Division of Health Service Regulation				FORW APPROVE	۔	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
TRE' MOR	E MANOR ALF		NE TOWN ROAD D, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ē
D 000	Initial Comments		D 000			
	The Adult Care Licenary annual survey on Mar	sure Section conducted an rch 23-24, 2022.				
D 131	10A NCAC 13F .0406	6(a) Test For Tuberculosis	D 131			
	(a) Upon employmer home, the administra any live-in non-reside tuberculosis disease measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, This Rule is not met Based on record revidenciality failed to ensure B) were tested for tube hire.	Test For Tuberculosis at or living in an adult care tor and all other staff and ents shall be tested for in compliance with control of the Commission for Health in 10A NCAC 41A .0205 amendments and editions. It is available at no charge by ement of Health and Human is Control Program, 1902 Raleigh, NC 27699-1902. The entry of t				
	personnel record reversible was hired on 03	/14/22 as a PCA. nentation of a TB skin test				
	revealed: -She had completed a -She thought she cou her previous TB skin	ed a TB skin test since her				

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

TITLE (X6) DATE

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL039018	B. WING		03/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	ΓE, ZIP CODE	
TDELMOR	E MANOR ALE	6016 PIN	E TOWN ROAD		
I RE' WOR	RE MANOR ALF	OXFORE	, NC 27565		
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETE
D 131	Continued From page 1		D 131		
D 234	12:50pm revealed: -Staff were told when needed to bring docu TB skin testIf staff did not provid completed TB skin te TB skin test to themShe did not have any when the facility oper not provided testing the without documentation testThe TB testing solution 03/22/22 and she plates TB skin tests to new TB skin testsStaff B told her that stest which was negated the documentationShe told Staff B that administer another TI she was responsible had a completed TB staff TB shall be tested to the shall be tested	y of the TB testing solution ned on 02/28/22, so she had o any newly hired employee on of a completed TB skin sion was delivered on nned to begin administering employees who needed a she had a previous TB skin live, but she did not provide she would have to B skin test to her. It is for ensuring employees skin test upon hire. B(a) Tuberculosis Test, munizatio	D 234		
	subsequent amendm the rule are available	or Health Services as C 41A .0205 including ents and editions. Copies of at no charge by contacting ealth and Human Services			

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMING TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED	
TRE' MORE MANOR ALF 6016 PINE TOWN ROAD OXFORD, NC 27565 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 6016 PINE TOWN ROAD OXFORD, NC 27565 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMING CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)			HAL039018	B. WING		03	/24/2022
TRE' MORE MANOR ALF OXFORD, NC 27565 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG OXFORD, NC 27565 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TRE' MOI	RE MANOR ALF					
D 204 O 11 15 O	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #2's current FL-2 dated 02/28/22 revealed diagnoses included major depressive disorder, hypertension, hypothyroidism, chronic kidney disease stage 4, chronic anemia, chronic gout, hypokalemia, hyperparathyroidism, primary osteoarthritis of bilateral knees, and unspecified edema. Review of Resident #2's Resident Register revealed there was an admission date of 02/28/22. Review of Resident #2's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test read as negative on 12/26/18 without documentation of a given dateThere was no documentation of a second TB skin test. Interview with Resident #2 on 03/23/22 at 6:15pm revealed: -He had TB skin tests in the past, but he could not remember the dateHis TB skin tests in the past, but he could not remember the dateHis TB skin test was negativeHe did not remember having another TB skin test once he was admitted.	D 234	Tuberculosis Control Center, Raleigh, Nor Center, Raleigh, Nor This Rule is not met Based on record rev facility failed to ensu (#2) had completed to testing in compliance for the Commission of the Commission of the General Review of Resident of 2/28/22 revealed didepressive disorder, hypothyroidism, chronic anemia,	Program, 1902 Mail Service th Carolina 27699-1902. as evidenced by: iews and interviews, the re 1 of 3 sampled residents two-step tuberculosis (TB) with the control measures for Health Services. #2's current FL-2 dated agnoses included major hypertension, onic kidney disease stage 4, onic gout, hypokalemia, primary osteoarthritis of unspecified edema. #2's Resident Register an admission date of #2's tuberculosis (TB) skin thation of a TB skin test read s/18 without documentation of mentation of a second TB ent #2 on 03/23/22 at 6:15pm as in the past, but he could ate. Se negative. Er having another TB skin	D 234			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
TRE' MOR	E MANOR ALF		NE TOWN ROAD			
	-	OXFOR	D, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 234	(RCC) on 03/24/22 at -The residents had the admission, and the secompleted by the Adr Registered Nurse (RI Professional Support from the facility contra-He did not have Respaperwork on the spreadetermine when docu-He thought Resident might be in another fi a resident of the facility-He or the Administrated admissions and the particle. The Administrator was the residents obtained Interview with the Administrator was the residents obtained Interview with the Administrator was responsible a completed TB skin facility. She thought Resident test upon admission. She had completed a was transferred from another facility locate. She did not know who Resident #2's TB skir	sident Care Coordinator t 11:53am revealed: teir first TB skin test upon econd TB skin test was ministrator who was a N), the Licensed Health (LHPS) nurse or the nurse acted pharmacy. ident #2's admission eadsheet he maintained to ments required updates. the because Resident #2 was they with the former owners. tor managed new maperwork. The second TB skin test the second TB skin test. The for ensuring defined the second TB skin test the for ensuring residents had test upon admission to the the previous facility to d in another town. The second TB skin test the foreign test when he the previous facility to d in another town. The second TB skin test the foreign test was located but she mentation of a first and	D 234			
D 290		l(c)(1) Nutrition And Food	D 290			
	10A NCAC 13F .0904 (c) Menus in Adult Ca	Nutrition And Food Service are Homes:				

