Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILBING.		С
		HAL092023	B. WING		09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
BBOOKB	ALE CARV	7870 CH	APEL HILL ROAD		
BROOKD	ALE CARY	CARY, N	C 27513		
(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 COMPLETE
D 000	Initial Comments		D 000		
	The Adult Care Licens annual survey from Al September 02, 2021.	sure Section completed an ugust 31, 2021 to			
D 161	10A NCAC 13F .0504 For LHPS Tasks	(a) Competency Validation	D 161		
	Licensed Health Profet (a) An adult care how non-licensed personn not practicing in their governed by their prac- licensing laws are cor- demonstration for any specified in Subparag Rule .0903 of this Sub- performing the task at	el and licensed personnel licensed capacity as ctice act and occupational mpetency validated by return v personal care task raph (a)(1) through (28) of ochapter prior to staff and that their ongoing ed through facility staff			
	reviews, the facility fa medication aides (Sta care aides (Staffs C, I competency validated professional support ( demonstration including stockings, obtaining fi	is, interviews, and record iled to ensure 1 of 3 iff A) and 2 of 3 personal E and F) had been I for licensed health (LHPS) tasks by return ing applying compression			
	The findings are:				
	personnel record reversible should be personnel record reverses as hired on 07/2007.				

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

TITLE (X6) DATE

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		HAL092023 B. WING			C 09/02/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE. ZIP CODE	1 00/02/2021
	ALE CARY		IAPEL HILL ROAI		
BROOKD	ALL CANT	CARY, N	IC 27513		
(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 COMPLETE
D 161	Continued From page	÷ 1	D 161		
	a LHPS competency	validation checklist.			
	administration record revealed: -Staff A documentatio days.	s electronic medication (eMAR) for August 2021 n of compression hose 3 obtaining fingerstick blood			
	Interview with Staff A on 09/02/21 at 1:10pm revealed: -She did not remember any specific training for LHPS task such as helping with transfers and applying compression stockingsShe would help residents transfer from their chairsShe would apply or remove compression stockings for residents that required them.				
	The Health and Wellr not available for inter 09/02/21.	ness Director (HWD) was view from 08/31/21 to			
	Refer to the interview Manager (ANM) on 0				
	Refer to the interview 09/01/21 at 3:00pm.	with the Administrator on			
	Refer to the interview at 4:45pm.	with the BOM on 09/02/21			
	at 4:45pm.  2. Review of Staff C's, personal care aide (PCA) personnel record revealed: -Staff C was hired on 04/05/21There was no documentation Staff C's completed a LHPS competency validation checklist since she was hired.				

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Division of Health Service Regulation

DIVISION	n rieditii Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1 .	
			5			
		HAL092023	B. WING	<del></del>	09/0	2/2021
NAME OF D		OTDEETAL	DDEGG OITY OT	TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ATE, ZIP CODE		
BBOOKD.	ALE CARY	7870 CH	APEL HILL ROA	D		
BROOKD	ALL OAKI	CARY, N	C 27513			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	NI	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 404		_	D 404			
D 161	Continued From page	e 2	D 161			
	Telephone interview v	with Staff C on 09/02/21 at				
	11:55am revealed:	With Stall C 011 09/02/21 at				
		1.11.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1				
	-	d third shift (11:00pm to				
	7:00am).					
	-She did not rememb	er any specific training for				
	LHPS task such as he	elping with transfers and				
	applying compression	n stockings.				
		er any staff doing a type of				
		d any return demonstration				
	since she had been hired.  -She helped residents transfer to and from their					
	•	s transfer to and from their				
	wheelchairs.					
	<b>-</b> 1 11 10 1347 11	D: ( (				
		ness Director (HWD) was				
	not available for inter	view from 08/31/21 to				
	09/02/21.					
	Refer to the interview	with the Area Nurse				
	Manager (ANM) on 0	9/02/21 at 12:30pm.				
	<b>3</b> ( )	•				
	Refer to the interview	with the Administrator on				
	09/01/21 at 3:00pm.	With the Figure 1				
	03/01/21 at 3.00pm.					
	Defende the interview	with the DOM on 00/02/24				
		with the BOM on 09/02/21				
	at 4:45pm.					
		s, personal care aide (PCA)				
	personnel record reve	ealed:				
	-Staff E was hired on	04/25/21.				
	-There was no docum	nentation Staff E's				
	completed a LHPS co	ompetency validation				
	checklist since she w	· ·				
	Telephone interview v	with Staff E on 09/02/21 at				
	12:50pm revealed:	Otali L 011 00/02/21 at				
	-	d different chifts first size				
	_	d different shifts, first and				
	third shifts.					
	-She completed certif					
	training prior to comir					
	-She did not rememb	er any specific training for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
						<u> </u>	
		HAL092023	B. WING		09/0	2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE			
BROOKD	ALE CARY		APEL HILL ROA	D			
		CARY, NO	27513				
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 161	Continued From page	<b>3</b>	D 161				
	LHPS task such as he -She provided care so from the bed to whee	uch as transferring residents					
	The Health and Wellness Director (HWD) was not available for interview from 08/31/21 to 09/02/21.						
	Refer to the interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm.						
	Refer to the interview 09/01/21 at 3:00pm.	with the Administrator on					
	Refer to the interview at 4:45pm.	with the BOM on 09/02/21					
	4. Review of Staff F's, personal care aide (PCA) personnel record revealed: -Staff F was hired on 03/25/21There was no documentation Staff F's completed a LHPS competency validation checklist since she was hire.						
	revealed: -She routinely worked -She did not rememb type of check off that demonstration since s -She helped residents	er nursing staff doing any required any return					
		ness Director (HWD) was view from 08/31/21 to					
	Refer to the interview	with the Area Nurse					

Division of Health Service Regulation

Manager (ANM) on 09/02/21 at 12:30pm.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	
			_		C
		HAL092023	B. WING		09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE CARY		APEL HILL ROAD	D	
		CARY, NO	C 27513		
(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 SHOUL CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE COMPLETE
D 161	Continued From page	÷ 4	D 161		
	Refer to the interview 09/01/21 at 3:00pm.	with the Administrator on			
	Refer to the interview with the BOM on 09/02/21 at 4:45pm.				
	Interview with the ANM on 09/02/21 at 12:30pm revealed: -The HWD was responsible to ensure staff were				
		I for tasks including LHPS			
		o residents should be LHPS efore providing care to the			
	-The HWD provided of completed LHPS to the	locumentation for ne Business Office Manager			
		ing with ensuring staff while the HWD was out of			
	3:00pm revealed:	ninistrator on 09/01/21 at			
	staff records in the B0 -The HWD was respo				
	had documentation for various positions or w scheduling and valida	or the requirements of the vere assisted with			
		ing with ensuring staff while the HWD was out of			
	revealed:	M on 09/02/21 at 4:45pm			
	-He became the BOM 2021.	I in the middle of February			

