STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C **09/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET** **SANFORD, NC 27330**

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 08/31/21 - 09/02/21. The complaint investigation was initiated by the Lee County Department of Social Services on 08/10/21 and 08/27/21.	{D 000}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations and interviews, the facility failed to ensure the facility was free of hazards including paint and polyurethane stored in an unlocked room and multiple cleaning products such as cleaner with bleach, cleaner/deodorizer/disinfectant, window cleaner, liquid bleach, bleach germicidal cleaner, and bleach disinfecting wipes being stored on an unsecured housekeeping cart. The findings are: Review of the facility's license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds.	{D 079}		

Division of Health Service Regulation
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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{D 079}	Continued From page 1 Review of the facility's census report dated 08/31/21 revealed: -The facility's in-house census was 48 residents. -There were 17 SCU residents residing on A hall. -There were 31 SCU residents residing on B hall. Observation of room #26 on 08/31/21 at 11:42am revealed. -The door to the room was unlocked. -There were 3 gallons of paint and 1 can of polyurethane on the top shelf in the unlocked closet to the left of the room. -Warnings for the 3 paints included: keep out of reach of children; causes serious eye damage/eye irritation; skin corrosive - causes skin irritation; suspected of causing cancer. -Warnings for the polyurethane included: danger - combustible liquid and vapor; may be harmful if inhaled; irritating and may injure eye tissue. -A SCU resident was across the hall eating lunch in his room. -There was no staff in view of the unlocked room #26. Interview with the Regional Clinical Director (RCD) on 08/31/21 at 12:25pm revealed: -Room #26 was an office and there should not be any paint or polyurethane in the room. -She did not know why it was in the room. -The office was supposed to be locked. -She thought the room was unlocked because the facility's contracted primary care provider (PCP) had been using the room earlier that day. Interview with the Administrator on 08/31/21 at 12:30pm revealed: -Room #26 was being used as a dietary office and should be locked when not in use by staff. -She was not aware of the paint or polyurethane	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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{D 079}	Continued From page 2	{D 079}		

Continued From page 2

being stored in room #26.
-It was the responsibility of maintenance and dietary staff to ensure room #26 was locked.

Observation of the hallway where the mop room, housekeeping room, and electrical room were located on the A hall on 09/02/21 at 9:38am revealed:
-There was an unattended housekeeping cart sitting in the hallway where these 3 rooms were located.
-The unattended housekeeping cart was across the hall from the television (TV) room used by the SCU residents on A hall and near the nurses' station.
-There was no housekeeping staff on A hall.
-There was no staff in view of the housekeeping cart.
-There was a plastic container on top of the housekeeping cart which contained two 32 ounce (oz) bottles of cleaner/deodorizer/disinfectant, a 12 oz spray bottle of window cleaner, a 32 oz spray bottle of cleaner with bleach, and a clear plastic spray bottle with a clear liquid with no manufacturer label with "bleach" handwritten on the bottle.
-Warnings for the cleaner/deodorizer/disinfectant spray included: keep out of reach of children; hazardous to humans and domestic animals; avoid contact with eyes or clothing; causes moderate eye irritation; if swallowed, call poison control center or doctor for treatment advice.
-Warning for the window cleaner included: keep out of reach of children and pets.
-Warnings for the cleaner with bleach included: causes eye irritation; may be corrosive to metals.
-The middle shelf on the housekeeping cart contained a 1-gallon jug of bleach germicidal cleaner, a container of bleach disinfecting wipes, and a 32 oz bottle of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

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{D 079}	Continued From page 3	{D 079}		

cleaner/deodorizer/disinfectant.
-Warnings for the bleach germicidal cleaner included: keep out of reach of children; causes moderate eye irritation; avoid contact with eyes or clothing.
-Warnings for the bleach disinfecting wipes included: keep out of reach of children; hazardous to humans and domestic animals; causes moderate eye irritation; avoid contact with eyes or clothing.
-There was dark colored, dirty water in the mop bucket on the housekeeping cart.

Observation of the A hall on 09/02/21 from 9:38am - 10:09am revealed:
-At 9:38am, there were 2 SCU residents (both documented as having wandering behaviors) sitting in the TV room across the hall from the unsecured housekeeping cart.
-There was 1 personal care aide (PCA) sitting in the TV room but she was not in view of the housekeeping cart.
-At 9:40am, a SCU resident walked down the hall and by the unsecured housekeeping cart.
-At 9:49am, another SCU resident (documented as having wandering behaviors) walked down the hall near the unsecured housekeeping cart.
-There was no staff in view of the unsecured housekeeping cart.
-At 9:51am, a medication aide (MA) walked down the hall and by the unsecured housekeeping cart.
-The MA did not attempt to secure the housekeeping cart.
-At 9:51am, there were 4 SCU residents (3 documented as having wandering behaviors) sitting in chairs in the hallway near the nurses' station just past the unsecured housekeeping cart.
-At 9:52am, the PCA in the TV room came out into the hallway and walked past the unsecured

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 079}	Continued From page 4 housekeeping cart to the nurses' station and then went back into the TV room, walking past the unsecured housekeeping cart a second time. -The PCA did not attempt to secure the housekeeping cart. -At 9:54am, the same MA walked down the hall past the unsecured housekeeping cart to the nurses' station. -The MA did not attempt to secure the housekeeping cart. -At 9:54am, another SCU resident (documented as having wandering behaviors) walked from the TV room to his resident room near the nurses' station past the unsecured housekeeping cart. -There was no staff in view of the housekeeping cart. -At 9:55am, the same PCA in the TV room came out into the hallway and walked past the unsecured housekeeping cart to the nurses' station and then went back into the TV room, walking past the unsecured housekeeping cart a second time. -The PCA did not attempt to secure the housekeeping cart. -At 9:56am, a second MA came into the A hall entrance doors and walked down the hall past the unsecured housekeeping cart to the vending room, then walked back by the unsecured housekeeping cart and out of the A hall exit doors. -The second MA did not attempt to secure the housekeeping cart. -At 9:56am, a second PCA came out of the common bathroom with a resident and walked down the hall past the unsecured housekeeping cart. -The second PCA did not attempt to secure the housekeeping cart. -At 9:57am, the same 4 SCU residents were sitting in chairs in the hallway near the nurses'	{D 079}		

