	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04	/22/2022	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ERRABE	LLA NEWTON		N, NC 28658	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 000	Initial Comments		D 000				
	The Adult Care Licen Catawba County DS follow-up survey on 0	S conducted an annual and					
D 137	10A NCAC 13F .0407 Qualifications	7(a)(5) Other Staff	D 137				
	(a) Each staff persor shall:(5) have no substant	7 Other Staff Qualifications n at an adult care home tiated findings listed on the n Care Personnel Registry 1E-256;					
	facility failed to ensur	and record reviews, the e 2 of 6 sampled staff (Staff stantiated findings listed on ealth Care Personnel					
	The findings are:						
	Personnel record revo -Staff B was hired on -She was full-time sta	01/19/22. aff. nentation a HCPR was					
		ICPR check dated 04/22/22 no substantiated findings.					
	revealed: -She had worked at t	on 04/22/22 at 3:45pm he facility as a MA. mber if the facility staff					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/22/2022	
		HAL018036	B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 137	Continued From page	e 1	D 137			
	Refer to the interview Director (SCD) on 04	with the Special Care /20/22 at 4:11pm.				
	Refer to interview witl Manager (BOM) on 0					
	Refer to interview with Coordinator (RCC) or	h the Resident Care n 04/22/22 at 3:45pm.				
	Refer to interview with 3:35pm.	h Administrator 04/22/22 at				
	revealed:	, MA, personnel record				
	-There was no record agency or at the facili -He was an agency s	-				
	was completed upon	nentation a HCPR check hire. nentation provided by the				
	staffing agency a HC completed prior to 04	PR check had been				
		ICPR check dated 04/22/22 no substantiated findings.				
	Refer to interview with (SCD) on 04/20/22 at	h the Special Care Director : 4:11pm.				
	Refer to interview with Manager (BOM) on 0					
	Refer to interview with Coordinator (RCC) or	h the Resident Care n 04/22/22 at 3:45pm.				
	Refer to interview with 3:35pm.	h Administrator 04/22/22 at				
	Attempted telephone	interview with Staff E on				

	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 137	Continued From page	e 2	D 137			
	04/22/22 at 3:40pm v	vas unsuccessful.				
	Interview with the SCD on 04/20/22 at 4:11pm revealed: -She was the current scheduler for staff in the facility					
	facility. -She was the liaison between the facility and the staffing agencies. -She created a template each month and					
	determined the days and shifts she would need to supplement with agency staff. -She worked with 5 different agencies for staffing to fill the staffing needs.					
	staff qualifications.	sible for documentation of				
	shift and assign them	s in the building during their				
	revealed:	0M on 04/22/22 at 3:33pm				
	the HCPR and bring -She was not aware s	ket together which included it to the RCC for processing. she needed to have proof of				
	the HCPR for the age Interview with the RC revealed:	C on 04/22/22 at 3:45pm				
	-The BOM was respo	onsible for giving her the MA essing including the HCPR				
	verification upon hire					
		cy staff records located in ne agency maintained all of				
		she needed the same [.] ed for regular facility staff as				

STATE FORM

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04/22/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
FRRARE	LLA NEWTON	1088 RA	DIO STATION ROA	D		
			N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 137	Continued From page	3	D 137			
	the agency staff.					
	3:35pm revealed: -The BOM was respo records to the RCC. -The BOM was respo staff records from the	agency had to provide				
D 164	10A NCAC 13F .0505 Diabetic Resident	i Training On Care Of	D 164			
	 the care of residents of unlicensed staff prior insulin as follows: (1) Training shall be practitioner. (2) Training shall incl (a) basic facts about in the management of (b) insulin action; (c) insulin storage; (d) mixing, measuring for insulin administration 	hall assure that training on with diabetes is provided to to the administration of provided by a registered rmacist or prescribing ude at least the following: diabetes and care involved f diabetes; g and injection techniques ion; evention of hypoglycemia neluding signs and nitoring; universal ions; nistration times; and				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	ROVIDER OR SUPPLIER	HAL018036	B. WING ADDRESS, CITY, STATE, ZIP CODE			/22/2022
FERRABE		NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 164	Continued From pag	e 4	D 164			
	facility failed to ensur aides (Staff A, B, C, I	and record reviews, the re 6 of 6 sampled medication D, E, and F), who obtained ars (FSBS) for residents,				
	The findings are:					
	personnel record rev -Staff A was hired on -She was full-time sta	02/24/22. aff. nentation she completed the				
		resident's February 2022 A did not check a FSBS and 02/01/22-02/28/22.				
		resident's March 2022 eMAR ked FSBS and administered 3/01/22-03/31/22.				
		resident's April 2022 eMAR cked FSBS and administered 04/10/22-04/20/22.				
	Attempted telephone 3:41pm was unsucce	interview on 04/22/22 at essful.				
	Refer to interview wit (SCD) on 04/20/22 a	th the Special Care Director t 4:11pm.				
	Refer to interview wit	th the Business Office				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE COMF	SURVEY PLETED
		HAL018036			04/22/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	ELLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 164	Continued From page	9 5	D 164			
	Manager (BOM) on 0	4/22/22 at 3:33pm.				
	Refer to interview wit Coordinator (RCC) or	h the Resident Care n 04/22/22 at 3:45pm.				
	Refer to interview wit 04/22/22 at 3:35pm.	h the Administrator on				
	personnel record reve -Staff B was hired on -She was full-time sta	01/19/22. iff. nentation she completed the				
		resident's February 2022 B checked a FSBS but did 02/01/22-02/28/22.				
	revealed Staff B did r	resident's March 2022 eMAR ot check a FSBS or rom 03/01/22-03/31/22.				
	revealed Staff B did r	resident's April 2022 eMAR ot check a FSBS or rom 04/10/22-04/20/22.				
	revealed: -She had worked at the administered insulin a	on 04/22/22 at 3:45pm ne facility as a MA and had and checked FSBS. any diabetic training at the				
	Refer to interview wit 4:11pm.	h the SCD on 04/20/22 at				
	Refer to interview wit 3:33pm.	h the BOM on 04/22/22 at				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING			0.4/00/0000	
JAME OF P	ROVIDER OR SUPPLIER	HAL018036	B. WING 04/22/20				
		1088 RA	DIO STATION ROA				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D 164	Continued From page	e 6	D 164				
	Refer to interview wit 3:45pm.	h the RCC on 04/22/22 at					
(- -	 Refer to interview with the Administrator on 04/22/22 at 3:35pm. 3. Review of Staff C's, medication aide (MA) personnel record revealed: Staff C was hired on 03/03/22. She was full-time staff. There was no documentation she completed the training on the care of diabetic residents. 						
	eMAR revealed Staff	resident's February 2022 C did not check a FSBS and sulin 02/01/22-02/28/22.					
	Review of a diabetic resident's March 2022 eMAR revealed Staff C did not check a FSBS or administered insulin from 03/01/22-03/31/22.						
	Review of a diabetic revealed Staff C chec administered insulin 04/10/22-04/20/22.						
	3:30pm revealed: -She was hired in Ma -She checked FSBS residents at the facilit	and administered insulin to y. d diabetic training from the					
	Refer to interview wit 4:11pm.	h the SCD on 04/20/22 at					
	Refer to interview wit 3:33pm.	h the BOM on 04/22/22 at					

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		HAL018036	_018036 B. WING		04	04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
FERRABE	ELLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETI DATE	
D 164	Continued From page	e 7	D 164				
	Refer to interview wit 3:45pm.	h the RCC on 04/22/22 at					
	Refer to interview wit 04/22/22 at 3:35pm.	h the Administrator on					
	revealed: -There was no hire da facility for Staff D.	s, MA, personnel record ate provide by the agency or nentation Staff D completed f diabetic residents.					
		resident's February 2022 D checked FSBS and 14 times from					
		resident's March 2022 eMAR cked FSBS and administered 03/01/22-03/31/22.					
		resident's April 2022 eMAR cked FSBS and administered 14/10/22-04/20/22.					
	revealed: -She was hired by the -She worked at the fa -She checked FSBS residents at the facilit	acility since November 2021. and administered insulin to ty. d diabetic training at the					
	Refer to interview wit 4:11pm.	h the SCD on 04/20/22 at					
	Refer to interview wit 3:33pm.	h the BOM on 04/22/22 at					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04/22/2022	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 164	Continued From page	28	D 164			
	Refer to interview wit 3:45pm.	h the RCC on 04/22/22 at				
	Refer to interview wit 04/22/22 at 3:35pm.	h the Administrator on				
	revealed:	, MA, personnel record ate provide by the agency or				
	facility for Staff E.	nentation Staff E completed				
		resident's February 2022 E checked FSBS and one time.				
		resident's March 2022 eMAR ked FSBS and administered 3/05/22-03/27/22.				
	Attempted telephone 04/22/22 at 3:07pm w	interview with staff E on vas unsuccessful.				
	Refer to interview wit 4:11pm.	h the MCM on 04/20/22 at				
	Refer to interview wit 3:33pm.	h the BOM on 04/22/22 at				
	Refer to interview wit 3:45pm.	h the RCC on 04/22/22 at				
	Refer to interview wit 04/22/22 at 3:35pm.	h the Administrator on				
	revealed:	, MA, personnel record				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	5.000		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		+/22/2022
TERRABE			DIO STATION ROAD	D		
			N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
D 164	Continued From pag	e 9	D 164			
	-There was no docur training on the care o	nentation Staff F completed of diabetic residents.				
	Review of a diabetic resident's March 2022 eMAR revealed Staff F checked FSBS and administered insulin 3 times from 03/12/22-03/20/22.					
	Telephone interview with Staff F on 04/22/22 at 3:23pm revealed: -She had worked at the facility as a MA and had administered insulin and checked FSBS.					
	-She did not receive facility.	any diabetic training at the per if she had diabetic				
	Refer to interview with	th the MCM with the Memory 1) on 04/20/22 at 4:11pm.				
	Refer to interview wit 3:33pm.	th the BOM on 04/22/22 at				
	Refer to interview wir 3:45pm.	th the RCC on 04/22/22 at				
	Refer to interview wi 04/22/22 at 3:35pm.	th the Administrator on				
	revealed:	CD on 04/20/22 at 4:11pm				
	facility.					
	staffing agencies.	between the facility and the				
	supplement with age	and shifts she would need to ncy staff.				
		lifferent agencies for staffing. sible for agency staff training				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		UAL 049026	B. WING				
	ROVIDER OR SUPPLIER	HAL018036	B. WING 04/22/2022 ET ADDRESS, CITY, STATE, ZIP CODE 04/22/2022				
TERRABE	LLA NEWTON	NEWTO	N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 164	Continued From page	e 10	D 164				
	shift and assign them a mentor. -She did not know wh obtaining agency stat -She did not know of received at the facility Interview with the BC revealed: -She was responsible pre-employment pact them to the RCC for -She was not aware at diabetic training for the Interview with the RC revealed: -The BOM was respond agency staff records. -She was not aware at verification of diabetic -There were no agen the facility because the those records. -She was not aware at personnel file with the required for agency as Interview with the Ad 3:35pm revealed:	s in the building during their n a medication aide (MA) as no was responsible for ff qualifications. training agency staff y. M on 04/22/22 at 3:33pm e for putting the ket together and to bring processing. she needed to have proof of ne agency MAs. C on 04/22/22 at 3:45pm onsible for giving her the the agency MAs needed					
	staff records from the -She did not know the	onsible for collecting agency agency upon hire. e agency had to provide c training for the MAs to the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			/* 55.25 NO.			
		HAL018036	B. WING		04/22/2022	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
ERRABE	LLA NEWTON		ADIO STATION ROAI N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 260	Continued From pag	e 11	D 260			
D 260	10A NCAC 13F .080	2(b) Resident Care Plan	D 260			
(b ba ad TI Ba fa to	10A NCAC 13F .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section					
	This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the resident's care plan due to a change in condition for 1 out of 6 sampled residents (#1).					
	The findings are:					
	02/24/22 revealed: -Diagnoses included	¢1's current FL2 dated dementia, . evel of care was the special				
		¢1's Resident Register mitted to the SCU on				
	8:45am revealed:	lent #1 on 04/20/22 at left leg knee immobilizer and				
	socks. -Her left lower leg wa	as edematous including her n indention from her socks.				
	Review of Resident # revealed there was n					
	Review of Resident # 03/02/22 revealed:	#1's current Care Plan dated				

STATE FORM

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If continuation sheet 12 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE DIO STATION ROA			
ERRABE	LLA NEWTON		N, NC 28658	-		
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 260	Continued From page	e 12	D 260			
	 260 Continued From page 12 She was independent with transfers. She required supervision with eating. She required limited assistance with toileting. She required extensive assistance with bathing, dressing and grooming. There was no documentation of Resident #1's knee immobilizer. Review of Resident #1's Emergency Room (ER) discharge dated 02/28/22 revealed: An Xray of Resident #1's left knee noted a left tibia plateau fracture. Discharge instructions included Resident #1 to maintain non-weight bearing to the left leg until seen by orthopedics. Review of Resident #1's orthopedic provider's order dated 03/03/22 revealed Resident #1 was 					
	(RCC) on 04/22/22 a - The Health and Well responsible for comp plans. - The HWD position h November 2021 and started working at the -From November 2022 completing the care p	Iness Director (HWD) was leting the residents' care ad been vacant since on 04/18/22 a new HWD e facility. 21, she was responsible for plans but she did not know a completed with in 10 days				
	revealed: -The HWD was respo was to be completed					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
FERRABE	LLA NEWTON		N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 260	Continued From page	e 13	D 260			
	working at the facility -She was informed b was responsible for o after November 2021 facility. -She did not know the completed correctly. Interview with the Ad 12:16pm revealed: -A nurse or the HWD completion of the car admission and with in change in a resident -After November 2022 for completion of the a significant change. -Since there was no the RCC was respon Regional Nurse for g the care plans. -She was not aware	y the Administrator the RCC completion of the Care Plans I until she started work at the e Care Plans were not ministrator on 04/22/22 at was responsible for re plan with in 30 days of n 10 days of a significant				
D 270	Supervision 10A NCAC 13F .090 Supervision (b) Staff shall provid	e supervision of residents in h resident's assessed needs,	D 270			
	This Rule is not met	-				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
TERRABE	LLA NEWTON		DIO STATION ROAI N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From pag	e 14	D 270			
	Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' current symptoms for 1 of 5 sampled residents who was assigned to the Special Care Unit (SCU) that had a history of a fall requiring the resident to be non-weight bearing after a left tibia plateau fracture (the upper part of the shin involving the knee joint).					
	The findings are:					
	Communication and -There was no date of -A fall was defined as rest on the ground, fl surface. -If a resident was four considered to have of -When a fall was not the Nurse and availa -The care manager w resident's communic significant change no -The Health Wellness Nurse/designee will n resident was assessed -The HWD/designee status in the resident Log.	on the policy. Is an unintentionally coming to oor or other lower level and on the floor, a fall was occurred. ed, the staff would contact ble care managers. vould document in the ation log the fall and any oted. Is Director (HWD) who is a notify the physician after the				
	to all staff at the starf -The HWD/designee Incident/Accident Re -The HWD will updat Intervention Plan. -The HWD will comp	t of the next shifts. will complete an port. e the care plan with a Fall lete a Fall Management estigation for Falls form.				