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	of Health Service Regu				T	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPLE	
		HAL092023	B. WING		09/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
BBOOKB	ALE CARV	7870 CH	HAPEL HILL ROAD			
BROOKD	ALE CARY	CARY, I	NC 27513			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 161	Continued From page	e 5	D 161			
	staff qualificationsThere was not a che requirements that he locate.	ccumentation for required  ck off list for staff  was aware of or could  onsible to ensure were in				
D 270	10A NCAC 13F .090 <sup>2</sup> Supervision	I(b) Personal Care and	D 270			
		e supervision of residents in n resident's assessed needs,				
	review the facility faile	ns, interviews, and record ed to provide supervision for ents (Resident #4) resulting				

The findings are:

Review of the facility's Falls Management policy revealed:

- -A falls risk evaluation was completed at the time of move-in.
- -Falls were recorded in the facility's computer system.
- -A post fall evaluation was completed after a resident had a fall.
- -Individualized interventions were considered and the evaluation was a part of the resident record.

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED
		HAL092023	B. WING		08	C <b>//02/2021</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
			APEL HILL ROAD			
BROOKDA	ALE CARY	CARY, NO	C 27513			
(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 270	Continued From page	÷ 6	D 270			
	disorientated.  Review of Resident #	mer's disease. n-ambulatory and constantly 4's Care Plan dated				
	03/18/21 revealed the dependent on staff for ambulation, bathing, of transferring.					
	Review of Resident #4's Licensed Health Professional Support evaluation dated 07/02/21 revealed: -Resident #4 was totally dependent on staff for all Activities of Daily Living (ADL)Resident #4 was unable to stand independently and was a two-person transfer.					
	dated 03/27/19 revea -A resident was consi there were one or mo responses with "yes" -Resident #4 was con with a "yes" response -Resident #4 had prol transferringResident #4 appeare ambulatingResident #4 had a hi  Review of Resident # 01/18/21 at 11:12pm, found on the floor." -Resident #4 was put	dered a "Level 3 fall risk" if bre level 3 question checked. Insidered a "Level 3" fall risk to checked to the following: blems ambulating and ed unsteady when distory of cognitive decline.  E4's progress note dated revealed "Resident #4 was				
	were completed on th	•				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL092023	B. WING		C 09/02/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BBOOKD	ALE CARY	7870 CHAI	PEL HILL ROA	D		
CARY, NC			27513			
(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 270	Continued From page	÷ 7	D 270			
	Review of Resident #4's physician notification form dated 01/18/21 revealed Resident #4 had a fall and "suffered a scrape to her left knee."					
	revealed: -At 10:00pm, Resider	ll report dated 01/18/21 at #4 was found lying on the				
	floor near her bed.  -The medication aide (MA) documented Resident #4 received a scrape to her left knee.  -The post-fall evaluation was initiated but not completed, the status was showing "error."					
	There was no docume service plan was revie according to the falls					
	Review of Resident #4's computerized clinical assessment worksheet revealed the post-fall evaluation status was "errors." It could not be determined exactly what the errors were related to.					
	There was no docume supervision to preven	entation of increased t Resident #4 from falling.				
	Telephone interview with a second shift MA on 09/02/21 at 11:42am revealed: -On 01/18/21, he found Resident #4 on the floor near her bedHe thought maybe Resident #4 was asleep in the bed and fell from the bed, but he was not sureResident #4's fall resulted in a scrape to the resident's knee and required first-aid treatmentHe documented Resident #4 was put on safety checks, but he did not document the safety checks were completedSafety checks were done for three days following					
	a resident's fall.	thecks were done every 30				

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DIVISION	n Health Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					C	;
		HAL092023	B. WING		09/0	2/2021
			•		•	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		7870 CHA	PEL HILL ROA	D		
BROOKDA	ALE CARY	CARY, NO	27513			
	0.000000		1	PROMPTED BLANCE CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
IAG		,	IAG	DEFICIENCY)		
D 270	Continued From page	8	D 270			
	minutes, up to 24 hou					
	<ul> <li>The second day safe</li> </ul>	ty checks were every hour				
	for 24 hours.					
	-The third day safety	checks were done every two				
		facility's regular protocol for				
	checking on residents					
	-Last year (2020), the					
		e completed safety checks,				
		ellness Director (HWD) told				
	him that he could no I	onger document the safety				
	checks because there	e was no order for safety				
	checks.	•				
	-Recause there was r	no order, safety checks				
		after a resident had a fall.				
	-	n for increased supervision				
	put in place for Resid					
		esident #4 was provided				
	every two hours for in	continent care as well as				
	the other residents.					
	Review of Resident #	4's progress note dated				
		evealed "Resident #4 was				
		dside her bed, no injuries."				
	loulid off the floor bed	iside nei bed, no injunes.				
	D : (D :1 1//	41 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
		4's physician notification				
		evealed Resident #4 was				
	found on the floor by	the bedside, no apparent				
	injuries.					
	Review of the post-fal	ll evaluation dated 05/03/21				
	revealed:					
	-Resident #4 fell at 3:	00nm				
	-The fall was near the	•				
	-The cause of the fall	was unknown.				
	Review of Resident #	4's computerized clinical				
	assessment workshee	et revealed the post-fall				
		plete and "still in progress."				

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There was no documentation of increased

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL092023	B. WING		C 09/02	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	•	
BROOKD	ALE CARY	7870 CHAI CARY, NC	PEL HILL ROA 27513	D		
(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	(X5) COMPLETE DATE
D 270	The MA who complete was not available for it Review of Resident # on 08/13/21 at 9:37pr lying on the floor in he injuries."  Review of Resident # form dated 08/13/21 r found lying on the floor apparent harm/injuries.  Review of Resident # 08/13/21 revealed: -At 10:00pm, Resident floor bedside her beddent # was lying apparent injuries.  -The post-fall evaluation completed. The status There was no docume supervision to preven linterview with the MA revealed: -The post-fall report with the management in the was partly secured in the HWD had to contemportFollowing the fall on the report.	t Resident #4 from falling.  ed the post-fall evaluation interview on 09/02/21.  4's progress note revealed in, "Resident #4 was found er room, no apparent  4's physician notification evealed Resident #4 was or by her bedside with no is.  4's post-fall evaluation dated in the was found lying on the interval of the was found lying on the interval of the was initiated but not in the showed "in-progress."  entation of increased it Resident #4 from falling.  on 09/02/21 at 11:42am  was showing "in-progress"	D 270	DEFICIENCY)		
	-Following the fall on orders had been given	n to supervise Resident #4 the required every two				