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	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

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{D 079}	Continued From page 5	{D 079}		

station just past the unsecured housekeeping cart.
-At 9:58am, the second PCA walked past the unsecured housekeeping cart again and did not attempt to secure the cart.
-At 10:01am, the first PCA walked by the unsecured housekeeping cart while passing snacks to the residents but she did not attempt to secure the cart.
-At 10:03am, the first PCA again walked by the unsecured housekeeping cart while passing out snacks and did not attempt to secure the cart.
-At 10:05am, another SCU resident (documented as having wandering behaviors) walked down the hall and past the unsecured housekeeping cart.
-The MA and a PCA were in the nurses' station but were not in view of the unsecured housekeeping cart.
-At 10:07am, the MA gave water to residents in the hallway passing by the unsecured housekeeping cart without attempting to secure the cart.
-At 10:09am, the housekeeping cart was in the same location and unsecured with multiple cleaning products and chemicals accessible to the SCU residents on the A hall.

Interview with the PCA on 09/02/21 at 10:09am revealed:
-She thought the unsecured housekeeping cart had been parked in the hallway on the A hall since she came into work that morning on first shift at 7:00am.
-She thought staff on third shift may have left it out if they had been cleaning.
-She had not seen any housekeepers working on the A hall that morning (09/02/21) since she came in at 7:00am.
-All staff had access to the housekeeping carts and could help with cleaning if needed.

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	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

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{D 079}	Continued From page 6	{D 079}		

Interview with the second PCA on 09/02/21 at 10:09am revealed:
-The housekeeping cart was usually locked in the housekeeping room.
-She did not know who left the housekeeping cart unattended in the hallway.
-She had not seen any housekeepers on A hall since she started her shift at 7:00am that morning.

Interview with a Maintenance Staff on 09/02/21 at 10:15am revealed:
-The housekeeping carts were usually kept locked in the housekeeping room.
-He did not have keys to the housekeeping room with him currently.
-Each housekeeper had a set of keys for the housekeeping room.
-The housekeeper assigned to the A hall was off today (09/02/21).
-The housekeeper for B hall stopped working at the facility yesterday (09/01/21).
-There was no housekeeper currently working in the facility today (09/02/21).
-There should be a key to the housekeeping room on the medication cart key ring for the MAs and PCAs to use if needed.
-He checked the halls first thing that morning, 09/02/21, and the housekeeping cart was not parked in the hallway on A hall at that time.

Interview with the Administrator on 09/02/21 at 10:18am revealed:
-The housekeeping cart should be locked in the housekeeping room so the residents could not access to the chemicals and cleaning products.
-The MAs and PCAs had access to the key to the housekeeping room and the MAs or PCAs should have locked the housekeeping cart in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

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{D 079}	Continued From page 7 housekeeping room. A second interview with the Administrator on 09/02/21 at 10:25am revealed: -There should be a key to the housekeeping cart on the cork board in the nurses' station but there was no key there. -If staff could not find the key, they should notify either Maintenance, the Administrator, or the Resident Care Coordinator (RCC). Interview with the MA on the A hall on 09/02/21 at 1:21pm revealed: -There was no housekeeper on A hall today (09/02/21). -She thought a PCA used the housekeeping cart to mop up something that morning, but she could not recall when or who. -She could not remember if it was before or after breakfast that morning (09/02/21). -She had a key to the housekeeping room on the medication cart key ring. -Maintenance staff and the PCAs did rounds each day to check for any unsecured cleaning products or chemicals. -No one asked her for the key to the housekeeping cart that morning or reported the unsecured housekeeping cart. -She did not notice the unsecured housekeeping cart when she walked by it several times on the A hall that morning (09/02/21). -If she had noticed the unsecured housekeeping cart, she would have locked it in the housekeeping room.	{D 079}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C **09/02/2021**

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{D 273}	Continued From page 8	{D 273}		

Continued From page 8

to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION.

The Type A2 Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#1, #5) related to a referral appointment to oncology and an order for a lab draw (#5); and not responding to blood sugar results as per ordered parameters (#1).

The findings are:

1. Review of Resident #5's current FL-2 dated 07/21/21 revealed:
-Diagnoses included sepsis (a life threatening complication of an infection), adenopathy near right lung and trachea (lymph nodes that are abnormal in size or consistency), atelectasis of both lungs (complete or partial collapse of a lung or section of a lung), acute kidney injury - resolved, hydronephrosis/hydroureter of right kidney (excess fluid in a kidney due to a backup of urine), hypokalemia (low potassium level) - resolved, type 2 diabetes mellitus (blood sugar disorder), hypertension (high blood pressure), seizure disorder, hypothyroidism (thyroid gland doesn't produce enough thyroid hormone), GERD (gastroesophageal reflux disease), and cognitive impairment.
-The resident was intermittently disoriented, required total care, and was semi-ambulatory.

a. Review of Resident #5's hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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{D 273}	Continued From page 9	{D 273}		

summary dated 07/21/21 revealed:
-He was hospitalized from 07/17/21 through 07/21/21 after being sent to the hospital via ambulance from the facility due to a fever and high heart rate.
-He had lung collapse of both lower lungs and the right upper lung, enlarged lymph nodes bilaterally near the lungs with a large node noted to the right of the trachea near the right lung, and there was a concern that the enlarged lymph nodes were due to either an infectious process or cancer.
-The resident had a CT scan (a series of x-rays taken from different angles to provide more detailed information than plain x-rays) of his chest while hospitalized that showed enlarged lymph nodes near his right lung and trachea.
-Additional evaluation was recommended with a referral to an oncologist (a doctor who treats cancer) due to a concern of the enlarged lymph nodes being lymphoma (a cancer of the lymph nodes).
-There was an undated handwritten note next to the referral that said: left message for appointment.
-There was another undated handwritten note next to the referral that said: calling back with appointment, pulling medical records.
-There was another undated handwritten note next to the referral that said: called back 08/27/21 to follow up about appointment.
-There was another undated handwritten note next to the referral that said: spoke to office, appointment may not be needed. Requested we do a chest CT. Sent to PCP (primary care provider) for order.

