Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURV			
ANDIEAN	or connection	BENTH IGATION NOWBER.	A. BUILDING: _			
		HAL027003	B. WING		C 09/30/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING I , NC 27958	DRIVE		
(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 0	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	Annual Survey and C	sure Section conducted an complaint Investigation on through September 30,				
D 188	10A NCAC 13F .060 <sup>2</sup> Other Staffing	4(e) Personal Care And	D 188			
	Staffing  (e) Homes with capa shall comply with the home is staffing to ce below 21 residents, the ahome with a census (1) The home shall his the needs of the residuty hours on each 8 be at least:  (A) First shift (morning for facilities with a ceresidents; and 16 howed additional hours of air 10 or fewer residents or capacity of 40 or mother, see Rule .0606 (B) Second shift (after duty for facilities with to 40 residents; and four additional hours additional 10 or fewer census or capacity of staffing chart, see Rule .0606 (C) Third shift (evenity per 30 or fewer residents census). (Found of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart, see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of this Subchaper of the staffing chart see Rule .0606 of the staffing chart see Ru	ernoon) - 16 hours of aide a census or capacity of 21 16 hours of aide duty plus of aide duty for every r residents for facilities with a 40 or more residents. (For ale .0606 of this Subchapter.) ng) - 8.0 hours of aide duty ents (licensed capacity or or staffing chart, see Rule oter.) have additional aide duty to				

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL027003	B. WING		09	C 9/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING DR K, NC 27958	RIVE		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 188	residents equal to the by Medicaid. As use "heavy care resident residing in an adult of "heavy care" by Medis receiving enhance (E) The Department if it determines the numet by the staffing residents were met by the staffing residents were met from 09/10/21 to 09/20. The findings are:  Review of the facility 01/01/21 revealed the capacity of 90 beds in (SCU) with a capacity dated 09/10/21 revealed the capacity of 25 residents, which first and second shift shift.  Review of the emplo 09/10/21 revealed the hours provided on season the facility dated 09/10/21 revealed the capacity of 8 hours.  Review of the facility dated 09/18/21 revealed the hours provided on season the facility dated 09/18/21 revealed the hours provided on season the facility dated 09/18/21 revealed the facilit	e amount of time reimbursed and in this Rule, the term, ", means an individual care home who is defined as licaid and for which the facility did Medicaid payments.  Is shall require additional staff eeds of residents cannot be equirements of this Rule.  It as evidenced by: It and record reviews, the re the required staffing hours gunit (AL) with a census of et for 5 of 15 shifts sampled 26/21.  It's current license effective e facility was licensed for a including a special care unit by of 48 beds.  It's resident census report alled there was an AL census the required 16 staff hours on third.	D 188			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		HAL027003	B. WING		C 09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING , NC 27958	DRIVE		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	E
D 188	Continued From page	2	D 188			
		ree timecards dated ere was a total of 8 staff st shift in the AL with a				
		ree timecards dated ere was a total of 9 staff cond shift in the AL with a				
	dated 09/19/21 revea of 28 residents, which	s resident census report led there was an AL census n required 16 staff hours on and 8 staff hours on third				
		ere was a total of 7.5 staff st shift in the AL with a				
		ree timecards dated ere was a total of 8 staff cond shift in the AL with a				
	7:00am for the entire scheduled.					
	one personal care aid unit (SCU) after 11:00	le (PCA) for the special care opm. ately 25% of her time on the				
	Interview with a secon 6:56pm revealed:	nd MA on 09/28/21 at				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		C	
		HAL027003	B. WING		1	0/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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		MOYOCK	NC 27958			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	e 3	D 188			
	work after 7:00pm for -There was 1 PCA for SCU and 1 MA to adr sides. Confidential interview 09/29/21 at 6:20am re	the AL side, 1 PCA for the minister medications to both with a staff member on evealed:				
	-Staff members would stay over from the 7:00am-3:00pm shift for a few hours but then the AL side would be short until 11:00pmThe facility would mainly be short from 5:00pm until 11:00pm on the weekends.					
	until 11:00pm on the weekends.  Interview with the Administrator on 09/30/21 at 3:52pm revealed:  -The staff schedule was previously made by a staff member that was no longer there.  -The staff schedule was currently being completed by the lead MA/scheduler.  -She came in on some shifts that they were short to help staff and she would clock in.  -She was in the process of hiring two more MAs because she was aware that staffing was an issue.  -It was not surprising to her that the facility was short staffed.  -Staff was allotted a 30 minute on site break for every 8 hours worked and an hour total break time for a 12 hour shift.  -Staff did not clock out for their break.					
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
		P. Health Care Assure referral and follow-up And acute health care needs				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			35.25,110.		c	
		HAL027003	B. WING		09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
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D 273	Continued From page	e 4	D 273			
	care provider of chan	n, record review and failed to notify the primary ges in skin condition for 1 of (#2) who had discolorations				
	The findings are:					
	Review of Resident #2's current FL-2 dated 05/18/21 revealed: -Diagnoses included capsular dementia and reactive depressionShe was incontinent of bladderShe was continent of bowelShe was intermittently disoriented.					
	Review of Resident #2's current care plan dated 07/01/21 revealed: -She was totally dependent on staff for toileting, bathing dressing, grooming and transferringShe was totally dependent on staff for ambulation, using a wheelchair for an assistive device.					
	Observation of Resident #2 on 09/29/21 at 6:52am revealed: -Two staff were performing incontinent careThere was purple bruising on the back of both of her hands that extended above the her wrists to her forearms and a palm sized, yellowish gray bruise on the inner aspect of her left thighThe skin over the heel of her left foot was shiny and red.					
	09/29/21 at 6:52am re -Resident #2's skin bu always new ones eve	ruised easily and there were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDEN	TIFICATION NUMBER.	A. BUILDING:		COMPLETED	
H.	AL027003	B. WING		C <b>09/30/2021</b>	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CURRITUCK HOUSE	141 MOYO	CK LANDING I	DRIVE		
CURRITUCK HOUSE	MOYOCK,	NC 27958			
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273 Continued From page 5 bruising on her hands and arm -He did not know how long the present on Resident #2's thigh -He saw the red area on her h weekend but did not report it to -He should have reported the l on Resident #2's heel to the m when he first observed it.  Interview with the second PCA 6:52am revealed that she had on the inner thigh or red area of heel before and did not know h  Interview with a MA on 09/28/2 revealed: -She was notified by the PCA of Resident #2 had redness on h not specify when she was mad -She had not looked at the cor #2's skin because she did not at the facilityThe process was for her to we and to notify the PCP for Resid in skin conditionShe had not notified the PCP busy with other tasks.  Telephone interview with a fam Resident #2 on 09/30/21 at 10 -The facility did not notify her of were found on Resident #2She saw bruises on Resident hands in various stages of hea social media pageShe expected the facility to no bruising occurredShe was not aware any press discoloration of the skin on any	ebruise had been a. eel the previous o anyone. bruise and the area nedication aide (MA)  A on 09/29/21 at not seen the bruise on Resident #2's now she got them.  21 at 7:13pm  on duty that er skin but would de aware. ndition of Resident bathe the residents rite a progress note dent #2 of changes  because she was  nilly member of 1:05am revealed: of any bruises that  #2's arms and aling on the facility's  otify her when	D 273			