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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. BUILDING: _		
		HAL092023	B. WING		C 09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PPOOKD	ALE CARY	7870 CHAF	EL HILL ROAI	D	
BROOKD	ALE CART	CARY, NC	27513		
(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 COMPLETE
D 270	Continued From page	<del>2</del> 10	D 270		
	Review of Resident # -On 05/18/21 at 8:39g on the floor, no injurie documentation a post completed on Reside facility's policy. There increased supervision from fallingOn 06/18/21 at 14:33 found on the floor in h documentation a post completed on Reside facility's policy. There	4's progress notes revealed: om, "Resident #4 was found es." There was no e-fall evaluation was int #4 as required by the was no documentation of into prevent Resident #4  Ipm, "Resident #4 was her room." There was no			
	Based on Resident #4's progress notes, post-fall reports and notification to the physician, Resident #4 had 5 falls (one January 2021, two in may 2021, one June 2021 and one in August 2021). One of the falls resulted in a scrape to the resident's knee. There was no documentation of increased supervision to prevent Resident #4 from falling.				
	revealed: -Resident #4's falls or resident attempted to -Resident #4 had den was totally dependent transferringIf Resident #4 tried to assistance she would -It was common for R falls because she was -Resident #4 was che according to the facilitian-There was no system	stand and walk. nentia and forgot that she t on staff for ambulation and o stand without staff			

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
						_
			B WING			
		HAL092023	B. WING		09/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
	1011211 011 001 1 21211					
BROOKD	ALE CARY		PEL HILL ROA	ע		
		CARY, NC	27513			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				DETICIENCY)		
D 270	Continued From page	e 11	D 270			
	Communa Trom page					
	every two hours for in	continent care.				
	Interview with Reside	nt #4's guardian on 09/01/21				
	at 4:18pm revealed:	-				
	-Resident #4 had abo	out 5 falls since the				
	beginning of the year	. 2021.				
		istory of falling because she				
		it she could no longer walk.				
		recall exact date) she asked				
	- ,	ng a mattress on the floor				
	because the majority	~				
		esident was getting out of				
	bed.					
	•	hat a mattress on the floor				
	was a fire hazard and					
		hey would put pillows on the				
		nt #4 fell out of bed she did				
	not get hurt.					
	-She had not been at	the facility to observe if				
	pillows were being us	sed.				
	-The facility had not to	alked with her about				
	implementing measur	res to increase supervision				
	to prevent Resident #	<sup>t</sup> 4's falls.				
	Interview with the Adr	ministrator on 09/01/21 at				
	10:20pm.					
	•	s falls happened on the				
	second shift so she in					
	Resident #4 up longe	•				
		ed, she would try to get up				
	out of the bed.	ou, one would by to get up				
		ucted to keep Resident #4				
	put Resident #4 dowr	activity at 6:30pm, and not to				
	•	•				
		o not send the resident to				
		n, but to try to keep the				
	The state of the s	m, so she would sleep all				
	night.					

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Based on observation, record review and

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL092023		B. WING		C 09/02	/2021	
ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		-	
ALE CARY						
	CARY, NC	27513				
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE	
Continued From page	12	D 270				
interviews it was dete interviewable.	rmined Resident #4 was not					
The HWD was not av 09/02/21.	ailable for interview on					
10A NCAC 13F .0902	(b) Health Care	D 273				
10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.						
Based on record reviet facility failed to ensure of 5 sampled resident	ews and interviews, the e physician notification for 1 s (#3) who had orders for					
The findings are:						
08/17/21 revealed dia	gnoses included dementia,					
(PCP) consultation not revealed: -He had a diagnosis of without complication a current use of insulinHe suffered from dial glipizide and metform -The PCP would order close monitoring.	of type 2 diabetes mellitus and without long-term oetes and was currently on in.					
	Continued From page interviews it was dete interviews it was dete interviewable.  The HWD was not ava 09/02/21.  10A NCAC 13F .0902 (b) The facility shall at to meet the routine and of residents.  This Rule is not met at Based on record reviet facility failed to ensure of 5 sampled resident finger stick blood sugaparameters.  The findings are:  Review of Resident # 08/17/21 revealed dia hyponatremia, B12 deand pain.  Review of Resident # (PCP) consultation not revealed:  -He had a diagnosis of without complication accurrent use of insulinHe suffered from dial glipizide and metform -The PCP would order close monitoring.	ROVIDER OR SUPPLIER  ALE CARY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12 interviews it was determined Resident #4 was not interviewable.  The HWD was not available for interview on 09/02/21.  10A NCAC 13F .0902(b) Health Care  (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) who had orders for finger stick blood sugar (FSBS) checks with parameters.  The findings are:  Review of Resident #3's current FL2 dated 08/17/21 revealed diagnoses included dementia, hyponatremia, B12 deficiency, urinary retention, and pain.  Review of Resident #3's Primary Care Physician's (PCP) consultation notes dated 08/19/21 revealed:  -He had a diagnosis of type 2 diabetes mellitus without complication and without long-term current use of insulin.  -He suffered from diabetes and was currently on glipizide and metformin.  -The PCP would order fasting blood sugars for	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STA  7870 CHAPEL HILL ROAI CARY, NC 27513  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12 interviews it was determined Resident #4 was not interviewable.  The HWD was not available for interview on 09/02/21.  10A NCAC 13F .0902(b) Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.  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ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7870 CHAPEL HILL ROAD CARY, NC 27513  SUMMARY STATEMENT OF DESICIENCIES (EACH DESICIENCY MUST BE PRECEDED BY PULL REGULATION OR LSC IDENTIFYING INFORMATION)  COntinued From page 12  Interviews it was determined Resident #4 was not interviews it was determined Resident #4 was not interviewable.  The HWD was not available for interview on 09/02/21.  10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.  This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) who had orders for finger stick blood sugar (FSBS) checks with parameters.  The findings are:  Review of Resident #3's current FL2 dated 08/17/21 revealed diagnoses included dementia, hyponatremia, B12 deficiency, urinary retention, and pain.  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This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (#3) who had orders for finger stick blood sugar (FSBS) checks with parameters.  The findings are:  Review of Resident #3's current FL2 dated 08/17/21 revealed diagnoses included dementia, hyponatremia, B12 deficiency, urinary retention, and pain.  Review of Resident #3's Primary Care Physician's (PCP) consultation notes dated 08/19/21 revealed:  He had a diagnosis of type 2 diabetes mellitus without complication and without long-term current use of insulin.  He suffered from diabetes and was currently on glipizide and metformin.  The PCP would order fasting blood sugars for close monitoring.	