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
			IE TOWN ROAD	ZII GODE		
TRE' MOF	RE MANOR ALF), NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 290	advance with serving	epared at least one week in quantities specified and in Daily Food Requirements in	D 290			
	failed to ensure week guidance of food serv	ns and interviews, the facility ly menus were available for				
	The findings are:					
	-	chen on 03/23/22 at 9:18am o weekly menu available for				
	03/23/22 at 9:20am re	trance to the dining room on evealed there was a daily nu did not list portions.				
	9:18am revealed the slice of French toast,	eakfast meal on 03/23/22 at residents were served one approximately 8 ounces of late chip muffins, and 3 to 4 offee and milk.				
	4:09pm revealed: -The residents were s ounces of meatloaf, 8 ounces of macaroni a	served approximately 8 ounces of baked beans, 8 and cheese and lemonade.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
TDE' MOD	E MANOR ALF		TOWN ROAD			
TRE WOR	E MANOR ALF	OXFORD,	NC 27565			
(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 COMPLE	ETE
D 290	Continued From page	÷ 5	D 290			
	light meal or a snack -The portions were big -They usually ate two a snack or a sandwick -They did not get hun snacks a day between	g, so they did not go hungry. meals a day and could have h in the evening. gry because they got three				
	4:43pm revealed: -She did the cooking of facilityShe did not have a wowner was responsibleShe used the daily moutside of the dining of preparing mealsShe had cooked for time, so she was family	for the residents at the reekly menu to follow; the le for the menus. The reekly were posted				
	at 4:48pm revealed: -The facility had just of vendors and he was of previous food vendorsHe had daily menus computer, so he printeresidents and for guidents.	printed and stored in his ed them out for the lance. eek at a glance menu, and				
D 296	10A NCAC 13F .0904 Service	(c)(7) Nutrition And Food	D 296			
	10A NCAC 13F .0904 (c) Menus in Adult Ca	Nutrition And Food Service Are Homes:				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		00/1 1/2021	
TDE' MOD	E MANOR ALF	6016 PINE	TOWN ROAD			
TICE WOR	OXFORD,		NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 296	Continued From page	e 6	D 296			
		nave a matching therapeutic ician-ordered therapeutic food service staff.				
	facility failed to have in for use as guidance in therapeutic diets for 3 #4) who were ordered	and record reviews, the matching therapeutic menus				
	The findings are:					
		chen on 03/23/22 at 9:18am o therapeutic diet menus ollow.				
	03/23/22 at 9:20am re	trance to the dining room on evealed there was a daily nu did not list therapeutic				
		t #1's FL-2 dated 03/01/22 n order for a pureed diet.				
	Refer to interview with 03/23/22 at 4:43pm.	n the Administrator on				
	Refer to interview with 03/24/22 at 10:48am.	n the facility owner on				
	2. Review of Residen revealed there was an concentrated sweet d					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
AIND LEVIN	51 CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING: _		COMPL	-120
		HAL039018	B. WING		03/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TRE' MOE	E MANOR ALF	6016 PINE	TOWN ROAD			
TIVE INION	E MANOR ALI	OXFORD,	NC 27565			
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 296	Continued From page 7		D 296			
	Refer to interview with 03/23/22 at 4:43pm.	h the Administrator on				
	Refer to interview with 03/24/22 at 10:48am.	h the facility owner on				
	-	t #4's FL-2 dated 02/28/22 n order for a mechanical soft				
	Refer to interview with the Administrator on 03/23/22 at 4:43pm. Refer to interview with the facility owner on 03/24/22 at 10:48am.					
	4:43pm revealed:	ministrator on 03/23/22 at				
	facility.	for the residents at the				
		veekly menu to follow nor a u; the owner was responsible				
	-She used the daily moutside of the dining reparing meals.	nenus that were posted room for guidance for				
	-She knew the consist the mechanical soft d					
	-She knew to serve the ordered an NCS diet	ne residents who were sugar free items.				
	at 10:48am revealed:					
	guidance.	erapeutic diet menu for upply vendor had provided				
		nenus. apeutic diet menus for about				
	three weeksHe had contacted a	dietitian on 03/24/22 and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		
		HAL039018	B. WING		03/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ΓE, ZIP CODE	
TRE' MOR	E MANOR ALF		E TOWN ROAD		
			, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 296	Continued From page	8	D 296		
	she was going to prov for the facility.	ride a therapeutic diet menu			
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310		
	(e) Therapeutic Diets(4) All therapeutic die supplements and thic	Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.			
	interviews the facility diets as ordered by the	s, record reviews, and failed to serve therapeutic e primary care provided led residents (#1, #4) who pureed diet and a who was ordered a			
	The findings are:				
		chen on 03/23/22 at 9:18am or therapeutic diet menus or ole for staff to follow.			
		trance to the dining room on evealed there was a daily			
	revealed:	ent FL-2 dated 03/01/22 vascular dementia and			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		
			A. BOILDING.			
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	E, ZIP CODE		
TDELMOE	DE MANOR ALE	6016 PIN	E TOWN ROAD			
I KE' MUR	RE MANOR ALF	OXFORD	, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	9	D 310			
	gastroesophageal ref -The resident was inte	lux disease (GERD). ermittently disoriented.				
	a. Review of Residen 03/01/22 revealed the pureed diet.	t #1's current FL-2 dated ere was an order for a				
	Observation of the breakfast meal on 03/23/22 at 9:18am revealed: -Resident #1 was served ground French toast, ground bacon, grits, whole blueberries used as garnish, and two chocolate chip muffins cut in half.					
	-She was provided paground French toast.	ancake syrup to add to her				
		ee, water and milk to drink. percent of her lunch meal.				
	Observation of the lur 3:49pm revealed:	nch meal on 03/23/22 at				
	gravy, pureed green b	ved pureed meatloaf and beans, pureed macaroni and ranges with ground nuts and				
	-She was served leme	onade to drink. percent of her lunch meal.				
	Interview with Reside 11:06am revealed: -She did not have any	nt #1 on 03/24/22 at y teeth and she did not wear				
	denturesShe did not know wh	y she was ordered pureed				
	-She could chew her	food even without teeth. trouble swallowing because uck in her throat.				
	was not cut up small	llowing because the food enough. ghed while she was eating				
	because her food was	s too dry.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	1 00/2-7/2022	
NAIVIE OF FI	NOVIDER OR SUFFLIER		E TOWN ROAD	TE, ZIF CODE		
TRE' MOR	E MANOR ALF		, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 10	D 310			
	-When she coughed, she would drink water to help swallowShe had never thrown up while coughing during eating. Telephone interview with Resident #1's primary care provider (PCP) on 03/24/22 at 11:18am revealed: -She was ordered a pureed diet because there were concerns of aspirationResident #1 had aspirated and had aspiration pneumonia over a year agoShe had not had any episodes of aspiration since she was ordered a pureed dietHe expected Resident #1's diet order to be followed.					
	11:47am revealed: -She knew Resident adietShe knew a puree country the spoon and not be spoon and not be she did not add always become runnyThe pureed consiste manageable for the redietThere should not be Resident #1 could che was soft enough for he-she did not know if she ateShe knew Resident #1 pneumonia some time.	ays add liquids when she e she did not want them to ncy should have been esident that was ordered the any big chunks of food. new her bread because it her to chew. Resident #1 coughed when #1 had an aspiration e ago.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			7. BOILDING.			
		HAL039018	B. WING		03/2	4/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TRE' MOI	RE MANOR ALF	6016 PINE OXFORD, I	TOWN ROAD NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 310	b. Review of Residen 03/01/22 revealed an supplements three tind. Observation of the brofrom 9:18am to 10:00 served a nutritional sit. Observation of the lural 3:49pm to 5:15pm revealed there were revealed. There was an entry ferscheduled three times and 6:00pm. The nutritional supplementation record revealed: There was an entry ferscheduled three times and 6:00pm. The nutritional supplementation record revealed: She was supposed to supplement three times and 6:00pm. The nutritional supplementation record revealed: She was supposed to supplementation three times and 6:00pm. The nutritional supplementation record revealed: She was supposed to supplementation received.	t #1's current FL-2 dated order for nutritional nes daily. eakfast meal on 03/23/22 am revealed she was not upplement to drink. Inch meal on 03/23/22 from wealed she was not served a to drink. It chen storage areas and 22 at 9:00am and 2:31pm no nutritional supplements er. Il personal refrigerator in the inator's (RCC's) office on evealed there were no ts available to administer. I's electronic medication (eMAR) for March 2022 For a nutritional supplement and adaily at 9:00am, 2:00pm The ment was documented as a copportunities. Int #1 on 03/24/22 at 1:00pm The have a nutritional es daily, but she only got an autritional supplement es daily, but she only got an autritional supplement es daily, but she only got an utritional supplement es she was admitted to the neg of the month.	D 310			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022
	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	TE, ZIP CODE	
(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 310	gain some weight. Telephone interview water provider (PCP) or revealed: -She was ordered the to weight lossResident #1 had decovered weight lossResident #1 was mater weight while on the material was resident #1's order of supplement should occordered. Interview with a media of ordered. Interview with the facilities of the second of ordered of ordered of ordered ordered. Interview with the Resident of ordered	vith Resident #1's primary on 03/24/22 at 11:18am Inutritional supplement due lined and had struggled with reginally maintaining her utritional supplement. For the nutritional ontinue to be followed as cation aide (MA) on revealed: to become a MA. edication administrations I medications to the y during her training. Resident #1 administered a t and she had never onal supplement to Resident #1's nutritional nued by the PCP because well. Resident #1 her nutritional past that morning or with her kfast.	D 310		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		HAL039018	B. WING		0:	3/24/2022
						5/2-4/2-022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
TRE' MOF	RE MANOR ALF		NE TOWN ROAD D, NC 27565			
040.1-	CLIMMADY CT.		·	DDOV/DED'S DI AN OF CODD	CCTION	0.5
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 310	Continued From page	: 13	D 310			
	as proof of purchaseHe thought there mig supplements in the kirungh the purchase nutritional supplement Resident #1; he did not specifically ordered. Interviews with the Act 12:37pm and 2:33pm -None of the residents supplementsShe did not know Renutritional supplement -Resident #1 ate very since she had been a -She was responsible supplements for any if for themShe was not aware conutritional supplement	Int be nutritional tchen. Ithe specific brand of the PCP ordered for ot know they were Iministrator on 03/23/22 at revealed: Is were ordered nutritional sident #1 had an order for tts. Well and had improved				
	not be substituted. 2. Review of Residen 02/28/22 revealed: -Diagnoses included gastroesophageal refiesophagitis, tardive d ParkinsonismThere was an order for the brug:18am revealed: -Resident #4 was seri	fux disease without yskinesia, and secondary for a mechanical soft diet. eakfast meal on 03/23/22 at wed a whole piece of French is of bacon, grits and two muffins.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL039018	B. WING	B. WING		24/2022	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓE, ZIP CODE	, , ,		
TRE' MORE MANOR ALF		E TOWN ROAD , NC 27565				
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL : IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
ate over 50 percent. Observation of the lunch 3:49pm revealed: -Resident #4 was served macaroni and cheese, b mandarin oranges with percent and the pecans out at Interview with Resident 12:55pm revealed: -He did not have teeth, secooked softer or cut upHe picked the nuts out accould not eat them with certain and the was often served for the was ordered a mechan he did not have any teet. Interview with the Admin 11:33am revealed: -She did not have a there she just knew to chop up Resident #4Resident #4Resident #4 was ordered because he did not know we French toast because she she was shim; she did not know we French toast because she she was served to the she was ordered and the she was ordered because she did not know we French toast because she she was served to the she was ordered because she did not know we French toast because she she was served to the she was ordered because she did not know we French toast because she she was served to the she was ordered because she did not know we French toast because she was served to the she was served to the she was ordered because she wa	h toast with his hand and meal on 03/23/22 at different meal on 03/23/22 at different meal on 03/23/22 at different meal of his meal, but he and did not eat them. #4 on 03/24/22 at different meal because he out teeth. Ods he could not chew. In Resident #4's primary 22 at 11:18am revealed anical soft diet because the and did not chew well. Inistrator on 03/24/22 at different meals or vegetables for the different median did fifculty sandwiches and bread for thy she did not cut up his he usually cut that up too. did the nuts before putting ranges.	D 310				