Review of Resident #5's PCP visit note dated 07/27/21 revealed there was an order for the resident to follow up with the oncology provider and get a chest CT per the hospital discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 10	{D 273}		

instructions.

Review of Resident #5's care notes revealed:
-The Resident Care Coordinator (RCC) left a message at the oncology office regarding the resident's referral on 07/27/21 at 3:12pm.
-The RCC left a message for the oncology office again on 08/25/21.
-A medication aide (MA) spoke to the oncology office and provided the requested information, the oncology office would call the facility back after requesting hospital records on 08/27/21.
-The RCC spoke to the oncology office again to provide more information on 08/30/21.
-The RCC spoke to the oncology office on 08/31/21 in which she was told they did not want to see Resident #5 until another chest CT had been completed.
-The RCC faxed an order request to Resident #5's PCP on 09/01/21 for a chest CT.
-The RCC scanned an order request to the PCP office on 09/02/21 for signature and added Resident #5 to the appointment list to be seen by the PCP on 09/07/21.

Telephone interview with a registered nurse at Resident #5's referred oncology clinic on 09/02/21 at 4:20pm revealed:
-She handled all referrals for the office to ensure patients had everything they needed when they arrived for their appointment.
-The oncology office received a faxed referral for Resident #5 a couple of days ago, around the end of August 2021.
-There had been no record or messages from facility calling the oncology office for a referral for Resident #5 in late July 2021.
-She called the facility on 08/30/21 to discuss the enlarged lymph nodes in Resident #5's chest and asked them to do a repeat chest CT prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

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{D 273}	Continued From page 11	{D 273}		

oncology office seeing him per the oncology doctor's orders.
-She followed up with the facility on 09/01/21 and spoke to the RCC who stated she was working on getting an order for Resident #5 to have a chest CT from the resident's PCP.
-She would have expected the facility to have followed up with the oncology office within one week if the facility had left a message for a referral appointment and had not heard anything back from the oncology office due to the concerns of Resident #5's recent hospitalization and possibility of having cancer.
-The oncology provider wanted Resident #5 to have had a repeat chest CT as soon as possible because if the resident still had enlarged lymph nodes; the provider would be concerned the resident had cancer.
-It was important for the facility to get Resident #5 a chest CT quickly so they could get him seen by the oncology provider quickly.

Interview with the RCC on 09/02/21 at 6:12pm revealed:
-She tried hard to document all her conversations for Resident #5 in the care notes and on the referral (hand written notes).
-She and a MA called the oncology provider a couple of times to get Resident #5 an appointment but she could not recall specific dates.
-She left a message on the oncology's office voicemail the first time she called but did not hear back.
-She called approximately two weeks after she left the first message and left another message.
-The oncology referral appointment and chest CT should have been completed before today (09/02/21).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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{D 273}	Continued From page 12	{D 273}		

Continued From page 12

Interview with the Administrator on 09/02/21 at 6:42pm revealed:
-The RCC was responsible for ensuring resident referral appointments were made and carried out as soon as possible.
-There should not have been a delay in Resident #5's referral appointment to the oncologist.
-She would have expected the RCC to have followed up sooner with Resident #5's oncology provider.
-She expected the RCC to have completed a referral appointment and chest CT for Resident #5 to be seen by the oncology provider prior to today (09/02/21) as ordered.

Attempted telephone interview with Resident #5's PCP on 09/02/21 at 5:00pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

b. Review of Resident #5's physician's order dated 07/28/21 revealed there was an order for the resident to receive a BMP (basic metabolic panel-a series of 8 blood tests measuring substances in the blood) laboratory draw.

Review of Resident #5's resident record, provider notes, and laboratory records revealed there was no documentation that the BMP lab draw had been completed or resulted.

Interview with the Resident Care Coordinator (RCC) on 09/02/21 at 6:12pm revealed:
-She was responsible for scheduling orders for lab appointments.
-The lab came to the facility to draw residents' blood when scheduled by the RCC.
-She thought the BMP lab for Resident #5 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 13	{D 273}		

been completed but the documentation was not in his record.
-She would contact the lab the next morning, 09/03/21, at 8:00am to get a copy of the result and fax proof of documentation at that time.

Review of all records received from the facility revealed that the documentation of Resident #5's BMP lab that had been requested on 09/02/21 at 5:00pm was not provided.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 09/02/21 at 5:00pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

2. Review of Resident #1's current FL-2 dated 07/27/21 revealed:
-Diagnoses included vascular dementia, acute kidney injury, and type 2 diabetes mellitus.
-There was an order to obtain finger stick blood sugars (FSBS) three times per day before meals. See PRN (as needed) orders if BS less than 60 or greater than 450.
-There was an order if FSBS 61-80, provide ½ cup of orange juice and recheck FSBS in 15 minutes; if FSBS less than 60, provide 1 cup of orange juice, recheck in 15 minutes and notify primary care provider (PCP), if FSBS low and resident was unresponsive, call emergency medical services (EMS) and PCP.