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morning and notify the PCP if FSBS was less

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING			
		HAL092023	B. WING	<del></del>	09/0	) 2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE CARY		PEL HILL ROAD	)		
		CARY, NO	; 27513			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 13	D 273			
	than 60 or more than	500.				
	Administration Record revealed: -There was an entry to in the morning for type physician if FSBS was than 500There was documen	d (eMAR) for August 2021 to check fasting blood sugar e 2 diabetes and notify the s less than 60 or greater tation Resident #3's FSBS 1/24/21 through 08/31/21, but entation of any FSBS				
	August 2021 revealed -On 08/23/21, there worder for FSBS to be -On 08/24/21, there w #3's FSBS was 286On 08/31/21, there w #3's FSBS was 98There was no other of	vas documentation of a new checked in the morning. vas documentation Resident vas documentation Resident documentation of Resident				
	-There was no other documentation of Resident #3's FSBS in August 2021.  Interview with a representative from the contracted pharmacy on 08/31/21 at 11:38am revealed:  -There was an order for Resident #3 to check FSBS in the morning and contact the physician for FSBS less than 60 or greater than 500.  -The order for FSBS was faxed to the pharmacy on 08/23/21 and the pharmacy entered the order on the eMAR on 08/23/21.  Interview with the Resident #3's family member on 08/31/21 at 11:50am revealed: -Resident #3 was diabeticResident #3 received FSBS checks, but she was					

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not sure how many times a day.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLE	
			, DOILDING		_	
			B. WING		C	
		HAL092023	B. WING		09/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DDOOKD	11 E 04 DV	7870 CHA	PEL HILL ROA	D		
BROOKD	ALE CARY	CARY, NO	27513			
(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	(X5) COMPLETE DATE
D 273	Continued From page	e 14	D 273			
	1:10pm revealed: -Resident #3 was hos admitted into the facil -She wrote an order for because his family was checkedShe was only going to in place for 2 weeks a orderResident #3 was not need to have his FSB Interview with a medic 08/31/21 at 3:37pm resumed to have his FSB Interview with a medic 08/31/21 at 3:37pm resumed to have his FSB Interview with a medic 08/31/21 at 3:37pm resumed to entered the ordersFSBS were able to enthe Health and Wellnes the Health and Welln	or FSBS for Resident #3 anted his FSBS to be  to leave the order for FSBS and then discontinue the  on insulin and really did not as checked.  cation aide (MA) on evealed: ter orders on the eMAR, but ess Coordinator (HWC) or ess Director (HWD) usually  documented on the eMAR, ocument FSBS in the  ave added an entry for the eMAR Resident #3's in 08/28/21, but she did not reading for 08/28/21. er what Resident #3's FSBS is/21. by there was not a space to lings on the eMAR or why mented daily for Resident ed the physician regarding ow if any other MA had an for FSBS reading less				

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Interview with the HWC on 08/31/21 at 3:50pm

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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	
			_		c	;
		HAL092023	B. WING		09/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BROOKD	ALE CARY		PEL HILL ROAL	D		
		CARY, NC				
(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 273	Continued From page	<del>2</del> 15	D 273			
	revealed: -She was new to work still in trainingShe did not know the document FSBS readings and on the eMAR and par followed as ordered but the eMARShe noticed there was FSBS readings on the who was responsible on the eMARShe did not ask how no one instructed her for Resident #3She documented FS progress notes on 08. 09/01/21She did not know who documented for Resident #3's contacted due to FSE above 500.  Interview with Reside 5:00pm revealed: -She did not know the Resident #3's FSBS resident #3's FSBS resident #3's FSBS resident #3's FSBS daily and the less than 60 or more	ere was not an entry to lings for Resident #3 on the BS had not been recorded ald have been documented ameters should have been by the physician.  In 09/01/21 at 10:00am as no space to document e eMAR, she did not know for entering FSBS readings or where to document, and how to document the FSBS BS for Resident #3 in his //24/21, 08/31/21, and by FSBS readings were not dent #3 daily and she did not PCP needed to be BS being less than 60 or ant #3's PCP on 09/01/21 at the ere was no documentation of readings. To check and record Resident to contact her with any FSBS than 500. Intracted by staff at the				

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Interview with the Administrator on 08/31/21 at

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL092023	B. WING		C 09/02/2021	
		HAL092023			1 09/02/2021	_
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		7870 CH	APEL HILL ROAI	)		
BROOKD	ALE CARY	CARY, N	IC 27513			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	_
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
				DETIGIENCY)		_
D 273	Continued From page	e 16	D 273			
	4:14pm revealed:					
		ere was no space on the				
		tion of FSBS readings for				
	Resident #3.					
		een documented on the				
	eMAR or in the progre					
		Resident #3's PCP needed				
	than 500.	SBS less than 60 or greater				
		t ESPS readings could have				
		t FSBS readings could have				
		eMAR by the HWC, HWD or				
	• • •	by the HWC, HWD or a				
	second MA.					
	The HMD was not av	ailable for interview from				
	08/31/21 through 09/0					
	00/31/21 tillough 09/0	02/21.				
D 344	10A NCAC 13F .1002	2(a) Medication Orders	D 344			
	10A NCAC 13F .1002	Medication Orders				
		ne shall ensure contact with				
		an or prescribing practitioner				
	for verification or clari					
	medications and treat					
		sion or readmission of the				
	• ,	d and signed within 24 hours				
	of admission or readn	•				
	(2) if orders are not cl					
		on forms are received upon				
		sion and orders on the				
	forms are not the sam					
		re that this verification or				
		ented in the resident's				
	record.					
	100014.					
	This Rule is not met	as evidenced bv:				
		ns. record review. and				

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interviews the facility failed to clarify medication

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	) PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED
					C
		HAL092023	B. WING		09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		7870 CHAP	EL HILL ROAI	D	
BROOKD	ALE CARY	CARY, NC			
040.15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 17	D 344		
	orders for 1 of 5 residents sampled (#4) who had orders for acid reflux medication and an order for routine pain medication.				
	The findings are:				
	05/06/21 revealed: -Diagnoses of Alzheir -Medication orders did 40mg once daily.  Review of Resident # hospital discharge su orders for pantoprazo treat gastroesophage  Review of Resident # 2021 electronic medic (eMAR) revealed ther	d not include pantoprazole  4's record revealed a mmary dated 08/01/21 with ble 40mg once daily (used to al reflux).  4's June, July and August cation administration record re was no entry for			
	hand on 09/01/21 at a -Pantoprazole 40mg administrationThere were three und 40mgEach medication card that spelled "PRN" in medication cardOne card was filled owere dispensed, there -A second card was fit tablets were dispensed remainingA third card was filled.	ent #4's medications on			

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Telephone interview with a representative from

