STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey with an onsite visit from January 19, 2022 - January 20, 2022 and a desk review survey on January 21, 2022 with a telephone exit on January 21, 2022.	{D 000}		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 exit doors accessible for residents' use on the Assisted Living (AL) sections had a sounding device that activated for safety for 9 of 9 sampled residents (#1, #2, #3, #6, #7, #8, #9, #10, #11) who were all assessed to be intermittently disoriented and assessed to have wandering behaviors (#1). The findings are:	D 067		

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D 067	Continued From page 1	D 067		

Observation of the facility's front entrance door on 01/19/22 at 8:45am revealed:
-There was no doorbell on the exterior of the door, door frame, or wall.
-The door was not locked, and entrance was easily accessed.
-There was not an audible alarm when the front entrance door was opened.
-A keypad was located to the right of the front door on the interior wall.
-A red switch labeled "Maglock Override" was located to the left of the keypad.
-The switch was flipped to the down position.
-A clear plastic cover was over the red switch; it was labeled "Maglock Override" and the words "Lift Here" at the bottom of the cover; it was no locked.

Interview with a medication aide/personal care aide (MA/PCA) on 01/19/22 at 2:19pm revealed:
-She had been working at the facility on a part-time basis.
-The facility's front entrance door "usually" alarmed when the door was opened.
-When she entered the facility through the front entrance door Monday, 01/17/21, the sounding device on the door did not alarm.
-She thought the facility's front entrance door did not alarm because the sounding device needed new batteries.
-Most of the residents residing on the AL section of the facility had "a touch" of disorientation, however, none of the residents wandered outside.

Interview with the Administrator on 01/19/22 at 2:26pm revealed:
-She thought the sounding device on the front entrance door was working yesterday, 01/18/22.
-She installed new batteries in the sounding

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 067	Continued From page 2 device on the front entrance door today, 01/19/22. Observation of the front entrance door of the AL section of the facility on 01/19/22 at 3:45pm revealed an audible alarm sounded when the door was opened. Interview with a resident in the AL section hallway near the facility's front entrance door on 01/19/22 at 3:45pm revealed she had never heard that "noise" when the front entrance door on the AL section was opened. Observation of the door exiting to the smoking area on 01/19/22 at 2:35pm revealed: -There was no audible sound when the door was opened. -There was an iron gate surrounding the area with 2 unlocked doors in the gate. Interview with a second resident in the smoking area on 01/19/22 at 2:59pm revealed: -He had never exited out the exterior iron gate door. -He saw other residents go out the exterior iron gate door when they had visitors. Interview with a housekeeper on 01/19/22 at 8:00am revealed: -She heard the door alarm sounding device today. -She had heard it before, but it was sometime last year. -She had not seen any residents wander out the doors. -She had never heard a door alarm sound at the exit door to the smoking area. Interview with the facility Maintenance Person on 01/19/22 at 1:10pm revealed:	D 067		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 067	Continued From page 3	D 067		

-The front door was unlocked from 8:00am to 7:00pm daily and locked 7:00pm to 8:00am nightly.
-The override switch was used to keep the front door unlocked during the day.
-The door was unlocked when the switch was flipped in the down position.
-The staff would know if a resident tried to override the locked door at night because there was a loud alarm when the clear cover was lifted to access the red override switch.

Observation of the Maglock Override switch cover on 01/19/22 at 1:12pm revealed a loud audible alarm sounded when lifted to access the switch.

1. Review of Resident #1's current FL-2 dated 08/20/21 revealed:
-The resident was ambulatory.
-The resident was intermittently disoriented.
-The resident wandered.

Review of Resident #1's current care plan dated 08/17/21 revealed:
-The resident was assessed by staff to exhibit child-like ways.
-The resident was sometimes forgetful and disoriented, and needed reminders.
-The resident was non-verbal.