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she would have to do better in the future.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, 251251110. <u> </u>	, a Boileanto.		
		HAL039018	B. WING		03	/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	E, ZIP CODE		
TRE' MOR	RE MANOR ALF	6016 PIN	IE TOWN ROAD			
TICE MOI	L MANON ALI	OXFORI	D, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 366		Medication Administration	D 366			
	medication administra staff person who adm immediately following medication to the res					
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARs) were accurate to include the initials of the Medication Aide (MA) who administered the medication for 3 of 3 sampled residents (#1, #2 and #3).					
	03/01/22 revealed: -Diagnoses included D deficiency, chronic schizophrenia, gastro hypertension, overace asthma, atrial flutter, -There was a medica 5mg (used to treat hy -There was a medica (used to treat or prevented)	n-esophageal reflux disease, tive bladder, hyperlipidemia, and spinal stenosis. tion order for amlodipine epertension) daily. tion order for artificial tears ent dry eyes) one drop in				
	tablets 600-10mg (us	tion order for calcium-D3				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILBING			
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		6016 PIN	E TOWN ROAD			
TRE' MOF	RE MANOR ALF	OXFORD), NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page	e 16	D 366			
	to treat or prevent vitablet daily. -There was a medical (used to prevent blood daily. -There was a medical 300mg (used to prevent blood daily. -There was a medical 75mg (used to treat betwee daily. -There was a medical 25mg (used to treat catablet daily. -There was a medical 25mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily. -There was a medical 2mg (used to treat catablet daily.					
	medication administrative revealed: -There was an entry tablet daily, schedule -There was document amlodipine by a PCA from 03/07/22 to 03/003/13/22, from 03/15 and from 03/18/22 to there was an entry drop in both eyes three was an entry three was document artificial tears by a PC 03/05/22, from 03/07	for amlodipine 5mg one and for 8:00am and 9:00am. Intation of administration of a from 03/02/22 to 03/05/22, 09/22, from 03/12/22 to 03/17/22 at 8:00am 03/22/22 at 9:00am. For artificial tears instill one see times daily, scheduled for 0pm, 3:00pm, 8:00pm, and obtain of administration of CA from 03/02/22 to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		_			
	HAL039018	B. WING		03/2	24/2022
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
TRE' MORE MANOR ALF	6016 PIN	E TOWN ROAD			
TRE MORE MANOR ALF	OXFORD), NC 27565			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366 Continued From page	e 17	D 366			
at 8:00am and from 0 9:00am. -There was documen artificial tears by a PC 03/04/22, from 03/07/03/12/22 to 03/13/22, at 2:00pm and from 0 3:00pm. -There was documen artificial tears by a PC on 03/17/22 and 03/2 -There was an entry fone tablet twice daily, 9:00am, 8:00pm, and -There was documen calcium-D3 by a PCA from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/18/22 to -There was documen calcium-D3 by the PC 03/07/22 and from 03 5:00pm. -There was documen calcium-D3 by the PC 03/19/22 to 03/20/22, -There was an entry form 03/07/22 to 03/00 03/13/22, from 03/15/and from 03/07/22 to 03/00 03/13/22, from 03/15/and from 03/18/22 to -There was an entry form 03/18/22 to -There was documen -There -The	tation of administration of CA from 03/02/22 to 03/10/22, from from 03/15/22 to 03/16/22 to 03/17/22 to 03/16/22 at tation of administration of CA on 03/16/22 at 8:00pm, for calcium-D3 600-10mg, scheduled for 8:00am, 19:00pm. tation of administration of CA on 03/02/22 to 03/05/22, 19/22, from 03/12/22 to 03/05/22, 19/22, from 03/02/22 at 8:00am 03/22/22 at 9:00am. tation of administration of CA on 03/02/22, 03/04/22, 03/04/22, 03/04/22, 03/13/22 at 100 (03/02/22) at 03/03/22/2 at 03/05/22, 03/04/22, 03/05/22, 03/05/22, 03/05/22 at 03/05/22, 03/05/22 at 03/05/22, 03/05/22 at 03/05/22, 03/05/22 at 03/05/22, 03/05/22 at 9:00am. for Eliquis 5mg one tablet diffor 8:00am, 9:00am,				