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DIVISION	of Health Service Regu	lation				
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
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		11AL027000			1 09/3	0/2021
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		444 MOV	OCK LANDING	DRIVE		
CURRITU	CK HOUSE			DRIVE		
		MOYOCK	, NC 27958			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 070		_	D 070			
D 273	Continued From page	e 6	D 273			
	Talambana intansiass.	with the emission of the state				
	Telephone interview v					
	·	esident #2 on 09/30/21 at				
	10:30am revealed:					
	-She had not been no	otified of a red area over				
	Resident #2's heel.					
	**	notified of any discoloration				
	<u> </u>					
		ent because deep tissue				
		hin hours that could extend				
	to the bone.					
	-She was aware of th	e bruising to Resident #2's				
	arms and hands but v	vas not aware of a bruise to				
	her thigh.					
		notified of the bruise found				
		h because the thigh was a				
	suspicious place to ha	ave a bruise.				
	Telephone interview v	vith the hospice nurse for				
	Resident #2 on 09/30	/21 at 11:00am revealed:				
	-She had noticed larg	e bruises on the hands of				
	Resident #2 that exte					
	09/14/21.	rided to rior whote on				
		port any bruises found				
	anywhere on Resider					
	-She expected to be r	notified of bruising and other				
	skin discoloration bed	cause tissue damage could				
	happen quickly in res	idents receiving hospice				
	services.					
		of a red area on the heel of				
	Resident #2.	or a rea area on the neer of				
	ixesiderit #2.					
		ministrator on 09/30/21 at				
	4:15pm revealed:					
	-If she had known abo	out the bruise on Resident				
	#2's inner thigh, she	would have submitted a				
		Health Care Personnel				
	Registry and begun a					
		<del>-</del>				
		report bruises of unknown				
	origin to her and the F					
	-She had not trained	staff to report bruises of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			
		HAL027003	B. WING		C 09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHRRITH	CK HOUSE	141 MOY	OCK LANDING I	DRIVE		
OOKKITO		мочоск	, NC 27958			
(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 273	Continued From page	e 7	D 273			
	was expectedShe was not notified Resident #2She expected staff to condition the PCP.  Based on observation determined she was n					
D 358	(a) An adult care horn preparation and admit prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures.  This Rule is not met TYPE B VIOLATION  Based on observation reviews, the facility farmedication as ordere #8, #9, #10) observed passes including errot treatment of psychiatic	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:  ns, interviews, and record illed to administer d for 4 of 5 residents (#4, d during the medication rs with a medication for ric behaviors and reflux ation (#8), allergies (#10),	D 358			
	The medication error	rate was 17% as evidenced				

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by the observation of 5 errors of 28 opportunities

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		HAL027003	B. WING		09/30	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
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		·	NC 27958			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 8	D 358			
	during the morning m	edication pass on 09/29/21.				
	03/08/21 revealed:	t #9's current FL-2 dated dementia, bipolar disorder, ase.				
		r for Risperidone 1mg, take (Risperidone is used to treat ).				
	09/29/21 revealed Ris	ed to Resident #9 when she				
	instructions to take or	administration record for Risperidone 1mg with the tablet twice a day, stration at 8:00am and s documented as				
	-	ent #9's medication on hand n revealed there was no on available for				
	from the facility's cont 09/30/21 at 8:15am re -There were 60 tablet Risperidone 1mg disp -The pharmacy receiv	evealed: is (1 month supply) of pensed on 08/20/21.				

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR\	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	ט
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		HAL027003	B. WING		09/30/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING D	RIVE		
		MOYOCI	K, NC 27958			
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	9	D 358			
	Interview with Reside revealed: -She could not recall Risperidone yesterda -The medication aide medication cup and s Risperidone was ther medication.	y. (MA) handed her the he assumed her				
	revealed: -She was not aware to her RisperidoneResident #9 was not behaviorsShe was just clicking eMAR and had not parameters and h	the multidose pack. Deacket was empty it was the MA's responsibility to fill harmacy for a refill. If a pharmacy refill form was is Risperidone.  The ministrator on 09/29/21 at the A to administer Resident ordered. A to complete the refill				
	•					

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-She was concerned that Resident #9 missing Risperidone doses could cause an increase in

