STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
			, a solesino.		С			
		FCL092276	B. WING		I	13/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE				
NORTH C	NORTH CAROLINA ASSISTED LIVING NO 2 5818 POOLE ROAD							
		RALEI	GH, NC 27610	T				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
C 000	Initial Comments		C 000					
	_	sure Section conducted an omplaint investigation on						
C 272	C 272 10A NCAC 13G .0904(d)(2) Nutrition and Food Service							
	(2) Foods and bevera residents' diets shall I to all residents as sna	1 Nutrition and Food Ints in Family Care Homes: Lages that are appropriate to the offered or made available lacks between each meal for the offered of the open care the						
		as evidenced by: as and interviews, the facility snacks available three						
	The findings are:							
	Interview with the Adr 9:14am revealed 4 re facility.	ninistrator on 05/13/21 at sidents resided in the						
	revealed: -She received a snac snack.	k when she asked for a ersonal care aide (PCA) for						
	a snack when she wa -She was not offered	inted one.						
	Interview with a second 9:20am revealed: -She received 1 snac	nd resident on 05/13/21 at k daily.						

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.	A. BUILDING: _			
		FCL092276	B. WING		C 05/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NORTHO	4 DOLUMA 4 0010TED 1 IN	5818 POC	LE ROAD			
NORTH C	AROLINA ASSISTED LIV	RALEIGH	, NC 27610			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 272	Continued From page 1 -The PCA gave snacks to her.		C 272			
		CA to get more snacks if she				
	Interview with a third 9:29am revealed:	resident on 05/13/21 at				
	-She received 1 snac	_				
	-The PCA gave snack	ks to her. CA for more snacks if she				
	wanted another snac					
	Review of the facility regular diet menu on 05/13/21 revealed:					
	-The morning snack v	acks a day on the menu. was a beverage of choice				
	and oatmeal cookies.					
	crackers.	was tomato juice and				
	-The evening snack was tomato juice and crackers. Interview with the PCA on 05/13/21 at 9:46am revealed:					
	asked for them.	nts with snacks when they				
		residents any snacks. ents were not hungry if they k".				
	Interview with the Adr 2:33pm revealed:	ministrator on 05/13/21 at				
	•	hat the PCA did not offer				
	residents a snack 3 ti					
	-She expected the PC offer the residents 3 s	CA to follow the menu and snacks a day.				
C 290	10A NCAC 13G .090	5 (b) Activities Program	C 290			
	10A NCAC 13G 0909	5 Activities Program				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPL		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _					
		FCL092276	FCL092276 B. WING			C 05/13/2021	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NORTH C	AROLINA ASSISTED LIV	ING NO 2	5818 POOL RALEIGH,				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 290	Continued From page	2		C 290			
	(b) The program sha active involvement by require any individual against his will. If the resident's ability to pa resident's physician s statement regarding t	all residents but is to participate in an tre is a question about articipate in an active thall be consulted to	not to y activity out a ity, the o obtain a				
	This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop an activity program that promoted active involvement for all residents who resided in the facility.						
	The findings are:						
	Interview with the Administrator on 05/13/21 at 9:14am revealed 4 residents resided in the facility.						
	Review of the activity 9:40am revealed: -There was an activity main living area dated: -Activities included: c games, board games -There was a total of per week.	y calendar posted ir d May 2021. hurch, cards, memo , yoga, and word se	n the ory earch.				
	Observation of the ac at 3:00 pm revealed t supplies in facility.	• • •					
	Interview with a resid revealed: -She watched televisi						

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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:		COMP	LETED		
					c		
FCL092276		B. WING		I	13/2021		
NAME OF D	POVIDER OR SURBUIED		DDRESS, CITY, STA	TE ZIR CODE			
INAIVIE OF PI	ROVIDER OR SUPPLIER			AL, ZII GODE			
NORTH C	AROLINA ASSISTED LIV	ING NO 2	DLE ROAD				
			, NC 27610				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE	
				DEFICIENCY)			
C 290	Continued From page	e 3	C 290				
	-She could play game	es it she wanted to. er when the last time she					
		vity provided by the facility.					
	participated in an acti	vity provided by the facility.					
	Interview with a secon	nd resident on 05/13/21 at					
	9:20am revealed:						
	-The facility did not of	fer any activities.					
	-She would like to par	rticipate in activities if they					
	were offered to her.						
		ched television as her daily					
	activities.						
	Intonious with a third	regident on 05/12/21 et					
	Interview with a third resident on 05/13/21 at 9:25am revealed:						
	-The facility did not of	fer any activities					
		rticipate in activities that					
	involved exercising.	naoipato in aotivito o triat					
	9						
		al care aide (PCA) on					
	05/13/21 at 10:06am						
	-She provided activities to the residents based off						
	of the activity calendar.						
	-The last time she provided an activity to the						
	residents was "last night". -Some of the residents did not want to participate in the activities that were provided to them. -Staff did not change activities if no one was interested in them.						
	Interview with the Sup	pervisor on 05/13/21 at					
	1:37pm revealed:						
	-The Administrator was responsible to create the						
	activity calendar for each month.						
	-She expected the activies listed on the activity						
		d to the residents in the					
	facility.						
		vity with the residents last					
	night.						
-She did not know why residents said the facility							

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did not offer activities.

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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		
		ECI 002276		B. WING			C		
		FCL092276				05	/13/2021		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
NORTH C	NORTH CAROLINA ASSISTED LIVING NO 2 5818 POOLE ROAD RALEIGH, NC 27610								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPOLETICIENCY)			(X5) COMPLETE DATE		

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