Interview with the Medication Aide/Supervisor (MAS) on 01/19/22 at 11:05am revealed:
-Resident #1 wandered in other resident rooms.
-Resident #1 did not talk.
-Resident #1 was "like a child".
-Staff kept Resident #1 in the dayroom so the resident could be monitored.

Interview with the Administrator on 01/19/22 at 4:17pm revealed:

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 067	Continued From page 4	D 067		

-There were no residents living in the AL section of the facility who were assessed to be wanderers.
-She was not aware Resident #1 was assessed to be a wanderer and intermittently disoriented according to the resident's FL-2.

Interview with Resident #1's Primary Care Provider (PCP) on 01/20/22 at 2:37pm revealed:
-Resident #1 was a wanderer.
-She had no concerns about Resident #1 eloping from the facility and was not aware of any resident elopements from the facility.
-She would not be surprised if there was an elopement by another resident (named).
-She heard the door alarm sound when she entered the facility on 01/20/22, and it was loud and caught her off guard.

Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm.

2. Review of Resident #7's current FL-2 dated 09/13/21 revealed the resident was intermittently disoriented.

Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm.

3. Review of Resident #2's current FL-2 dated 09/24/21 revealed resident was intermittently disoriented.

Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm.

4. Review of Resident #3's current FL-2 dated 08/17/21 revealed:
-The resident was semi-ambulatory with a walker/rollator.

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 067	Continued From page 5 -The resident was intermittently disoriented. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. 5. Review of Resident #6's current FL-2 dated 10/20/21 revealed: -The resident was semi-ambulatory with a walker/rollator. -The resident's orientation status was blank. Review of Resident #6's current assessment and care plan dated 10/21/21 revealed the resident was sometimes disoriented, forgetful and needed reminders. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. 6. Review of Resident #8's current FL-2 dated 09/17/21 revealed: -The resident was semi-ambulatory. -The resident was intermittently disoriented. Observation of the smoking area on 01/19/22 at 3:10pm revealed: -Resident #8 was seated in his wheelchair in the smoking area. -There were no staff in the smoking area. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. 7. Review of Resident #9's current FL-2 dated 02/15/21 revealed: -The resident was semi-ambulatory. -The resident was intermittently disoriented. Observation of the smoking area on 01/19/22 at 3:02pm revealed:	D 067		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 067	Continued From page 6 -Resident #9 was seated in his wheelchair in the smoking area. -There were no staff in the smoking area. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. 8. Review of Resident #10's current FL-2 dated 01/18/21 revealed: -The resident was semi-ambulatory. -The resident was intermittently disoriented. Observation of the smoking area on 01/19/22 at 2:41pm revealed: -Resident #10 was seated in her wheelchair in the smoking area. -There were no staff in the smoking area. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. 9. Review of Resident #11's current FL-2 dated 05/27/21 revealed: -The resident was semi-ambulatory. -The resident was intermittently disoriented. Observation of the smoking area on 01/19/22 at 2:41pm revealed: -Resident #11 was seated in her wheelchair in the smoking area. -There were no staff in the smoking area. Refer to the telephone interview with the Administrator on 01/21/22 at 2:00pm. _____ Telephone interview with the Administrator on 01/21/22 at 2:00pm revealed: -The purpose of sounding devices on the exit doors on the AL section of the facility was for staff to be alerted when the exit doors were opened.	D 067		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 067	Continued From page 7 -It was important to have a sounding device on all the exit doors because there were residents assessed with disorientation. .	D 067		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the heating system maintained a temperature of 75 degrees Fahrenheit under winter conditions resulting in residents feeling cold and or uncomfortable. The findings are: Observation of resident room #404 on 01/19/22 at 10:24am revealed the resident was lying in bed wrapped in a blanket that covered her body with only her face exposed. Interview with the resident residing in resident room #404 on 01/19/22 at 10:24 am revealed: -She felt cold and had felt cold in her room for about 2-3 weeks. -She did not remember if she reported being cold to anyone at the facility.	D 106		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