Review of Resident #1's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain FSBS three times per day before meals at 7:30am, 11:30am, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 14	{D 273}		

4:30am. See PRN orders if BS less than 60 or greater than 450.
-There was an entry if FSBS 61-80, provide ½ cup of orange juice and recheck FSBS in 15 minutes; if FSBS less than 60, provide 1 cup of orange juice, recheck in 15 minutes and notify PCP, if FSBS low and resident was unresponsive, call EMS and PCP.
-On 08/07/21 at 8:00am, the resident's FSBS was 80.
-There was no documentation that juice was provided or a repeat FSBS was performed on 08/07/21.
-On 08/13/21 at 8:00am, the resident's FSBS was 70.
-There was no documentation that juice was provided or a repeat FSBS was performed on 08/13/21.
-On 08/14/21 at 8:00am, the resident's FSBS was 74.
-There was no documentation that juice was provided or a repeat FSBS was performed on 08/14/21.
-On 08/18/21 at 8:00am, the resident's FSBS was 76.
-There was no documentation that juice was provided or a repeat FSBS was performed on 08/18/21.
-On 08/24/21 at 8:00am, the resident's FSBS was 73.
-There was no documentation that juice was provided or a repeat FSBS was performed on 08/24/21.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry to obtain FSBS three times per day before meals at 7:30am, 11:30am, and 4:30am. See PRN orders if BS less than 60 or greater than 450.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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{D 273}	Continued From page 15	{D 273}		

-There was an entry if FSBS 61-80, provide ½ cup of orange juice and recheck FSBS in 15 minutes; if FSBS less than 60, provide 1 cup of orange juice, recheck in 15 minutes and notify PCP, if FSBS low and resident was unresponsive, call EMS and PCP.
-On 09/02/21 at 8:00am, the resident's FSBS was 73.
-There was no documentation that juice was provided or a repeat FSBS was performed on 09/02/21.

Review of Resident #1's physician notification forms revealed there was no documentation or physician notification forms notifying the PCP of a low FSBS or interventions to treat a low FSBS for 08/07/21, 08/13/21, 08/14/21, 08/18/21, and 08/24/21.

Review of Resident #1's care notes and eMAR notes revealed there was no documentation of low FSBS with interventions for providing juice or rechecking the FSBS for August or September 2021.

Interview with the Resident Care Coordinator (RCC) on 09/02/21 at 6:12pm revealed:
-There was no documentation of interventions the facility could provide regarding follow up and implementation of low FSBS orders for Resident #1's low FSBS on 08/07/21, 08/13/21, 08/14/21, and 09/02/21; it probably was not done.
-She expected the medication aide (MA) that obtained the low FSBS on those dates to have followed the orders for parameters of FSBS and document the interventions on the eMAR, then fill out a provider notification form.
-The MAs should then leave provider notification forms for her to follow up with the PCP.
-Staff were expected to follow orders for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 16	{D 273}		

parameters of FSBS for resident safety.

Interview with the Administrator on 09/02/21 at 6:42pm revealed she expected staff to respond to low FSBS per PCP orders for parameters of FSBS and document interventions per facility policy.

Attempted telephone interview with Resident #1's PCP on 09/02/21 at 5:00pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

{D 338} 10A NCAC 13F .0909 Resident Rights {D 338}

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A1 VIOLATION.

The Type A1 Violation is abated. Non-compliance continues.

Based on observation, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled residents (#4, #12) in the special care unit (SCU) were spoken to with dignity and respect while being redirected (#4) and while requesting assistance by staff (#12).

The findings are:

1. Review of Resident #4's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 338}	Continued From page 17	{D 338}		

03/02/21 revealed:
-Diagnoses included vascular dementia with behaviors, hypertension, repeated falls, muscle weakness, chronic obstructive pulmonary disease, psychotic disorder, anxiety disorder, and age-related physical debility.
-The resident was constantly disoriented and had wandering behaviors.
-The resident was ambulatory and incontinent of bowel and bladder.

Review of Resident #4's current assessment and care plan dated 03/02/21 revealed:
-The resident wandered with little communication.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident was ambulatory and had daily of incontinence of bowel and bladder.
-The resident required limited assistance by staff for eating, ambulation, and transferring.
-The resident required extensive assistance by staff for toileting, bathing, dressing, and grooming.

Review of Resident #4's charting notes dated 06/06/21 - 09/02/21 revealed:
-On 06/06/21 at 4:44am, the resident got up and went into another resident's room; Resident #4 urinated in his room, pulled off his under garment and threw it in the bed of the other resident room.
-On 07/01/21 at 9:43pm, the resident urinated on the floor.
-On 07/17/21 at 6:34am, the resident was pacing up and down the hall all night and staff found several puddles of urine on the floor because the resident was urinating on the floor.

Observation of a medication aide (MA) on 09/01/21 from 8:24am to 8:28am:
-The MA was sitting at the staff workstation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 338}	Continued From page 18	{D 338}		

working on the computer.
-A female resident came to the workstation and notified her that Resident #4 was in the television (TV) room unzipping his pants and about to urinate on the floor.
-The MA got up and walked to the TV room.
-The MA engaged Resident #4 who was about to urinate on the floor and assisted him in pulling his pants up while stating "nobody wants to see what you have in your pants, the ladies would be all over you, is that what you want?".

Interview with the MA on 09/02/21 at 2:15pm revealed:
-She was "joking" with Resident #4 when she spoke to him in the TV room while pulling up his pants and redirecting him.
-Her words and tone could easily be misinterpreted as disrespectful.
-She had received education on resident rights since July 2021 but could not recall the date.

Interview with the Administrator on 09/01/21 at 4:05pm revealed:
-It was not appropriate for the MA to respond to or speak to Resident #4 in the way that she did.
-The comments the MA made to Resident #4 were disrespectful and violated his rights in dignity and respect.
-Staff had been trained in two staff meetings since July 2021 on how to treat and speak to residents regarding resident rights.
-She expected staff to treat and speak to residents with dignity and respect.