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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	
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		HAL027003	B. WING		09/30/2021
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D 358	Continued From page	: 10	D 358		
	including increased a	hat Resident #9 had missed			
	03/08/21 revealed the	aily (Pantoprazole is used to			
	09/29/21 revealed Pa	ed to Resident #9 when she			
	tablet once a day, sch 8:00am.	administration record or Pantoprazole 40mg 1 neduled for administration at tablet was documented as			
	on 09/29/21 at 11:15a	ent #9's medication on hand im revealed there was a cole 40mg tablets with 26			
	from the facility's cont 09/30/21 at 8:15am re	evealed there were 30 ly) of Pantoprazole 40mg			
	revealed:	nt #9 on 09/30/21 at 3:14pm reflux disorder, but it was symptoms.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		_
		HAL027003	B. WING		C 09/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CURRITU	CK HOUSE	141 MOYO	OCK LANDING I	DRIVE	
		MOYOCK	, NC 27958		
(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 APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE COMPLETE
D 358	Continued From page	e 11	D 358		
	-She could not recall Pantoprazole yesterd -The medication aide medication cup and s	if she received her ay. (MA) handed her the			
	Interview with the medication aide (MA) on 09/29/21 at 12:55pm revealed: -She was not aware that Resident #9 had not received her Pantoprazole during the morning medication pass (09/29/21)She was just clicking off medication on the eMAR and had not paid attention if the Pantoprazole was in the multidose packShe should have checked the eMAR against the medication to ensure Resident #9 received her ordered medication including the Pantoprazole.  Interview with the Administrator on 09/29/21 at 2:10pm revealed she expected the MA to administer Resident #9's Pantoprazole as				
	Telephone interview with Resident #9's primary care provider (PCP) on 09/30/21 at 9:50am revealed:  -Resident #9 had an extensive history of gastric reflux disorder that was well controlled with Pantoprazole.  -She expected Resident #9 to receive her Pantoprazole as ordered.  -Resident #9 missing a dose of her Pantoprazole could have caused an increase in reflux including indigestion, nausea, and stomach discomfort.  2. Review of Resident #8's current FL-2 dated 09/03/21 revealed:  -Diagnoses included hypertension, gastroesophageal reflux disorder and heart				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	1120
					c	;
		HAL027003	B. WING		09/3	0/2021
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	(0.115 E. (0.11 E. E. (1.11 E		CK LANDING			
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D 358	Continued From page	e 12	D 358			
	failure.					
		for Miralax 17gm daily				
		eat occasional constipation).				
		for Milk of Magnesia 30ml at				
	bedtime as needed for	or constipation (Milk of				
	Magnesia is used to t	reat constipation).				
	01 (1 61)					
	Observation of the mo	orning medication pass on				
		ed Milk of Magnesia as he				
	was leaving the dining	<del>-</del>				
		(MA) prepared Miralax				
		on from the facility's house				
		e Miralax 17gm at 8:38am.				
	Review of Resident #					
	electronic medication (eMAR) revealed:					
	•	or Miralax 17gm daily,				
	scheduled for adminis	or Milk of Magnesia 30ml to				
	<del>_</del>	is needed for constipation.				
		nl was documented as				
	administered on 09/2					
	reason given as "resi					
		vith a pharmacy technician				
	from the facility's conf					
	09/30/21 at 8:15am re					
	09/26/21 for a one-mo					
		ed a request on 09/29/21				
	for a refill but informe early to fill the reques	d the facility that it was too t.				
	Interview with Reside	nt #8 on 09/30/21 at				
	11:20am:					
	-He usually requested	Miralay after breakfast	1			

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because it helped keep his bowel movements

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Division o	of Health Service Regu	lation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED	
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		HAL027003	B. WING		09/3	0/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓΕ. ZIP CODE			
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CURRITU	CK HOUSE			KIVE			
			K, NC 27958				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
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IAG		130 IDEIXIII TIIXO IXI OTXIII XIIOTX	IAG	DEFICIENCY)	// TU/TIE		
			<del>                                     </del>				
D 358	Continued From page	e 13	D 358				
	regular.						
		er whether he asked for Milk					
	of Magnesia or Mirala						
	because he got the tv						
	<sub>լ</sub> -He wanted the Mirala	ax, which was what he					
	received.						
	Interview with the MA	on 09/29/21 at 12:55pm					
	revealed:						
	-Resident #8 requeste	ed a laxative after most			ļ		
	breakfast meals.						
	-She got the names c	of Milk of Magnesia and					
		t was why she said Milk of					
	Magnesia instead of I	•					
	(09/29/21).						
		tered Resident #8 Miralax,					
	not Milk of Magnesia.						
	Interview with the Adv	ministrator on 09/29/21 at					
	2:10pm revealed:	Tillistrator on 09/29/21 at					
		A to administer Decident					
		A to administer Resident					
	#8's medication as or						
		that the MA mixed up the					
	names of Miralax and	I Milk of Magnesia.					
	l <b>-</b>						
		with Resident #8's primary					
		on 09/30/21 at 9:50am					
	revealed:						
	-She expected Reside						
		d including Miralax and Milk					
	of Magnesia.						
		ded to be obsessive about					
	his bowel regimen an						
	expected the MA to e	nsure that she was					
	administering his med	dications appropriately.					
	3. Review of Residen	it #10's current FL-2 dates					
	08/27/21 revealed dia	agnoses included					
	rheumatoid arthritis, h						

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hyperlipidemia.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
			, DOILDING			<b>.</b>
		HAL027003	B. WING		1	, 0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE	141 MOYO MOYOCK,	CK LANDING I NC 27958	DRIVE		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 14	D 358			
	dated 09/07/21 reveal 137mcg inhale 2 spray day (Azelastine is use symptoms).  Observation of the 8:09/29/21 revealed the administered one spray in each in 8:50am.  Review of Resident # electronic medication (eMAR) revealed: -There was an entry f spray, inhale 2 sprays scheduled for adminis 8:00pmAzelastine 137mcg r	200am medication pass on the medication aide (MA) and of Azelastine 137mcg ostril to Resident #10 at				
	Interview with the MA revealed: -She was not sure ho Resident #10 receive morning (09/29/21) di medication passIt was easy to confus sprays because multi sprays during the mo-She was aware that eMAR prior to admini nasal spray but she wand missed it.	w many sprays of Azelastine d in each nostril that uring the morning se residents with nasal ple residents received nasal rning medication pass. she should be checking the stration of Resident #10's vas in a hurry this morning				
	Interview with the Adr 2:10pm revealed:	ministrator on 09/29/21 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING: COMPLETED				
			A. BOILDING.			
		HAL027003	B. WING		09	C 9/ <b>30/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OUDDITU	ok House	141 MOY	OCK LANDING DE	RIVE		
CURRITU	CK HOUSE	MOYOCI	K, NC 27958			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page		D 358			
	sprays into each nost	elastine 137mcg of two ril. A to review Resident #10's				
		interview with Resident ovider (PCP) on 09/30/21 at ssful.				
		ns, interviews, and record nined Resident #10 was not				
		t #4's current FL-2 dated ignoses included prostate ostatic hyperplasia.				
	09/18/21 revealed the Polymyxin B Sulfate- administer 2 drops int day for 14 days (Poly	Frimethoprim eye drops, to the effected eye twice a				
	09/22/21 revealed the Erythromycin eye oin	4's physician order dated ere was an order for tment twice a day to the right nromycin is used to treat eye				
	09/28/21 revealed: -The medication aide Erythromycin ointmer at 8:58am Polymyxin B Sulfate	orning medication pass on  (MA) administered  It to Resident #4's right eye  -Trimethoprim eye drops  dministered to Resident #4				