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MUITIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		HAL092023	B. WING		09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
	=		PEL HILL ROAL		
BROOKD	ALE CARY	CARY, NO	27513		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 18	D 344		
	3:00pm revealed: -The pharmacy receive pantoprazole 40mg of Pantoprazole 40mg of hospital discharge sufficient of the pantoprazole 40mg of and 28 tablets were severy monthThere had been no compantoprazole 40mg, so the medication as ordered Pantoprazole 40mg, so the medication as ordered 40mg, so the medica	n 06/03/21.  was initially ordered from a mmary report dated  once daily was on cycle fill scheduled to be dispensed orders to discontinue so the pharmacy dispensed dered.  It medication orders should			
	09/01/21 at 3:22pm re- lt was her understan was not administered -She did not realize F 40mg was ordered or medication was not a -She did not read the aware the administrat administer the medicat -She had not contacte Care Provider (PCP) -The MA that wrote "F pantoprazole medicate	ding Resident #4 currently any medications. Resident #4's pantoprazole nce daily and was sure the dministered. medication card and was tion instructions were to ation daily. ed the resident's Primary to clarify the order. PRN" (as needed) on the tion card should have put a medication and called the			

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Interview with Resident #4's PCP on 09/01/21 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
HAL092023				C	
		HAL092023	B. WING		09/02/2021
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE CARY		APEL HILL ROA	D	
CARY, NC		27513			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 19	D 344		
	11:12am revealed: -She visited the facilit medicationsShe did not recall ord once dailyThe medication may resident's last hospitaShe expected all me as orderedIf the facility was not the pantoprazole they.  Interview with the Adr 5:13pm revealed: -If the MA was not ad she should let the HV should contact the retthe medication was note. The HWD did medication was note. The HWD should has PRN but was not contact the residentified Resident #4 as PRN but was not contact the resident from the HWD should has PCP and clarified the Based on observation interview it was deterninterview it was deterninterviewable.  The HWD was not av 09/02/21.  b. Review of Residen 05/06/21 revealed an tablets (650mg) every pain. There was no o	dering pantoprazole 40mg  have been ordered from the al visit. dications to be administered  sure about administering y should have contacted her.  ministrator on 09/02/21 at  ministering a medication, VD know and the HWD sident's PCP or find out why ot administered. ation cart audits monthly to not used and expired. the HWD should have t's pantoprazole was marked ordered PRN. ve contacted the resident's order for the pantoprazole.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	EIED
					С	
		HAL092023	HAL092023 B. WING		09/0	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
BBOOKE	ALE CARV	7870 CHAF	EL HILL ROA	D		
BROOKD	ALE CARY	CARY, NC	27513			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 344	Continued From page	20	D 344			
	Review of Resident # hospital discharge su	4's record revealed a mmary dated 08/01/20 with mg 2 tablets (650mg) twice				
	2021 eMAR revealed	4's June, July and August there was no entry for ts (650mg) twice daily on				
	hand on 09/01/21 at 1 -Tylenol 325mg 2 tabl for administration. -There were six unuse	ent #4's medications on I:52pm revealed: lets (650mg) was available ed cards of tylenol 650mg Iminister the medication				
	-There was two partia 650mg with instruction medication twice daily -There was hand-writi					
	-One card had a fill datablets were dispense remainingTwo cards with a fill of	ate of 02/18/21 and 56 ed. There were 12 tablets date of 05/13/21 and 56 dispensed. One card had				
	56 tablets remaining. tablets remaining. -Two cards with a fill of	The second card had 22 date of 06/10/21 and 56				
	56 tablets remaining. The on the eMAR the med -Two cards with a fill of	ed per each card. One card The second card had 48 ere was no documentation dication was administered. date of 07/08/21 and 56				
	112 tablets remaining -Two cards with a fill of	date of 08/05/21 and 56 ed per each card, there were				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI E	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BUILDING: _		
			D WING		C
		HAL092023	B. WING		09/02/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		7870 CH	APEL HILL ROA	D	
BROOKD	ALE CARY	CARY, N	C 27513		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEI IGIENCI )	
D 344	Continued From page	e 21	D 344		
	Peview of Pesident #	4's record revealed there			
		n clarifying the order for			
		daily or notifying the PCP			
	that tylenol 650mg tw				
	administered.	loo daily was not			
	danimiotoroa.				
	Telephone interview v	vith a representative from			
		d pharmacy on 09/01/21 at			
	3:00pm revealed:				
	-The pharmacy receive	ed an order dated 08/01/21			
	for tylenol 325mg 2 ta	ablets (650mg) twice daily.			
	-Tylenol 325mg 2 tab	lets (650mg) were cycle			
	filled and dispensed e	•			
		cted the facility on 08/01/20			
		50mg twice daily because			
	_	nad an order for tylenol			
	, ,	as needed for pain. There			
	no response from the				
		o clarify the tylenol 650mg			
	twice daily, so the pha				
	dispense the medicat	orders discontinuing tylenol			
	650mg twice daily, so	<b>5</b>			
	dispensed monthly.	the medication was			
	dispensed monthly.				
	Interview with Reside	nt #4's primary care provider			
	(PCP) on 09/01/21 at				
	,	enol 650mg twice daily.			
		have been ordered when			
	the resident went to the				
	-The facility should cl	arify the order instead of not			
	administering the med	dication.			
		complain a lot of pain and			
	did not know why the	hospital ordered tylenol			
	650mg twice daily.				
		ministrator on 09/02/21 at			
	5:13pm revealed:				
	│ -The HWD did a cart⊸	audit monthly and should			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			R WING		С
		HAL092023	B. WING		09/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
BROOKD	ALE CARY		PEL HILL ROA	D	
		CARY, NC	27513		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 22	D 344		
	ordered twice daily buthe medication cardThe HWD should hat PCP to clarify the ord administering the medication and the state of the				
D 358	10A NCAC 13F .1004 Administration	4(a) Medication	D 358		
	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.				
	facility failed to ensur administered as orde physician for 1 of 5 sa	n, records and interviews the			
	The findings are:				
	Review of Resident # 06/07/21 revealed dia Alzheimer's dementia				