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D 106	Continued From page 8 Observation of resident room #315 on 01/19/22 at 10:40am revealed: -The room was considerably colder than other resident's rooms and the 300 Hallway. -The resident was covered by two comforter style blankets with her hands tucked in under her chin. -She was wearing sweatpants, a sweatshirt, and socks. Interview with the resident residing in resident room #315 on 01/19/22 at 10:40am revealed: -Her room was always cold, and she always slept with two blankets. -The room was much colder than usual this past week because of the colder weather. -She had reported the cold room temperature to staff in the past, but it "doesn't do any good". -She cannot recall when or to whom she last reported the cold temperatures. -She has had cold-like symptoms for the past few days; runny nose, cough and congestion that she felt were caused by the cold room temperature. Interview with a resident assigned to resident room #412 on 01/19/22 at 3:10pm revealed: -The heat in his room had not worked correctly for last few months. -When outdoor temperatures were warm during the daytime, he could feel heat in his room, however, when outdoor temperatures were very cold at night, hot air would not blow from the vents in his room. -When outdoor temperatures dropped into the 20's - 30's at night, his room felt cold and he had to "bundle up" with blankets to stay warm during the night. -When outdoor temperatures were cold all day and all night, then his room stayed cold, day and night.	D 106		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 9 -He had "told and told" the facility's Maintenance Person about the lack of heat in his room. -He had reported the cold room temperatures in his room to the Maintenance Person at least 3 - 4 times, however he was unable to recall the last time he had reported the lack of heat in his room. -The lack of heat in his room made him feel uncomfortable. -His blood was "thin" because he took a blood thinner medication which caused him to be "cold, cold" and more sensitive to cold temperatures. -He knew the Maintenance Person had checked the heating/air unit outside that controlled his room (no date provided). -The heating/air unit would "freeze up" and the Maintenance Person would shut the heating/air unit down to allow the unit to thaw out, however the unit would eventually freeze up again, causing the cold room temperatures in his room. -The outside walls of the facility were made from cinder blocks which made the room feel colder with the lack of heat in his room. -The resident had not been sick from the varying temperatures in his room. -He was concerned about the heat availability in his room with the upcoming winter storm projected in the coming days. -He had never reported the cold room temperatures to the Administrator because he had reported it to the Maintenance Person. Interview with a second resident assigned to resident room #412 on 01/19/22 at 3:14pm revealed: -His room was stayed cold. -He had to "Wrap up" in blankets when the room was cold at night. Interview with the Maintenance Person on 01/19/22 at 3:23pm revealed:	D 106		

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D 106	Continued From page 10	D 106		

-Different residents on the 300 and 400 halls had mentioned their rooms were cold.
-He checked rooms by going into the room and would "feel for hot air".
-He talked to the corporate Maintenance Supervisor when concerns came up about the room temperatures and would be instructed to cut the heating unit off, then turn it back on and "maybe" the heating unit would reset.
-When the heating unit was turned off, it took about 30 minutes to one hour for the heating unit to warm back up.
-The Unit 10 heating unit that serviced the 400 hall rooms, including rooms 410 and 412, was not working and a heating and air conditioning company came to the facility.
-He would provide a copy of the service report for review.
-It had been a "couple weeks" since he talked to the Administrator about the heating in residents' rooms.
-He did not have a thermometer to check the resident's room temperatures.
-Different residents had mentioned concerns with the heating in their room, it was never the same resident that had concerns with their rooms being cold.
-Facility staff were "messing" with the heating/air thermostats which had caused the units to freeze up.
-The heat source would not come on in resident rooms if the room temperature was warmer than what the thermostat was set on.
-He was not an "air conditioner tech".

Review of a service invoice from the facility's contracted heating and air company dated 11/05/21 revealed unit 10 was found not heating due to a bad outdoor extension valve; system on " e heat at as of now"; pricing and part availability

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FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 11	D 106		

would be completed on Monday, (11/08/21).