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from 03/15/22 to 03/17/22 at 8:00am and from

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
TDE' MOE	RE MANOR ALF	6016 PIN	E TOWN ROAD		
TICE MOI	L MANOIT ALI	OXFORD	, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE
D 366	Continued From page	e 18	D 366		
	03/18/22 to 03/22/22	at 9:00am.			
		tation of administration of			
	Eliquis by a PCA on 0	03/16/22 at 8:00pm, on			
	03/17/22 and 03/22/2	•			
	_	or gabapentin 300mg one			
		ly, scheduled for 8:00am,			
		Opm, 8:00pm, and 9:00pm.			
	-There was documentation of administration of gabapentin by a PCA from 03/02/22 to 03/05/22, from 03/07/22 to 03/09/22, from 03/12/22 to				
		/22 to 03/17/22 at 8:00am			
	and from 03/18/22 to	03/22/22 at 9:00am.			
		tation of administration of			
	, ,	from 03/02/22 to 03/04/22,			
		0/22, from 03/12/22 to /22 to 03/16/22 at 2:00pm			
	and from 03/17/22 to	•			
		tation of administration of			
		on 03/16/22 at 8:00pm, on			
		or metoprolol 25mg one			
	tablet twice daily, sch 8:00pm, and 9:00pm.	eduled for 8:00am, 9:00am,			
		tation of administration of			
		a PCA from 03/02/22 to			
	03/05/22, from 03/07/				
	·	from 03/15/22 to 03/17/22 03/18/22 to 03/22/22 at			
	9:00am.	10,22 to 03,22,22 at			
		tation of administration of			
	metoprolol 25mg by a	a PCA on 03/16/22 at			
	8:00pm, on 03/17/22	and 03/22/22 at 9:00pm.			
		or metoprolol 50mg one			
		eduled for 8:00am, 9:00am,			
	8:00pm, and 9:00pm.				
		tation of administration of a PCA from 03/02/22 to			
	03/05/22, from 03/07/				
		from 03/15/22 to 03/17/22			

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at 8:00am and from 03/18/22 to 03/22/22 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	,
			IE TOWN ROAD		
TRE' MOR	RE MANOR ALF	OXFORE), NC 27565		
(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 366	metoprolol 50mg by t 8:00pm, on 03/17/22 -There was an entry f tablet daily, schedule -There was documen myrbetriq by a PCA fr from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/18/22 to -There was an entry f tablet twice daily, sch 8:00pm, and 9:00pmThere was documen risperidone by a PCA from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/18/22 to -There was documen risperidone by a PCA	tation of administration of he PCA on 03/16/22 at and 03/22/22 at 9:00pm. For myrbetriq 25mg one d for 8:00am and 9:00am. Station of administration of som 03/02/22 to 03/05/22, 19/22, 19/22 to 03/17/22 at 8:00am. For risperidone 2mg one eduled for 8:00am, 9:00am, 10:00am,	D 366		
	03/17/22 and 03/22/22 at 9:00pm. -There was an entry for sertraline 100mg one tablet daily, scheduled for 8:00am and 9:00am. -There was documentation of administration of sertraline by a PCA from 03/02/22 to 03/05/22, from 03/07/22 to 03/09/22, from 03/12/22 to 03/13/22, from 03/15/22 to 03/17/22 at 8:00am and from 03/18/22 to 03/22/22 at 9:00am. Interview with Resident #1 on 03/24/22 at 11:06am revealed the MA administered medications to her. Refer to interview with a PCA on 03/24/22 at 11:03am. Refer to interview with the Resident Care Coordinator (RCC) on 03/24/19 at 11:53am.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE		2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		HAL039018	B. WING		03/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TDELMOE	DE MANOR ALE	6016 PINE	TOWN ROAD			
IKE, MOR	RE MANOR ALF	OXFORD,	NC 27565			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 366	Continued From page	e 20	D 366			
	Refer to telephone in	terview with the				
	Administrator on 03/2					
	2. Review of Residen	t #2's current FL-2 dated				
	02/28/22 revealed:					
	-Diagnoses included	major depressive disorder,				
	hypertension, hypothy	yroidism, chronic kidney				
		nic anemia, chronic gout,				
	••	parathyroidism, primary				
		eral knees, vitamin deficiency				
	and unspecified eden					
		tion order for allopurinol				
	_ ,	gout) one tablet daily.				
		tion order for certavite				
		o treat or prevent vitamin				
	deficiency) one tablet					
		tion order for famotidine				
	- '	llcers of the stomach) one				
	tablet daily.	tion order for furosemide				
		d the body of extra fluids)				
	one tablet daily.	a the body of extra halas)				
	_	tion order for hydrocortisone				
		eat skin conditions) spread				
	topically twice daily to	rash.				
	-There was a medica	tion order for sertraline				
	100mg (used to treat	depression) one tablet daily.				
	Review of Resident #	2's March 2022 electronic				
	medication administra					
	revealed:	•				
	-There was an entry f	or allopurinol 100mg daily,				
	scheduled for 8:00am					
	-There was an entry f	or certavite senior tablets				
	daily, scheduled for 8	:00am and 9:00am.				
		or famotidine 20mg daily,				
	scheduled for 8:00am					
		or furosemide 80mg daily,				
	scheduled for 8:00am					

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-There was an entry for hydrocortisone cream 1%

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL039018	B. WING		03/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
TRE' MOR	RE MANOR ALF		E TOWN ROAD		
	I		, NC 27565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
D 366	Continued From page 21		D 366		
	apply twice daily, sche 8:00pm, and 9:00pmThere was an entry f scheduled for 8:00am -A PCA's initials were to 03/05/22, from 03/003/12/22 to 03/13/22 03/17/22 at 8:00am w famotidine, furosemid and sertraline were at -A PCA's initials were to 03/22/22 at 9:00am famotidine, furosemid and sertraline were at Interview with Reside revealed the male stato him.	eduled for 8:00am, 9:00am, or sertraline 100mg daily, and 9:00am. documented from 03/01/22 07/22 to 03/09/22, from and from 03/15/22 to then allopurinol, certavite, e, hydrocortisone cream, dministered daily. documented from 03/19/22 in when allopurinol, certavite, e, hydrocortisone cream			
	, ,	n 03/24/19 at 11:53am.			
	Refer to telephone int Administrator on 03/2				
	03/01/22 revealed: -Diagnoses included of behavioral disturbance congestive heart failur hypertension, overact disorder bipolar depresatherosclerotic heart of the congestive at the congestive heart of the congestive heart failure has been accompanied heart of the congestive heart failure hypertension, overact disorder his congestive heart failure hypertension, overact disorder his congestive heart of the conges	re, type II diabetes, ive bladder, schizoaffective essive type, and disease. cion order for anastrozole 1 ast cancer after			