2. Review of Resident #12's current FL-2 dated 06/15/21 revealed:
-Diagnoses included vascular dementia with behavioral disturbance, schizophrenia, hypertension, and dysphagia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

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{D 338}	Continued From page 19	{D 338}		

-The resident was constantly disoriented, had wandering behaviors, and was injurious to others.

Review of Resident #12's current assessment and care plan dated 06/14/21 revealed:
-The resident was documented as having wandering behavior.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident required supervision by staff for ambulation, dressing, and transferring.
-The resident required extensive assistance by staff for grooming.

Observation of a medication aide (MA) and Resident #12 on 09/01/21 from 8:22am to 8:24am revealed:
-The MA was sitting at the staff workstation working on the computer.
-Resident #12 approached the workstation and requested the MA help him with cutting his toenails, scheduling an appointment with his primary care provider (PCP), and assisting him in obtaining a medical emergency tag that he could wear.
-The MA responded to Resident #12 that his requests were "above my paygrade".
-The MA did not offer to assist the resident or attempt to get anyone else to assist the resident.
-The resident turned around, lowered his shoulders and his head, and sat in a chair in the hallway.

Interview with the MA on 09/02/21 at 2:15pm revealed:
-She could not understand what Resident #12 was asking for.
-Her words and tone toward Resident #12 could easily be misinterpreted as disrespectful.
-She had received education on resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

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{D 338}	Continued From page 20 since July 2021 but could not recall the date. Interview with the Administrator on 09/01/21 at 4:05pm revealed: -If the MA was unable to understand or assist Resident #12 with his requests, she should have gotten a staff member who was able to assist him with his needs and requests. -Staff had been trained in two staff meetings since July 2021 on how to treat and speak to residents regarding resident rights. -It was not appropriate for the MA to speak to Resident #12 that way and she expected staff to speak to the residents with dignity and respect.	{D 338}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents (#6, #7) observed during the medication passes including errors with administering insulin (#7) and a vitamin supplement (#6). The findings are:	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 21	{D 358}		

The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 8:00am/9:00am and 12:00pm medication passes on 09/01/21 and the 8:00am/9:00am medication pass on 09/02/21.

a. Review of Resident #7's current FL-2 dated 02/02/21 revealed:
-Diagnoses included type II diabetes mellitus and vascular dementia.
-There was an order to check the resident's finger stick blood sugar (FSBS) three times a day before meals at 8:00am, 12:00pm, and 5:00pm.
-There was an order if FSBS 61-80, provide ½ cup of orange juice and recheck FSBS in 15 minutes; if FSBS less than 60, provide 1 cup of orange juice, recheck in 15 minutes and notify primary care provider (PCP), if FSBS low and resident was unresponsive, call emergency medical services (EMS) and PCP.
-There was an order for Lantus insulin, inject 17 units twice daily at 9:00am and 9:00pm. (Lantus is used to lower blood sugar.)

Review of Resident #7's PCP visit dated 06/15/21 revealed:
-The resident was seen for follow-up to an emergency room (ER) visit on 06/08/21.
-The resident was seen in the ER on 06/08/21 for hypoglycemia (low blood sugar).
-Facility staff reported the resident's blood sugar was 20 that day (06/08/21).
-The resident was discharged back to the facility with no new orders the same day (06/08/21).

Review of a physician's order for Resident #7 dated 06/29/21 revealed an order to change the Lantus administration to 8 units twice daily with breakfast and at bedtime due to recent episodes of hypoglycemia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ________ B. WING ________	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 22	{D 358}		

Review of a progress note dated 09/01/21 revealed Resident #7 had a FSBS of 71 at 9:00am requiring the resident to receive ½ cup of juice while the staff notified her PCP.

Review of the facility's undated medication management policy revealed physician's orders for specific medication administration times shall be followed.

Observation of the 8:00am/9:00am medication pass on 09/02/21 at 7:59am revealed:
-The medication aide (MA) prepared and administered Resident #7's medications scheduled for 8:00am/9:00am at 7:59am.
-The MA did not prepare or offer to administer Lantus insulin during the 8:00am/9:00am medication pass.

Observation of Resident #7 on 09/02/21 at 8:05am revealed the resident received and began eating her breakfast.

Review of Resident #7's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS three times daily before meals scheduled for 7:30am, 11:30am, and 4:30pm.
-There was an entry for Lantus 8 units twice daily at breakfast and at bedtime with scheduled administration times of 8:00am and 8:00pm.

Interview with the MA on 09/02/21 at 9:43am revealed:
-She checked Resident #7's FSBS at 6:40am on 09/02/21.
-She administered Resident #7's Lantus at 7:46am on 09/02/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 23	{D 358}		

Continued From page 23

-Breakfast was normally served around 8:00am.
-She tried to follow the facility's policy and administer medications ordered with food right before the resident ate.

Observation of Resident #7's September 2021 eMAR on the computer screen with the MA on 09/02/21 at 9:43am revealed:
-The MA documented the resident's FSBS as 289 on 09/02/21 at 6:40am.
-The resident's Lantus was documented as administered at 7:46am, 19 minutes prior to breakfast being served, instead of with the meal as ordered.

Interview with the Resident Care Coordinator (RCC) on 09/02/21 at 11:18am revealed:
-If insulin was ordered to given with breakfast, she expected staff to administer the insulin immediately before the meal.
-Resident #7 had recent issues with low blood sugar which was the reason her PCP ordered her insulin to be administered with meals.
-Resident #7's Lantus insulin should have been administered once her breakfast was sitting in front of her.

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

Attempted telephone interview with Resident #7's PCP on 09/02/21 at 5:00pm was unsuccessful.

Review of a medication error report for Resident #7 dated 09/02/21 revealed a response and new order from the resident's PCP dated 09/03/21 to administer the Lantus insulin 8 units twice daily after breakfast and at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 24	{D 358}		

b. Review of Resident #6's current FL-2 dated 12/14/20 revealed:
-Diagnoses included Vitamin D deficiency, osteoarthritis, and dementia.
-There was an order for Vitamin D3 2,000IU, one tablet daily. (Vitamin D3 is a vitamin supplement to replace low levels of Vitamin D in the body.)