Review of a service invoice from the facility's contracted heating and air company dated 11/18/21 revealed:
-Unit 10 was serviced with replacement of refrigerant and repairs completed.
-The system was operating properly at that time.

Observation of resident room #414 on 01/19/22 at 3:36pm revealed:
-The room's ceiling vent for the heating and air was near the residents' bed.
-The vent was in a closed position preventing the free flow of air into the room.

Interview with the resident assigned to room #414 on 01/19/22 at 3:36pm revealed:
-It was usually freezing at night in his room.
-He had mentioned the cold room temperatures at night to "someone" (a staff) but nothing was done about it.

Interview with the Maintenance Person on 01/19/22 at 3:38pm revealed:
-All the thermostats for the units were in the closed hallway leading to the offices of the Administrator and other management staff.
-No one was checking the settings of the heating and air thermostats.
-He and the corporate Vice President of Maintenance (VPM) had previously discussed possible ways to lock the thermostats that controlled the heating and air to limit staff's ability to adjust the settings of the thermostats (no date provided).

Interview with the Administrator on 01/19/22 at 3:55pm revealed:
-There had not been any recent concerns about

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FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 12	D 106		

the heat since the last time the facility was surveyed (11/2021).
-She thought a local heating and air conditioning company had installed a new fan or motor to a heating unit at the facility.
-She had not been notified by the Maintenance Person about any resident complaints of being cold in their rooms or any staff adjusting the heating thermostats.
-She would expect the thermostats to be set for the residents' comfort.
-The temperature control thermostats were on the wall in the administrative office and were set between 72 and 74 degrees.
-She usually looked at the thermostat settings in the morning when she came to work.
-If there was an issue with the heating, the Maintenance Person was supposed to contact the corporate VPM.
-She was not aware the heating unit in the facility was supposed to be able to maintain heat at 75 degrees Fahrenheit (F).

Observation of temperatures in resident room #412 using an infrared thermometer on 01/19/22 at 5:30pm revealed:
-A reading of 72.5 degrees F was obtained at the ceiling vent.
-A reading of 72.1 degrees F was obtained in the room.

Observation of temperatures in resident room #410 using an infrared thermometer on 01/19/22 at 5:33pm revealed:
-The entrance door to the room was closed.
-A reading of 71.4 degrees F was obtained at the ceiling vent.
-A reading of 74.3 degrees F was obtained at a second ceiling vent located close to the rooms entrance door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 106	Continued From page 13 -A reading of 72.3 degrees F was obtained in the room. Observation of temperatures in resident room #315 using an infrared thermometer on 01/19/22 at 5:37pm revealed: -The entrance door to the room was in a closed position. -The warm felt cold. -A reading of 88.2 degrees F was obtained at the ceiling vent. -A reading of 73.6 degrees F was obtained at a second ceiling vent located close to the rooms entrance door. -A reading of 67.5 degrees F was obtained in the room. Observation in the 300-hallway using an infrared thermometer on 01/19/22 at 5:37pm revealed a reading of 73.8 degrees F was obtained at the ceiling vent located near resident room #315. Interview with the Administrator on 01/20/22 at 7:36am revealed: -She met with staff who denied adjusting the facility's thermostats to the heating/air units. -She adjusted all the thermostats to 75 degrees, however the thermostats reset back to 70 degrees F. -There was "something" in the programming of the thermostats that read "permanent hold". -She changed the "permanent hold" setting to 75 degrees F. -She instructed staff to check the thermostats to the heating/air unit every 2 hours last night (01/19/22) to ensure the setting did not revert to 70 degrees F. -She had not checked in the resident rooms yet to ensure there were no issues with the heat during the night.	D 106		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 14 Observation of the thermostats of the heating and air conditioning units at the facility on 01/20/22 at 8:00am revealed: -Eleven thermostats were lined up on a wall in a hallway near the Administrator's office numbered from 1-11. -Each thermostat regulated the temperature in a certain area in the facility. -The thermostat of unit #10 was set at 75 degrees Fahrenheit but the temperature read 66 degrees Fahrenheit. A second interview with the resident residing in room #412 on 01/20/22 at 8:15am revealed: -His room was cold again last night, 01/19/22. -The heat turned off in his room at around 4:00am on 01/20/22 and "did not come back on or blow warm air". -He bundled up with blankets to keep warm. Observation of the temperatures in resident room #412 on 01/20/22 at 8:18am revealed: -The temperature of the outside wall with a window was 67.3 F. -The temperature of the interior wall parallel to the hallway was 66.4 F. -The temperature of the air blowing from the air in the center of the room was 65.7 F. Observation of the facilities thermostats on 01/20/22 at 8:20am revealed all thermostats were set at 75.0 F. Interview with a staff on 01/20/22 at 8:00am revealed: -The temperature in resident rooms were "up and down". -The beginning of the hall to the middle of the hall was really warm, and the middle of the hall to the	D 106		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 15	D 106		