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Division c	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		HAL027003	B. WING		09/30/2021	
					1 03/00/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING I	DRIVE		
		МОУОСК	K, NC 27958			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	,	
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IAG		200 IDENTIFY THE INTERNATION,	IAG	DEFICIENCY)		
7.050	. <u></u>					$\overline{}$
D 358	Continued From page	∍ 16	D 358			
	during the morning medication pass.					
	<b>3</b>	,				
	Review of Resident #	4's September 2021				
	electronic medication	administration record				
	(eMAR) revealed:					
	-There was an entry f	or Polymyxin B				
	Sulfate-Trimethoprim	eye drops, administer 2				
		d eye twice a day for 14				
	_	administration at 8:00am and				
	8:00pm.					
		-Trimethoprim eye drops,				
	· · · · · · · · · · · · · · · · · · ·	to the effected eye twice a				
		documented as administered				
	on 09/29/21 at 8:00ar					
	-There was an entry f					
	•	to the right eye for 30 days,				
		stration at 8:00am and				
	8:00pm.					
		intment was documented as				
	administered on 09/2	9/21 at 8:00am.				
	Observation of Resid	ent #4's medication on hand				
	on 9/29/21 at 11:17ar					
		Trimethoprim eye drops				
	available for administ					
		ration.				
	Interview with Reside	ent #4 on 09/28/21 at 7:45pm				
	revealed:					
		infection for about two				
	weeks.					
	-The eye doctor recer	ntly changed the drops that				
	he was receiving for t	the eye infection.				
	-He did not have any	pain, but he did have blurry				
	vision that still has no	ot improved even with the				
	change in medication	is.				
		on 09/29/21 at 12:55pm				
	revealed:					
	-She was told by ano	ther MA that Resident #4's				

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eye drops had been discontinued.

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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	
			7 501251110		С
		HAL027003	B. WING		09/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE	-
			OCK LANDING I		
CURRITU	CK HOUSE	MOYOCK	K, NC 27958		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	: 17	D 358		
	for administration on t -She should have dou Resident #4 prior to a medications.	ible checked the eMAR for dministering his			
		ninistrator on 09/29/21 at expected Resident #4 to as ordered.			
	care provider (PCP) or revealed: -She received a call the clarify if Resident #4 to Polymyxin B Sulfate-Talong with the Erythrough -She discontinued the Sulfate-Trimethoprim she expected to recei	Frimethoprim eye drops omycin ointment.			
	administered as order during the medication receive her psychiatricat increased risks for including increased as not receiving her module to the could have caused an stomach discomfort. This antibiotic eye drop resulted in continued failure to ensure medical as ordered was detrinand safety of the resided Wiolation.	gitation and anxiety, as well nedication for reflux which increase in indigestion or Resident #4 did not receive as for his eye infection which blurred vision. The facility's factions were administered mental to the health, welfare dents and constitutes a Type			

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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	
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	HAL027003	B. WING		09/30/2021	
R OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
JSE	MOYOC	K, NC 27958			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
nued From page	= 18	D 358			
iolation.					
ATION SHALL N					
	4(f) Medication	D 363			
medications are vance, the follow mented to keep pint of administration and spedications are dage such as united with the name of the medications ent. If the multipations are dapped or sealed edications not ded package as sealed edic	prepared for administration ving procedures shall be the drugs identified up to ation and protect them from sillage: ispensed in a sealed dose and multi-paks that is e of each medication and dipackage. The labeled ins is to remain unopened a capped or sealed led with the resident's name, are administered to the pak is also labeled with the less not have to be enclosed discontainer; ispensed in a sealed and pecified in Subparagraph (1) kept enclosed in a sealed es the name and strength of loared and the resident's her is used for each resident ministration of the led according to (2) of this Paragraph; and placed together on a				
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR Indication.)  RECTION DATE ATION SHALL No.  NCAC 13F .1004 inistration  NCAC 13F .1004 inistration  NCAC 13F .1004 inistration  NCAC 13F .1004 inistration  NCAC 13F .1004 inistration and specifications are defications in the multiple of the medications and defications and defications and defications and laberary and laberary are reacted tray or other are tray or other are tray or other are tray or other areas and incomplete are reacted tray or other areas and incomplete areas are tray or other areas and incomplete areas are tray or other areas are tray or other areas are areas and incomplete areas are tray or other areas are areas are areas areas and incomplete areas are areas	HAL027003  R OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Inued From page 18  iolation.  RECTION DATE FOR THE TYPE B ATION SHALL NOT EXCEED NOVEMBER 021.  NCAC 13F .1004(f) Medication Administration medications are prepared for administration wance, the following procedures shall be mented to keep the drugs identified up to oint of administration and protect them from imination and spillage: edications are dispensed in a sealed age such as unit dose and multi-paks that is ed with the name of each medication and gth in the sealed package. The labeled age of medications is to remain unopened tept enclosed in a capped or sealed iner that is labeled with the resident's name, the medications are administered to the ent. If the multi-pak is also labeled with the ent's name, it does not have to be enclosed apped or sealed container; edications not dispensed in a sealed and ed package as specified in Subparagraph (1) is Paragraph are kept enclosed in a sealed iner that identifies the name and strength of medication prepared and the resident's	HAL027003  ROR SUPPLIER  STREET ADDRESS, CITY, STATE  141 MOYOCK, NC 27958  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  ID PREFIX TAG ID	ROR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  141 MOYOCK LANDING DRIVE  MOYOCK, NC 27958  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Deficiency flust action sho CROSS-REFERENCE TO THE APPR DEFICIENCY)  DIPRETER  REGULATORY OR LSC IDENTIFYING INFORMATION)  DATE TAG  DATE CROSS-REFERENCE TO THE APPR DEFICIENCY)  DATE CROSS-REFERENCE TO THE CROSS-REFERENCE TAG CROSS-REFERENCE	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL027003	B. WING		09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CHRRITH	CK HOUSE	141 MOY	OCK LANDING	DRIVE		
MOYOCK		K, NC 27958				
(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 363	Continued From page	e 19	D 363			
		s only accessible to staff as				
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that medications that were prepared for administration in advance were kept in a sealed and labeled package for 5 of 5 residents (#2, #11, #12, #13, and #14).					
	The findings are:					
	1. Observation of the medication aide on duty on 09/29/21 from 6:38am to 6:40am revealed: -She removed a small clear medication cup with applesauce and a pill from the locked medication cartThere was a letter on the medication cupShe entered Resident #11's room and had the resident swallow the applesauce and pills.					
	03/08/21 revealed: -Diagnoses included gastroesophageal ref -There was an order take one tablet daily (treat thyroid disorder) -There was an order to	lux disorder.  for Levothyroxine 88mcg,  Levothyroxine is used to  .  for Pantoprazole 40mg, take  ning (Pantoprazole is used to				
	Review of Resident # electronic medication (eMAR) revealed:	11's September 2021 administration record				