Review of Resident #6's lab report dated 02/16/21 revealed the resident's Vitamin D level was low at 27.2, normal range was expected to be between 30-100.

Review of Resident #6's lab report dated 04/24/21 revealed the resident's Vitamin D level was 33, normal range was 30-100.

Review of Resident #6's physician's order dated 02/19/21 revealed an order for Vitamin D3 2,000IU, two tablets daily.

Observation of the 8:00am/9:00am medication pass on 09/01/21 revealed the medication aide (MA) prepared and administered 1 tablet of Vitamin D3 2,000IU to Resident #6 at 8:05am, instead of 2 tablets as ordered.

Review of Resident #6's September 2021 electronic medication administration record (eMAR) revealed an entry for Vitamin D3 2,000IU, two tablets daily at 8:00am.

Observation of Resident #6's medications on hand on 09/01/21 at 2:09pm revealed:
-There were two bubble pack cards of Vitamin D3 2,000IU dispensed on 08/24/21.
-The instructions on the medication labels were to administer two tablets once daily.

Interview with the MA on 09/01/21 at 2:07pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 25	{D 358}		

revealed:
-She normally administered Resident #6 only 1 tablet of Vitamin D3 2,000IU daily.
-She did not realize Resident #6's Vitamin D3 order had changed to 2 tablets daily.
-She did not read the order on the eMAR or medication label prior to administration of Resident #6's Vitamin D3.

Interview with the Resident Care Coordinator (RCC) on 09/01/21 at 2:13pm revealed:
-MAs were trained to read eMARs and labels prior to medication administration.
-She reminded MAs in training to always check the dose prior to administering medications because orders could change.
-She expected medications to be administered as ordered and for any medications errors to be reported to her immediately.
-Resident #6 should have received 2 Vitamin D3 tablets as ordered that morning, 09/01/21.

Interview with the Administrator on 09/01/21 at 2:40pm revealed:
-She expected staff to administer medications as ordered by checking the order and medication labels prior to administration.
-It was not acceptable for staff to administer medication from memory.
-Resident #6 should have received 2 Vitamin D3 tablets as ordered that morning, 09/01/21.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 09/02/21 at 5:00pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

D 366 Continued From page 26 D 366

D 366 10A NCAC 13F .1004 (i) Medication Administration D 366

10A NCAC 13F .1004 Medication Administration

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the recording of the administration of medication administration records was by the medication aide who actually administered the 8:00am/9:00am medications to 5 of 5 residents sampled (#4, #8, #9, #10, #11) on A hall on 09/01/21.

The findings are:

Observation of the A hall medication room on 09/01/21 at 12:47pm revealed there were two medication carts in the room; one blue cart and one red cart.

Interview with the medication aide (MA) assigned to A hall on 09/01/21 at 8:22am revealed:
-She finished administering medications to the residents on A hall at approximately 8:10am.
-A second MA helped her that morning by administering the medications from a second medication cart for A hall residents.

Interview with the second MA on 09/01/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 27	D 366		

8:41am revealed:
-She was a MA, but she was assigned on A hall that shift as a personal care aide (PCA).
-She assisted the other MA on A hall with administering medications that morning, 09/01/21.
-The other MA prepared the medications for the morning medication pass and documented the administration of the medications on the residents' electronic medication administration records (eMARs) for three residents (#4, #8, #9), but she was the one who actually administered the medications to those residents.

A second interview with the first MA on 09/01/21 at 11:18am revealed:
-She administered medications from the red cart and the second MA administered medications from the blue cart on A hall that morning.
-She prepared the medications from the blue cart for one resident at a time and the second MA administered those medications to the residents.
-She did not observe the second MA administer the medications to the residents.
-She documented administration of the medications on the eMARs based on what the second MA told her the residents took.
-She did not know the facility's policy for documenting the administration of medications if the MA who prepared the medications did not actually administer the medications.
-It was normal procedure for the MAs to work together and administer medications that way if there were 3 MAs working on first shift.
-The Resident Care Coordinator (RCC) was aware the MAs administered medications this way.

Interviews with the second MA on 09/01/21 at 12:47pm and 2:03pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 28	D 366		

-The first MA pulled medications and prepared them for the residents from the blue cart on A hall that morning.
-She administered the medications the first MA prepared while the first MA documented administration of the medications for Residents #4, #8, #9, #10, and #11.
-Preparing and administering medications in this manner was not the facility's accepted or normal procedure, but it was something the MAs sometimes did when things were busy.
-They worked together that morning, 09/01/21, to pass the medications to make sure all the residents received their medications on time.
-She observed the first MA prepare the medications for each resident one at a time, so she knew which medications were for each resident.

1. Review of Resident #4's current FL-2 dated 03/02/21 revealed diagnoses included vascular dementia with behaviors, hypertension, Vitamin B12 deficiency, repeated falls, muscle weakness, chronic obstructive pulmonary disorder, psychotic disorder, anxiety disorder, age related physical disability.

Review of Resident #4's September 2021 electronic medication administration record (eMAR) revealed:
-Eight medications scheduled for 7:30am and 9:00am were documented as administered on the morning of 09/01/21: Tylenol 500mg (for mild pain), Xanax 0.25mg (for anxiety), Norvasc 5mg (for high blood pressure), Depakote 125mg (for seizures or mood disturbances), Seroquel 50mg (for psychotic disorder), Zoloft 100mg (for depression), Vitamin B12 1,000mg (for Vitamin B deficiency), and Vitamin D3 1,000IU (for Vitamin D deficiency).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 29	D 366		

Continued From page 29

-The initials of the medication aide (MA) who prepared the medications was documented as administering those 8 medications instead of the MA who actually administered them.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with the Resident Care Coordinator on 09/01/21 at 6:00pm.