Division of Health Service Regu STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		HAL018036	B. WING		04/22/2022	
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 15	D 270			
	internally. -The HWD will sugger identified in the comp resident or responsib Review of Resident # 02/24/22 revealed: -Diagnoses included femur fracture, hyper failure, and anemia. -She was semi-ambud device was not indicat Review of Resident # Transfer/Discharge S revealed: -Resident #1 was dist Home back to the fact -Diagnoses included left hip replacement. -Resident #1's level of -Continue with physic signs of infection, device other complications. -Assistance was need and to prevent falls. -There were hip prec more weeks with ass management below to crossing legs. -Resident #1 was diat	21's current FL-2 dated vascular dementia, left tension, epilepsy, heart latory, and an assistive ated. 21's Nursing Home summary dated 02/24/22 charged from a Nursing sility. status post-operative partial				
	-Resident #1 was a h					
		1's care plan dated 03/02/22				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	_018036 B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		02	4/22/2022
	LLA NEWTON	1088 RA	DIO STATION ROA			
(X4) ID	SUMMARY S		N, NC 28658	PROVIDER'S PLAN C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	D THE APPROPRIATE	COMPLET
D 270	Continued From pag	e 16	D 270			
	revealed:					
	-She required superv					
		assistance with toileting.				
		sive assistance with bathing,				
	dressing and groomi	-				
	-She was independe	nt with transfers.				
	Observation of Resid	lent #1 on 04/20/22 at				
	10:15am revealed:					
	-Resident #1 was lyi	ng in bed, wearing an				
	incontinent brief.					
	-	left leg knee immobilizer				
	•	left leg from bending) and				
	socks.	a adamataya inalyding bar				
	-	as edematous including her nindention from her socks.				
		oximately 50 feet down the				
		Station, around the corner				
	and the second room					
	-There was no direct	visualization of the room				
	from the Nurses stati room or day room.	ion, main hallway, dining				
	a. There was no sigr	ificant change to the care				
	plan after Resident # on 02/28/22.	1's left tibia plateau fracture				
	There was no Incide 02/28/22 documentir	nt/Accident Report dated ng a fall.				
	Review of Resident # dated 02/28/22 revea	#1's Resident's Care Notes aled:				
	-Resident #1 was in barely stand or move	severe pain, could not walk, e.				
	-Resident #1 receive	d an Xray earlier in the day.				
	-Resident #1's family					
		nsported to the ER for				
	evaluation.	nonartad to the ED st				
	-Resident #1 was tra 8:30pm.	nsported to the ER at				
alam of Lla	alth Service Regulation					

Division of Health Service Regulation STATE FORM

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING	B. WING		/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 17	D 270			
	discharge summary of -Resident #1 was dia left tibia plateau (the involving the knee joi -Resident #1 was to left leg until evaluated -Follow-up with ortho -A referral was initiated orthopedics follow-up -A knee immobilizer w left leg. Review of Resident # dated 03/01/22 revea -Resident #1 was dia left tibia plateau.	hot bear any weight on the d by orthopedics. pedics. ed on 02/28/22 for o. was placed on Resident #1's				
	left leg until evaluated -An agency medication Resident Care Coord #1 fell on 02/28/22 at -On 02/28/22, the MA floor, lying on her back	d by orthopedics. on aide (MA) notified the linator (RCC) that Resident				
	Review of Resident # visit notes dated 03/0 -She was diagnosed fracture on 02/28/22. -Resident #1 was cor surgical candidate so left tibia plateau fract	t1's Orthopedic follow-up 03/22 revealed: with a left tibia plateau nsidered an extremely poor o continue treatment for the				
	orders dated 03/03/2	1's orthopedic specialist 2 revealed: for a knee immobilizer to the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, 2	ZIP CODE		HZZIZUZZ
TERRABE	ELLA NEWTON		DIO STATION ROAD N, NC 28658)		
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	left leg and daily neu -There was an order on skin to include poor (the back and lower p -There was an order to the left leg. Interview with the Sp 04/20/22 at 9:25am r -The staff were to che hour. -She was not aware of checking on Residen not document the inc she did not check to completing the safety Interview with the Sp (SCC) on 04/20/22 at were to check on Resident possible. Refer to interview with 9:25am. Refer to interview with 9:30am. Refer to interview with Director (HWD) on 04 Refer to interview with 04/22/22 at 11:36am	rovascular and skin checks. to keep a close eye/checks sterior thigh and distal leg part of the leg). for strict non-weight bearing ecial Care Director (SCD) on evealed: eck on Resident #1 every of how often the staff were t #1 because the staff did reased safety checks and see how often the staff were t ecial Care Coordinator t 9:30am revealed the staff sident #1 as often as h a SCD on 04/20/22 at h the SCC on 04/20/22 at h the RCC on 04/20/22 at h the Health Wellness 4/20/22 at 12:17pm. h a medication aide (MA) on	D 270			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 19	D 270			
	Refer to interview wit at 1:26pm.	h a second PCA on 04/22/22				
		terview with Resident #1's an (PCP) on 04/21/22 at				
	Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm.					
	Refer to interview wit 04/22/22 at 12:16pm	h the Administrator on				
	Report dated 03/07/2 -Resident #1 was fou -There were no injuri	ventions documented to				
	Review of Resident # dated 03/07/22 revea documentation of inc					
	Refer to interview wit 9:25am.	h a SCD on 04/20/22 at				
	Refer to interview wit 9:30am.	h the SCC on 04/20/22 at				
	Refer to interview wit 12:11pm.	h the RCC on 04/20/22 at				
	Refer to interview wit 12:17pm.	h the HWD on 04/20/22 at				
	Refer to interview wit 11:36am.	h a MA on 04/22/22 at				
	Refer to interview wit	h a PCA on 04/22/23 at				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04/22/2022	
ame of Pf	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		NDIO STATION ROA	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From pag	e 20	D 270			
	1:12pm.					
	Refer to interview wit at 1:26pm.	th a second PCA on 04/22/22				
	Refer to telephone interview with Resident #1's PCP on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm. Refer to interview with the Administrator on 04/22/22 at 12:16pm.					
	Report dated 03/28/2 -Resident #1 was fou -There were no injuri	ventions documented to				
	Review of Resident # dated 03/28/22 revea documentation of inc					
	orders dated 03/31/2 -There was an order knee immobilizer.	#1's orthopedics physician 2 revealed: for daily skin checks under for strict non-weight bearing				
	-	th a SCD on 04/20/22 at				
	Refer to interview wit 9:30am.	th the SCC on 04/20/22 at				
	Refer to interview with 12:11pm.	th the RCC on 04/20/22 at				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		NDIO STATION ROA N, NC 28658	D		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 21	D 270			
	Refer to interview wit 12:17pm.	h the HWD on 04/20/22 at				
	Refer to interview wit 11:36am.	h a MA on 04/22/22 at				
	Refer to interview wit 1:12pm.	h a PCA on 04/22/23 at				
	Refer to interview wit at 1:26pm.	h a second PCA on 04/22/22				
	Refer to telephone in PCP on 04/21/22 at 8	terview with Resident #1's 3:47am.				
	-	terview with Resident #1's on 04/21/22 at 3:41pm.				
	Refer to interview wit 04/22/22 at 12:16pm	h the Administrator on				
	Report dated 04/06/2 -Resident #1 was fou -There were no injurio	ventions documented to				
	revealed on 04/06/22 documented, the pers noticed Resident #1's	t1's Resident Care Notes , there was no time stamp sonal care aide (PCA) s left foot was swollen, and PCA notified RCC.				
	Refer to interview wit 9:25am.	h a SCD on 04/20/22 at				
	9:30am.	h the SCC on 04/20/22 at				
sion of Hea TE FORM	alth Service Regulation		⁶⁸⁹⁹ YG	9F11	If continua	tion sheet 22 o

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
D 270	Continued From page	22	D 270			
	Refer to interview with 12:11pm.	h the RCC on 04/20/22 at				
	Refer to interview with 12:17pm.	h the HWD on 04/20/22 at				
	Refer to interview with 11:36am.	h a MA on 04/22/22 at				
	Refer to interview with 1:12pm.	h a PCA on 04/22/23 at				
	Refer to interview with at 1:26pm.	h a second PCA on 04/22/22				
	Refer to telephone in PCP on 04/21/22 at 8	terview with Resident #1's 3:47am.				
		terview with Resident #1's on 04/21/22 at 3:41pm.				
	Refer to interview with 04/22/22 at 12:16pm.	h the Administrator on				
	Report dated 04/15/2 -Resident #1 was fou	ented to Resident #1's back,				
	-Resident #1 complai	ned of left leg pain. ventions documented to				
	revealed;	1's Resident Care Notes am, Resident #1 rolled out				
	-On 04/17/22, at 12:0	0pm, Resident #1 and pain and there were no				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 04/22/2022	
		HAL018036				
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FERRABI	ELLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 270	 #1's right hand was s the last 2 fingers and -On 04/18/22, an Xra right hand and revea fifth proximal phalany finger). Review of Resident # 04/18/22 revealed ar proximal phalanx. Refer to interview wit 9:25am. Refer to interview wit 9:30am. Refer to interview wit 12:11pm. Refer to interview wit 12:17pm. Refer to interview wit 11:36am. Refer to interview wit 11:36am. Refer to interview wit 11:2pm. Refer to interview wit 11:26pm. Refer to telephone in PCP on 04/21/22 at 8 Refer to telephone in 	Dam, staff observed Resident swollen and bruised around palm of hand. Ty was taken of Resident #1's led an acute fracture of the c (a fracture of the pinky #1's Right hand Xray dated the acute fracture of the fifth th a SCD on 04/20/22 at th the SCC on 04/20/22 at th the RCC on 04/20/22 at th the HWD on 04/20/22 at th a MA on 04/22/22 at th a PCA on 04/22/23 at th a second PCA on 04/22/22 terview with Resident #1's	D 270			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING	04	/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
TERRABE	LLA NEWTON		N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From pag	e 24	D 270			
	Refer to interview wi 04/22/22 at 12:16pm	th the Administrator on				
	Interview with a SCD on 04/20/22 at 9:25am revealed:					
	-She considered Resident #1 a fall risk because in February 2022 Resident #1 fell and broke her left hip. -Resident #1 returned from rehab the end of					
		ell fracturing her left leg.				
	considered non-weight bearing on her left leg. -Resident #1 fell a couple more times after that because Resident #1 could not remember to ask					
		ould get up on her own and				
	-Resident #1 developed a DVT in the left lower leg and fell a few more times causing injury to her					
		e to her right hand. eck on Resident #1 every sident #1's injury to her left				
	leg. -After a fall, the staff	were to complete an				
	injuries in the 24-hou	ort, document the fall and Ir book, report it to her, the lent Care Coordinator (RCC).				
		ion from the RCC on how fety check of Resident #1				
	-There were no fall n recommendations in	-				
	revealed:	CC on 04/20/22 at 9:30am				
		ut 4-5 times since February ack from rehab with a left hip e of the falls.				
	-After a fall, the staff	were to complete an ort, document the fall and				

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If continuation sheet 25 of 102

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 25	D 270			
	SCD, or to the RCC. -The Nurse, who was was to review the inc make recommendation Management Policy. -There was not a Nur November 2021, so as responsible for makin -The recommendation non-skid socks, and in 1 on 1 supervision and interventions. -The normal safety cli- the Special Care Unit -Resident #1 was con- because Resident #1 and because she was left leg fracture and D -There were no fall more recommendations init #1's falls and staff we as often as possible. Interview with the Ref (RCC) on 04/20/22 ar -The HWD who was an	ncreased supervision up to ad she did not ask for those necks were every 2 hours in t (SCU). Insidered a high fall risk forgot what she was told, is non-weight bearing due to DVT. Inanagement tiated after each of Resident ere to check on Resident #1 sident Care Coordinator				
	incident/accident rep recommendations of resident who had mo	what to do in the case of a				
	the MA to notify her a completing the report -The MA was respon- falls, injuries and pro- increased supervision in her office.	and she would assist in				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	L018036 B. WING		04	/22/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 270	Continued From page	e 26	D 270			
	it was the responsibil fall management pro- recommendations of and increased super- -Since the nurse or H the facility, she receive reports and would car recommendations. -She did not know wh Regional Nurse for re -The staff were to con every 15- 30 minutes -She did not know wh Resident #1 closer to -On 04/19/22, she ar about Resident #1 ne but nothing was put i -She could have calle about other intervent recommendations for not and did not know -There should have to the Administrator, SC #1 came back to the discuss interventions increased supervision dementia, but there w Interview with the HW revealed:	fall mats, non-skid socks vision. IWD position was vacant at ved all the incident/accident II the Regional Nurse for by she did not contact the ecommendations. mplete frequent checks on Resident #1. by the facility did not move the Nurse's Station. The Administrator talked beeding a higher level of care, into motion. The Administrator talked beeding a higher level				
	-It was the responsib incident/accident rep RCC. -If the incident report	ility of the MA to fill out the ort and submit it to her or the was related to a fall the discuss the incident and				
		discuss the incident and the next stand up meeting				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROAI N, NC 28658	0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 27	D 270			
	as, fall mat, gripper s suggestion to the phy supervision/safety ch -It was her responsibl incident/accident rep management program vacant at the facility of the responsibility of t incident/accident rep Regional Nurse for re- Since Resident #1's she could not remem broken leg, Resident supervision. -After the first fall the implemented a fall m prevent falls as well a from every 2 hours to minutes or 1-hour sa	ility to review the orts and implement the fall m but since the position was until now it would have been he RCC to review the orts and contact the ecommendations. dementia was at the point ober to not stand up on a #1 could have used the 1:1 Regional Nurse should have at and gripper socks to help as increased supervision o every 15 minutes, 30 fety checks. of any increased supervision				
	revealed: -She witnessed Resi the past 2 weeks, ou her dresser which wa -Resident #1 was known -Staff were constantly sit back down in her bed. -She had not been in frequency of supervision -Resident #1 sustain injuries with each fall fall.	own to have fallen frequently. y redirecting Resident #1 to chair or lay back down in her structed to increase sion or to document any				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. DOILDING.			
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 28	D 270			
	SCD or the Administr supervision. -She tried to check in minutes to an hour if -Resident #1 could m assistance. -All the falls reported was found on the floo got there. -Resident #1 was a to the non-weight bearin Interview with a PCA revealed: -Resident #1 needed off her leg, stay in the up without assistance -She found Resident chair when she was to at risk for falls. -Resident #1's demen remember to not get -She had not been in frequency of superviso	ot remember to ask for to her were Resident #1 or, never witnessed how she wo person assist because of ng on the left leg. on 04/22/23 at 1:12pm constant reminders to stay e chair or bed and do not get e. #1 up and out of her bed or to be non-weight bearing and ntia made it hard for her to up without assistance. structed to increase sion or to document any n.				
	1:26pm revealed: -Resident #1 would n and she would find he without staff present.	nd PCA on 04/22/22 at ot stay in her chair or bed er standing in her room				
	-Resident #1 fell mar injuries. -The normal checks o 2 hours.	ot remember what to do. ny times and sustained many on the residents were every				
	on Resident #1.	red to increase supervision				

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NAME OF PF			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PF	HAL018036		B. WING				
VAIVIE OF PF			B. WING 04/22/202				
	ROVIDER OR SUPPLIER						
ERRABE	LLA NEWTON		N, NC 28658	-			
(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 AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page 29		D 270				
	non-skid socks, or ind Resident #1.	creased supervision for					
	04/21/22 at 8:47am r						
	-On 02/07/22, Resident #1 received a partial left hip replacement due to a fall.						
	-On 02/28/22, the phy	ysical therapy assistant					
	called reporting Resid her left leg and was in	dent #1 could not straighten					
	-Resident #1 was mo						
	03/08/22.	100/001					
		/28/22 he received a fax dent #1 fell and there were					
	no injuries.						
	-On 04/06/22, the on-call physician received a call from the facility Resident #1 fell and there were no injuries.						
	-On 04/18/22, he rec Resident #1 fell and s	eived a fax from the facility sustained bruises and an					
	-	right hand was requested. risk for falls due to dementia					
		not remember minutes after					
		were provided and an even ince Resident #1 broke her					
	leg on 02/28/22 and	was non-weight bearing on					
	her left leg.	esponsibility to call and					
		s as soon as they happened,					
	and the type of injurie						
	appropriate and infor care of Resident #1.	mative decisions about the					
		s dementia, and the partial					
		left leg fracture, and the on the left leg, Resident #1					
	required increased su	upervision of at least every					
	15 minutes to even 1 the amount of falls ar	:1 supervision to decrease nd injuries.					
	Telephone interview	with Resident #1's					
ision of Hea ATE FORM	alth Service Regulation						