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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		
		HAL039018	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	03/24/2022	
TDELMO	DE MANOR ALE	6016 PINE	TOWN ROAD			
IKE, MOI	RE MANOR ALF	OXFORD,	NC 27565			
(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 COMPLE	ETE
D 366	Continued From page	e 22	D 366			
D 3000	(used to relieve eye deye drop in each eye drop in each eye -There was a medica 500mg chew (used to tablet daily. -There was a medica 75mg (used to prever one tablet daily. -There was a medica cream (used to moist topically to feet every -There was a medica 20mg (used to rid the Monday, Wednesday -There was a medica touch (used to contro units daily. -There was a medica 500mg (used to contro units daily. -There was a medica succinate extended rehigh blood pressure) -There was a medica 21mg/24hr (used to a cessation) one patch old patch. -There was a medica 7.5mg (used to treat a certain mood/mental -There was a medica 2mg (used to treat a certain mood/mental -There was a medica 2mg (used to treat a certain sood mental -There was a medica 2mg (used to treat a certain mood/mental -There was a medica 2mg (used to treat a certain mood/mental -There was a medica 3.6mg-50mg (used to treat a constipation) one cap -There was a medica 150mg (used to treat a constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constipation) one cap -There was a medica 150mg (used to treat to constitute to constitute to constipation) one cap -There was a medica 150mg (used to tre	Iryness and irritation) one three times a day. tion order for Cal-Gest of treat stomach ulcers) one tion order for clopidogrel of heart attacks and strokes) tion order for Dermacerin urize dry skin) spread morning before breakfast. tion order for furosemide body of extra water) every, and Friday. tion order for Levemir flex I high blood sugar) inject 25 tion order for metformin ol high blood sugar) one tion order for metoprolol elease 25mg (used to treat daily. tion order for nicotine patch issist with smoking on skin daily after removing tion order for risperidone ratin mood/mental to daily. tion order for stool softener or treat occasional				

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250mg/5ml solution 10 ml (used to treat seizure

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING:			
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TDELMO	DE MANOR ALE	6016 PIN	IE TOWN ROAD			
IKE, MOR	RE MANOR ALF	OXFORI	D, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366	Continued From page	23	D 366			
	daily in the morningThere was a medica 1,000 unit (used to tre	n mood/mental conditions) tion order for vitamin D3 eat vitamin deficiency) daily. 3's March 2022 electronic				
	medication administration record (eMAR) revealed: -There was an entry for anastrozole 1mg daily, scheduled for 9:00amThere was documentation of administration of					
	anastrozole by a PCA from 03/07/22 to 03/0	tation of administration of A from 03/02/22 to 03/05/22, 18/22, from 03/12/22 to 3/15/22 to 03/22/22 at				
	drop in both eyes three 9:00am, 3:00pm, and	or artificial tears instill one se times daily, scheduled for 9:00pm. tation of administration of				
	artificial tears by a PC 03/05/22, from 03/07/03/12/22 to 03/13/22,	CA from 03/02/22 to				
	artificial tears by a PC 03/04/22, from 03/07/03/12/22 to 03/13/22,					
	artificial tears by a PC and 03/22/22 at 9:00p	tation of administration of CA from 03/16/22 to 03/17/22 om. for Cal-Gest chew 500mg				
	one tablet daily, sche -There was documen Cal-Gest by a PCA from 03/07/22 to 03/0 03/13/22, and from 03 9:00am.	duled for 9:00am. tation of administration of om 03/02/22 to 03/05/22, 18/22, from 03/12/22 to 3/15/22 to 03/22/22 at				
	tablet daily, schedule	or clopidogrel 75mg one d for 9:00am.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATI		
		A. BUILDING:	A. BUILDING:		
	HAL039018	B. WING		03	3/24/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
	6016 PII	NE TOWN ROAD			
TRE' MORE MANOR ALF		D, NC 27565			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 366 Continued From page	D 366 Continued From page 24				
-There was documental clopidogrel by a PCA from 03/07/22 to 03/08/03/13/22, and from 03/9:00amThere was an entry for topically to feet every 9:00amThere was documental Dermacerin cream by 03/05/22, from 03/07/203/12/22 to 03/13/22, 03/22/22 at 9:00amThere was an entry for Monday, Wednesday, 9:00amThere was documental furosemide by a PCA of 03/07/22, 03/16/22, 03/9:00amThere was an entry for units daily, schedule for there was documental Levemir by a PCA of 03/09/22, from 03/12/203/15/22 to 03/16/22 at 03/17/22 to 03/16/22 at 03/17/22 to 03/16/22 at 03/17/22 to 03/16/22 at 03/17/22 to 03/15/22 at 03/13/22, from 03/15/22 and from 03/07/22 to 03/08/03/13/22, from 03/15/22 and from 03/15/22 to 03/07/22 at 5:00pm, of to 03/20/22, and 03/22/22, and 03/2	ation of administration of from 03/02/22 to 03/05/22, 8/22, from 03/12/22 to 15/22 to 03/22/22 at or Dermacerin cream apply morning, scheduled for ation of administration of a PCA from 03/02/22 to 22 to 03/08/22, from and from 03/15/22 to or furosemide 20mg every and Friday, scheduled for ation of administration of on 03/02/22, 03/04/22, 8/18/22, and 03/21/22 at or Levemir flextouch 25 or 8:00am and 9:00am. ation of administration of 03/05/22, from 03/07/22 to 22 to 03/13/22, from at 8:00am and from at 9:00am. or metformin 500mg one aduled for 8:00am, 9:00am, ation of administration of om 03/02/22 to 03/05/22, from 03/12/22 to 03/16/22 at 8:00am of administration of om 03/02/22 at 9:00am. ation of administration of om 03/02/22 at 9:00am. ation of administration of no 03/02/22, 03/03/22, no 03/17/22, from 03/19/22	D 366			