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_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		1 ' '	(3) DATE SURVEY COMPLETED	
			_		c	:	
		HAL027003	B. WING		1	0/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE			
CURRITU	CK HOUSE		CK LANDING I	DRIVE			
		MOYOCK, I	NC 27958				
(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	(X5) COMPLETE DATE	
D 363	Continued From page	20	D 363				
D 363	-There was an entry fitake one tablet daily, at 7:00amLevothyroxine 88mcg administered on 09/29 -There was an entry fone tablet every morradministration at 7:00 -Pantoprazole 40mg wadministered on 09/29 Refer to interview with on 09/29/21 at 7:38ar Refer to interview with 09/29/21 at 2:10pm. Refer to telephone into contracted primary ca 09/30/21 at 9:50am.  2. Observation of the duty on 09/29/21 from revealed: -She removed a small applesauce and pills to cartThere was a letter or -She entered Resider resident swallow the are resident #	for Levothyroxine 88mcg, scheduled for administration g was documented as 9/21 at 7:00am. For Pantoprazole 40mg, take hing, scheduled for fam.  Was documented as 9/21 at 7:00am.  In the medication aide (MA) m.  In the Administrator on the erview with the facility's are provider (PCP) on medication aide (MA) on a 6:42am to 6:46am  I clear medication cup with from the locked medication in the medication cup. In	D 363				
	dated 08/30/21 revea	for Pantoprazole 40mg, take					

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DIVISION	n Health Service Negu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		HAL027003	B. WINO		09/3	0/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			OCK LANDING			
CURRITU	CK HOUSE			DKIVE		
		MOYOCK	NC 27958			
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			-			
D 363	Continued From page	e 21	D 363			
	(Pantoprazole is used disorder).	d to treat gastric reflux				
	,	for Sucralfate 1gm, take one				
		y, one hour before each				
		(Sucralfate is used to treat				
	stomach inflammation	•				
	Stornach innammation	1).				
	Review of Resident #	13's Sontombor 2021				
	electronic medication					
		administration record				
	(eMAR) revealed:	ion Dontonnonolo 40mm toles				
	-	for Pantoprazole 40mg, take				
	one tablet every morr	G.				
	administration at 7:00					
	-Pantoprazole 40mg					
	administered on 09/2					
		or Sucralfate 1gm, take one				
		y, one hour before each				
	meal and at bedtime	scheduled for administration				
	at 7:00am, 11:00am,	4:00pm, and 8:00pm.				
	-Sucralfate 1gm was	documented as				
	administered on 09/29	9/21 at 7:00am				
	Refer to interview with	h the medication aide (MA)				
	on 09/29/21 at 7:38ar	m.				
	Refer to interview with	h the Administrator on				
	09/29/21 at 2:10pm.					
	•					
	Refer to telephone int	terview with the facility's				
	contracted primary ca					
	09/30/21 at 9:50am.					
	55,00,21 at 5.00am.					
	3 Observation of the	medication aide on duty on				
	09/29/21 from 6:49an					
		Il clear medication cup with				
		from the locked medication				
	cart.	0 8 6				
	-There was a letter or	n the medication cup.				
	-She entered Recider	TI III I I I I I I I I I I I I I I I I	1	1		

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resident swallow the applesauce and pill.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '			X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL027003	B. WING	·····	09	C / <b>30/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	•	
		141 MOY	OCK LANDING D	RIVE		
CURRITU	CK HOUSE	MOYOCE	K, NC 27958			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 363	Continued From page	22	D 363			
	05/18/21 revealed: -Diagnoses included l -There was an order f	for Levothyroxine 50mcg, Levothyroxine is used to				
	(eMAR) revealed: -There was an entry f take one tablet daily, at 7:00am.	administration record or Levothyroxine 50mcg, scheduled for administration g was documented as				
	09/29/21 from 6:54am -She removed a smal applesauce and a pill cartThere was a letter or	I clear medication cup with from the locked medication the medication cup.  If #14's room and had the				
	12/07/20 revealed: -Diagnoses included of the control of the contr	for Levothyroxine 100mcg, Levothyroxine is used to				
	(eMAR) revealed: -There was an entry f take one tablet daily, at 7:00am.	14's September 2021 administration record for Levothyroxine 100mcg, scheduled for administration cg was documented as				

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						;
		HAL027003	B. WING		09/3	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ALE, ZIP CODE		
CURRITU	CK HOUSE	141 MOY	OCK LANDING	DRIVE		
CURRITU	CK HOUSE	MOYOCK	K, NC 27958			
0/10/15	QLIMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 363	Continued From page	e 23	D 363			
	administered on 09/2	0/21 at 7:00am				
	auministered on 09/2	9/21 at 7.00am.				
	5 01 1: 1:1	P 6 11 14				
		medication aide on duty on				
	09/29/21 from 7:01an					
	-She removed a smal	ll clear medication cup with				
	applesauce and a pill	from the locked medication				
	cart.					
	-There was a letter or	n the medication cup.				
	-She entered Resider	nt #2's room and had the				
	resident swallow the					
	Review of Resident #	2's current FL-2 dated				
	05/18/21 revealed:	23 danent i E-2 dated				
	-Diagnoses included					
		for Levothyroxine 100mcg,				
	,	Levothyroxine is used to				
	treat thyroid disorder)	)				
	Review of Resident #	2's September 2021				
	electronic medication	administration record				
	(eMAR) revealed:					
		or Levothyroxine 100mcg,				
	•	scheduled for administration				
	at 7:00am.	concaded for dammed allon				
		cg was documented as				
	administered on 09/2	9				
	auministered on 09/2	9/21 at 7.00am.				
	56 4 3 4 3 4 3 4					
		h the medication aide (MA)				
	on 09/29/21 at 7:38ar	n.				
	Refer to interview with	h the Administrator on				
	09/29/21 at 2:10pm.					
	Refer to telephone int	terview with the facility's				
	contracted primary ca					
	09/30/21 at 9:50am.					
	JOIOUIZ I at J.Juaiii.					
	Intorvious with the re-	dication aids (MA) as				
	Interview with the me					
	09/29/21 at 7:38am re					
	-She prepared the mo	orning medications on the				