ND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVI COMPLETED	
		HAL018036	B. WING		04	/22/2022
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 30	D 270			
	revealed: -On 02/07/22, Reside hip replacement due -On 02/28/22, an Xra plateau fracture after -On 04/08/22, a veno indicated a blood clot -On 04/18/22, a right fracture of the pinky f -There were 3 falls re and 04/18/22. -On 03/03/22, he saw a follow-up appointme plateau fracture and i present, the important maintaining non-weig because of Resident remembering instruct eye on Resident #1, on necessary to help pre- injuries and dislodger left leg. -He considered Resident replacement, and mo with injuries requiring 02/28/22 because of strict non-weight beau increased risk of fall I causing vascular corr interruption of the blo	y indicated a left tibial a fall. us doppler ultrasound in Resident #1's left leg. hand Xray indicated a inger after a fall. ported between 02/28/22 v Resident #1 in his office for ent related to the left leg tibia nformed the staff member ce of Resident #1 ht bearing on the left leg, #1's dementia and lack of ions, the staff must keep an every 15 minutes to 1:1 if event more falls, more ment of the blood clot in her dent #1 an increased fall risk es after returning to the om her partial left hip re of an increased fall risk more supervision on Resident #1's dementia, ring of her left leg, and eading to dislodgement and opromise (partial or complete od flow).				
	12:16pm revealed: -The required safety of	ministrator on 04/22/22 at checks in the SCU were ere to be increased based on ds.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
			B. WING				
		HAL018036					
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,				
ERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page	Continued From page 31					
	incident/accident rep management program recommendations su socks, increase the si based on their care in the physician and asi -The HWD did not re- non-skid socks or inco- -Since the facility did the RCC was respon- incident/accident rep Regional Nurse for a of the fall manageme recommendations. -Based on Resident asi as a hip fracture, left fracture, a blood clot #1's dementia causin instruction within 1-2 expected the staff to every 15 to 30 minute supervision. -She did not check to supervision was impl did not inform her of -She was not aware a program was not imp Based on observation reviews, it was detern interviewable. The facility failed to p	ility of the HWD to review all orts and implement a fall m and after every fall, make ich as; a fall mat, non-skid supervision of the resident needs and/or notification to k for physical therapy. quire an order for fall mats, creased supervision. not have an HWD on duty, sible for receiving the orts and notifying the ssistance in implementation ent program and #1's fall history, injuries such leg fracture, right hand in the left leg and Resident ag Resident #1 to forget minutes after being told, she be checking on Resident #1 es up to even 1:1 o ensure the increased emented because the RCC any concerns. the fall management blemented. ms, interviews and record mined Resident #1 was not					
	for 1 of 5 sampled re returning from rehab	sidents (#1) who after with a partial left hip e times in 53 days resulting					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04	/22/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From page	e 32	D 270			
	in her left leg. This fa	dislodgment of the blood clot ailure resulted in serious eglect to the resident and I Violation.				
		a plan of protection in . 131D-34 on April 20, 2022				
	CORRECTION DATE VIOLATION SHALL N 2022.	E FOR THE TYPE A1 NOT EXCEED MAY 22,				
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273			
		2 Health Care assure referral and follow-up nd acute health care needs				
	This Rule is not met TYPE A2 VIOLATION	-				
	facility failed to ensur meet the routine and 2 of 5 sampled reside fasting blood sugar (I	and record reviews, the re referral and follow-up to acute health care needs for ents (#3, and #6) related to a FSBS) greater than 400 (#6) f a blood thinner medication #3).				
	The findings are:					
		nt #6's FL2 dated 01/24/22 ncluding type II diabetes				
	Review of a physicial	n's order for Resident #6				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	4/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	e 33	D 273			
	meals and at bedtime	aled to monitor FSBS before e, and to notify physician if than 120 or greater than 400.				
	Review of Resident #6's March 2022 electronic Medication Administration Records (eMAR) revealed:					
	meals and at bedtime blood sugar less than documented at 7:30a	to monitor FSBS before e and to notify provider if n 120 or greater than 400 nm, 11:30am, 4:30pm, and				
	as 408, 03/18/22, at 4:30pm as 438, 03/2	nted on 03/16/22, at 4:30pm 4:30pm as 407, 03/19/22, at 0/22, at 4:30pm as 488,				
	03/20/22, at 8:00pm as 495, 03/21/22, at 11:30am as 446, 03/22/22, at 11:30am as 426, 03/22/22, at 4:30pm as 426, 03/23/22, at 11:30am as 416, 03/24/22, at 4:30pm as 416,					
	as 410, 03/26/22, at 4:30pm as 490, 03/2	as 529, 03/26/22, at 7:30am 11:30am as 419, 03/26/22, at 6/22, at 8:00pm as 571, as 432, 03/27/22, at 8:00pm				
	as 445, 03/28/22, at 4:30pm as 457, 03/2 03/30/22, at 7:30am	as 432, 03/27722, at 0.00pm 11:30am as 436, 03/29/22, at 9/22, at 8:00pm as 491, as 436, and 03/30/22, at				
		nentation on the exception ian was notified when the an 400.				
	Review of Resident #6's April 2022 eMAR revealed:					
	meals and at bedtime blood sugar less than	to monitor FSBS before e and to notify provider if n 120 or greater than 400 um 11:30am 4:30am and				
	8:00pm. -FSBS were docume	nm, 11:30am, 4:30pm, and nted on 04/1/22 at 4:30pm 00pm as 472, 04/2/22 at				

Division of Health Service Regul STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		ADIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From page 34		D 273			
	7:30am as 493, 04/3/ 04/3/22 at 8:00pm as 427, 04/6/22 at 8:00p 4:30pm as 431, 04/9/ 04/13/22 at 11:30am as 451, 04/15/22 at 8 8:00pm as 537, 04/1 04/18/22 at 8:00pm as 8:00pm as 421. -There was no docum note page the physic FSBS was greater th Review of progress m revealed there was no physician was notifie greater than 400 on 0 03/20/22, 03/21/22, 04/ 03/26/22, 03/27/22, 04/ 04/7/22, 04/9/22, 04/ 04/7/22, 04/9/22, 04/ 04/16/22, 04/17/22, 04/ 04/16/22, 04/17/22, 04/ 04/16/22, 04/17/22, 04/ 04/16/22 at 11:30an -It was the responsib physician when a FS -It was the responsib the greater than 400 the physician in the 2 -She was not aware 1 greater than 400. -She was responsible and 24 hour logs aud Wellness Director (H audited the medicatio	/22 at 11:30am as 466, a 435, 04/4/22 at 11:30am as bom as 455, 04/7/22 at /22 at 4:30pm as 453, as 402, 04/14/22 at 7:30am B:00pm as 480, 04/16/22 at 7/22 at 8:00pm as 416, as 407, and 04/19/22 at mentation on the exception ian was notified when the an 400. motes for Resident #6 to documentation the d about the elevated FSBS D3/16/22, 03/18/22, 03/19/22, D3/22/22, 03/23/22, 03/24/22, D3/28/22, 03/29/22, 03/30/22, 3/22, 04/4/22, 04/6/22, 13/22, 04/14/22, 04/15/22, D4/18/22, or 04/19/22. ent Care Coordinator (RCC) m revealed: ility of the MA to notify the BS was greater than 400. ility of the MA to document FSBS and the notification to				
		s were concerned, she was ng a report of the eMARs				
	-	documentation of FSBS				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BOILDING.			
		HAL018036	B. WING		04	/22/2022
iame of Pf	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From page	e 35	D 273			
	-It was her expectation physician for a FSBS further orders. -It was her expectation or HWD, RCC, and A	I physician notification. on the MA would contact the greater than 400 to receive on the MA inform the nurse administrator with concerns when the physician was				
	4/21/22 at 4:00pm re -Resident #6 was ne -Resident #6 was las reassess Resident #6	w to her. ht seen on 03/28/22 to 6's FSBS. lent #6's FSBS greater than er to manage his				
	-There was documen record dated 03/23/2 594 and insulin was hour was also ordere -The facility staff was if Resident #6's FSB because she would of insulin, a recheck in emergency room (EF was still high. -A FSBS greater than	Atation in Resident #6's office 2, Resident #6's FSBS was ordered and a recheck in 1 ed. 5 responsible for notifying her S was great than 400 order a one time dose of 1 hour and to send out to the R) for evaluation if the FSBS on 400 that was not improving se of insulin put Resident #6				
	11:45am revealed: -The MA was respon physician for a FSBS the physician's recon -The MA was respon 911 for a FSBS great -The MA was respon	greater than 400 and follow nmendations at that point. sible for notifying the calling				

STATE FORM

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If continuation sheet 36 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING				
	ROVIDER OR SUPPLIER	HAL018036	ADDRESS, CITY, STATE		04	/22/2022	
ERRABE	LLA NEWTON	NEWTO	N, NC 28658				
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From page	e 36	D 273				
	to a FSBS greater tha -The MA was response the 24-hour log when FSBS greater than 50 -The HWD and the R auditing the 24-hour left the eMARs for completing the physician for the -It was her expectations as written by the physical 2. Review of Resident # an admission date of a. Review of Resident # other was no docum Normalized Ratio (IN time it takes for one's -There was an order warfarin 6mg to be ac through Friday, and 4 Saturday and Sunday Review of Resident # 01/24/22 revealed: -Resident #3's INR of -Based on the INR, th by the physician was	sible for documentation in 911 was called related to a 00. CC were responsible for logs, medication carts and etion of the orders to notify FSBS greater than 400. on the MAs follow the order sician. It #3's FL2 dated 11/19/21 included a history of a and anxiety. 3' resident register revealed 04/07/07. It #3's physician order on inentation of an International R), used to determine the blood to clot. sent to the pharmacy for diministered daily on Monday and to be administered on y. 3's physician order dated in 01/24/22 was 4.6. he warfarin dosage ordered 2mg on Monday and Friday Tuesday, Wednesday,					
	Review of Resident # 02/07/22 revealed: -The INR results on 0	3's physician order dated					

of Health Service Regu of DEFICIENCIES of CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
	HAL018036	B. WING		04/22/2022		
ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
LLA NEWTON			D			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE	(X5) COMPLETE DATE	
Continued From page	e 37	D 273				
Monday and Friday a	nd 4mg on Tuesday,					
03/31/22 revealed: -INR drawn on 03/31/	/22 was 1.7.					
by the physician was and 4mg on Tuesday	2mg on Monday and Friday , Wednesday, Thursday,					
04/11/22 revealed: -INR results on 04/11 -Based on the INR, th	/22 was 1.6. ne warfarin dosage ordered					
worksheet dated 01/2 -Resident #3's coura the date the INR was current couradin dos adjustment and the n	24/22 revealed: adin worksheet documented drawn, the INR results, the sage, the coumadin ext date the INR was					
4.6. -There was an entry f	for warfarin 6mg to be					
was no documentatio 01/24/22 or a physicia	on of INR results on an's order for warfarin 6mg					
medication administra revealed :	ation record (eMAR)					
	Review of Resident # 04/11/22 revealed: -INR results on 04/11 -Based on the INR, tf by the physician was and 4mg on Tuesday Saturday and Sunday Review of Resident # 04/11/22 revealed: -INR drawn on 03/31, -Based on the INR, tf by the physician was and 4mg on Tuesday Saturday and Sunday Review of Resident # 04/11/22 revealed: -INR results on 04/11 -Based on the INR, tf by the physician was and 4mg on Tuesday Saturday and Sunday Review of Resident # 04/11/22 revealed: -INR results on 04/11 -Based on the INR, tf by the physician was Review of Resident # worksheet dated 01/2 -Resident #3's coura the date the INR was current couradin dos adjustment and the n scheduled to be draw -INR results on 01/24 4.6. -There was an entry fa administered Monday Review of Resident # was no documentatic 01/24/22 or a physici to be administered da Review of Resident #	IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: INALO18036 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 37 -The warfarin dosing continued at 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. Review of Resident #3's physician order dated 03/31/22 revealed: -INR drawn on 03/31/22 was 1.7. Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. Review of Resident #3's physician order dated 04/11/22 revealed: -INR results on 04/11/22 was 1.6. -Based on the INR, the warfarin dosage ordered by the physician was 4mg daily. Review of Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed: -Resident #3's coumadin worksheet documented the date the INR was drawn, the INR results, the current coumadin dosage, the coumadin adjustment and the next date the INR was scheduled to be drawn. -INR results on 01/24/22 were documented as 4.6. -There was an entry for warfarin 6mg to be administered Monday through Friday. Review of Resident #3's record revealed there was no documentation of INR results on 01/24/22 or a physician's order for warfarin 6mg to be administered daily Monday through Friday. Review of Resident #3's February 2022 electronic	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HAL018036 B. WING HAL018036 STREET ADDRESS, CITY, STATE LLA NEWTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 37 D 273 Review of Resident #3's physician order dated 03/31/22 wes 1.7. Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday Aud 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. Review of Resident #3's physician order dated Aud/11/22 revealed: <td colspa<="" td=""><td>F CORRECTION DENTFICATION NUMBER: A BUILDING: HAL018036 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLA NEWTON 1088 RADIO STATION ROAD NEWTON, NC 28658 PROVIDER'S PLANO IGAD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDER'S PLANO Continued From page 37 D 273 -The warfarin dosing continued at 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. D 273 Review of Resident #3's physician order dated 03/31/22 revealed: 03/31/22 revealed: -INR drawn on 03/31/22 was 1.7. -Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. Review of Resident #3's physician order dated 04/11/22 revealed: 04/11/22 revealed: -INR fresults on 04/11/22 revealed: -Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed: -Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed: -Resident #3's coumadin (warfarin) worksheet date the INR was scheduled to be drawn. -INR results on 01/24/22 were documented at 4.6. -There was an entry for warfarin 6mg to be administered Monday through Friday. Review of Resident #3's record revealed there was no documentation of INR results on 01/24/22 or a physician's order fo</td><td>FE CORRECTION IDENTIFICATION NUMBER A BUILDING: </td></td>	<td>F CORRECTION DENTFICATION NUMBER: A BUILDING: HAL018036 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLA NEWTON 1088 RADIO STATION ROAD NEWTON, NC 28658 PROVIDER'S PLANO IGAD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDER'S PLANO Continued From page 37 D 273 -The warfarin dosing continued at 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. D 273 Review of Resident #3's physician order dated 03/31/22 revealed: 03/31/22 revealed: -INR drawn on 03/31/22 was 1.7. -Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. 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WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLA NEWTON 1088 RADIO STATION ROAD NEWTON, NC 28658 PROVIDER'S PLANO IGAD DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PROVIDER'S PLANO Continued From page 37 D 273 -The warfarin dosing continued at 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. D 273 Review of Resident #3's physician order dated 03/31/22 revealed: 03/31/22 revealed: -INR drawn on 03/31/22 was 1.7. -Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday. Review of Resident #3's physician order dated 04/11/22 revealed: 04/11/22 revealed: -INR fresults on 04/11/22 revealed: -Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed: -Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed: -Resident #3's coumadin (warfarin) worksheet date the INR was scheduled to be drawn. -INR results on 01/24/22 were documented at 4.6. -There was an entry for warfarin 6mg to be administered Monday through Friday. Review of Resident #3's record revealed there was no documentation of INR results on 01/24/22 or a physician's order fo	FE CORRECTION IDENTIFICATION NUMBER A BUILDING:

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ERRABE	LLA NEWTON		ADIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	e 38	D 273			
	at 8:00pm.					
	•	for warfarin 6mg one tablet				
		aily on Monday, Tuesday,				
		ay and Friday at 8:00pm.				
		ntation Resident #3 was not				
		n on 02/04/22, 02/06/22,				
		02/23/22 and 02/28/22.				
		warfarin dosing 6 of 28				
	possible opportunitie	5.				
	Review of Resident #	#3's March 2022 eMAR				
	revealed :					
		for warfarin 4mg one tablet				
		aily on Saturday and Sunday				
	at 8:00pm.					
		for warfarin 6mg one tablet				
		aily on Monday, Tuesday, ay and Friday at 8:00pm.				
		ntation Resident #3 was not				
		n on 03/10/22- 03/11/22,				
		3/23/22, 03/25/22, and				
	03/28/22-03/31/22.					
	-Resident #3 missed	warfarin dosing 13 out of 31				
	possible opportunitie	S.				
	Observation Resider	nt #3's medications on hand				
	on 04/21/22 at 3:05p					
		card of warfarin 2mg				
		n Monday and Friday.				
		card of warfarin 4mg				
	administer 1 tablet of Wednesday, Thursda					
	Interview with the co	cond shift medication aide on				
	04/22/22 at 4:32pm r					
		ation carts in the SCU and				
		er Resident #3's medications				
	on her shift.					
		warfarin and it was not				
	available for adminis	tration, she would contact				