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DIVISION	n nealth Service Regu	lation				
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		TED
			B. WING			
		HAL039018	B. WING		03/24	4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		6016 PINI	TOWN ROAD			
TRE' MOR	RE MANOR ALF		NC 27565			
			NC 27505			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 366	Continued From page	e 25	D 366			
	tablet deily, sebadula	d for 0.00 om				
	tablet daily, schedule					
		tation of administration of				
		from 03/02/22 to 03/05/22,				
		8/22, from 03/12/22 to				
		3/15/22 to 03/22/22 at				
	9:00am.					
	-There was an entry f	or nicotine 21mg/24hr one				
	patch on skin daily af	ter removing old patch,				
	scheduled for 9:00am	1.				
	-There was documen	tation of refusal for the				
	nicotine patch by a Po	CA on 03/03/22, 03/05/22,				
	from 03/07/22 to 03/0	8/22, from 03/12/22 to				
		/22 to 03/16/22, and from				
	03/18/22 to 03/22/22					
		or olanzapine 2.5mg one				
		eduled for 8:00am, 9:00am,				
	8:00pm, and 9:00pm.					
		tation of administration of				
		a PCA from 03/02/22 to				
	03/05/22, from 03/07/					
		from 03/15/22 to 03/16/22				
	•	3/15/22 to 03/22/22 at				
	9:00am.	13/13/22 to 03/22/22 at				
		tation of administration of				
		tation of administration of				
		a PCA on 03/16/22 at				
		and 03/22/22 at 9:00pm				
	•	or olanzapine 5mg one				
		eduled for 9:00am and				
	9:00pm.					
		tation of administration of				
		PCA from 03/02/22 to				
	03/05/22, from 03/07/					
		and from 03/15/22 to				
	03/22/22 at 9:00am.					
		tation of administration of				
	olanzapine 5mg by a	PCA from 03/16/22 to				
	03/17/22, and 03/22/2	22 at 9:00pm.				
		or risperidone 2mg one				
		d for 8:00am and 0:00am				

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-There was documentation of administration of

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TRE' MOR	E MANOR ALF		TOWN ROAD			
		OXFORD, I	NC 27565			
(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 366	Continued From page 26		D 366			
	risperidone by a PCA from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/17/22 to -There was an entry f tablet daily, scheduler-There was documen sertraline by a PCA from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/17/22 to -There was an entry f tablet daily, scheduler-There was documen sertraline by a PCA from 03/07/22 to 03/0 03/13/22, from 03/15/and from 03/07/22 to 03/0 03/13/22, from 03/17/22 to -There was an entry for tablet twice daily, 9:00pm. -There was document stool softener by a PC 03/05/22, from 03/07/03/12/22 to 03/13/22, at 9:00am and from 00/3/22/22 at 9:00pm. -There was an entry for example of the proposition of the proposi	from 03/02/22 to 03/05/22, 9/22, from 03/12/22 to 03/16/22 at 8:00am 03/22/22 at 9:00am. For sertraline 50mg one of for 8:00am and 9:00am. Station of administration of om 03/02/22 to 03/05/22, 19/22, from 03/12/22 to 1/22 to 03/16/22 at 8:00am 03/22/22 at 9:00am. For sertraline 100mg one of for 9:00am. Station of administration of om 03/02/22 to 03/05/22, 19/22, from 03/12/22 to 1/22 to 03/16/22 at 8:00am 03/02/22 at 9:00am. Station of administration of om 03/02/22 to 03/05/22, 19/22, from 03/12/22 to 1/22 to 03/16/22 at 8:00am 03/22/22 at 9:00am. For stool softener 8.6-50mg of scheduled for 9:00am and 1/22 to 03/08/22, from 1/22 to 03/15/22 to 03/17/22, and 1/22 to 03/03/22/22 at 1/22 to 03/03/22/22 at 1/22 to 03/03/22/22 at 1/222 to 03/03/22/				
	-There was documen	d for 9:00am. tation of administration of from 03/02/22 to 03/05/22				

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from 03/07/22 to 03/08/22, from 03/12/22 to

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL039018	B. WING		0.3	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	•	DDRESS, CITY, STATE	= ZIP CODE	1 00	II TI T
NAME OF T	NOVIDER OR GOLF EIER		E TOWN ROAD	1, ZII OODE		
TRE' MOF	RE MANOR ALF		, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 366	D 366 Continued From page 27		D 366			
	03/13/22, and from 03/15/22 to 03/22/22 at 9:00am. Interview with Resident #3 on 03/23/22 at 2:27pm revealed the male medication aide (MA) gave her medications. Refer to interview with a PCA on 03/24/22 at 11:03am. Refer to interview with the Resident Care Coordinator (RCC) on 03/24/19 at 11:53am.					
	Refer to telephone in Administrator on 03/2					
	03/24/18 at 11:03am -She worked at the farShe was a certified in the first shiftShe administered to residents when she is during the morning in the documented the residents' medication because she was in the system and document the MA/RCC was adminisertable medication.	acility since 02/28/22. Inursing aide and worked on pical medications to the shadowed the MA/RCC medication pass. It is a within the eMAR system training to be a MA. It is sess of learning the eMAR inted within the system while ministering the oral and its. It is a within the system while ministering the oral and its. It is a worker of the system while ministering the oral and its.				
	revealed: -He provided access	to the eMAR system to the ould practice documenting				

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medication administration.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL039018	B. WING		03/24/2022	
	ROVIDER OR SUPPLIER	6016 PINE	RESS, CITY, STA	TE, ZIP CODE		
	-	OXFORD, I	NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 366	Continued From page 28		D 366			
	-The PCAs were in training to become MAs and shadowed him or another MA to observe the administration of the medications. -He administered the medications to the residents, but the PCAs documented the administration of the medication. -He taught the PCAs how to document for medications and activities of daily living within the eMAR system. Interview with the Administrator on 03/24/22 at 12:55 pm revealed: -She did not know the RCC and another MA were not signing off the medications on the eMAR. -She knew the PCAs were shadowing the RCC and MA to learn how to administer medications. -She should have reviewed the eMARs to ensure accurate documentation was occurring. -The MAs were responsible for ensuring they document after administering medications.					
D 612	Control Program (tem 10A NCAC 13F .1801 PREVENTION AND 0 (c) When a communic been identified at the emerging infectious disease threat, the fai implementation of the policies and procedur published guidance is if guidance or directiv communicable disease outbreak or emerging have been issued in vilocal health	INFECTION CONTROL PROGRAM cable disease outbreak has facility or there is an cility shall ensure facility 's IPCP, related es, and ssued by the CDC; however, es specific to the	D 612			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		HAL039018	B. WING		03/	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TRE' MOR	RE MANOR ALF		TOWN ROAD NC 27565			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	DRRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 612	Continued From page	e 29	D 612			
	shall be implemented by the facility.					
	This Bula is not mot	as suideneed by:				
	This Rule is not met Based on observation	as evidenced by. ns, record reviews, and				
	interviews, the facility					
		d guidance established by				
	the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human					
Services (NC DHHS) were implemented and maintained to provide protection to 12 residents						
	during the global cord	, ,				
	pandemic as related	• • •				
	[· · · · · · · · · · · · · · · · · · ·	quipment (PPE) face masks risk of transmission and				
	· ·	ng of staff and residents.				
	The findings are:					
	1. Review of the CDC	Interim Infection Prevention				
	_	nendations for Healthcare				
	Personnel (HCP) Dui dated 02/02/22 revea	ring the COVID-19 Pandemic				
	-Source control meas					
	implemented for HCF					
		red to the use of a well-fitting				
	1	person's mouth and nose to				
	[· · · · · · · · · · · · · · · · · · ·	f respiratory secretions when alking, sneezing, or coughing.				
		P should wear source control				
	when they were in ar	eas of the facility where they				
	could encounter resid					
		e established a process to ing the facility, regardless of				
		us, who has a positive test				
		oms of COVID-19, or close				
		posure to COVID-19.				
	Review of the North (Carolina Department of				
	Health and Human S					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL039018	B. WING		0:	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TRE' MOR	RE MANOR ALF		NE TOWN ROAD D, NC 27565			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 612	COVID-19 Infection F Care Facilities dated control referred to the masks to cover a pers Observation of the fro 03/23/22 at 8:45am re that read all visitors m masks and maintain s Observation of a fema 8:45am revealed she mask when she appro door. Observation of the Re	Prevention for Long-Term 11/19/21 revealed source a use of well-fitting face son's mouth and nose. Ont entrance to the facility on evealed there was a sign must always wear face	D 612			
	and began to administered the entered the dining meal and administered residents without a faround a faround a faround a brief conversation whave on a facemask. Observations in the hog/23/22 at 9:20am residents	g room during the breakfast ad medications to multiple				
	03/23/22 from 9:05an -Two contracted cons main hallway multiple basement and a hallw remodeled.					