end of the hall was cooler.
-It was "always" cold in one room on the end of 300 hall, and the residents in that room were "always bundled up".

Interview with a second staff on 01/20/22 at 8:17am revealed:
-Some residents had complained that their rooms were cold.
-A resident (named) would ask for another blanket before the staff left work.
-A resident on the 400-hall complained of cold air blowing out of the vent and would say that about three times a week.
-The staff would usually let the Maintenance Person know when the residents complained.
-Sometimes the staff would go in the room on the 400-hall and the air coming out the vent felt like "a little breeze".

Interview with a third staff on 01/20/22 at 9:16am revealed:
-The building temperature was usually warmer in the halls than resident rooms.
-The rooms closer to the end of the hall tended to be cooler.
-A resident on the 400-hall "always" complained about the room being too hot or too cold.
-She checked the thermostat setting once when she worked second shift and they were set at 72- or 73-degrees Fahrenheit.
-If the residents complain, she would get them an extra blanket.
-She had not notified the Administrator of resident complaints about their room temperatures.

Interview with a fourth staff on 01/20/22 at 2:15pm revealed:
-Named residents on the 400-hall would mention they were cold at night.

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 106	Continued From page 16	D 106		

-She provided extra blankets for the residents.
-It was "kind of cool" by rooms 412 and 414.

Interview with the Administrator on 01/20/22 at 1:26pm revealed:
-She contacted the facility's contracted heating and air conditioning company today, 01/20/22 because the thermostat setting for unit 10 had dropped back to 70 degrees F.
-The contracted heating and air conditioning company would make a service call today, 01/20/22.

Interview with the repair technician with the facility's contracted heating and air conditioning company on 01/20/22 at 1:36pm revealed:
-He received a work order for the facility due unit #10 not heating.
-Services were provided for the facility on an as needed basis.\
-The last services provided for the facility's heating and air units prior to today (01/20/22) was 11/22/21.
-Unit #10 was assessed and found to need an auxiliary heat strip.
-The need for an auxiliary strip could have affected the residents room temperatures in the middle of the night when the temperatures were really cold outside, the unit would form ice, would go into default mode causing the room to receive cold air briefly; no one would know about the temperature change in the room unless they were in the room.