STATE FORM

STATEMENT	f Health Service Region OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL018036	B. WING		04	04/22/2022	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
FERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From pag	le 39	D 273				
	04/22/22 at 4:40 pm -She administered m on the Assisted Livin Care Unit (SCU). -If there was a medic to administer for a re- pharmacy to order in evening. -She would let the R needed a refill or a p follow up in the morn -She did not contact -She thought there w warfarin was not ava -She documented or medication was unaw Review of the 24 hou	redications to the residents of community and the Special cation that was not available esident she would contact the backup to be received that CC know if a medication prescription so the RCC could hing with the physician. the physicians. were times Resident #4's hilable for administration. In the eMAR notes when a vailable.					
	through 04/01/22 of medications due to r administration.	not having them available for					
	the primary care phy 04/22/22 at 11:20am -The PCP reviewed sent from the home I prescribed the warfa	Resident #3's INR results health nurse (HHN) and rin dosing.					
	HHN, who contacted warfarin orders.	was communicated to the I the RCC with the new ce did not contact the					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
		HAL018036	B. WING		04	4/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
TERRABE	LLA NEWTON		N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	e 40	D 273			
	pharmacy with the nerequested a new pre- -The last prescription office for Resident #3 warfarin 4mg sixty ta warfarin 6mg ten tab -The facility staff had prescriptions, and the any missed doses of -If they had been not warfarin or incorrect would have been ord -The prescribing phy Medical Assistant, stanot receiving proper clots, an internal blee Telephone interview Specialist at the Hom 04/22/22 at 11:45am -The HHN contacted reported the INR resision ordered by the PCP. -If there were any ne staff was responsible pharmacy. -She had not been in Resident #3 had mission warfarin in February -If the facility reported warfarin doses, she we PCP. Interview with the RC revealed:	ew orders unless the facility scription for refills. In that was sent from this 3's warfarin was 01-04/22 for blets with 11 refills and lets with 11 refills and lets with 11 refills. In ot requested any additional ey had not been notified of warfarin. If if of missed doses of doses, a new blood draw ered to determine the INR. sician, as relayed by the ated possible outcomes to warfarin dosing were blood ed or a stroke. With the Administrative he Health agency on revealed: the RCC at the facility and ults and the warfarin dosing w prescriptions, the facility of for forwarding them to the formed by facility staff sed several doses of 2022 and March 2022. d Resident #3 missed would have informed the				
	INR and warfarin dos -She kept a record of lab values of the INR	e for tracking Resident #3's sing. f the date of the last INR, the , and the date the next INR Coumadin (Warfarin)"Hot				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
FERRABE	LLA NEWTON		DIO STATION ROAL N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	je 41	D 273			
	List".					
		sults of the INR blood draw				
	and new warfarin or					
		ontacted her by telephone e order on the coumadin hot				
		e order on the cournadin not				
	list documentation.	by the ordere also had written				
		-She did not know why the orders she had written on the coumadin hot list did not match the orders				
	documented by the p					
		any new prescriptions from				
	the physician's off ice					
		pility of the MAs to report				
	when a medication was not administered and the					
	reason why					
		bility of the MAs to document				
		or a medication error in the				
	24 hour progress not					
	-She reviewed the bi					
	administered.	the eMAR for medications not				
		tion report she ran daily did				
	not capture medication administered.	ons documented as not				
	-She did not know R	esident #3 had 6 missed				
		February 2022 and 13				
	missed doses of war					
		oorted the missed doses to				
	the physician if she h	nad been notified.				
		Iministrator on 04/21/22 at				
	3:10pm revealed:					
	-	pility of the HWD to oversee				
	medication orders ar					
	•	nad been vacant from				
		22 and the RCC tried to do				
	both jobs during that					
		medication reviews suffered				
	with the absence of a					
		medication was not available				
	for administration, th					1

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
				A. BUILDING:			
		HAL018036	B. WING		04/22/202		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From page	e 42	D 273				
	order through the back RCC and document is binder -She did not know Revealed an order for daily. Review of Resident #3 04/01/22 - 04/20/22 r -There was an entry mouth once daily at 8 -On 04/02/22 - 04/09 documented as not a -Latuda was docume	ck up pharmacy, notify the in the 24 hour progress note esident #3 missed 6 doses of 2022 and missed 13 doses warfarin. ility of the MAs to inform the tion was not available for hen a medications was ility of the RCC to notify the the missed medications. e physician had not been 's warfarin had 6 missed 022 and 13 missed doses in cian's order dated 11/19/21 fatuda 60mg take one tablet #3's April 2022 eMAR, from revealed: for Latuda take 1 tablet by 3:00pm. /22 Latuda 60mg was administered. /22 Latuda 60mg was					
	for a prescription'. -Latuda was docume of 20 possible opport	ented as not administered 6 cunities in April 2022.					
	available for administ 3:05pm revealed the	lent #3's medications tration on 04/21/22 at re was a bubble card of ed on 04/11/22, with 21					

STATE FORM

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04/22/202	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
FERRABE	ELLA NEWTON		DIO STATION ROA N, NC 28658	D		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 273	Continued From pag	e 43	D 273			
	10:30am revealed: -Resident #3 was pre- behaviors and agitati -If a resident did not consecutive days the symptoms, gastrointe ideation or an increas -She had not been in had missed Latuda 6 in April 2022. Interview with the RC revealed: -The resident's medic facility for April's cycl RCC and lead MA b medication carts. -The process was to bubble card with the correct, the medicatio -Resident #3's Latud pharmacy and placed -She did not know La of 20 opportunities in -She did not notify th documentation any o physician of Residen -She was responsible since the Health and left, she had not beel carts on a regular ba Interview with the Ad 3:10pm revealed: -It was the responsib to perform weekly ca -It was the responsib	formed by staff Resident #3 of 20 possible opportunities CC on 04/22/22 at 3:20pm cations that were sent to the e fill were checked by the efore placing them in the compare the label on the eMAR order and if they were on was placed in the cart. a was checked as sent from d in the medication cart. atuda was not administered 6 a April 2022. e physician and there was no of the MAs notified the t #3's missed medications. e for weekly cart audits, but Wellness Director (HWD) n audited the medication sis. ministrator on 04/21/22 at illty of the RCC or designee				

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
TERRABE	ELLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 273	Continued From pag	e 44	D 273			
	missed. -It was the responsib physician if a resider -She did not know th notified Resident #3 of 20 possible opport Attempted telephone prescribing physician unsuccessful. 3. Review of Resider revealed: -Diagnoses included neuromuscular disor -The level of care wa Special Care Unit (Si Review of Resident # (PCP) visit summary revealed: -Resident #2 had rec sides of his inner che his tongue. -There was an order swish inside the oral times a day for 14 da Review of Resident # medication administr 03/16/22 -03/30/22 re -There was an entry swish and spit three be administered at 8	 interview with the in on 04/22/22 at 2:50pm was int #2's FL2 dated 03/07/22 dementia and der of the bladder. as documented as the CU). #2's primary care physician's note dated 03/15/22 Idened patches on both eeks and a white coating over for Nystatin suspension, cavity and spit out three ays. #2's March electronic ration record (eMAR) from evealed: for nystatin suspension times a day for 14 days, to :00am, 2:00pm and 8:00pm. 				
	be administered at 8 -There was documer administered on 03/1 8:00pm, 03/19/22-03 8:00pm, and 03/22/2	:00am, 2:00pm and 8:00pm. ntation nystatin was not 16/22 at 8:00am, 03/18/22 at /20/22 at 2:00pm and				

Division of Health Service Regulation STATE FORM

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If continuation sheet 45 of 102

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		HAL018036	B. WING		04/22/202		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From page	e 45	D 273				
	administered nystatin suspension 7 of 42 possible opportunities. -Nystatin was documented as not administered due to 'medication not on the cart.' Observation of Resident #2 on 04/22/22 at						
	10:25am revealed the	e inner cheek on the right raised area and his tongue					
	contracted pharmacy revealed:	armacist at the facility's on 04/22/22 at 11:35am in suspension 630ml (a 14					
	facility. -The nystatin suspen	d on 03/15/22 and sent to the sion was returned when the ontinued after 14 days with					
	150ml remaining in the -lf the resident did no						
	-The yeast infection of	causes discomfort when the resident may refuse to infection was active.					
	Interview with a medi 04/22/22 at 4:20pm r -Resident #2 had an	evealed: order for nystatin					
	-Staff supervised Res	es a day in March 2022. sident #2 when he was n suspension, prompting him					
	-She did not know wh remaining in the susp returned to the pharn	pension bottle when it was					
	nystatin suspension.						
	Interview with the Re alth Service Regulation	sident Care Coordinator					

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	HAI 018036	B. WING		04/22/2022	
ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		<i>122/2022</i>
LLA NEWTON	NEWTO	N, NC 28658			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
Continued From page	e 46	D 273			
-She knew Resident suspension for a posidays. -She did not know Re administered nystatir opportunities. -It was the responsib if they could not local -She did not know 15 was returned to the p 14 days. Interview with the Ad 3:10pm revealed: -It was the responsib pharmacy and the Re locate a medication of -She did not know Re	#2 had an order for nystatin sible yeast infection for 14 esident #2 was not n suspension 7 of 42 possible ility of the MAs to contact her te a medication on the cart. 50ml of nystatin suspension oharmacy at the end of the ministrator on 04/21/22 at ility of the MAs to contact the CC when they could not on the cart. esident #2 was not				
provider was notified greater than 400, for increased a risk for d and a blood thinning times over 7 weeks v for a blood clot or stru- missed doses of a su- infection in the mouth of appetite and weigh (Resident #2). This fa a substantial risk for	a resident's FSBS was 38 times over 34 days that liabetic coma (Resident #6), medication was missed 19 which put the resident at risk oke (Resident #3), and 7 uspension to treat a yeast in which could lead to a loss int loss due to discomfort ailure placed the residents at physical harm and neglect				
	(EACH DEFICIENC REGULATORY OR REGULATORY OR Continued From pag (RCC) on 04/22/22 a -She knew Resident suspension for a pos days. -She did not know Re administered nystatir opportunities. -It was the responsib if they could not loca -She did not know 15 was returned to the p 14 days. Interview with the Ad 3:10pm revealed: -It was the responsib pharmacy and the Re locate a medication of -She did not know Re administered nystatir opportunities. Attempted interview for at 10::25am was uns The facility failed to e provider was notified greater than 400, for increased a risk for of and a blood clot or str missed doses of a su infection in the mouth of appetite and weigt (Resident #2). This fa a substantial risk for	DEF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: HAL018036 ROVIDER OR SUPPLIER STREET A LLA NEWTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 (RCC) on 04/22/22 at 3:20pm revealed: -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. She kid not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. -It was the responsibility of the MAs to contact her if they could not locate a medication on the cart. -She did not know 150ml of nystatin suspension was returned to the pharmacy at the end of the 14 days. Interview with the Administrator on 04/21/22 at 3:10pm revealed: -It was the responsibility of the MAs to contact the pharmacy and the RCC when they could not locate a medication on the cart. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HAL018036 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, LLA NEWTON 1088 RADIO STATION ROAD NEWTON, NC 28658 ID Continued From page 46 D 273 (RCC) on 04/22/22 at 3:20pm revealed: -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. D 273 -It was the responsibility of the MAs to contact her if they could not locate a medication on the cart. -She did not know 150ml of nystatin suspension was returned to the pharmacy at the end of the 14 days. Interview with the Administrator on 04/21/22 at 3:10pm revealed: -It was the responsibility of the MAs to contact the pharmacy and the RCC when they could not locate a medication on the cart. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. Attempted interview with Resident #2 on 04/22/22 at 10::25am was unsuccessful. The facility failed to ensure the primary care provider was notfied a resident's FSBS was greater than 400, for 38 times over 34 days that increased a risk for diabetic coma (Resident #3), and 7 missed doses of a suspension to treat a yeast infection in the mouth which could lead to a loss of appetite and weight loss due to discomfort (Resident #2). This failure placed the residents at a subustantial risk for physical harm and neglect	F CORRECTION IDENTIFICATION NUMBER: A BUILDING: HAL018036 B WING ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LLA NEWTON 1088 RADIO STATION ROAD NEWTON, NC 28658 SUMMARY STREEMENT OF DEFICIENCIES (RACH DERIVISY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE Continued From page 46 (RCC) on 04/22/22 at 3:20pm revealed: -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. D 273 Continued From page 46 (RCC) on 04/22/22 at 3:20pm revealed: -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. D 273 It was the responsibility of the MAs to contact her if they could not locate a medication on the cart. - - - - - - - - - - - - - - - - - - -	FCORRECTION IDENTIFICATION NUMBER: A BUILDING: COM HAL018036 B. WING 02 COMDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZP CODE LLA NEWTON 1088 RADIO STATION ROAD REGULATORY OR LSD IDENTIFICATION WIGT BE PRECEDED BY FULL ID REQUATORY OR LSD IDENTIFICATION NOT CORRECTIVE ADDRESS (DTV, STATE, ZP CODE ID Continued From page 46 ID 273 (RCC) on 04/2222 at 3:20pm revealed: TAG -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. D 273 -She knew Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. D 273 -It was the responsibility of the MAs to contact her if they could not locate a medication on the cart. -She did not know Resident #2 was not administered to the pharmacy at the end of the 14 days. 11/2 three responsibility of the MAs to contact the pharmacy and the RCC when they could not locate a medication on the cart. -She did not know Resident #2 was not administered notified a resident #2 was not administered not the cart. -She did not know Resident #2 was not administered notified a resident #3 was not administered notified a resident #2 was not administered notified a resident #2 was not administered notifi

STATEMEN	of Health Service Regure FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	E CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 47	D 273			
	accordance with G.S. for this violation.	. 131D-34 on April 21, 2022				
	CORRECTION DATE VIOLATION SHALL N 2022.	E FOR THE TYPE A2 NOT EXCEED MAY 22,				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	following in the reside (3) written procedures a physician or other li and (4) implementation of	ssure documentation of the				
	reviews, the facility fa physician's orders for related to blood press administration of a mo pressure was too low as needed (PRN) me	ns, interviews, and record illed to implement 1 of 5 sampled residents sure checks prior to the edication if the blood and the administration of an edication if the systolic blood parameters set by the				
	03/15/22 revealed dia dementia, dysphagia,	4's current FL2 dated agnoses included vascular , coronary artery disease failure and anxiety disorder.				
	there was an order fo	er dated 03/17/22 revealed				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ERRABE	LLA NEWTON		ADIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 276	Continued From page	Continued From page 48				
	systolic blood pressu	re was less than 120.				
	medication administr 03/17/22 to 03/31/22 -There was an entry administered three ti 2:00pm and 8:00pm, pressure less than 12 -There was documen was administered 32 March 2022 with no r reading before admir A request was made #4's blood pressure r	for hydralazine 100mg to be mes daily, at 8:00am, hold for systolic blood 20. Itation hydralazine 100mg out of 42 opportunities in recording of a blood pressure				
	04/01/22-04/20/22 re -There was an entry administered three til 2:00pm and 8:00pm, pressure less than 12 -There was document	for hydralazine 100mg to be mes daily, at 8:00am, hold for systolic blood 20. Itation hydralazine was of 58 possible opportunities recording of a blood				
	on 04/20/22 at 10:05 -She administered hy Resident #4 during th -There was no entry blood pressure reading prior to administering	vdralazine 100mg to ne morning medication pass. on the eMAR to document ng, so she did not check it the hydralazine. v to document the readings plood pressure.				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
iame of Pi	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 276	Continued From page	e 49	D 276			
	Coordinator (RCC).					
	3:50pm revealed: -She administered Re second shift.	cond shift MA on 04/22/22 at esident #4's medications on				
	8:00pm. -The dashboard high	e hydralazine 100mg at lighted the medications and ring the medication pass.				
	-There was no drop of hydralazine order to or reading.	lown menu on the enter a blood pressure				
		alone task to take Resident before hydralazine was				
	Telephone interview	with the pharmacist at the				
	11:35am revealed:	harmacy on 04/22/22 at medication was written to				
	include a blood press administration of the	sure to be taken before medication, the facility staff menu for the blood pressure				
	readings. -The pharmacy staff o	only enter blood pressure eparate from the medication				
	order. -The hydralazine med	dication order was written to sure parameters, so the				
		blood pressure reading was				
	10:30am revealed:	with the PCP on 04/22/22 at PCP had ordered 2 blood				
	pressure medications hypertension.	or blood pressure checks				