Division of Health Service Regulation

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DIVISION	of Health Service Regu	liation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
					C
		HAL027003	B. WING		09/30/2021
			•		-
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	ΓE, ZIP CODE	
		141 MOY	OCK LANDING D	DRIVE	
CURRITUCK HOUSE			(, NC 27958		
			1,110 27000		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
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TAG	INEGOLATORI ORT	ESCIDENTII TIING INI ONWATION)	TAG	DEFICIENCY)	UAIL 57.112
				,	
D 363	Continued From page 24		D 363		
	oonanaoa i rom paga	<u> </u>			
	assisted living (AL) si	ide of the facility and then			
		care Unit (SCU) side of the			
		ir morning medications,			
	while the AL medicati	•			
		ons solicit in the			
	applesauce.				
		ed about being woken up to			
		so she placed them in the			
	applesauce so that it	was easier for the residents			
	to swallow.				
	-The cups were mark	ed with the resident's first			
	initial and locked in th				
		rson with access to the			
		t stayed locked if she was			
	not at it.				
		the medications on the			
	electronic medication	administration record			
	(eMAR) until the med	lications were given.			
	-She prepared reside	nts medications ahead of			
	· · ·	s the only MA administering			
		and in order to not get			
	_	to prepare the medications			
		to prepare the medications			
	ahead.				
	Interview with the Adr	ministrator on 09/29/21 at			
	2:10pm revealed:				
	-She was not aware t	that the MA prepared her			
	medications prior to a	administration.			
	-She had recently fire				
		ons and was not aware that			
	other staff were also				
		o prepare one resident's			
		and administer them			
	immediately.				
	-She was concerned	that residents' medications			<b> </b>
	would get mixed up c	ausing serious health			<b> </b>
	issues.	•			<b> </b>
	Telephone intonious	with the facility's contracted			
	primary care provider	r (PCP) on 09/30/21 at			

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9:50am revealed:

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
7.1.12 . 27.1.1		.5	A. BUILDING: _			
		HAL027003	B. WING		C 09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE	141 MOYO	CK LANDING I	DRIVE		
CURRITU	CK HOUSE	MOYOCK,	NC 27958			
(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	(X5) COMPLETE DATE
D 363	Continued From page 25		D 363			
	administer medication -She was concerned sitting in a substance properties that make therefore effecting the works.	that medications that were to soften may lose them extended release, e away the medication that residents may not				
D 367	D 367 10A NCAC 13F .1004(j) Medication Administration		D 367			
	10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).					
		as evidenced by: ns, interviews, and record led to ensure medication				

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Division of Fleatin Service Regulation				1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
						<u>,</u>	
		HAL027003	B. WING		09/30/2021		
		TIALUZI 003			09/3	0/2021	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
	141 MOYO		OCK LANDING	DRIVE			
CURRITUCK HOUSE MOYOCK.		K, NC 27958					
0(0)15	STIMMADV ST	ATEMENT OF DEFICIENCIES	<u>,                                      </u>	PROVIDER'S PLAN OF CORRECTION	.1	0/5)	
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				DEFICIENCY)			
D 367	Continued From page	26	D 367				
2 00.	Continued From page	, 20					
		s were accurate for 5 of 9					
		cluding medications for					
		nanagement and reflux					
	\ /'	ation (#8), allergy relief					
	(#10), and an eye infe	ection (#4).					
	The findings are:						
		t #9's current FL-2 dated					
	03/08/21 revealed:						
	_	dementia, bipolar disorder,					
	and Alzheimer's disea						
		for Risperidone 1mg, take					
		(Risperidone is used to treat					
	psychiatric behaviors	).					
	01 1: (11 0)	00 1: 1:					
		00am medication pass on					
	09/29/21 revealed Ris	•					
		ed to Resident #9 when she					
	received her other mo	~					
	8:43am from the med	lication aide (MA).					
	Indominacy with the NAA	that assumed to d Danidant					
		that completed Resident					
	•	ion pass on 09/29/21 at					
	•	e had not administered					
	Risperdone to Reside	ent #9.					
	Review of Posidont #	0's Santambor 2021					
	Review of Resident #	administration record					
	(eMAR) revealed:	auministration record					
		or Risperidone 1mg with					
	-						
	instructions to take or	าย เสมเยเ เพเตย a day, stration at 8:00am and					
		Suauun at o.uuani anu					
	8:00pm.	a decumented as					
	-Risperidone 1mg wa						
	administered on 09/29	9/∠1 at 8:00am.					
	Defer to the interview	with the MA on 00/20/21 of					
		with the MA on 09/29/21 at					
	12:55pm.						

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
			A. BUILDING: _			
		HAL027003	B. WING		09	C 0/ <b>30/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
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CURRITUCK HOUSE MOYOCK,		K, NC 27958				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	27	D 367			
	Refer to the interview with the Administrator on 09/29/21 at 2:10pm.  Refer to the telephone interview with the facility's primary care provider (PCP) on 09/30/21 at 9:50am.  3. Review of Resident #9's current FL-2 dated 03/08/21 revealed there was an order for Pantoprazole 40mg daily (Pantoprazole is used to treat gastric reflux disorder).  Observation of the 8:00am medication pass on 09/29/21 revealed Pantoprazole was not administered or offered to Resident #9 when she received her other morning medications at 8:43am from the medication aide (MA).  Review of Resident #9's September 2021 eMAR on 09/29/21 at 10:22 am revealed:  -There was an entry for Pantoprazole 40mg 1 tablet once a day, scheduled for administration at 8:00am.  -Pantoprazole 40 mg tablet was documented as administered on 09/29/21 at 8:00am.					
	Refer to the interview 12:55pm.	with the MA on 09/29/21 at				
	Refer to the interview 09/29/21 at 2:10pm.	with the Administrator on				
		e interview with the facility's (PCP) on 09/30/21 at				
	09/03/21 revealed:	t #8's current FL-2 dated for Miralax 17gm daily				

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(Miralax is used to treat occasional constipation).

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL027003	B. WING		C <b>09/30/2021</b>	
				TE 710 0005	1 09/30	1/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA C <b>K Landing</b> I			
CURRITUCK HOUSE MOYOCK,			3442			
(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	(X5) COMPLETE DATE
D 367	Continued From page	28	D 367			
B 307	-There was an order of bedtime as needed for Magnesia is used to the Control of the model of the Magnesia is used to the Control of the model of the Magnesia is used to the Control of the model of the Magnesia is used to the Control of the Magnesia is used to the Magnesia	for Milk of Magnesia 30ml at or constipation (Milk of reat constipation).  Derning medication pass on the defended with the factor of the fact				
	scheduled for administration at 9:00am.  -There was an entry for Milk of Magnesia 30ml to be given at bedtime as needed for constipation.  -Milk of Magnesia 30ml was documented as administered on 09/29/21 at 8:34am with a reason given as "resident asked for it".  Refer to the interview with the MA on 09/29/21 at					
	09/29/21 at 2:10pm. Refer to the telephone	with the Administrator on e interview with the facility's (PCP) on 09/30/21 at				
	primary care provider (PCP) on 09/30/21 at 9:50am.  5. Review of Resident #10's current FL-2 dates 08/27/21 revealed diagnoses included rheumatoid arthritis, hypertension and hyperlipidemia.					