Division of Health Service Regulation

STATE FORM 6899 OKHI11 If continuation sheet 23 of 34

Division of Health Service Regulation

DIVISION	n nealth Service Negu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		1141 000000	B. WING		C
		HAL092023	B: Wii(0		09/02/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		7870 CHA	PEL HILL ROA	n	
BROOKD	ALE CARY	CARY, NO			
			7 2/513		T.
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
IAG		,	IAG	DEFICIENCY)	
D 358	Continued From page	e 23	D 358		
	Daview of Davidout #	Fla was and was sailed are and an			
		5's record revealed an order			
		alopram 20mg once daily			
	(used to treat major d	lepression).			
		5's June 2021 electronic			
	medication administra	ation record (eMAR)			
	revealed:				
	-There was an entry f	or citalopram 20mg once			
	daily scheduled for ac	dministration at 9:00am.			
	-There was documen	tation citalopram 20mg was			
	first administered 06/2	21/21 at 9:00.			
	-There was documen	tation citalopram 20mg once			
		ed every day from 06/22/21			
	through 06/30/21 as o				
	-There was no docum				
		mg or the medication was			
	not administered.	9			
	Review of Resident #	5's July 2021 eMAR			
	revealed:	0 0 0 any 202 1 0 m a 1			
		or citalopram 20mg once			
	<del>_</del>	dministration at 9:00am.			
		tation citalopram 20mg once			
		ed every day from 07/01/21			
	through 07/31/21 as of	• •			
	•				
	-There was no docum				
	•	mg or the medication was			
	not administered.				
	Deview -f.D. 11 17	Fla Avenuet 2004 - NAAD			
		5's August 2021 eMAR			
	revealed:				
		for citalopram 20mg once			
		dministration at 9:00am.			
		tation citalopram 20mg once			
	-	ed every day from 08/01/21			
	through 08/31/21 as o	ordered.			
	-There was no docum	nentation the resident			
	refused citalopram 20	mg or the medication was			

Division of Health Service Regulation

not administered.

STATE FORM 6899 OKHI11 If continuation sheet 24 of 34

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION    AND PLAN OF CORRECTION   (X1) PROVIDER OR SUPPLIER   CATION NUMBER:   B, WING   CATION STATE AND PLAN OF CORRECTION	Division of Health Service Regulation							
INAME OF PROVIDER OR SUPPLIER  THAT STREET ADDRESS, CITY, STATE, ZIP CODE  TROOR DATE CARY  TROOR CHAPEL HILL ROAD CARY, NC 27513    PREPLY   FRANCE CORRECTION   PREPLY   PREPLY   PROVIDERS PLAN OF CORRECTION   PREPLY   PREPLY   PROVIDER OF TAKE   PREPLY   PREPLY	STATEMENT	` '		(X2) MULTIPLE	CONSTRUCTION			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE ZIP CODE  770 CHAPEL HILL ROAD CARY, NC 27513  SUMMARY STATEMENT OF DEFICIENCIES PRETIX TAG  SUMMARY STATEMENT OF DEFICIENCY BUT BE PRECEDED BY FULL PRETIX TAG  D 358  Continued From page 24  D 358  Continued From page 24  Observation of Resident #5's medications on hand revealed: -Citalopram 20mg was filled on 08/21/21 for a quantity of 30 tablets. There were 16 tablets remainingCitalopram 20mg was filled on 08/21/21 for a quantity of 30 tablets. There were 16 tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  According to review of eMAR documentation and dispensed dates, there was an overage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was no verage of 26 citalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets remaining.  Interview with Resident #5's guardian on 09/02/21 at 9:00am revealed: -Resident #5 was admitted to the facility on 08/09/21.  -When Resident #5 was admitted to the facility on 08/09/21.  -When Resident #3 according to the facility on 08/09/21.  -The new medications were not put on the medication cart until 09/06/21.  -The new medications were not put on the medication cart until 09/06/21.  -The new medications from both cards	AND PLAN C	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7870 CHAPFEL HILL ROAD  CARY, NC 27513  (KA) ID  PROVIDER'S PLAN OF CORRECTION  SUMMARY STATEMENT OF DEFICIENCIES  FEACH DEFICIENCY MUST BE PRICEDED BY FULL  PRECILATIONY OR LSC IDENTIFYMB INFORMATION)  D 388  Continued From page 24  Observation of Resident #5's medications on hand revealed:  - Citalogram 20mg was salield on 08/04/21 for a quantity of 28 tablets, there were 10 tablets remaining.  - Citalogram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  - Citalogram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  - Citalogram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  - Citalogram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  - Citalogram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remaining.  Interview with Resident #5's guardian on 09/02/21 at 9:00am revealed:  - Resident #5 was admitted to the facility on 00/09/21.  - When Resident #5 was admitted to the facility on 00/09/21.  - Citalogram 20mg once daily was ordered one to two weeks after the resident was admitted to the facility.  Interview with the medication aide (MA) on 00/01/21 at 3:22pm revealed:  - The new medications were not put on the medication cart until 09/08/21.  - The MA was pulling medications from both cards					-			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7870 CHAPEL HILL ROAD CARY, NC 27513   DAY, ID PREFIX  CAND, ID PREFIX  CEACH OPERICENCY MUST BE PRECEDED BY FULL TAG  CROSS-REFERENCED OR HAPPROPRIATE DAYS  COMMUNITY TAG  D 358  Continued From page 24  D 358				R WING		1		
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   CEACH CORRECTIVE ACTION SHOULD BE CARD STAGE   CEACH CORRECTIVE ACTION SHOULD BE CARD STAGE   CARD S			HAL092023	B. WING		09/0	2/2021	
CARY, NC 27513   CARY   CARY   CARY, NC 27513   CARY, N	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
CARY, NC 27513   CARY   CARY   CARY, NC 27513   CARY, N			7870 CH4	PEL HILL ROA	n.			
SUMMARY STATEMENT OF DEFICIENCIES   The PRODUCT SET PLAN OF CORRECTION (INCAD EPICIENCY)   THE PROPERTY IN T	BROOKDA	ALE CARY			5			
D 358 Continued From page 24  Observation of Resident #5's medications on hand revealed: -Citalopram 20mg was available for administrationThere were three cards of citalopram 20mgCitalopram 20mg was filled on 06/21/21 for a quantity of 30 tablets, there were 16 tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there were no tablets remainingCitalopram 20mg was filled on 08/04/21 for a quantity of 28 tablets, there was an overage of 26 citalopram 20mg tablets, there should only have been 13 tablets remaining.  Interview with Resident #5's guardian on 09/02/21 at 9:00am revealed: -Resident #5 was admitted to the facility on 06/09/21When Resident #5 was admitted to the facility on 06/09/21When Resident #5 was admitted to the facility.  Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed: -The new medications were not put on the medication cart until 09/06/21The MA was pulling medications from both cards				2/513				
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been ordered citalopram.  -Citalopram 20mg once daily was ordered one to two weeks after the resident was admitted to the facility.  Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed:  -The new medications were not put on the medication cart until 09/06/21.  -The MA was pulling medications from both cards		06/09/21.						
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two weeks after the resident was admitted to the facility.  Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed: -The new medications were not put on the medication cart until 09/06/21The MA was pulling medications from both cards		been ordered citalopr	ram.					
Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed: -The new medications were not put on the medication cart until 09/06/21The MA was pulling medications from both cards		-Citalopram 20mg on	ce daily was ordered one to					
Interview with the medication aide (MA) on 09/01/21 at 3:22pm revealed: -The new medications were not put on the medication cart until 09/06/21The MA was pulling medications from both cards		two weeks after the re	esident was admitted to the					
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medication cart until 09/06/21.  -The MA was pulling medications from both cards								
-The MA was pulling medications from both cards								
· •								
of citalopram, which was why there were so many								
citalopram 20mg tablets left.		· · · · · · · · · · · · · · · · · · ·	-					
-She also thought that maybe Resident #5 came								
to the facility with citalopram 20mg but was not								