STATE FORM

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	4/22/2022
AME OF PF	OVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LA NEWTON		N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 276	Continued From page	e 50	D 276			
	her at an increased r as a stroke. -She had not had any readings so it was ur error. Interview with the RC at 2:45pm revealed: -She did not know it y responsibility to add the eMAR. -She did not know the Resident #4's blood p administering hydrala Interview with the He (HWD) on 04/22/22 a -She expected the M before administration pressure parameters -The MAs should hav attention of the RCC. -She took Resident 4 today and the systoli -Clonidine 0.1mg wa medication twice dail greater than 180, and -She administered th contacted the physic Interview with the Ad 3:40pm revealed she not taking Resident #	blood pressure readings to e MAs were not taking pressure before azine three times a day. ealth and Wellness Director at 4:50pm revealed: As to take a blood pressure of a medication with blood b. ve brought that to the ''s blood pressure earlier c reading was above 180. s prescribed as a PRN by for systolic blood pressure d notify the physician. the clonidine 0.1mg and				
	pressure parameters	n of a medication with blood and a medication for are readings greater than				
	A request was made th Service Regulation	for documentation Resident				

If continuation sheet 51 of 102

TATEMENT	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		NDIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 276	Continued From page	e 51	D 276			
	-	readings from 04/01/22 to t provided prior to survey				
	03/17/22 revealed the clonidine 0.1mg take	nt 4's PCP's order dated ere was an order for one tablet twice daily for ater than 180 and call the				
	03/17/22 to 03/31/22 -There was an entry tablet twice daily for s than 180 and call the -There was no docun blood pressure reading	for clonidine 0.1mg take one systolic pressure greater physician. nentation of Resident #4's ngs. nentation clonidine was				
	04/01/22 to 04/20/22 There was an entry for tablet twice daily for s than 180 and call the -There was no docum blood pressure reading	or clonidine 0.1mg take one systolic pressure greater physician. nentation of Resident #4's ngs. nentation clonidine was				
	04/20/22 at 10:05am -She did not administ 0.1mg as needed for 180.	at shift medication aide on revealed: ter Resident #4's clonidine systolic blood pressure over to take Resident #4's blood				
	Interview with the sec 3:50pm revealed:	cond shift MA on 04/22/22 at				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
				B. WING			
NAME OF PI	ROVIDER OR SUPPLIER	HAL018036	B. WING 04/22/2022 EET ADDRESS, CITY, STATE, ZIP CODE				
	LLA NEWTON	1088 RA	DIO STATION ROA N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
D 276	medication and was r medication pass on th -She was not triggere blood pressure since an order. Telephone interview v facility's contracted pl 11:35am revealed the	e 52 ine was an as needed not highlighted during the ne computer dashboard. ed to take Resident #4's it was not on the eMAR as with the pharmacist at the harmacy on 04/22/22 at e clonidine 0.1mg order was blood pressure parameters,	D 276				
D 344	so the drop down me readings was the res to enter on the eMAR	nu for blood pressure ponsibility of the facility staff	D 344				
	the resident's physicia for verification or clar medications and trea (1) if orders for admis resident are not dated of admission or readr (2) if orders are not c (3) if multiple admissi admission or readmis forms are not the san The facility shall ensu	ne shall ensure contact with an or prescribing practitioner ification of orders for tments: ssion or readmission of the d and signed within 24 hours nission to the facility; lear or complete; or on forms are received upon ssion and orders on the					
	reviews, the facility fa provider for 1 of 5 sam	as evidenced by: ns, interviews and record iled to clarify orders with the mpled residents, related to epressant (Resident #4).					

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 344	Continued From page	e 53	D 344			
	The findings are:					
		#4's FL2 dated 11/19/21 ncluded a history of a and anxiety.				
	02/23/22 revealed the	#4's physician orders dated ere was an order for ly (used to treat depression).				
	medication pass on 0 -The medication aide medications for Resid -There was a bubble take one half tablet (-Sertraline 25mg, one administered.	card of sertraline 25mg, 12.5mg) in the morning.				
	10:05am revealed: -There was a bubble computer generated one half tablet in the 02/21/22 . -There were 82 table card.	tration on 04/20/22 at card of 90 tablets with a label 'sertraline 25mg take morning' and a fill date of ts remaining in the bubble				
	100mg on the medica medication supplies.					
	from 02/23/22-02/28/ -There was an entry half tablet (12.5mg) e	#4's February 2022 eMAR 22 revealed: for sertraline 25mg take one every morning at 8:00am. ntation Resident #4 was on a				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 344	Continued From page	e 54	D 344			
	leave of absence from	m 02/24/22 to 02/28/22.				
	03/09/22 to 03/31/22 -There was an entry one tablet every more	for sertraline 100mg take ning at 8:00am. ntation sertraline 100mg was				
	04/01/22 to 04/20/22 There was an entry for tablet every morning	or sertraline 100mg take one at 8:00am. itation sertraline 100mg was				
	facility's contracted p 11:35am revealed Re	with the pharmacist at the harmacy on 04/22/22 at esident #4's Sertraline vas never filled by the harmacy.				
	pharmacy technician revealed: -Sertraline 25mg take morning was filled an to the facility on 02/2 -No other sertraline p Resident #4 since Ja	prescriptions were filled for nuary 2022. line 100mg prescription was				
	revealed: -She thought Resider tablets had been cha to an evening dose.	A on 04/20/22 at 9:50am nt #4's sertraline 12.5mg nged from a morning dose he eMAR entry and observe e.				

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If continuation sheet 55 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
D 344	Continued From page	e 55	D 344			
	care provider (PCP) or revealed: -She expected the sta as prescribed by the					
	-She did not know Re not administered as p	esident #4's sertraline was prescribed.				
	revealed:	C on 04/20/22 at 2:45pm				
	audits.	ility to conduct weekly cart				
	-In the absence of a I Director, she has dele cart audits to the MAs	egated the completion of				
	eMARs for each resid	ollowed was to print the dent and ensure the ne cart and was the correct				
	dosage.					
		cument the results of the cart nmunicate verbally to her				
	audits were done cor	nd the MAs to ensure the cart rectly. or HWD could fax an order to				
	the pharmacy but Re her medications from	sident #4 does not receive the facility contracted				
	her medications.	nacy technicians only profile				
	the new order to the t did not send a copy t	ver sent the prescription with facility contracted pharmacy o the resident's preferred				
	never sent.	w sertraline dosage was ility of the MAs administering				
	the medication to do	their 3 checks, comparing ed on the eMAR and the				
		As to report to her if there				

YG9F11

If continuation sheet 56 of 102

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA I, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 344	Continued From page	e 56	D 344			
	physician or pharmad -She did not know Re not been clarified with continued to receive Interview with the HW revealed she expected medication order for the bubble card of a to the eMAR did not ma Interview with the Ad 2:40pm revealed: -Ongoing, it would be HWD to oversee med liaison with physician amongst other clinica -The cart audits and completed as schedu HWD. -It was the responsib the HWD or RCC tha match an order enter same medication.	esident #4's sertraline had h the physician and she the incorrect dosage. VD on 04/22/22 at 4:50pm ed the MAs to clarify a any resident whose label on medication and the entry on atch ministrator on 04/20/22 at e the responsibility of the dications, eMAR review, is and training of the staff, al responsibilities. medication reviews were not alled with the absence of an ility of the MAs to report to it a medication label did not red on the eMAR for the esident #4's sertraline order				
D 358	10A NCAC 13F .1004 Administration	4(a) Medication	D 358			
	 (a) An adult care hore preparation and adm prescription and non- by staff are in accord (1) orders by a licensi 	4 Medication Administration me shall assure that the inistration of medications, prescription, and treatments ance with: sed prescribing practitioner t in the resident's record; and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		UAL 049026		B. WING		0.4/00/0000	
	ROVIDER OR SUPPLIER	HAL018036	ADDRESS, CITY, STATE		04	/22/2022	
	LLA NEWTON		DIO STATION ROA				
		NEWTO	N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From page 57		D 358				
	(2) rules in this Section and procedures.	ion and the facility's policies					
	This Rule is not met TYPE A2 VIOLATION	-					
	reviews, the facility fa medications as order observed during the r to a medication used medications to contro- increase low iron in the anti-depressant (#4), available as ordered (#2, #3, and #4), inclu- anxiety (#4), medicate clots and treat deprese used to treat mouth se The medication error	red for 1 of 5 residents medication pass as related to thin the blood, two of high blood pressure, and of high cholesterol and he blood and an and medications not for 3 of 5 sampled residents uding a medication for ions used to prevent blood ssion (#3), and a medication cores (#2).					
		the 8:00am medication pass					
	03/15/22 revealed dia dementia, dysphagia	nt #4's current FL2 dated agnoses included vascular , coronary artery disease failure and anxiety disorder.					
	03/15/22 revealed the clopidogrel 75mg, (ar	nt #4's current FL2 dated ere was an order for n anticoagulant used to thin nt clots), to be administered					
	medication pass on (pecial Care Unit (SCU))4/20/22 at 9:15am revealed: e (MA) prepared 7 oral					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	8036 B. WING		04/22/2022	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLET
D 358	Continued From page	e 58	D 358			
	medications for Resid -Clopidogrel was not #4.	dent #4. administered to Resident				
	Observation of Resid available for administ 10:05am revealed clo for administration.					
	medication administra 04/01/22 to 04/20/22 -There was an entry f administered daily at -Clopidogrel was not	for clopidogrel 75mg to be 8:00am. administered 18 of 20				
	was unavailable" or "	2022 due to the "medication waiting on a prescription".				
	revealed:	on 04/20/22 at 9:50am e Resident Care Coordinator				
	clopidogrel 75mg on	the eMAR the medication				
	-She was not given a regarding the medica Coordinator (RCC).	ny further directives tion from the Resident Care				
	12:01pm revealed:	technician on 04/22/22 at				
	her prescriptions to the clopidogrel 75mg ord supply of tablets and	er was filled for a 90 day sent on 01/31/22.				
	-There was a prescrip for a 7 day supply fille	otion received on 04/20/22 ed the same day.				
	Telephone interview	with Resident \$4's PCP on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
D 358	Continued From page	e 59	D 358			
	04/22/22 at 10:30am -Resident #4 was a r -She had a prosthetic was prescribed to pre possible complication -She did not know Re clopidogrel dosage for 2022. Interview with the RC revealed: -She knew Resident 75mg available to be -The MA had informe not on the cart earlier -She did not know it w days in April 2022. -The Administrator w have the medication b. Review of Resider 03/15/22 revealed the amlodipine 10mg, (a blood pressure), to b Observation of the St 04/20/22 at 9:15am -The MA prepared 7 Resident #4. -Amlodipine was not	revealed: new client as of April 2022. c heart valve and clopidogrel event bloods clots due to ns. esident #4 had missed her or 18 of 20 days in April 2C on 04/20/22 at 2:45pm #4 did not have clopidogrel administered. ed her the medication was r this week. was unavailable for 18 of 20 as working with the family to sent to the facility. at #4's current FL2 dated ere was an order for medication used to control e administered daily. CU medication pass on evealed: oral medications for administered to Resident #4.				
		nlodipine 10mg was not on r in the back up medication				
	04/01/22 to 04/20/22	4's April 2022 eMAR, from , revealed: for amlodipine 10mg to be				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL018036	B. WING		04	/22/2022	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From page	e 60	D 358				
	administered daily at 8:00am. -There was documentation that amlodipine was						
	not administered 16	out of 20 opportunities in					
	April 2022 due to the						
	unavailable" or "waiti	ng on a prescription".					
	Interview with the SC	CU MA on 04/20/22 at 9:50am					
	revealed:						
		e RCC on 04/18/22 that					
		nave amlodipine 10mg on the					
	medication cart.	the eMAR the medication					
	was' not available to						
	Telephone interview	with Resident #4's					
		technician on 04/22/22					
	12:01pm revealed:						
	tablets.	as filled 04/15/22 for 90					
	-That was the only tir filled for Resident #4	ne amlodipine had been since January 2022.					
	Telephone interview 04/22/22 at 10:30am	with Resident #4's PCP on revealed:					
		PCP had ordered 2 blood					
		s to be administered daily for					
	hypertension.						
		cations, this would place her					
	at an increased risk of a stroke.	of an adverse event such as					
	-She had not had any	y recent blood pressure					
	readings so it was ur	clear as to the effect of this					
	error.						
		otified the resident was not					
	possible opportunitie	bine 10mg, 16 out of 20 s in April 2022.					
	Interview with the PC	C on 04/20/22 at 2:45pm					
	revealed:	0 011 04/20/22 at 2.40pm					
		#4 did not have amlodipine					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL018036	B. WING		04	4/22/2022	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
FERRABE	ELLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
D 358	Continued From page	e 61	D 358				
	not on the cart earlie -She did not know it l of 20 days in April 20 c. Review of Reside dated 03/15/22 reve 100mg, (a medication pressure), to be adm Observation of the S 04/20/22 at 9:15am r -The MA prepared 7 Resident #4.	ed her the medication was r this week. had not been available for 16 022. nt #4's current FL2 order aled an order for hydralazine n used to control high blood inistered three times daily. CU medication pass on revealed:					
	available for adminis 10:05am revealed hy	lent #4's medications tration on 04/20/22 at /dralazine was not on the the back up medication					
	04/01/22 - 04/20/22 -There was an entry administered three tii 2:00pm and 8:00pm. -There was documer administered 27 out o	for hydralazine 100mg to be mes daily, at 8:00am, ntation hydralazine was not of 58 opportunities in April dication was unavailable" or					
	12:01pm revealed: -Hydralazine was fille day supply).	with Resident #4's / technician on 04/22/22 at ed 03/2/22 for 360 tablets (90 me hydralazine was filled for					