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Review of Resident #10's physician's orders

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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	
			A. BOILDING.		С
		HAL027003	B. WING		09/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CURRITU	CK HOUSE	141 MOYOG Moyock, I	CK LANDING I NC 27958	DRIVE	
(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 367	137mcg inhale 2 spraday (Azelastine is use symptoms).  Observation of the 8:09/29/21 revealed the Resident #10 adminis Azelastine 137mcg na 8:50am.  Review of Resident #electronic medication (eMAR) revealed: -There was an entry f spray, inhale 2 sprays scheduled for adminis 8:00pmAzelastine 137mcg rinto each nostril twice administered on 09/29/21 Refer to the interview 12:55pm.  Refer to the interview 09/29/21 at 2:10pm.  Refer to the telephone primary care provider 9:50am.  6. Review of Resident #09/18/21 revealed the 09/18/21 revealed the	led an order for Azelastine bys into each nostril twice a sed to treat allergy  Doam medication pass on a medication aide (MA) stered one spray of asal spray in each nostril at  10's September 2021 administration record  for Azelastine 137mcg nasal into each nostril twice daily, stration at 8:00am and  pasal spray, inhale 2 sprays adaily was documented as 9/21 at 8:00am.  with the MA on 09/29/21 at  with the Administrator on  the interview with the facility's (PCP) on 09/30/21 at  the #4's current FL-2 dated agnoses included prostate ostatic hyperplasia.  4's physician order dated are was an order for	D 367	DEFICIENCY)	
		Trimethoprim eye drops, to the effected eye twice a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		HAL027003	B. WING		09/30	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE		CK LANDING	DRIVE		
		·	NC 27958			
(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	(X5) COMPLETE DATE
D 367	Continued From page	÷ 30	D 367			
	day for 14 days (Polymyxin B Sulfate-Trimethoprim is used to treat bacterial eye infections).					
	09/28/21 revealed Po Sulfate-Trimethoprim or administered to Re	eye drops were not offered				
	Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Polymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days, scheduled for administration at 8:00am and 8:00pmPolymyxin B Sulfate-Trimethoprim eye drops, administer 2 drops into the effected eye twice a day for 14 days was documented as administered on 09/29/21 at 8:00am.					
	Refer to the interview 12:55pm.	with the MA on 09/29/21 at				
	Refer to the interview 09/29/21 at 2:10pm.	with the Administrator on				
		e interview with the facility's (PCP) on 09/30/21 at				
	medication administra	revealed: to check the electronic ation record (eMAR) before tion which indicated that the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL027003	B. WING		09	C 9/ <b>30/2021</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
CHEDITH	CK HOUSE	141 MO	YOCK LANDING DE	RIVE		
CURRITU	CK HOUSE	MOYOC	K, NC 27958			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 31	D 367			
	matched the medicat -She understood the eMAR and the harm	e for ensuring that the eMAR ions she administered. importance of an accurate that it could cause the issed doses or unnecessary th regimen.				
	2:10pm revealed: -She expected the eNaccurateIt was the MA's respeMAR was accurate a-There was no audit p	MAR to be complete and complete. Process currently in place to e accurate and complete.				
	provider (PCP) on 09 -She expected the eNaccurateShe was concerned being made based or were receiving what reshe adjusted some runderstanding that the accurateIt was vitally importa	with the facility's primary care /30/21 at 9:50am revealed: MAR to be complete and that medical decisions were in the idea that residents medications were recorded. Medications based on the e eMAR was complete and that the eMAR accurately ions the residents are				
D 465	10A NCAC 13F .1308 (a) Staff shall be presufficient number to residents; but at no tione staff person, who training requirements	me shall there be less than meets the orientation and	D 465			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
		HAL027003	B. WING		C 09/30/202	1
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D 465	Continued From page	32	D 465			
	additional resident; a	our of staff time for each nd one staff person for up to shift and .8 hours of staff al resident.				
	reviews, the facility fa staffing hours for the	ns, interviews, and record iled to ensure the required special care unit (SCU) with nts were met for 5 of 15				
	The findings are:  Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of 90 beds including a special care unit (SCU) with a capacity of 48 beds.  Review of the facility's resident census report dated 09/18/21 revealed there was a SCU census of 14 residents, which required 14 staff hours on first and second shift and 11.2 staff hours on third shift.					
		ere was a total of 9.5 staff cond shift in the SCU with a				
		ere was a total of 9.5 staff rd shift in the SCU with a				
	dated 09/25/21 revea of 14 residents, which	s resident census report led there was a SCU census n required 14 staff hours on and 11.2 staff hours on third				

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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		
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		HAL027003	B. WING		09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE	141 MOYO Moyock, I	CK LANDING I	DRIVE		
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PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
D 465	Continued From page 33		D 465			
	Review of the employee timecards dated 09/25/21 revealed there was a total of 9.5 staff hours provided on third shift in the SCU with a shortage of 1.7 hours.					
	Review of the facility's resident census reports dated 09/26/21 revealed there was a SCU census of 13 residents, which required 13 staff hours on first and second shift and 10.4 staff hours on third shift.					
	Review of the employee timecards dated 09/26/21 revealed there was a total of 9.5 staff hours provided on third shift in the SCU with a shortage of 0.9 hours.					
	Interview with a Personal Care Aide (PCA) on 09/29/21 at 6:31am revealed: -She worked the 11:00pm to 7:00am shift Monday through Friday and every other weekend on the Special Care Unit (SCU)She had worked alone on weekendsShe last worked alone about 3 to 4 weeks agoThe shift had always been short staffed (did not give dates)Working alone presented challenges because there were some residents with acting out					
	walked a lot during th	nings and some residents e night. nd PCA on 09/29/21 at				
	6:42am revealed: -He worked the 11:00 various days and on t -He worked alone on when he worked on tt -He last worked alone	lam to 7:00am shift on the weekends on SCU. 11:00am to 7:00am shift ne weekends. e on 09/24/21 and 09/25/21.				
	Interview with a med	ication aide (MA) on				