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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: _			
		HAL039018	B. WING		03/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TRE' MOR	E MANOR ALF		TOWN ROAD NC 27565			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE	JLD BE	(X5) COMPLETE DATE
D 612	Interview with a residence vealed: -Staff sometimes workHe had seen the main Resident Care Coord maskHe thought the RCC and he did not know with mask on that dayThe Administrator was but she usually wore. Interview with anothe 10:42am revealed: -The Administrator did facemask while in the the standard of the revealed: -The RCC did not alw had seen him outside facemask. Interview with a third 10:49am revealed: -She did not usually mand the RCC had on she did recall seeing RCC without facemas when. Interview with a person 03/24/22 at 11:03am face mask at the facil Interview with the RC revealed:	e main hallway. Is in the main hallway when ers were also in the hallway. It is in the main hallway when ers were also in the hallway. It is in the main hallway when ers were also in the hallway. It is in the main hallway when ers were also in the hallway. It is face masks. It is staff who was the inator (RCC) without a face I usually wore a face mask why he did not wear a face as not wearing a face mask, a face mask as well. It is resident on 03/23/22 at I ded not always wear her is facility. It is facemask; she is of his office without his I resident on 03/23/22 at I notice if the Administrator a facemask. I the Administrator and the isk but could not remember I onal care aide (PCA) on revealed she always wore a	D 612			
	working in close proxi					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
TRE' MOR	RE MANOR ALF	6016 PI	NE TOWN ROAD			
		OXFOR	D, NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 612	-Close proximity was medications, conduct (ADL) or assisting a right and reductions. -He wore his facemas medications. -He typically would have the administered in the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room at have been thinking allow one of the dining room of the dining room at have been thinking allow one of the dining room of the dini	when administering ing activities of daily living resident in anyway. Sk when he administered are put on his face mask d a resident her medication breakfast, but he must not bout it that morning, struction workers who were cility were not required to cause they were not in close in ause they were not in close in ause they were not in close in o 2/28/22. The fully vaccinated for eccived their COVID-19 C guidelines concerning were that if staff were fully lisk was not required. The last email she eccember 2021. For proof of vaccination when for was not vaccinated a face was, but she did not have a in 03/23/22 because she was refir in long term care facilities wearing a face mask. The for ensuring the CDC wed concerning wearing face lity.	D 612	DEFICIENC		
	2. Review of the Cen	ters for Disease Control and				

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DATE OF THE ADDRESS O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S COMPLI	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TRE' MORE MANOR ALF 6016 PINE TOWN ROAD OXFORD, NC 27565 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET			A. BUILDING: _			
TRE' MORE MANOR ALF 6016 PINE TOWN ROAD OXFORD, NC 27565 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.		HAL039018	B. WING		03/2	4/2022
TRE' MORE MANOR ALF OXFORD, NC 27565 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE COMPLETE CONTROL OF A SUBSTITUTION OF A	TRE' MORE MANOR ALF					
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
Prevention (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19 incetionThe options could include (but were not limited to): individual screening upon arrival to the facility or implement an electronic monitoring system in which individuals can self-report any of the above before entering the facility. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/20/21 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19. Review of three residents' March 2022 electronic medication administration records (eMARs) revealed there was no documentation of daily temperatures. Observation of thermometers in the facility on 03/23/22 at 8-48am revealed there was a hand-held thermal scan thermometer stored on	Prevention (CDC) Integrated and Control Recommorpersonnel during the (COVID-19) pandemital Facilities should estage anyone entering the fivaccination status, whe following three criterian managed: a positive symptoms of COVID-someone with COVID-someone with COVID-the options could into): individual screenitor implement an elect which individuals can before entering the factor of the CDC Ir and Control Recommorphisms of the CDC Ir and Control Recommorphisms of the North (Could be a supported by the Nor	erim Infection Prevention endations for healthcare coronavirus disease 2019 c dated 02/02/22 revealed: ablish a process to identify acility, regardless of no has any one of the a so that they can be viral test for COVID-19, 19, or close contact with 0-19 infection. Clude (but were not limited ing upon arrival to the facility tronic monitoring system in self-report any of the above cility. Interim Infection Prevention endations to prevent in Nursing Homes dated sidents should be evaluated in COVID-19 and actively fever. Carolina Department of ervices COVID-19 Post fection Control Assessment (a) tool dated 10/2021 sidents should be actively in the country of	D 612			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL039018	B. WING		03/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TRE' MOR	RE MANOR ALF	6016 PINE OXFORD, I	TOWN ROAD NC 27565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 612	2 Continued From page 34		D 612			
	the medication cart.					
	Interview with a resident on 03/23/22 at 10:03am revealed the staff did not take her temperature. Interview with another resident on 03/23/22 at 10:42am revealed her temperature was taken about once a week. Interview with a third resident on 03/23/22 at 10:49am revealed she had her temperature taken periodically but, her temperature had not been taken today, 03/23/22.					
	03/24/22 at 11:03am -She did not take her when she entered the -She began taking he entered the facility on -She did not know she	temperature every day facility. r temperature when she				
	revealed: -He was not vaccinateHe did not do a daily or for symptoms of Co each shift at facilityHe thought there we from the CDC and NO transition to the new remarks the start of their shift documentedResidents were not sincluding temperatureResidents were mon	ed against COVID-19. screening for temperatures OVID-19 prior to the start of the new recommendations CDHHS, so the facility was in recommendations. The required to screen prior to but he did not know if it was the commendation of COVID-19. The required for symptoms of the country of the co				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL039018	B. WING		03	3/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
TRE' MOR	RE MANOR ALF		NE TOWN ROAD D, NC 27565			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 612	taken when residents -Visitors were screer symptoms prior to er not know if the scree -The Administer was related to COVID-19 Interview with the Ad 10:25am revealed: -The residents were residents and if they temperatures were ta -Staff reported to her or had a feverShe thought staff we temperatures when a did not document the -She did not know th screened daily for sig COVID-19She did not know th screening of staff and -The residents' temp dailyShe was responsible guidelines were follow	s complained of symptoms. and for temperatures and attering the facility but he did nings were documented. responsible for any policies ministrator on 03/23/22 at vaccinated except for two had any symptoms their aken. when they did not feel well ere obtaining their arriving for their shift, but they a temperatures. e residents should be gn and symptoms of	D 612			
D935	Training and Competer G.S. § 131D-4.5B (b. Medication Aides; Tr. Evaluation Requirem) Adult Care Home aining and Competency	D935			
	home is prohibited from	om allowing staff to perform edication aide duties unless				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL039018	B. WING		03	3/24/2022	
		•			1 00	// L-1/ L V L L	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	:, ZIP CODE			
TRE' MOI	RE MANOR ALF		IE TOWN ROAD				
040.15	OXFORD, NC 27565						
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D935	Continued From pag	e 36	D935				
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 staff (Staff B and C) sampled who administered medications had completed 5, 10, or 15-hour mandated						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL039018		B. WING	B. WING		03/24/2022		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE	1 03/	24/2022	
	RE MANOR ALF		E TOWN ROAD	,			
TICE MICH	E MANOR ALI	OXFORD	, NC 27565				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D935	Continued From page	e 37	D935				
	medication clinical skills competency validation prior to administering medications.						
	The findings are:						
	Review of Staff B's, personal care aide (PCA), personnel record revealed: There was no documentation Staff B had completed a 5-hour medication training class. There was no documentation Staff B passed the state written medication examination. There was no documentation Staff B completed an additional 10-hour medication training class. There was no documentation Staff B completed the medication clinical skills competency validation.						
	medication administra revealed Staff B's init administering medica	nts March 2022 electronic ation records (eMARs) ials were documented for tions from 03/19/22 to on 03/16/22 at 8:00pm, 2 at 9:00pm.					
	revealed: -She began working a -She had completed r Administrator.	on 03/23/22 at 4:34pm at the facility on 03/14/22. medication training with the completed a medication ency validation.					
	Refer to interview witl Coordinator (RCC) or	h the Resident Care n 03/24/22 at 11:53am.					
	Refer to interview with 03/24/22 at 12:55pm.	h the Administrator on					
	2. Review of Staff C's personnel record reve	s, personal care aide (PCA), ealed:					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING				
		HAL039018	B. WING		03	3/24/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
		6016 PIN	E TOWN ROAD				
IKE, MOP	RE MANOR ALF	OXFORD	, NC 27565				
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
D935	-There was no documentation Staff C had completed a 5-hour medication training classThere was no documentation Staff C passed the state written medication examinationThere was no documentation Staff C completed an additional 10-hour medication training classThere was no documentation Staff C completed the medication clinical skills competency validation. Review of two residents March 2022 electronic medication administration records (eMARs) revealed Staff C's initials were documented for administering medications from 03/01/22 to 03/05/22, from 03/07/22 to 03/09/22, from 03/12/22 to 03/13/22, from 03/15/22 to 03/17/22 at 8:00am. Interview with Staff C on 03/24/22 at 11:04am revealed: -She began working at the facility on 02/28/22She had not completed a 5-hour medication training class or medication clinical skills competency validationShe was observed administering topical medications by the Resident Care Coordinator (RCC) and the night shift Supervisor/medication aide (MA)She did not administer any oral or injectable medications and was shadowing the RCC and night shift Supervisor/MA to learn how to administer medicationsShe did sign into the electronic medication administration record system to document the administration of the medications because she		D935		ALTIONNIL		
	administration of the was learning the syst -She was assigned at RCC so that she coul administration of med	medications because she em. ccess to the system by the d learn how to document the					