Telephone interview with the Resident Care Manager (RCM) on 01/21/22 at 12:16pm revealed:
-The contracted heating service and repair company was at the facility in November 2021 for service and repair of a unit on the 400 Hallway.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 106	Continued From page 17 -Residents had not reported problems with their rooms heating since November 2021. -Staff had not reported residents' complaints of cold rooms to her between the dates of November 2021 to present. -She expected staff to report resident complaints and concerns to her immediately. -Staff members had access to her cell phone number and were instructed to call her anytime there is a resident issue. -Maintenance Personnel had not reported any resident concerns regarding their rooms being cold to her between November 2021 and present. -Staff members, such as medication aides (MAs) and personal care aides (PCAs), the RCM, and the Maintenance Person attended a "Stand-Up" meeting each shift change for reporting any issues or concerns regarding residents and/or the facility to the oncoming staff. -She was expected to notify the Administrator of any reports she received from staff concerning resident issues or concerns. -She was unable to notify the Administrator of the heating issues in resident rooms because she was not aware of the issue. -The facility Maintenance Person contacted the corporate VPM for guidance if he was unable to successfully repair facility appliances. -She was not sure of the corporate process of contacting service or repair companies after the facility Maintenance Person reported issues to the VPM. Telephone interview with the Administrator on 01/21/22 at 2:00pm revealed she expected to be notified of the residents' concerns related to the lack of heat in resident rooms in order to follow-up on the situation for the residents. The facility failed to ensure the facility	D 106		

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	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 106	Continued From page 18 temperature was maintained at 75 degrees Fahrenheit (F) during winter conditions which resulted in insufficiently heated resident rooms with temperatures as low as 66 degrees F and residents feeling cold and uncomfortable. The failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes an Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/24/22 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 20, 2022.	D 106		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by:	D 612		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 19 Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to delayed COVID-19 testing for residents residing in the Assisted Living Section of the facility.. The findings are: Review of the CDC guidelines dated 09/10/21 for Interim infection prevention and control recommendations to Prevent SARS-CoV-2 in long term care facilities revealed: -A strong infection prevention and control program was critical to protect both residents and healthcare personnel. -When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. -If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility). -Broader approaches might also be required if the facility was directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. -Perform testing for all residents and health care personnel (HCP) on the affected unit(s), regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later.	D 612		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 20 Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed facilities should adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 96 beds including a special care unit (SCU) with a census of 40 residents. Review of the facility's resident census report dated 01/19/22 revealed there was a memory care unit (MCU) census of 37 residents and an Assisted Living (AL) census of 48 residents. Interview with the Administrator on 01/19/22 at 9:05am revealed: -In house COVID-19 testing for residents was performed at the facility on 01/11/22 in the MCU after a resident who resided in the MCU tested positive for COVID-19 on 01/10/22 during a hospital visit. -There were 16 residents in the MCU that tested positive for COVID-19 on 01/11/22. -The facility had not performed any COVID-19 testing of the residents since 01/11/22. -She was waiting for an outside agency to come to the facility to perform resident COVID-19 testing. -She had 25 boxes of COVID-19 rapid test on hand to use. -Residents living in the AL section of the facility had not been tested for COVID-19. -The local health department was involved with facility management of COVID-19. -The corporate clinical nurse and Division Vice	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 612	Continued From page 21	D 612		

President were involved in the system/policy used at the facility to monitor residents for COVID-19.

Interview with a member of the Coronavirus 2019 (COVID-19) Response Team member at the county health department on 01/21/22 at 11:57am revealed:
-She was the Outbreaks and Clusters Contact Tracer for the county.
-She was the contact person to be notified when the facility's residents or staff tested positive.
-She became aware residents tested positive in the memory care unit (MCU) at the facility on 01/10/22.
-She contacted the facility's Administrator on 01/10/22 by telephone regarding the facility's outbreak status.
-Outbreak status was defined by two or more positive residents or staff within a 14-day period.
-She emailed the facility's Administrator on 01/10/22 a copy of the COVID-19 Toolkit for Post-Acute Care Settings for guidance.
-The facility should conduct facility-wide COVID-19 testing when resident(s) in one unit tested positive, unless there was a separate entrance/exit, separate kitchen and no staff from the affected unit entering the unaffected unit(s).
-She was not aware the facility did not conduct COVID-19 testing for residents in the AL section.