Division of Health Service Regulation

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Division c	<u>of Health Service Regu</u>	ılation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			B. WING		C	
		HAL092023	D. WING		09/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		7870 CH	APEL HILL ROA	n		
BROOKDA	ALE CARY		C 27513	_		
			<u> </u>			
(X4) ID		TATEMENT OF DEFICIENCIES  BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
		,		DEFICIENCY)		
			<del></del>			
D 358	Continued From page	e 25	D 358			
	sure.					
	Interview with the MA	on 09/02/21 at 9:25am				
	revealed:	1011 00702/21 at 0.20am				
		nes refused her citalopram,				
	which may account fo	•				
		he resident refused the				
	medication when she					
		the PCP but planned to do				
	so today.	110 1 0. Sat pla21 12 12				
	_	efused there should be				
		e MAR that showed the date				
		MA that attempted to				
	administer the medica	•				
		verage of citalopram 20mg				
	was because Resider					
		MA was clicking off as if the				
		inistered, instead of going				
		d showing the medication				
	was refused.	a onewing the medication				
	Interview with Reside	ent #5's primary care provider				
	(PCP) on 09/02/21 at					
	,	esident #5 on 08/13/21 and				
	adjusted another med					
	,	ty weekly and was not made				
		as not being administered				
	the citalopram 20mg.  -No one told her anything about the resident					
	refusing the medication	•				
	_	pression and did not like to				
	come out of her room					
		s not given for whatever				
		ould notify her to clarify how				
	the medication should					
		cation to be effective she				
		tion to be administered as				
	ordered.	non to be daminiotored de				
,	o. ao. oa.					

Division of Health Service Regulation

Based on observation, record review and

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL092023	B. WING		O9/02	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BROOKDA	ALE CARY		PEL HILL ROA	D		
		CARY, NO	27513			
(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 358	Continued From page	26	D 358			
	interview it was deter interviewable.	mined Resident #5 was not				
	The HWD was not av 09/02/21.	ailable for interview on				
	Interview with the Administrator on 09/02/21 at 5:13pm revealed: -The HWD was responsible for doing monthly cart audits.					
		ve identified Resident #5 alopram 20mg and				
	-If the resident was refusing the medication there should be documentation related to medication refusal.					
		notified when a medication .				
D934	G.S. 131D-4.5B. (a) A Requirements	ACH Infection Prevention	D934			
	G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements  (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount					
	determined by the De continuing education	partment, toward the requirements for adult care				
	home medication aides established by the					

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	IDENTIFICATION NOWBER.		A. BUILDING: _		COMPLETED	
		HAL092023	B. WING		C <b>09/02/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DD001/D		7870 CHAI	PEL HILL ROA	D		
BROOKD	ALE CARY	CARY, NC	27513			
(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 COMPL	ETE.
D934	Continued From page	÷ 27	D934			
2001	Continued From page 27  This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) who were employed as medication aides had completed the state approved annual infection control training.					
	The findings are:					
	Review of Staff B's, medication aide personnel record revealed: -Staff B was hired on 12/21/16There was documentation Staff B's last state approved infection control training was completed on 07/25/19There was no documentation of completion of the state approved infection control training since 07/25/19 available for review in Staff B's personnel record.  Telephone interview with Staff B on 09/02/21 at 11:50am revealed: -He had completed the state approved infection control training several timesHe did not remember participating in an infection control training recentlyThe Business Office Manager (BOM) had been keeping all of his infection control training certificates.					
	3:00pm revealed: -The BOM was respo staff records in the BO -The Health and Welli responsible for ensuri for competency require for the requirements of were assisted with so	nsible for maintaining the DM office. ness Director (HWD) was ing all staff were checked off rements, had documentation of the various positions or heduling and validating ments including infection				

Division of Health Service Regulation

STATE FORM 6899 OKHI11 If continuation sheet 28 of 34

Division of Health Service Regulation

Division of Health Service Regulation							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:		COMPLETED	
					С		
			B. WING		1		
		HAL092023	B. WING		09/0	)2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE			
			, ,	,			
BROOKD	ALE CARY		APEL HILL ROA	ע			
		CARY, NO	27513				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE	
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	CIATE	DATE	
D934	Continued From page	e 28	D934				
	control training.						
	Interview with the BO	M on 09/02/21 at 4:45pm					
	revealed:						
	-He became the BOM	/l in the middle of February					
	2021.						
	-He had not audited s	staff records for					
	completeness and do	ocumentation for required					
	staff qualifications.						
	-There was not a che	ck off list for staff					
	requirements that he	was aware of or could					
	locate.						
	-The HWD was respo	onsible to ensure MAs					
		ntrol training annually.					
		······································					
	The HWD was unava	ilable for interview from					
	08/31/21 to 09/02/21.						
	00/01/21 10 00/02/21:						
Door			Door.				
D935		ACH Medication Aides;	D935				
	Training and Compete	ency					
	G.S. § 131D-4.5B (b)						
		aining and Competency					
	Evaluation Requireme	ents.					
	, , ,	er 1, 2013, an adult care					
		om 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						
		ides training and instruction				[	
	in all of the following:	-					
	a. The key principles	of medication					
	administration.						
	b. The federal Centers for Disease Control and						

Division of Health Service Regulation

Prevention guidelines on infection control and, if

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Division of Health Service Regulation

Division of fleath Service Regulation				1		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					C	;
		HAL092023	B. WING	<del></del>	09/0	2/2021
NAME OF D	DOVIDED OD SUDDUJED	STREET AD	DDEEC CITY OTA	TE 710 CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
BROOKDA	ALE CARY	7870 CHA	PEL HILL ROA	D		
ומיטונים		CARY, NO	27513			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D935	Continued From none	- 20	D935			
Dasa	Continued From page	29	Dasa			
	applicable, safe inject	tion practices and				
		oring or testing in which				
	=					
	-	e potential for bleeding				
	exists.					
	(2) A clinical skills eva	aluation consistent with 10A				
	NCAC 13F .0503 and	I 10A NCAC 13G .0503.				
	(3) Within 60 days fro	m the date of hire, the				
		completed the following:				
	a. An additional 10-ho					
		partment that includes				
		on in all of the following:				
	1. The key principles	of medication				
	administration.					
	2. The federal Center	s of Disease Control and				
	Prevention guidelines	on infection control and, if				
	applicable, safe inject					
		oring or testing in which				
	=					
	~	e potential for bleeding				
	exists.					
		veloped and administered				
	by the Division of Hea	alth Service Regulation in				
	accordance with subs	section (c) of this section.				
	This Rule is not met	as evidenced by:				
		ews and interviews, the				
		e 2 of 3 sampled staff who				
	administered medicat					
		kills Competency Validation				
	(Staff A), and had successfully passed the written medication aide examination (Staff D).					
	The findings are:					
	-					
	Review of Staff D's, personal care aide					
		e (MA) personnel record				
	` '	e (www.) personner record				
	revealed:	10/00/00				
	-Staff D was hired on					
		e Medication Clinical Skills				
	Competency Validation	on on 05/07/21 and				