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MALO39018 MALO39018 STREETADRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
CALL CALL		HAL039018 B. WING		03/24/2022			
CX4 ID SUMMARY STATEMENT OF DERICIENCIES DISPERIN CEACH DERICIENCY MIST BE PRECISED BY FULL REGOLATORY OR LSC DENTIFYING INFORMATION) PREPRIX TAG TAG DEFICIENCY MIST BE PRECISED BY FULL REGOLATORY OR LSC DENTIFYING INFORMATION) PREPRIX TAG DEFICIENCY OR LSC DENTIFYING INFORMATION) D935 D935 Continued From page 39 D935 System to document residents' activities of daily living (ADL). Refer to interview with the Resident Care Coordinator (RCC) on 03/24/22 at 11:53am. Refer to interview with the Administrator on 03/24/22 at 12:55pm. Interview with the RCC on 03/24/22 at 11:53am revealed:	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PREFIX TAG Continued From page 39 system to document residents' activities of daily living (ADL). Refer to interview with the Resident Care Coordinator (RCC) on 03/24/22 at 11:53am. Refer to interview with the Administrator on 03/24/22 at 12:55pm. Interview with the RCC on 03/24/22 at 11:53am revealed: -The PCAs were in training for medication administration. -He administration of the medications in the eMAR system for the PCAs documented the administrator on 03/24/22 at 12:55pm. Interview with the Administrator on the eMAR system for the PCAs so that they could learn the eMAR system for the PCAs so that they could learn the eMAR system for the PCAs were administration of the medications in the eMAR system for the PCAs so that they could learn the eMAR system for the PCAs so that they could learn the eMAR system for the PCAs were document residents' activities of daily living (ADLs). Interview with the Administrator on 03/24/22 at 12:55pm revealed: -She did not know the PCAs were documenting the administration of medications. -She should have reviewed what was documented in the eMAR system for the administration of medications. -She knew that the staff who administered medications should document the medications. -She was responsible for ensuring staff had completed medication to administering	TRE' MOR	E MANOR ALF					
system to document residents' activities of daily living (ADL). Refer to interview with the Resident Care Coordinator (RCC) on 03/24/22 at 11:53am. Refer to interview with the Administrator on 03/24/22 at 12:55pm. Interview with the RCC on 03/24/22 at 11:53am revealed: -The PCAs were in training for medication administration. -He administered the medications and the PCAs documented the administration of the medications in the eMAR system. -He provided access into the eMAR system for the PCAs so that they could learn the eMAR system but also to document residents' activities of daily living (ADLs). Interview with the Administrator on 03/24/22 at 12:55pm revealed: -She did not know the PCAs were documenting the administration of medications. -She should have reviewed what was documented in the eMAR system for the administration of medications. -She knew that the staff who administered medications should document the medications. -She was responsible for ensuring staff had completed medication aide training and competency evaluation prior to administering	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETE
medications or documenting the administration of medications.	D935	system to document in living (ADL). Refer to interview with Coordinator (RCC) or Refer to interview with 03/24/22 at 12:55pm. Interview with the RC revealed: -The PCAs were in transministrationHe administrationHe administered the documented the administration in the eNamedications in the eNamedications in the eNamedications in the Administration of daily living (ADLs). Interview with the Administration of medications should down was responsible completed medication competency evaluation medications or documented in the completed medication or documented in the administration of medications or documented in the enamedication of the completed medication or documented in the enamedication of the completed medication or documented in the enamedication of the completed medication or documented in the enamedication of the enamedication or documented in the enamedication of the enamedication of the enamedication of the enamedication or documented in the enamedication of the enamedication of the enamedication of the enamedication or documented in the enamedication of the ena	the Resident Care in 03/24/22 at 11:53am. In the Administrator on The Con 03/24/22 at 11:53am aining for medication medications and the PCAs inistration of the MAR system. Into the eMAR system for or could learn the eMAR cument residents' activities The PCAs were documenting medications. It is a PCAs were documenting medication medications. It is a PCAs were documenting medication	D935			

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