Telephone interview with the Administrator on 01/21/22 at 11:50am revealed:
-On 01/20/22, an outside provider completed COVID-19 testing for the 19 residents residing on the SCU who had negative results when COVID-19 testing was done by the facility on 01/11/22.
-She had not received any results for the MCU residents COVID-19 test results yet.
-The outside provider would return to the facility

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 612	Continued From page 22	D 612		

on 01/24/22 to complete COVID-19 testing on all the resident residing on the AL section of the facility.
-The local health department (LHD) had provided the facility with written guidance and recommendations regarding COVID-19 when COVID-19 first began.
-She had not received any information from the LHD regarding guidance or recommendations for COVID-19 testing for the residents however, she had ongoing correspondence with the communicable disease nurse with the LHD because she sent the positive COVID-19 test results forms to her.
-The facility received COVID-19 guidance and recommendation updates from DHHS and CDC through the adult home specialists (AHS).
-The facility followed the facility's corporate written guidance and recommendations for COVID-19.
-The facility's corporate guidance and recommendations followed the same recommendations and guidance from DHHS and CDC guidance.

A Second telephone interview with the Administrator on 01/21/22 at revealed:
-An outside provider would complete COVID-19 testing for all the residents residing on the AL section of the facility on 01/24/22.
-Residents on the AL section of the facility were not tested for COVID-19 because the "outbreak" of COVID-19 was on the MCU.
-Since the outbreak of the MCU residents testing positive for COVID-19, she had been working with two outside providers to complete COVID-19 testing for the AL section since 01/10/22 or 01/11/22.
-The outside provider could not complete COVID-19 testing for the entire facility on

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
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 612	Continued From page 23	D 612		

01/20/22 due to the outside providers scheduling and staffing, and would return Monday, 01/24/22 to perform COVID-19 testing for the residents residing on the AL section of the facility.
-The residents on the AL section of the facility had not been tested for COVID-19 since the residents in the MCU tested positive for COVID-19.
-The facility had rapid COVID-19 testing kits available for staff testing but she was now aware those test kits could be used to test the residents.
-She was not planning to use the COVID-19 tests she had on hand for resident testing until the "outbreak' occurred on the MCU.
-Residents on the AL section of the facility were not tested for COVID-19 on 01/11/22 because daily temperature checks and COVID-19 screening questions were completed.
-Since there had been no AL residents with COVID-19 symptoms, she was attempting to schedule an outside provider to complete COVID-19 testing for the AL residents, however, she did not realize it would take the outside provider one week to 10 days to provide a COVID-19 test date for the residents.
-When the outbreak of COVID-19 occurred in the MCU, the LHD sent her a toolkit for COVID-19 guidance and recommendations.

Telephone Interview with the facility's Divisional Clinical Director on 01/21/22 at 255pm revealed:
-When residents tested positive for COVID-19, the facility followed guidelines from the LHD.
-When there were residents who tested positive for COVID-19, the facility established and implemented COVID-19 testing and symptom monitoring guidelines for the residents.
-She was not aware the residents residing on the AL section were not tested for COVID-19 on 01/11/22.
-She had concerns that the facility could have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051060	A. BUILDING: _____ B. WING _____	R 01/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

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D 612	Continued From page 24 continued spread of the COVID-19 infection throughout the facility when COVID-19 testing was not completed for the residents residing on the AL section of the facility. -A directive was provided to the Administrator on 01/09/22 to perform COVID-19 testing on all the residents at the facility. -The residents residing on the AL section of the facility would be tested for COVID-19 today, 01/21/22. -When a resident tested positive for COVID-19, it was expected all residents were tested for COVID-19 which included residents residing on the AL sections of the facility.	D 612		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the heating system maintained a temperature of 75 degrees Fahrenheit under winter conditions resulting in	{D912}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D912}	Continued From page 25 residents feeling cold and or uncomfortable. [Refer to Tag D0338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].	{D912}		