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	UAL 049026			0.4/00/0000	
ROVIDER OR SUPPLIER			, ZIP CODE	04	/22/2022
	NEWTO	N, NC 28658			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
Continued From page	e 62	D 358			
Resident #4 since Ja	nuary 2022.				
revealed: -She did not know ho hydralazine was not a -She had contacted t	ow long Resident #4's available to be administered. he RCC and informed her				
04/22/22 at 10:30am -There was no docum pressure readings, se effect of this error. -She was not notified administered Hydrala	revealed: nentation of recent blood o it was unclear as to the I the resident had not been azine 100mg 27 out of 58				
revealed: -She knew Resident 100mg available to b -The MA had informe not on the cart earlier -She did not know it v	#4 did not have hydralazine e administered. ed her the medication was r this week. was unavailable for 27 out of				
03/15/22 revealed the atorvastatin 40mg, (a	ere was an order for a medication used for high				
04/20/22 at 9:15am r -The MA prepared 7 Resident #4.	evealed: oral medications for				
	ROVIDER OR SUPPLIER LLA NEWTON SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pag Resident #4 since Ja Interview with the M4 revealed: -She did not know ho hydralazine was not -She had contacted t the medication was r Telephone interview 104/22/22 at 10:30am -There was no docur pressure readings, se effect of this error. -She was not notified administered Hydrala opportunities in April Interview with the RC revealed: -She knew Resident 100mg available to b -The MA had informe not on the cart earlie -She did not know it 10 58 opportunities in April d. Review of Residert 03/15/22 revealed the atorvastatin 40mg, (a cholesterol), to be ad Observation of the S 04/20/22 at 9:15am r -The MA prepared 7 Resident #4. -Atorvastatin 10mg w	IDENTIFICATION NUMBER: HAL018036 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 62 Resident #4 since January 2022. Interview with the MA on 04/20/22 at 9:50am revealed: -She did not know how long Resident #4's hydralazine was not available to be administered. -She had contacted the RCC and informed her the medication was not on the cart on 04/18/22. Telephone interview with Resident #4's PCP on 04/22/22 at 10:30am revealed: -There was no documentation of recent blood pressure readings, so it was unclear as to the effect of this error. -She was not notified the resident had not been administered Hydralazine 100mg 27 out of 58 opportunities in April 2022. Interview with the RCC on 04/20/22 at 2:45pm revealed: -She knew Resident #4 did not have hydralazine 100mg available to be administered. -The MA had informed her the medication was not on the cart earlier this week. -She did not know it was unavailable for 27 out of 58 opportunities in April 2022. d. Review of Resident #4's current FL2 dated 03/15/22 revealed there was an order for atorvastatin 40mg, (a medication used for high cholesterol), to be administered daily. Observation of the SCU medication pass on 04/20/22 at 9:15am revealed: -The MA prepared 7 oral medications for Resident #4.	PF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: HAL018036 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 62 D 358 Resident #4 since January 2022. D 358 Interview with the MA on 04/20/22 at 9:50am revealed: D 358 -She did not know how long Resident #4'S hydralazine was not available to be administered. -She had contacted the RCC and informed her the medication was not on the cart on 04/18/22. Telephone interview with Resident #4'S PCP on 04/22/22 at 10:30am revealed: -There was no documentation of recent blood pressure readings, so it was unclear as to the effect of this error. -She was not notified the resident had not been administered Hydralazine 100mg 27 out of 58 opportunities in April 2022. Interview with the RCC on 04/20/22 at 2:45pm revealed: -She was not notified her the medication was not on the cart earlier this week. -She kew Resident #4 did not have hydralazine 100mg available to be administered. -She kew of Resident #4's Current FL2 dated 03/15/22 revealed there was an order for atorvastatin 40mg, (a medication used for high cholesterol), to be administered daily. Observation of the SCU medication pass on 04/20/22 at 9:15am revealed: -The MA prepared 7 oral medications for Resident #4. <	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: HAL018036 B. WING B. WING B. WING LLA NEWTON STREET ADDRESS, CITY. STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAND SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAND CACHOS RECTIVE OR DEFICIENCIES ID PROVIDER'S PLAND Continued From page 62 D 358 D 358 Continued From page 62 D 358 D 358 Continued From page 62 D 358 D 358 Resident #4 since January 2022. D 358 PROVIDER'S PLAND Interview with the MA on 04/20/22 at 9:50am Prevaled: PROVIDER'S PLAND -She did not know how long Resident #4's hydralazine was not available to be administered. -She had contacted the RCC and informed her Former of the medication was not on the cart on 04/18/22. Thee was not could the resident had not been administered Hydralazine 100mg 27 out of 58 Opportunities in April 2022. Interview with the RCC on 04/20/22 at 2:45pm Interview with the RCC on 04/20/22 at 2:45pm -She was not notified the resident for 27 out of 58 Opportunities in April 2022. Interview with the SCU medication was not out for atorvastatin 40mg, (a medication spas on 04/20/22 at 9:55m reveal	PE CORRECTION IDENTIFICATION NUMBER: A BULDING:

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
TERRABE	LLA NEWTON		NDIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 63	D 358			
	available for administration on 04/20/22 at 10:05 am revealed atorvastatin was not on the medication cart or in the back up medication supplies. Review of Resident #4's April 2022 eMAR, from					
	04/01/22 to 04/20/22 -There was an entry administered daily at -There was documer	, revealed: for atorvastatin 40mg to be 8:00am. ntation atorvastatin was not of 20 possible opportunities				
	12:01pm revealed: -Atorvastatin 40mg w tablets.	/ technician on 04/22/22 at vas filled on 04/15/22 for 90 me atorvastatin has been				
	Interview with the MA revealed: -She did not know ho atorvastatin was una	A on 04/20/22 at 9:50am ow long Resident #4's vailable to be administered. the RCC and informed her				
	04/22/22 at 10:30am -Resident #4 had an -This placed her at a adverse event such a	elevated cholesterol level. n increased risk of an as a stroke. esident #4 had not been				
	dated 03/15/22 revea	nt #4's physician's orders aled an order for ferrous edication used for low blood				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL 019026		B. WING			
	ROVIDER OR SUPPLIER	HAL018036	ADDRESS, CITY, STATE		04	/22/2022	
	LLA NEWTON	1088 RA	DIO STATION ROA				
		NEWTO	N, NC 28658				
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From page 64		D 358				
	iron), to be administe	ered daily.					
	04/20/22 at 9:15am r -The MA prepared 7 Resident #4.						
	10:05am revealed th	lent #4's medications tration on 04/20/22 at ere was no ferrous sulfate on r in the back up medication					
	04/01/22 to 04/20/22 -There was an entry be administered daily -There was documen was not administered	for ferrous sulfate 325mg to / at 8:00am ntation that ferrous sulfate d 14 out of 20 opportunities on was unavailable" or					
	Telephone interview contracted pharmacy	with Resident #4's ⁄ technician on 04/22/22 at ere was no record ferrous					
	revealed: -She did not know ho sulfate was not availa	A on 04/20/22 at 9:50am ow long Resident #4's ferrous able to be administered. mber if she informed the was not available for					
	04/22/22 at 10:30am	with Resident #4's PCP revealed she expected the medications as prescribed by					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		UAL 049026	HAL018036 B. WING			0.4/00/0000	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE	04	/22/2022	
EDDARE		1088 RA	DIO STATION ROA	D			
		NEWTO	N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From page	e 65	D 358				
	the physician.						
	revealed she did not sulfate 325mg had no	CC on 04/20/22 at 2:45pm know Resident #4's ferrous ot been available for c of 20 possible opportunities					
	f. Review of Resident #4's physician order dated 02/23/22 revealed there was an order for sertraline 100mg daily (used to treat depression).						
	04/20/22 at 9:15am r -The MA prepared 7 Resident #4. -Sertraline 100mg wa						
	10:05am revealed: -There was a bubble computer generated one half tablet in the 02/21/22 . -There were 82 table card. -There were no other 100mg on the medica medication supplies.	tration on 04/20/22 at card of 90 tablets with a label 'Sertraline 25mg take morning' and a fill date of ets remaining in the bubble bubble cards for Sertraline ation cart or with the					
	from 02/23/22 to 02/2 -There was an entry half tablet (12.5mg) e -There was documen	#4's February 2022 eMAR 28/22 revealed: for sertraline 25mg take one every morning at 8:00am. Itation Resident #4 was on a m 02/24/22 to 02/28/22.					
	Review of Resident #	4's March 2022 eMAR from					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
			A. BUILDING.			
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
FERRABE	LLA NEWTON		DIO STATION ROA	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page	e 66	D 358			
	one tablet every mori- There was document administered from 03 Review of Resident # 04/01/22 - 04/20/22 r There was an entry for tablet every morning -There was document administered from 04 Telephone interview contracted pharmacy 12:01pm revealed: -Sertraline 25mg take morning was filled and to the facility on 02/2 -No other sertraline p Resident #4 since Ja -Resident #4's physic	for sertraline 100mg take ning at 8:00am. Itation Sertraline 100mg was 8/09/22 to 03/31/22. 44's April 2022 eMAR from evealed: or sertraline 100mg take one at 8:00am. Itation Sertraline 100mg was 9/01/22-04/20/22. with Resident #4's 1 technician on 04/22/22 at e one half tablet in the Ital a 90 day supply was sent 1/22. prescriptions were filled for				
	Interview with the MA revealed: -She did not adminisi 12.5mg tablets becau changed from mornir -She did not compare the bubble card with -She did not observe card was 12.5mg and was 100mg. Telephone interview 04/22/22 at 10:30am	A on 04/20/22 at 9:50am ter Resident #4's sertraline use she thought the time had ng to evening administration. the dosage on the label of the dosage on the eMAR. the dosage on the bubble d the dosage on the eMAR				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	HAL018036	ADDRESS, CITY, STATE		04	/22/2022
FERRABE	LLA NEWTON	NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 358	Continued From page	e 67	D 358			
	 disorder or generalized anxiety disorder, may increase with incorrect dosing or missed doses. -She did not know Resident #4's sertraline was not administered as prescribed. g. Review of Resident #4's physician's orders dated 03/17/22 revealed an order for lorazepam 0.5mg, (a medication used to treat anxiety and agitation), one half tablet to be administered at bedtime. 					
	4:15pm revealed lora	lent #4's medications tration on 04/20/22 at izepam 0.25mg was not on r in the back up medication				
	03/17/22 to 03/31/22 -There was an entry one half tablet (0.25n 8:00pm. -There was document not administered 14 of	for lorazepam 0.5mg take ng) to be administered at ntation that lorazepam was put 14 possible opportunities o the "medication was				
	04/01/22 to 04/20/22 -There was an entry one half tablet (0.25m at 8:00pm. -There was documen	for lorazepam 0.5mg take ng) to be administered daily ntation lorazepam was not of 20 possible opportunities he "medication was				
		with Resident #4's / technician on 04/22/22 at prescription for lorazepam				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page 68		D 358			
	0.25mg was not filled	by their pharmacy.				
	04/22/22 at 10:30am -Resident #4 was pre- previous PCP for anx -She was not informe was not receiving the -She had not had any resident experienced -She would expect to and anxiety in the eve several doses of Lora -She expected the fa- medications as preso Interview with the RC revealed: -Resident #4's preso 03/17/22 was sent to pharmacy. -The pharmacy techr they did not fill her m -The prescription was preferred pharmacy. -She did not know R 0.25mg had not been from 03/17/22 throug	escribed lorazepam by the kiety and agitation at night. ed by the facility the resident a medication. y reports from the facility the l increased agitation at night. o observe increased agitation ening if the resident missed azepam. cility to administer cribed by the physician. CC on 04/20/22 at 2:45pm ription for lorazepam dated the facility's contracted nician entered the order, but edications. s never sent to the resident's essident #4's lorazepam a available for administration				
	facility contracted pha fill, unless the family medications.	cations were delivered by the armacy on a monthly cycle delivered the resident's				
	next fill date, or had a the MA contacted the	on a medication before the a new medication ordered, pharmacy and the sent from the local backup				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL018036	B. WING		04/22/2022	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 358	Continued From pag	e 69	D 358			
	member if they provi medications. -If the medication was next day or two, the again and the RCC was member, or the phar -Resident #4 did not from the facility conta- -A family member or medications from a r -The medications was supply to the facility. -When Resident #4 H supply, the MA conta- informed the RCC. -There were times R medications. -She was not sure have of some of her medica- -The MAs were instru- #4's medications from the family's request. -She documented or medication was not a- when there was non -The medication doe medication in the eM know why. -She was not directed further. Interview with a second 8:25am revealed: -It was the responsib- pharmacy or family r medication had 7 tak- -The pharmacy woul- through back up by t	as not delivered within the MA would inform the RCC would contact the family macy. receive her medications racted pharmacy. dered Resident #4's nail order company. ere delivered with a 90 day had less than a 10 day acted the family member and esident #4 did not have ow long Resident #4 was out cations. ucted not to order Resident on the eMAR that the available to be administered nedication on the cart. is not record as a missed IAR program, but she did not of by the RCC to do anything ond SCU MA on 04/21/22 at bility of the MA to contact the member and the RCC when a olets remaining. d send the medication				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 70	D 358			
	were not filled by the -A second call was m only a 4 day supply a -If a resident's media administer, she inform documented the media administered'. -The RCC had not in else. Telephone interview responsible family m 12:55pm revealed: -She was responsible medications to the fa mail order pharmacy -She had requested send the prescription quantities of a 90 da -When the medication preferred pharmacy member received no -She was contacted was told Resident # -According to her received no -She does not want to medication, she wan medication they show Interview with the RC revealed: -The facility was on a the residents' medication	hade if the medication had and was still not on the cart. cation was not available to med the RCC and dication on the eMAR as 'not estructed her to do anything with Resident #4's ember on 04/22/22 at e for providing Resident #4's acility, and contracted with a Resident #4's physician to as to this pharmacy in ay supply. In was shipped from the to the facility, the family tification. last week by facility staff and 4 was out of 5 medications. cords, there should be until the next 90 day fill. history of a stroke and the facility to order more ts them to find the uld have for the resident. CC on 04/20/22 at 2:45pm a monthly cycle fill for most of ations.				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page	e 71	D 358			
	back up pharmacy or was not in the buildin -The MA should also new prescription was -The MAs should be family as well as the day supply of the me -The MAs should cor medication continued day supply. -The RCC followed up pharmacy at that time -If a family member or medication she refer Administrator. -The MA should also progress book so the -She communicated medication refills, but communicate to all th -It was her responsib weekly. -In the absence of a l Director (HWD), she responsibilities and d MAs. -The MAs do not doc audits, they commun -She reviewed the mi daily, but did not know as 'not administered' report. -She did not review th an issue. That was th -If a family member we	contact the physician if a needed. contacting the pharmacy or RCC when there was a 10 dication remaining. ttact the RCC if the to be unavailable with a 7 p with the family or e. efused to supply the red them them to the document in the 24 hour following shift can follow up. to her staff the process for t it was challenging to he agency staff. ility to complete cart audits Health and Wellness assumed additional lelegated cart audits to the ument the results of the cart icate verbally with her. issed medication reports w medications documented were not captured in that the eMARs unless alerted to he responsibility of the HWD. yould not allow us to order				
		back up if there was none tration, she refer red them to				
	-If she was not able t	o order medications for a				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,			
TERRABE	LLA NEWTON		DIO STATION ROAI N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page	e 72	D 358			
	resident due to family not approving, she notified the physician and tried to get a hold or discontinue order from the physician. -She did not document these physician notifications.					
	revealed: -She started in her pro- -She did not know Revealed in her pro- medications available -It would be her respected the eMARs for misses medications not availed in the expected the Merica in the exp	onsibility ongoing to review ed medications and lable for administration. As to contact the pharmacy ded a refill medication and a if a new prescription was As to inform the RCC and ons were unavailable. he physician and order the the backup pharmacy until ed so the resident did not				
	2:40pm revealed: -It was the responsib medications, eMAR r physicians and training clinical responsibilities -The HWD position h 11/01/22 until 04/18/2 -The RCC tried to do with assistance from staff available for que -The cart audits and with the absence of a -When a resident 's r	ng of the staff, amongst other es. lad been vacant from 22. both jobs during that time, the regional clinical support estions. medication reviews suffered				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL018036	B. WING		04	/22/2022	
iame of Pi	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From pag	e 73	D 358				
	provided the residen -Resident #4's family facility not to order m pharmacy when need -She has been trying members on this issue Based on observation reviews it was detern interviewable. 2. Review of Residen 11/19/21 revealed dia a pulmonary emboliss a. Review of Residen 01/24/22 revealed: -Resident #3 had an determine the effect it treatment (for the rist clotting) while taking -The laboratory resul expressed in an Inter (INR), with the therap 3.0. -Resident #3's INR of -Based on the INR, 2 and Friday and 4mg Wednesday, Thursday was ordered.	ges with medications tration when a family it's medications. I member had instructed the hedications from the backup ded. I to work with family ue. Ins, interviews, and record nined Resident #4 was not In #3's current FL2 dated agnoses included a history of ism and anxiety. Int #3's physician order dated order for a blood draw to veness of her anticoagulation k of bleeding or blood warfarin medication. Its of the blood draw were rmational Normalized Ratio poeutic range between 2.0 - In 01/24/22 was 4.6. Emg of warfarin on Monday of warfarin on Tuesday, ay, Saturday and Sunday					
	02/07/22 revealed: -The INR results on 0 -Warfarin 2mg on Mo	onday and Friday and sday, Wednesday, Thursday,					

