirements of Abuse, Neg Injury of Unknown Origin, Exploitation Fraud. In addition,re-training was corr Managing and De-escalating Aggress 	th set ies lan s a w." ersonnel ct, injury aud will be the Initial 4 hour a. In bleted and 2020 by ts, and glect, and pleted on	
-The resident was constantly disoriented and semi-ambulatory. -There was an order for aspirin (used to prevent blood clots) 81mg once daily. Review of Resident #3's Care Plan dated	semi-ambulatory. -There was an order blood clots) 81mg or	semi-ambulatory. -There was an order for aspirin (used to prevent blood clots) 81mg once daily.		skin/shower observations to identify a of unknown origin and Executive Dire complete random monthly audits to en	ny injury	

Reviewed and Accepted 10/23/20 RH

Joector	10/20/2020
	If continuation sheet 1 of 4

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Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ B. WING HAL002003 09/17/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 350 SCHOOL DRIVE TAYLORSVILLE HOUSE TAYLORSVILLE, NC 28681 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 438 D 438 Continued From page 1 07/06/20 revealed: -The resident was always disoriented and was forgetful and needed reminders. -The resident was ambulatory with a rollator. -The resident required limited assistance with toileting, ambulation/locomotion, bathing, and dressing. -The resident required supervision/set up with grooming/personal hygiene. Review of Resident #3's Incident Report dated 08/07/20 revealed: -On 08/03/20, the resident was in the kitchen "screaming" at dietary. -The resident had behavior symptoms in the form of delusions or hallucinations. -The resident was physically threatening staff and dietary. -The resident was verbally abusive and attempted to hit staff with a telephone. -The resident was "hitting and kicking" at staff. Review of Resident #3's Initial Allegation Report dated 08/07/20 revealed: -The allegation/incident type was resident abuse. -The incident date was 05/05/19. -The date the facility became aware of incident was 05/06/19. -The time the facility became aware of incident was 8:00pm. -The allegation was received from the local DSS representative of suspected abuse related to bruising of unknown origin to residents forearms. -Details of physical or mental injury/harm was "bruising noted to both forearms." -The incident was not reported to law enforcement. -The form was completed by the Administrator and signed 08/07/20.

Division of Health Service Regulation STATE FORM

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If continuation sheet 2 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION			A. BUILDING:			CONFLETED	
		HAL002003	B. WING		09	/17/2020	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	VILLE HOUSE	350 SCH	OOL DRIVE				
IAILONO		TAYLOR	SVILLE, NC 28681				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 438	Continued From page	e 2	D 438				
	Telephone interview 1 09/14/20 at 1:27pm r -He was not in the fac incident had occurred 08/03/20. -He was notified of th telephone call on 08/ -He and the Divisional Services had looked spoke with the reside -The resident did not the incident. -Statements were ob the statements did not -The color of the brui was why they had de injury of unknown so -The incident date or was a "misprint." -The incident date or was a "misprint." -The incident had oc -He had known he w allegation report and Personnel Registry v -"That was my error." -He felt he needed a understand what hap report and had reque from the Divisional D -"That's the only reas turned in within 24 he injury. Telephone interview Clinical Services on -She had been made surrounding the incid 08/06/20.	with the Administrator on evealed: cility at the time of the d involving Resident #3 on ne incident by his staff via 03/20 at 8:00pm. al Director of Clinical at the bruises together and ent. remember anything about tained from employees and ot "look like abuse." ising on the resident's arms etermined the bruising was an urce. In the initial allegation report curred on 08/03/20. as supposed to do an initial i turn it into the Health Care vithin 24 hours.					
	assess the resident - They determined in	and talk to staff. the investigation it was an					

Division of Health Service Regulation STATE FORM

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If continuation sheet 3 of 4

PRINTED: 09/30/2020 FORM APPROVED

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 10 - 13	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL002003	B. WING		09/17/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			OL DRIVE		
TAYLORS	VILLE HOUSE		VILLE, NC 2868	81	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 438	initial allegation repor -The incident date on were a "mistake."	arce. strator had completed the t together on 08/07/20. the initial allegation report ad used a previous 24 hour	D 438		
Division of He	ealth Service Regulation				

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