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DIVISION	n Health Service Negu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
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	OU IN MA A DV OT			DDOWDEDIO DI ANI OF CODDECTION		
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1710		,	17.0	DEFICIENCY)		
			1			
D 465	Continued From page	e 34	D 465			
	00/00/04 -4 0-50					
	09/28/21 at 6:53pm re					
	_	MA scheduled to work when				
	she got off at 7:00pm					
	-The on-coming MA v	vould work on both the				
	special care unit (SCI	U) and the assisted living				
	(AL) side of the facility	V.				
	• •	y only 1 MA for the facility				
	but she could not say	·				
	but she oodid not say	now onen.				
	Interview with a second MA on 09/28/21 at					
	6:56pm revealed:					
	_	A and 2 personal care aides				
	(PCA) scheduled to w	vork after 7:00pm for the				
	facility.					
	-There was 1 PCA for	r the AL side, 1 PCA for the				
	SCU and 1 MA to adr	minister medications to both				
	sides.					
	oldoo.					
	Interview with a third	MA on 09/28/21 at 7:45pm				
	revealed:	WA 011 09/20/21 at 7.45pm				
		A scheduled from 7:00pm to				
		facility every shift that she				
	was scheduled.					
	-Approximately half of	f the time there was only				
	one PCA for the SCU	after 11:00pm.				
	-She spent approxima	ately 25% of her time on the				
	SCU and 75% on the					
	Interview with the Adr	ministrator on 09/28/21 at				
		fing was a concern for her				
	and she was hoping t	o mie more stair.				
	0 1					
	Second interview with					
	09/30/21 at 3:52pm re					
	-The staff schedule w	as previously made by an				
	employee that was no	o longer there.				
		as now being completed by				
	the lead MA/schedule					
		ess of hiring two more MA				
	because she knew sta					
	pecause sile kilew St	anny was an issut.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL027003	B. WING		09	C 0/ <b>30/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
CURRITU	CK HOUSE		OCK LANDING DE	RIVE		
		MOYOC	K, NC 27958			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 465	65 Continued From page 35		D 465			
	short staffedStaff was allotted a 3	to her that the facility was 0 minute on site break for and an hour total break ft.				
D912	D912 G.S. 131D-21(2) Declaration of Residents' Rights		D912			
	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 observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration and Medication Aide Training and Competency Validation.					
	The findings are:					
	reviews, the facility fa medication as ordered #8, #9, #10) observed passes including erro treatment of psychiatr disorder (#9), constipa	d for 4 of 5 residents (#4, d during the medication rs with a medication for ric behaviors and reflux ation (#8), allergies (#10), #4). [Refer to Tag D0358 (a) Medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	THE THE THE TOTAL PROPERTY OF CONTROL TO THE		A. BUILDING: _			LETED
HAI 027003 B. WING				С		
		HAL027003	B. WING		09	/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	FE, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING D	DRIVE		
		MOYOCK	, NC 27958			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D912	Continued From page	e 36	D912			
	2. Based on interview facility failed to ensure C) who was administe completed the 5-hour training and complete validation checklist primedications. [Refer to 4.5B(b) Medication Ai	vs and record reviews, the e 1 of 5 sampled staff (Staff ering medications had r online medication aide ed the medication skills rior to administering o Tag D935 G.S. 131-D				
D935	G.S.§ 131D-4.5B(b) A	ACH Medication Aides; ency	D935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requireme	aining and Competency				
	home is prohibited from any unsupervised methat individual has premedication aide during an adult care home of the following:  (1) A five-hour training	or 1, 2013, an adult care of allowing staff to perform edication aide duties unless eviously worked as a graph the previous 24 months in r successfully completed all groups graph developed by the edes training and instruction				
	in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monito bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days fro	of medication s for Disease Control and s on infection control and, if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL027003	B. WING		C 09/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CURRITUCK HOUSE 141 MOYOCK, N			CK LANDING I NC 27958	DRIVE		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D935	training and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. b. An examination deby the Division of Heat accordance with substitute and the procedure of the exists. This Rule is not met TYPE B VIOLATION  Based on interviews a facility failed to ensure C) who was administed completed the 5-hour training and completed validation checklist primedications.  The findings are:  Review of Staff C's, in personnel record reversible had a hire date of the New Completed	our training program coartment that includes in in all of the following: of medication  s of Disease Control and is on infection control and, if tion practices and oring or testing in which is potential for bleeding  veloped and administered alth Service Regulation in section (c) of this section.  as evidenced by:  and record reviews, the is 1 of 5 sampled staff (Staff iering medications had is online medication skills irior to administering  medication aide (MA) evalued: of 09/01/21. Medication Administration 5 is for Adult Care Homes on  on the Medication Clinical	D935			
	-She started working	at the facility as a MA on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND LEAR OF GOTALESTICA			A. BUILDING: _		0	
		HAL027003	B. WING		C 09/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE		CK LANDING I	DRIVE		
			NC 27958			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D935	Continued From page	÷ 38	D935			
	cart before she starte independentlyShe passed medicat on 09/07/21She completed the 5 09/21/21 and was sig Clinical Skills Checkli nurse on 09/22/21She was not aware t medications independ Medication Clinical Sl Medication Administrator Adult Care Homes  Review of September administration record administration record administered medication	ation 5 Hour Training Course  2021 electronic medication				
	Checklist and Medication Administration 5 Hour Training Course for Adult Care Homes from					
	09/29/21 revealed: -Staff C made 5 mediresidentsStaff C did not admirordered for psychiatriand an eye infectionStaff C administered nasal spray ordered for the control of the contr	nister medications as c behaviors, reflux disease, an incorrect dosage on a				
	breakfastOn the morning of 09 administered her med	0/29/21, she was dication by the MA that				

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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
					С
		HAL027003	B. WING		09/30/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDI			DRESS, CITY, STA	TE, ZIP CODE	
OUDDITU		141 MOY	OCK LANDING	DRIVE	
CURRITU	CK HOUSE	MOYOCK	, NC 27958		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D935	Continued From page	39	D935		
		second dose of medication r her breakfast on the same			
	09/30/21 at 2:25pm re-She was not aware to take the 5-hour training medication skills check medications.  -She completed the Machine Checklist with Staff Cappan passing medications independent was her responsible completed the prior to the medications independent interview with the Adra 3:52pm revealed:  -She was not aware to completed the appropriate in the prior passing medications in the prior to the p	hat Staff C was required to an course and complete the cklist prior to passing  Medication Clinical Skills on 09/22/21 after she ations independently. lity that newly hired MA's aining prior to passing dently.  ministrator on 09/30/21 at that Staff C had not oriate training prior to independently.			
	to ensure that all staff passing medications in Observation of the merevealed a medication Refer to Tag D0358 1 Medication Administra  The facility failed to enaide, completed the Mand Medication Admin Course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medications in the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administering medication and the course for Adult Carefailure to ensure Staff to administration and the course for Adult Carefailure to ensure Staff to administration and the course for Adult Carefailure to ensure Staff to administration and the course for Adult Carefailure to ensure the course for Adult Carefailure to ensure the course	edication pass on 09/29/21			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  Output  A. BUILDING:	_
	30/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CURRITUCK HOUSE 141 MOYOCK LANDING DRIVE MOYOCK, NC 27958	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935  Continued From page 40 pass on 09/29/21 and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.  The facility provided a plan of correction in accordance with G.S. 131D-34 on 09/29/21 for this violation.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2021.	

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