STATE FORM

6899

If continuation sheet 74 of 102

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
TEDDADE		1088 RA	DIO STATION ROA	D		
		NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 74	D 358			
	03/31/22 revealed: -INR drawn on 03/31 -Based on the INR, w Friday and warfarin 4 Wednesday, Thursday was ordered. Review of Resident # 04/11/22 revealed: -INR results on 04/11 -Based on the INR, w ordered. Review of Resident # medication administry revealed : -There was an entry to be administered day at 8:00pm. -There was an entry to be administered day Wednesday, Thursday	varfarin 2mg on Monday and Img on Tuesday, ay, Saturday and Sunday #3's physician order dated I/22 was 1.6. varfarin 4mg daily was #3's February 2022 electronic				
	administered on Tues Saturday and Sunday -There was documen administered warfarin	ntation Resident #3 was not n on 02/04/22, 02/06/22,				
	-There was documen the incorrect dosage 02/01/22-02/03/22, 0 02/15/22-02/18/22, 0	2/08/22-02/11/22,				
	possible opportunitie	warfarin dosing 6 of 28 s. ministered the incorrect				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL018036	B. WING			/22/2022
IAME OF Pr	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ERRABE	LLA NEWTON		N, NC 28658	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page	e 75	D 358			
	dosage of warfarin 14 opportunities.	4 of 28 possible				
	Review of Resident # revealed :	≴3's March 2022 eMAR				
	-There was an entry for warfarin 4mg one tablet to be administered daily on Saturday and Sunday at 8:00pm.					
	-There was an entry for warfarin 6mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm.					
	-There was no entry for warfarin 2mg one tablet to be administered daily on Monday and Friday. -There was no entry for warfarin 4mg to be					
	administered on Tues Saturday and Sunda	sday, Wednesday, Thursday, y.				
	administered warfarin	ntation Resident #3 was not n on 03/10/22- 03/11/22, 3/23/22, 03/25/22, and				
	03/28/22-03/31/22. -There was documer	ntation Resident #3 received				
	the incorrect dosage 03/01/22-03/04/22, 0	of warfarin (6mg) on				
	03/14/22-03/18/22, a -Resident #3 missed possible opportunitie	warfarin dosing 13 out of 31				
		ministered the incorrect				
	Review of Resident # 04/01/22-04/20/22 re	≴3's April 2022 eMAR, from evealed :				
		on 04/01/22 for warfarin administered daily on y at 8:00pm.				
	2mg one tablet to be	on 04/01/22 for warfarin administered daily on /ednesday, Thursday and				
	Friday at 8:00pm.	on 04/11/22 for warfarin 4mg				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 76	D 358			
	to be administered daily. -There was documentation Resident #3 received					
	the incorrect dosage					
	•	nd 04/18/22-04/19/22.				
	-Resident #3 was ad	ministered the incorrect				
	dosage of warfarin 9 of 9 possible opportunities.					
	Interview with the se	cond shift medication aide on				
	04/22/22 at 4:32pm r	evealed:				
		edications to the residents				
	on the Assisted Livin Care Unit (SCU).	g community and the Special				
	1 1	ation that was not available				
		sident she would contact the				
	pharmacy to order in evening.	backup to be received that				
	0	the medication in that				
		contact the Resident Care				
		nd document in the 24 hour				
	-There were 2 medic	ation carts in the SCU and				
	she did not administe on her shift.	er Resident #3's medications				
		warfarin and it was not on				
	the cart, she would c	ontact the pharmacy and the				
	RCC and contact the	on call physician if she				
	could not get the me	dication in that evening.				
	Interview with a anot 04/22/22 at 4:40 pm	her second shift MA on revealed:				
		edications to the residents				
		g community and the Special				
	Care Unit (SCU).					
		ation that was not available				
		sident she would contact the				
	pharmacy to order in evening.	backup to be received that				
	-	CC know if a medication				
		rescription so the RCC could				
	follow up in the morn					

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		HAL018036	B. WING		04	/22/2022	
iame of Pf	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From pag	e 77	D 358				
	-She did not contact the physicians. -Warfarin tablets were available to be administered on the cart the evenings she worked in the SCU.						
	Resident #3's primar office on 04/22/22 at -The PCP reviewed F sent from the home F prescribed the warfar -The warfarin dosing HHN, who contacted warfarin orders. -The physician's offic pharmacy with the ne requested a new pre -The last prescription office for Resident #2 2022 for warfarin 4m and warfarin 6mg ter -The facility staff had prescriptions, and we any missed doses of .The last INR recorded 1.6. -The new dosing ord 04/11/22 was 4mg ev 04/28/22.	Resident #3's INR results health nurse (HHN) and rin dosing. was communicated to the the RCC with the new ce did not contact the ew orders unless the facility scription for refills. In that was sent from this 3's warfarin was January 4, g sixty tablets with 11 refills in tablets with 11 refills. I not requested any additional e have not been notified of f warfarin. ed was on 04/11/22 and was ered by the physician on very day and re-check on					
	Resident #3's Home 04/22/22 at 11:45am -Resident #3's PCP	with the Office Manager at Health (HH) agency on revealed: would send orders for her subsequent warfarin orders					
aion of the		IN to visit the facility and					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HAL018036			04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
D 358	Continued From page	e 78	D 358			
	-She forwarded Resir PCP and received net Assistant . -She communicates it the HHN. -The HHN contacts th th result and the dosi -If there were any net staff was responsible pharmacy. -She did not know Res several doses of war March 2022, or that i administered. Interview with the RC revealed: -She was responsible INR and warfarin dos -She kept a record of lab values of the INR was scheduled on a List". -She usually received HHN for the current w -She documented the an INR Log and sent -She did not know with PCP's office had diffe she had transcribed. -It was the responsib pharmacy for refills o needed to contact the -The MAs should also medication was not a the 24 hour progress	dent #3's INR results to the ew orders from their Medical the new warfarin orders to he facility (RCC) and reports ing ordered by the PCP. w prescriptions, the facility e for forwarding them to the esident #3 had missed farin in February 2022 and ncorrect doses were CC on 04/22/22 at 3:20pm e for tracking Resident #3's sing. If the date of the last INR, the e, and the date the next INR Coumadin (Warfarin)"Hot d a verbal order from the warfarin order from the PCP. e current warfarin dosage on the log to the pharmacy. hy the HH agency and the erent warfarin orders than ility of the MAs to contact the or if a new prescription was e physician's office. o contact her when a available and document in				
	Resident #3's warfari	cumentation regarding in. he eMAR for medications not				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL018036	B. WING		04/22/2022		
iame of Pi	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
D 358	Continued From page	e 79	D 358				
	not capture medication administered. -She did not know Red doses of warfarin in F missed doses of war Review of the INR Lo -On 01/24/22 the RC dosage as 6mg Mone Saturday and Sundar HHN. -On 01/25/22 she set and it was entered in -On 02/07/22 the RC dosage as 6mg Mone Saturday and Sundar HHN. -On 02/09/22 she set and it remained on th -On 03/31/22, the RC dosage as 2mg on M 4mg all other days, p HHN. -On 03/31/22, she set to be entered on the -On 04/11/22, the RC	og on 04/22/22 revealed: C documented the warfarin day through Friday and 4mg y, per verbal orders from the nt this order to the pharmacy to the eMAR. C documented the warfarin day through Friday and 4 mg y, per verbal orders from the nt this order to the pharmacy be eMAR with no changes. C documented the warfarin londay through Friday and ber verbal order from the ent this order to the pharmacy					
	4mg all other days. -On 04/12/22, she se pharmacy to be ente	ent the new order to the red on the eMAR.					
	3:10pm revealed: -It was the responsib Wellness Director (H orders and eMAR rev -The HWD position h	ministrator on 04/21/22 at ility of the Health and WD) to oversee medication views. nad been vacant from 22 and the RCC tried to do					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING				
	OVIDER OR SUPPLIER	HAL018036	B. WING 04/22/2022 EET ADDRESS, CITY, STATE, ZIP CODE				
ERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From page	e 80	D 358				
	both jobs during that time. -The cart audits and medication reviews suffered						
	with the absence of a	a nurse.					
		nedication was not available					
		e MAs were instructed to					
	order through the bac the RCC.	ck up pharmacy and notify					
	-She did not know Re	esident #3 had 6 missed					
	doses of warfarin in F	February 2022 and 13					
	missed doses of war	farin in March 2022.					
		sident #3 had received the					
		sage 14 times in February					
	2022, 13 times in Ma 2022.	rch 2022 and 9 times in April					
	b. Review of a physician's order dated 11/19/21 revealed an order for Latuda 60mg take one tablet daily.						
		#3's April 2022 eMAR, from					
	04/01/22 to 04/20/22						
		for Latuda take 1 tablet by					
	mouth once daily at 8	•					
		4/22 Latuda 60mg was Idministered due to the					
		vailable" or "waiting for a					
	prescription".						
		9/22 Latuda 60mg was					
		idministered due to the					
	"medication was una	vailable" or "waiting for a					
	prescription".						
		nted as not administered 6					
	of 20 opportunities in	April 202.					
	Observation of medic	cations available for					
		ed there was a bubble card					
		n 04/11/22, with 21 tablets					
	remaining.						
	Tolophono intonviouv	with Resident #3's PCP on					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL018036	B. WING		04	/22/2022	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,				
ERRABE	LLA NEWTON		NIO STATION ROAI				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
D 358	Continued From page	e 81	D 358				
	04/22/22 at 10:30am	revealed.					
	-Resident #3 had been prescribed Latuda 60 mg for behaviors and agitation.						
		t receive the Latuda 2 or					
		ys there could withdrawal					
		estinal symptoms, suicidal					
	ideation or an increas						
		C on 04/22/22 at 3:20pm					
	revealed:						
		t were sent to the facility for					
		accounted for before placing					
	them on the medicati						
	-	compare the label on the					
		MAR order and if they n was placed on the cart.					
		a was checked as sent from					
		d on the medication cart.					
		ny the medication was not					
		opportunities in April 2022.					
	Interview with the Ad	ministrator on 04/21/22 at					
	3:10pm revealed:						
		ility of the RCC or designee					
	to perform weekly ca						
	-She did not know Re						
		mented as not administered					
	6 of 20 opportunities	in April 2022.					
	3. Review of Resider	nt #2's current FL2 dated					
	03/07/22 revealed:						
	-Diagnoses included	dementia and					
	neuromuscular disord						
	-The level of care wa	s documented as Special					
	Care Unit (SCU).						
	Review of Resident #	2's primary care provider 's					
	(PCP) visit summary						
	revealed:						
	-Resident #2 had red						

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL018036	B. WING		04	/22/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
FERRABE	LLA NEWTON		ADIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page	e 82	D 358			
	-There was an order	coating over his tongue. for Nystatin suspension, cavity and spit out three ays.				
	medication administr 03/16/22 to 03/30/22 -There was an entry swish and spit three be administered at 8 -There was documer administered on 03/1 8:00pm, 03/19/22 to 8:00pm, and 03/22/2 -There was documer administered nystatir	for nystatin suspension times a day for 14 days, to :00am, 2:00pm and 8:00pm. ntation nystatin was not 6/22 at 8:00am, 03/18/22 at 03/20/22 at 2:00pm and 2 at 8:00pm. ntation Resident #2 was not				
	contracted pharmacy revealed: -Resident #2's nystat filled on 03/15/22 and -The nystatin suspen suspension was disc 150ml remaining in the -If the resident did no dosage of nystatin, the	sion was returned when the ontinued after 14 days with				
	eating or drinking, so	causes discomfort when the resident may refuse to infection was active.				
	04/22/22 at 4:20pm r -He was very complia -He had an order for times a day in March	ant with his medications. nystatin suspension three				

STATE FORM

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If continuation sheet 83 of 102

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		04	12212022
			DIO STATION ROA			
IERRABE	ELLA NEWTON	NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	le 83	D 358			
	and spit.					
		much but she did not know if				
	that was due to his n					
		noutri sores.				
	Interview with the Re	esident Care Coordinator				
	(RCC) on 04/22/22 a					
		#2 had an order for nystatin				
	suspension for a pos	ssible yeast infection, swish				
	and spit three times					
	-She did not know R					
	-	n suspension 7 of 42 possible				
	opportunities.					
		/ MAs may not have been				
	on the cart.	ement of bottled medications				
		pility of the MAs to contact her				
	-It was the responsibility of the MAs to contact her if they can not locate a medication on the cart.					
	Interview with the Ad 3:10pm revealed:	Iministrator on 04/21/22 at				
	pharmacy and the R	bility of the MAs to contact the CC when they could not				
	locate a medication					
	-She did not know R					
	opportunities.	n suspension 7 of 42 possible				
	Based on observatio	ons, interviews, and record				
		mined Resident #2 was not				
	The facility failed to e	ensure medications were				
	-	ered for 1 of 5 residents				
		n pass, who had a history of				
		sion, including a blood thinner				
		ood clot and blood pressure				
		control high blood pressure				
		another stroke, and did not				
		vailable for administration				
	used for high choles	terol, depression and anemia				

Division of Health Service Regulation STATE FORM

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If continuation sheet 84 of 102

STATEMENT	of Health Service Regure FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	FCORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET
D 358	Continued From page	e 84	D 358			
	that was not complete This failure placed res	antifungal oral suspension ed. sidents at substantial risk of n and constitutes and Type				
		a plan of protection on ce with G.S. 131D-34 for				
	CORRECTION DATE VIOLATION SHALL N 2022.	E FOR THE TYPE A2 NOT EXCEED MAY 22,				
D 464	10A NCAC 13F.1307 Profile & Care Plan	Special Care Unit Res.	D 464			
	Profile & Care Plan In addition to the requ .0801 and 13F .0802 facility shall assure th (1) Within 30 days of care unit and quarterl develop a written resi assessment data that behavioral patterns, s daily living skills, spec physical abilities and cognitive impairment. (2) The resident care 13F .0802 of this Sub or revised based on ti specify programming social and health care resident attain or main	admission to the special ly thereafter, the facility shall ident profile containing t describes the resident's self-help abilities, level of cial management needs, disabilities, and degree of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		HAL018036			04	/22/2022
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ERRABE	LLA NEWTON		N, NC 28658			
(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 DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 464	Continued From page	e 85	D 464			
	 Continued From page 85 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed was completed within 30 days of admission, quarterly and within 10 days following a significant change in the resident's condition for 2 of 5 sampled residents (Resident #1) with recurrent falls, injuries and becoming non-weight bearing and (Resident #4) who did not have documentation of a care plan within 30 days of admission, quarterly profiles or a significant change care plan after a stroke. The findings are: 					
		s current license effective vas licensed with a special a capacity of beds.				
	02/24/22 revealed: -Diagnoses included	nt #1's current FL2 dated dementia, . evel of care was the SCU.				
	Review of Resident # revealed she was ad 03/24/10.	1's Resident Register mitted to the SCU on				
	8:45am revealed: -Resident #1 was lyir incontinent brief.	lent #1 on 04/20/22 at ng in the bed, wearing an eft leg knee immobilizer and				
	Review of Resident # revealed there was n and profile completed admission to the SCU	o SCU resident care plan d with in 30 days of				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	HAL018036	ADDRESS, CITY, STATE		04	/22/2022
ERRABE		NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 464	Continued From page	e 86	D 464			
	03/02/22 revealed: -She was independen- -She required superv -She required limited -She required extens dressing and groomin Review of Resident # 02/24/22 revealed Ref from a skilled nursing hip replacement on 0 Review of Resident # discharge dated 02/2 -An Xray of Resident # discharge instruction maintain non-weight seen by orthopedics. Review of Resident # order dated 03/03/22 to maintain non-weig Refer to interview witt Coordinator (RCC) of Refer to interview witt Director (HWD) on 04	ision with eating. assistance with toileting. ive assistance with toileting. ive assistance with bathing, ng. 1 transfer form dated esident #1 was transferred facility post op a left partial 2/07/22. 1's Emergency Room (ER) 8/22 revealed: #1's left knee noted a left ns included Resident #1 to bearing to the left leg until 1's orthopedic provider's revealed Resident #1 was ht bearing to left leg. h the Resident Care n on 04/22/22 at 11:25am h the Health and Wellness				
	04/22/22 at 12:16pm Based on interviews, review Resident #1 w	observations and record vas not interviewable.				
	Resident #1's SCU c requested prior to exi	are plan and profile was t on 04/22/22.				