Refer to interview with the Administrator on 09/01/21 at 6:00pm.

2. Review of Resident #8's current FL-2 dated 08/24/20 revealed diagnoses included dementia, essential hypertension, and dyslipidemia (abnormal amounts of lipids in the blood).

Review of Resident #8's September 2021 electronic medication administration record (eMAR) revealed:
-Seven medications scheduled for 7:30am and 9:00am were documented as administered on the morning of 09/01/21: Norvasc 5mg (for high blood pressure), Buspar 10mg (for depression), Trilipix DR 135mg (for cholesterol), Keppra 250mg (for seizures or mood disturbances), Namenda 5mg (for dementia), Paxil 40mg (for depression), and Vitamin B12 1,000mcg (for Vitamin B deficiency).
-The initials of the medication aide (MA) who prepared the medications was documented as administering those 7 medications instead of the MA who actually administered them.

Refer to interview with the Resident Care Coordinator on 09/01/21 at 6:00pm.

Refer to interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 30	D 366		

09/01/21 at 6:00pm.

3. Review of Resident #9's current FL-2 dated 05/18/21 revealed diagnoses included dementia with behaviors, bipolar disorder, major neurocognitive disorder, chronic small vessel disease, chronic kidney disease, constipation, osteoporosis, bursitis right hip, and occasional urinary incontinence.

Review of Resident #9's September 2021 electronic medication administration record (eMAR) revealed:
-Five medications scheduled for 8:00am and 9:00am were documented as administered on the morning of 09/01/21: Daily-Vite (vitamin supplement), Voltaren 1% gel (topical pain reliever), Colace 100mg (for constipation), Trusopt 2% eye drops (for glaucoma), and Senna 8.6mg (for constipation).
-The initials of the medication aide (MA) who prepared the medications was documented as administering those 5 medications instead of the MA who actually administered them.

Based on observations, interviews, and record reviews, it was determined Resident #9 was not interviewable.

Refer to interview with the Resident Care Coordinator on 09/01/21 at 6:00pm.

Refer to interview with the Administrator on 09/01/21 at 6:00pm.

4. Review of Resident #10's current FL-2 dated 02/01/21 revealed diagnoses included neurocognitive disorder, dementia, bipolar disorder and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 31	D 366		

Review of Resident #10's September 2021 electronic medication administration record (eMAR) revealed:
-Eight medications scheduled between 7:30am and 9:00am were documented as administered on the morning of 09/01/21: Norvasc 10mg (for high blood pressure), Zestril 20mg (for high blood pressure), Mobic 15mg (for pain), Namenda 5mg (for dementia), Prilosec 20mg (for acid reflux), Seroquel 100mg (for bipolar disorder), Vitamin B12 1,000mg (for Vitamin B deficiency), and Vitamin D3 1,000IU (for Vitamin D deficiency).
-The initials of the medication aide (MA) who prepared the medications was documented as administering those 8 medications instead of the MA who actually administered them.

Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable.

Refer to interview with the Resident Care Coordinator on 09/01/21 at 6:00pm.

Refer to interview with the Administrator on 09/01/21 at 6:00pm.

5. Review of Resident #11's current FL-2 dated 05/11/21 revealed diagnosis included major neurocognitive disorder due to Alzheimer's disease with probable behavioral disturbance.

Review of Resident #11's September 2021 electronic medication administration record (eMAR) revealed:
-Ten medications scheduled at 8:00am and 9:00am were documented as administered on the morning of 09/01/21: Tylenol 325mg (for mild pain), Aspirin 81mg (a blood thinner), Calcium 600mg + Vitamin D3 4,000IU (for Calcium and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366		D 366		

Continued From page 32

Vitamin D deficiency), Daily-Vite tablet (vitamin supplement), Proscar 5mg (for enlarged prostate), Zyvox 600mg (treats bacterial infections), Protonix 40mg (for acid reflux), Miralax 17g (for constipation), Senokot-S 8.6mg/50mg (treats constipation), and Vitamin D3 2,000IU (for Vitamin D deficiency).
-The initials of the medication aide (MA) who prepared the medications was documented as administering those 10 medications instead of the MA who actually administered them.

Based on observations, interviews, and record reviews, it was determined Resident #11 was not interviewable.

Refer to interview with the Resident Care Coordinator on 09/01/21 at 6:00pm.

Refer to interview with the Administrator on 09/01/21 at 6:00pm.

____

Interview with the Resident Care Coordinator (RCC) on 09/01/21 at 6:00pm revealed:
-She did not know the medication aides (MAs) had split the duties of medication administration, they had not been trained to administer medications that way, and it was not appropriate.
-She expected the same MA that prepared a medication to administer and then document the administration of the medication.
-If a MA did not observe a resident take a medication, they could not know how to document accurately.
-Each MA should work only from the medication cart they were assigned; it was not appropriate to split administration of medication duties with preparing, administering, and documenting medication administration.
-It was the facility's policy that one MA would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

D 366 Continued From page 33 D 366

prepare, administer, and document medications individually.
-The eMAR was not capable of capturing two MAs splitting the duties of medication administration for documentation purposes.

Interview with the Administrator on 09/01/21 at 6:00pm revealed:
-She was unaware the MAs had split the duties of medication administration and it was not appropriate.
-It was not appropriate for one MA to prepare and document medication administration while another MA administered the medications.
-She expected MAs to prepare, document, and administer medications they were responsible for.
-She expected MAs to administer and document the administration of medications in accordance with the rules for resident safety.
-The facility's policy and procedure was for the same MA to prepare, administer and document medications individually.

{D 465} 10A NCAC 13F .1308(a) Special Care Unit Staff {D 465}

10A NCAC 13F .1308 Special Care Unit Staff
(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 465}		{D 465}		

Continued From page 34

The Type B Violation was abated.
Non-compliance continues.

Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 5 of 18 shifts sampled from 08/21/21 - 08/23/21 and 08/27/21 - 08/29/21.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds.

Interview with a medication aide (MA) on 08/31/21 at 11:10am revealed the first shift hours were 7:00am - 3:00pm, the second shift hours were 3:00pm - 11:00pm and the third shift hours were 11:00pm - 7:00am.

Review of the facility's resident census report dated 08/21/21 there was a SCU census of 49 residents, which required 49 staff hours on first and second shift and 39.2 staff hours on third shift.

Review of the punch detail records for staff dated 08/21/21 revealed:
-There were 44.52 staff hours provided on second shift, a shortage of 4.48 hours.
-There were 31.59 staff hours provided on third shift, a shortage of 7.64 hours.

Review of the facility's resident census report dated 08/22/21 there was a SCU census of 48 residents, which required 48 staff hours on first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 465}	Continued From page 35	{D 465}		

and second shift and 38.4 staff hours on third shift.

Review of the punch detail records for staff dated 08/22/21 revealed there were 24.56 staff hours provided on third shift, a shortage of 14.14 hours.

Review of the facility's resident census report dated 08/23/21 there was a SCU census of 48 residents, which required 48 staff hours on first and second shift and 38.4 staff hours on third shift.

Review of the punch detail records for staff dated 08/23/21 revealed there were 30.67 staff hours provided on third shift, a shortage of 7.73 hours.

Review of the facility's resident census reports dated 08/28/21 and 08/29/21 revealed there was a SCU census of 48 residents on each of those days, which required 48 staff hours on first and second shifts and 38.4 staff hours on third shift.

Review of the punch detail records for staff dated 08/28/21 revealed there were 32.2 staff hours provided on third shift in the SCU, a shortage of 6.2 staff hours.

Interview with the Administrator on 09/02/21 at 5:56pm revealed a supervisor from a sister facility and the Resident Care Coordinator (RCC) completed the staffing schedule.

Interview with the RCC on 09/02/21 at 5:59pm revealed:
-The supervisor from a sister facility completed the schedule.
-She would look at the schedule once it was complete.
-When there were shifts that needed coverage,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 465}	Continued From page 36	{D 465}		

herself, the supervisor from a sister facility, and the Administrator would work those shifts so the facility would not be short staffed.
-Staff was supposed to call out at least 4 hours in advance to give them time to find coverage but that did not always happen.
-There were times staff that was working would work over to help cover the shift.
-Since July 2021, she had worked hard on the staff to try and have enough staff each shift.
-She did not think the facility had worked short staffed on those shifts.
-Sometimes staff would clock in at the sister facility then come to this facility to work so the punches for that staff would not show up on the facility's time cards.
-Any changes to the staffing for the shift she documented it on the assignment sheet.
-If someone from the sister facility filled in to cover a shift, they may not be able to clock in at this facility.
-The assignment sheets were correct.

{D935} G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency {D935}

G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.

(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:
(1) A five-hour training program developed by the Department that includes training and instruction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D935}	Continued From page 37	{D935}		

in all of the following:
a. The key principles of medication administration.
b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (C) who administered medications had completed the Medication Administration Clinical Skills Competency Validation and the 5-hour medication aide training course prior to administering medications in the facility.

The findings are:

Review of the Instructions for Completing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ______ B. WING ______	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	**1115 CARTHAGE STREET SANFORD, NC 27330**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D935}	Continued From page 38	{D935}		

Medication Administration Clinical Skills Checklist revealed unlicensed staff who administer medications and supervisors of staff responsible for administering medications in adult care homes must have a registered pharmacist or registered nurse validate the staff's competency for tasks or skills that will be performed in the facility prior to the unlicensed staff administering medications.

Review of the Course Introduction, Description and Instructions for the state approved 5-hour, 10-hour, and 15-hour medication aide training courses revealed:
-The 5-hour training course was built around the current skills checklist required for medication staff in adult care homes.
-Individuals were expected to pass the skills sets check offs with 100% competency demonstrated for the 5-hour training course.
-The 10-hour training course was built upon content in the initial 5-hour training course and developed as a refresher for the employee.
-The 10-hour training course included random competency validation of skills required for medication administration.
-A prerequisite for the 10-hour training course was successful completion of the 5-hour training course.

Review of Staff C's personnel record revealed:
-Staff C was hired on 08/06/21 as a medication aide (MA).
-There was documentation Staff C passed the written MA exam on 07/07/16.
-There was documentation Staff C had taken the 10-hour on medication aide training course on 08/05/21.
-There was documentation Staff C completed the Medication Administration Clinical Skills Competency Validation on 08/17/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: ____ B. WING ____	R-C 09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D935}	Continued From page 39	{D935}		

-There was no documentation Staff C completed the 5-hour or 15-hour medication aide training courses.
-There was no documentation Staff C had a Medication Aide Verification form to exempt her from taking the 5-hour, 10-hour, or 15-hour medication aide training courses.

Review of two residents' August 2021 electronic medication administration records (eMARs) revealed:
-Staff C documented the administration of medication on 08/08/21, 08/21/21 and 08/22/21 at 8:00pm.
-Staff C documented the administration of medication on 08/20/21 at 9:00pm and 08/28/21 and 08/22/21 at 9:00am and 9:00pm.

Telephone interview with Staff C on 09/01/21 at 9:00pm revealed:
-She worked 3rd shift, 11:00pm-7:00am.
-She was hired as a MA at the facility.
-She had taken the 5-hour and 10-hour of medication aide training courses.
-She did her training through the facility contracted pharmacy.
-She gave her certificates to the Resident Care Coordinator (RCC).

Interview with the Administrator on 09/02/21 revealed:
-The former Business Office Manager (BOM) was responsible for the staff records.
-There would be a new BOM starting on 09/21/21.
-For now, she and the receptionist were responsible for the staff records.
-She thought all the MA training was in the staff records, including for Staff C.