Division of Health Service Regulation

completed the 15-hour medication administration

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		COMPLETED		
			A. BUILDING: _			
					С	
		HAL092023	B. WING		09/02/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		7870 CHA	PEL HILL ROA	D		
BROOKD	ALE CARY	CARY, NO		_		
0/10/15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d 0/5	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
				DEFICIENCY)		
D935	Continued From page	30	D935			
	. •					
	training course on 04/					
		nentation Staff D passed the				
	written medication aid	le exam.				
	Review of 2 residents	' June 2021, July 2021 and				
		ic Medication Administration				
	Record (eMAR) revea					
	-Staff D documented					
	medications 10 days					
	-Staff D documented					
	medications 13 days	in July 2021.				
	-Staff D documented					
	medications 9 days in	n August 2021.				
	-	-				
	•	with Staff D on 09/01/21				
	and 09/02/21 at 11:30	am were unsuccessful.				
	Interview with the Adr	ministrator on 09/01/21 at				
	3:00pm revealed:	Tillistrator on 09/01/21 at				
	-The Business Office	Manager (BOM) was				
		aining the staff records in				
	the BOM office.					
	-The Health and Well	ness Director (HWD) was				
		ing all staff were checked of				
	for competency require	rements, had documentation				
	for the requirements of	of the various positions or				
	were assisted with sc	heduling and validating				
	completion of require	ments including MA training				
	and competency valid					
	-The HWD was responsible to ensure the					
		the training requirements				
	•	n MA examination in order				
	to pass medicationsThe BOM and HWD should assist each other to					
	ensure the facility was	s compliant with staff				
	requirements.	lo to pobodula taka sad				
		le to schedule, take and				
		n of successful passing of				
		within the 60 day restriction				
	ii tiley did flot flave do	ocumentation of previously	1			

Division of Health Service Regulation

STATE FORM 6899 OKHI11 If continuation sheet 31 of 34

Division of Health Service Regulation

DIVISION	n nealth Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
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		HAL092023	B. WING		09/02/2021	
		I INCOLUZO			UJIUZIZUZ I	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
BBOOKE	ALE CARV	7870 CH	APEL HILL ROA	D		
BROOKD	ALE CARY	CARY, N	C 27513			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE	
D935	Continued From page	e 31	D935			
	nagging the aver					
	passing the exam.					
	Interview with the BO	M on 09/02/21 at 4:45pm				
	revealed:	W 511 05/02/21 at 4.40pm				
		I in the middle of February				
	2021.	Thrane made or repracty				
	-He had not audited s	staff records for				
		cumentation for required				
	staff qualifications.	•				
	-There was not a che	ck off list for staff				
	requirements that he	was aware of or could				
	locate.					
	-The MAs were inform	ned upon hire and				
	completion of the Med					
		on by the facility HWD of the				
		ule and successfully pass				
		nation within 60 days of hire				
	as a MA.					
		onsible to ensure MAs				
		were in compliance with				
	staff requirements.	(ANIA)i-ti				
		nager (ANM) was assisting				
	the HWD was out of v	mpleted validations while				
	THE TIVED Was out OF V	WOIK.				
	The HWD was unava	ilable for interview from				
	08/31/21 to 09/02/21.					
	Review of Staff A's, medication aide (MA)     personnel record revealed:					
	-Staff A was hired on	07/05/21.				
	-Staff A passed the w	ritten MA exam on 09/26/13.				
		plete Medication Clinical				
		alidation partially completed				
	on 07/22/21.					
	=	ation administration on				
	09/02/21 at 7:30am re	evealed Staff A administered				

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5 medications to a resident.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′	A. BUILDING:		COMPLETED	
		HAL092023	B. WING		O9/02	2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
BBOOKE	N E CADY	7870 CHA	PEL HILL ROA	D			
BROOKDA	ALE CARY	CARY, NO	27513				
(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	(X5) COMPLETE DATE	
D935	Continued From page	32	D935				
	Review of 2 residents' August 2021 electronic Medication Administration Record (eMAR) revealed Staff A documented the administration of medications 15 days in August 2021.  Interview with the Area Nurse Manager (ANM) on 09/02/21 at 12:30pm revealed: -MAs routinely have training at a designated facility not this facilityThe MA should have returned from the off-site training with a partially completed Medication Clinical Skills Competency Validation completed by the training nurseThe nurse at the MA's assigned facility would be responsible to complete the Medication Clinical Skills Competency Validation to include the validations for the particular facility and sign off for the MAStaff A's Medication Clinical Skills Competency Validation had not been completed by the current facility nurse.  Interview with Staff A on 09/02/21 at 1:10pm revealed: -She had the Medication Clinical Skills Competency Validation partially completed on 07/22/21 at another facility as part of her orientationShe did not know she should have the remaining items on the Medication Clinical Skills Competency Validation completed by the nurse in current facilityShe had not had additional competencies validated by the facility nurse.						
	Interview with the Adr 3:00pm revealed: -The Business Office	ministrator on 09/01/21 at  Manager (BOM) was					

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the BOM office.

responsible for maintaining the staff records 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		
		HAL092023	B. WING		C 09/02	2/2021
	ROVIDER OR SUPPLIER		RESS, CITY, STA			
(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	(X5) COMPLETE DATE
D935	responsible for ensure for competency requirements of were assisted with so completion of requirements.  Interview with the BO revealed: -He became the BOM 2021He had not audited so completeness and do staff qualificationsThere was not a che requirements that he locateThe HWD was responsasing medications staff requirementsThe Area Nurse Man with ensuring staff co the HWD was out of were the staff requirements.	ness Director (HWD) was ing all staff were checked of rements, had documentation of the various positions or heduling and validating ments including MA training  M on 09/02/21 at 4:45pm  I in the middle of February  staff records for cumentation for required ock off list for staff was aware of or could ensible to ensure MAs were in compliance with lager (ANM) was assisting mpleted validations while work.	D935			

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