STATE FORM

	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY
		HAL018036	B. WING		04/22/2022	
AME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
D 464	Continued From page	e 87	D 464			
	11/24/21 revealed: -Diagnoses included right sided hemiplegia kidney failure, anxiety disease . -The recommended I Review of Resident # revealed she was add 06/24/20. Review of Resident # -There was no docum Profile and Care Plan admission. -There were no Quar Review of Resident # -There was one care -Activities of daily livit	44's record revealed: mented SCU Resident a completed within 30 days of terly profiles. 44's record revealed; plan dated 09/13/21. ng were documented as; pulation and eating; cues and taff assistance for				
	revealed: -Resident #4 returned after her stroke on 02 -Resident has an ord	a note entry on 03/17/22 d from rehabilitation facility 2/23/22. er for a wheelchair and occupational therapy.				
		44's record revealed there Care Plan upon return of the itation.				
	Telephone interview physician (PCP) on 0	with the primary care)4/13/22 at 1:25pm revealed:				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING				
	ROVIDER OR SUPPLIER	HAL018036	ET ADDRESS, CITY, STATE, ZIP CODE				
ERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 464	Continued From page	e 88	D 464				
	-Resident #4 was a new client since April 2022. -The facility had not sent a care plan for her to review. Refer to interview with the RCC on on 04/22/22 at 11:25am Refer to interview with the HWD on 04/22/22 at 11:45am.						
	Refer to interview wit 04/22/22 at 12:16pm	h the Administrator on					
	Based on interviews, review Resident #4 w	observations and record vas not interviewable.					
	Resident #4's SCU c requested prior to exi	are plan and profile was it on 04/22/22.					
	revealed:	C on 04/22/22 at 11:25am					
	residents' care plans						
		ad been vacant since on 04/18/22 a new HWD a facility					
	-From November 202 completing the care p	21, she was responsible for blans but she did not know a completed with in 10 days					
		VD on 04/22/22 at 11:45					
	Profile and Care Plan	onsible for the SCU Resident and was to be completed					
		nission, quarterly and within ignificant change in the					
	-The HWD position h	ad been vacant since on 04/18/22 she started					

STATE FORM

EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
	HAL018036	B. WING		04	/22/2022		
VIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE				
LA NEWTON			D				
		N, NC 28658					
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pag	e 89	D 464					
She was informed b was responsible for of Care Unit Resident F November 2021 until facility. She did not know the Profile and Care Plar correctly. Interview with the Ad 12:16pm revealed: A nurse or the HWD completion of the car admission and with in change in a resident" The Special Care Di responsible for comp Profile before admiss The SCD was new t	y the Administrator the RCC completion of the Special Profile and Care Plans after she started work at the e Special Care Unit Resident ns were not completed ministrator on 04/22/22 at was responsible for re plan with in 30 days of n 10 days of a significant s condition. rector (SCD) was letion of the SCU Resident sion and quarterly there after. o her position and she was						
G.S. 131D-21 Decla Every resident shall I 2. To receive care an adequate, appropriat relevant federal and regulations. This Rule is not met Based on observatio nterviews, the facility residents received ca	ration of Residents' Rights have the following rights: and services which are e, and in compliance with state laws and rules and as evidenced by: ns, record reviews, and / failed to ensure the are and services that were	D912					
	DVIDER OR SUPPLIER LA NEWTON SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page working at the facility She was informed b was responsible for of Care Unit Resident F November 2021 until facility. She did not know the Profile and Care Plar correctly. Interview with the Ad 12:16pm revealed: A nurse or the HWD completion of the car admission and with in change in a resident" The Special Care Di responsible for comp Profile before admiss The SCD was new t aware the quarterly p G.S. 131D-21 (2) Dec G.S. 131D-21 Declal Every resident shall H 2. To receive care and adequate, appropriat regulations. This Rule is not met Based on observatio Interviews, the facility residents received car adequate, appropriat	HAL018036 WIDER OR SUPPLIER STREET A LA NEWTON 1088 RA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 89 working at the facility. She was informed by the Administrator the RCC was responsible for completion of the Special Care Unit Resident Profile and Care Plans after November 2021 until she started work at the acility. She did not know the Special Care Unit Resident Profile and Care Plans were not completed correctly. Interview with the Administrator on 04/22/22 at 12:16pm revealed: A nurse or the HWD was responsible for completion of the Secial Care Unit Resident Profile and Care Plans were not completed correctly. Interview with the Administrator on 04/22/22 at 12:16pm revealed: A nurse or the HWD was responsible for completion of the care plan with in 30 days of admission and with in 10 days of a significant change in a resident's condition. The Special Care Director (SCD) was responsible for completion of the SCU Resident Profile before admission and quarterly there after. Che SCD was new to her position and she was aware the quarterly profiles were not completed. G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Summary resident shall have the following rights: Corrective care and services which are adequate, appropriate, and in compliance with el	HAL018036 B. WING HAL018036 B. WING LA NEWTON STREET ADDRESS, CITY, STATE 108 RADIO STATION ROA NEWTON, NC 28658 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 89 D 464 vorking at the facility. She was informed by the Administrator the RCC was responsible for completion of the Special Care Unit Resident Profile and Care Plans after November 2021 until she started work at the acility. D 464 She did not know the Special Care Unit Resident Profile and Care Plans were not completed correctly. Not a significant shange in a resident's condition. The Special Care Director (SCD) was esponsible for completion of the SCU Resident Profile before admission and quarterly there after. The SCD was new to her position and she was sware the quarterly profiles were not completed. D912 G.S. 131D-21 (2) 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 elevant federal and state laws and rules and eguilations. D912	HAL018036 B. WING WIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1088 RADIO STATION ROAD REVENDN 1088 RADIO STATION ROAD NEWTON, NC 28658 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In PREFIX REGULATORY OR DESCIPTION ON DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL Resolut TORY OR LSC IDENTIFYING INFORMATION) In Continued From page 89 working at the facility. D 464 She was informed by the Administrator the RCC was responsible for completion of the Special Care Unit Resident Profile and Care Plans after November 2021 until she started work at the acility. D 464 She did not know the Special Care Unit Resident Profile and Care Plans were not completed correctly. D 464 A nurse or the HWD was responsible for completion of the SCU Resident Profile before admission and yuarterly there after. D The Special Care Director (SCD) was esponsible for completion of the SCU Resident Profile before admission and quarterly there after. D The SCU was new to her position and she was ware the quarterly profiles were not completed. D S.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 elevant federal and state laws and rules and egulations. D This Rule is not met as evidenced by: Based on observations, record reviews, and nterviews, the facility failed to ensure the esidents r	HALD18036 B. WING 04 WIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, ZIP CODE 1088 RADIO STATION ROAD LANEWTON 1088 RADIO STATION ROAD NEWTON, KC 26685 SUMMARY STREET OF DEPICIENCIES (RECH DEFICIENCY WIST REPECEDED BY FULL RECULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX FAG PROVIDER'S PLAN OF CORRECTION (EACH ORGENTY WAST AND ADDRESS) D PROVIDER'S PLAN OF CORRECTION (EACH ORGENTY WAST ADDRESS) Continued From page 89 D 464 444 D PREFIX (EACH ORGENTY WAST ADDRESS) D PROVIDER'S PLAN OF CORRECTION (EACH ORGENTY WAST ADDRESS) Continued From page 89 D 464 444 444 She did not Know the Special Care Unit Resident Profile and Care Plans after sovermber 2021 until she started work at the acility. D 464 She did not Know the Special Care Unit Resident Profile and Care Plans of a significant shamission and with 10 10 days of a significant shamission and sum of the SCU Resident Profile and Care Director (SCD) was esponsible for completion of Residents' Rights D 912 35. 131D-21 Declaration of Residents' Rights Subact on observations, record reviews, and therviews, the facility faile to ensure the esidents received care and services which are adequate, appropriate, and in compliance with elevant federal		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		HAL018036	B. WING		04	/22/2022
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D912	Continued From page	e 90	D912			
	and competency.					
	The findings are:					
	facility failed to ensur A, B, C, D, E and F) medications had com Training and 2 of 6 sa had completed the cl administering medica G.S. 131D-4.5B(b) A	pleted the Medication Aide ampled staff (Staff A and F) inical skills checklist prior to ations. [Refer to tag 0935,				
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914			
	Every resident shall h	ration of Residents' Rights nave the following rights: al and physical abuse, tion.				
		and record reviews, the re all residents were free to Personal Care and				
	The finding are:					
	reviews, the facility fa accordance with the for 1 of 5 sampled re the Special Care Uni	tions, interviews, and record ailed to provide supervision in residents' current symptoms sidents who was assigned to t (SCU) that had a history of sident to be non-weight				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
				G:			
		HAL018036	B. WING		04	/22/2022	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ERRABE	LLA NEWTON		ADIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D914	Continued From page	e 91	D914				
	 bearing after a left tibia plateau fracture (the upper part of the shin involving the knee joint). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 5 sampled residents (#3, and #6) related to a fasting blood sugar (FSBS) greater than 400 (#6) and missed doses of a blood thinner medication and mood stabilizer (#3). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 						
	reviews, the facility far medications as order observed during the it to a medication used medications to contro- medications to contro- increase low iron in the anti-depressant (#4), available as ordered (#2, #3, and #4), inclu- anxiety (#4), medicate clots and treat depres- used to treat mouth s	ed for 1 of 5 residents medication pass as related to thin the blood, two ol high blood pressure, and ol high cholesterol and he blood and an and medications not for 3 of 5 sampled residents uding a medication for ions used to prevent blood ssion (#3), and a medication cores (#2). [Refer to Tag 3F .1004(a) Medication					
D935	G.S.§ 131D-4.5B(b) Training and Compet	ACH Medication Aides; ency	D935				
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirem	aining and Competency					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:			
		HAL018036 B. WING			04	/22/2022	
IAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	92	D935				
	home is prohibited fro any unsupervised me that individual has pro- medication aide durin an adult care home of of the following: (1) A five-hour trainin Department that inclu- in all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe injec procedures for monito- bleeding occurs or th exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days fro individual must have a. An additional 10-ho developed by the Dep training and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe injec procedures for monito- bleeding occurs or th exists. b. An examination de- by the Division of Hea	ag the previous 24 months in r successfully completed all g program developed by the ides training and instruction of medication rs for Disease Control and s on infection control and, if tion practices and oring or testing in which e potential for bleeding aluation consistent with 10A d 10A NCAC 13G .0503. The date of hire, the completed the following: our training program partment that includes on in all of the following: of medication rs of Disease Control and s on infection control and, if tion practices and oring or testing in which e potential for bleeding veloped and administered alth Service Regulation in section (c) of this section.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL018036			04/22/2022	
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,		02	1/22/2022
	LLA NEWTON	1088 RA	DIO STATION ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D935	Continued From page	e 93	D935			
	facility failed to ensur A, B, C, D, E and F) medications had com Training and 2 of 6 sa had completed the cl administering medica The findings are:	pleted the Medication Aide ampled staff (Staff A and F) inical skills checklist prior to				
	written MA exam on 0 -There was no docun 5/10/15 hour training	02/24/22. Itation she passed the 04/28/21. Inentation she completed the Inentation Staff A completed				
	medication administr	s February 2022 electronic ation record (eMAR) not administer medications.				
	medications on 03/12	s March 2022 eMAR Imented administering 2/22, 03/13/22, 03/23/22, 03/26/22, and 03/31/22.				
		s April 2022 eMAR revealed administering medications on				
	Refer to interview wit Manager (BOM) on 0	h the Business Office)4/22/22 at 3:33pm.				
	Refer to interview wit Coordinator (RCC) o	h the Resident Care n 04/22/22 at 3:45pm.				

STATE FORM

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING		04/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D935	Continued From page	94	D935			
	Refer to interview with 04/22/22 at 3:35pm.	n the Administrator on				
	2. Review of Staff B's revealed: -Staff B was hired on	, MA personnel record				
	-There was documen written MA exam on 1	tation she passed the				
	-There was documen	tation Staff B completed the ills competency validation				
		s February 2022 eMAR mented administering /22.				
	medications on 03/01 03/08/22, 03/09/22, 0	mented administering /22, 03/03/22, 03/07/22, 3/13/22, 03/16/22, 03/17/22, 3/23/22, 03/24/22, 03/27/22,				
	Staff B documented a	s April 2022 eMAR revealed administering medications on 4/08/22, 04/10/22, 04/12/22				
	Refer to interview with 3:33pm.	n the BOM on 04/22/22 at				
	Refer to interview with 3:45pm.	n the RCC on 04/22/22 at				
	Refer to interview with 04/22/22 at 3:35pm.	n the Administrator on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			HAL 018036 B. WING				
		HAL018036			04	/22/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
FERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	e 95	D935				
	 3. Review of Staff C's revealed: Staff C was hired on There was document written MA exam on the staff C was hired on the staff C was hired on the staff C have a staff c have	s, MA personnel record 03/03/22. Itation she passed the 10/23/18. Inentation she completed the itation Staff C completed the cills competency validation s February 2022 eMAR not administer medications.					
	3:45pm. Refer to interview wit 04/22/22 at 3:35pm.	h the Administrator on					
	revealed: -There was no hire da -Staff D was agency -There was documen written MA exam on 0	itation she passed the 01/10/22. nentation she completed the					

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING			/22/2022
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	02	HZZIZUZZ
FERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D935	Continued From pag	e 96	D935			
	-There was documentation Staff D completed the medication clinical skills competency validation on 01/10/22.					
	Review of a resident's February 2022 eMAR revealed there was documentation Staff D administered medications for 17 days from 02/08/22 to 02/28/22.					
	Review of a resident's March 2022 eMAR revealed there was documentation Staff D administered medications for 19 days from 03/01/22 through 03/31/22.					
	there was documenta	's April 2022 eMAR revealed ation Staff D administered ays from 04/01/22 through				
	Refer to interview wit 3:33pm.	th the BOM on 04/22/22 at				
	Refer to interview wit 3:45pm.	th the RCC on 04/22/22 at				
	Refer to interview wit 04/22/22 at 3:35pm.	th the Administrator on				
	revealed:	s, MA personnel record ate documented for Staff E.				
	-Staff E was agency -There was documer written MA exam on	ntation she passed the				
	-There was no docur 5/10/15 hour training	mentation she completed the				
		kills competency validation				

Division of Health Service Regulation STATE FORM

6899

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL018036	B. WING			04/22/2022
NAME OF PRO	VIDER OR SUPPLIER		ADDRESS, CITY, STATE, Z		04	12212022
TERRABELL	ANEWTON		NDIO STATION ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
R rea 0 R rea 0 R th r R 3 R 3 R 0 6 re 	evealed there was d dministered medica 2/28/22. Review of a resident' evealed there was d dministered medica 3/01/22 through 03/ Review of a resident' here was no docume nedications from 04/ Refer to interview wit :33pm. Refer to interview wit :45pm. Refer to interview wit 4/22/22 at 3:35pm. . Review of Staff F's evealed: Staff F was hired on Staff F was hired on Staff F was agency s There was documen (10/15 hour training There was no docum he medication clinica alidation. Review of a resident' evealed there was no	s February 2022 eMAR locumentation Staff E tions one day 02/01/22 to s March 2022 eMAR locumentation Staff E tions for four days from 31/22. s April 2022 eMAR revealed entation Staff E administered /01/22 through 04/20/22. th the BOM on 04/22/22 at th the RCC on 04/22/22 at th the Administrator on s, MA personnel record 12/01/21. staff hired as a MA. tation she passed the 05/31/17. nentation she completed the	D935	DEFICIE	NCY)	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	HAL018036	B. WING		04	/22/2022	
	CONDER OR SUPPLIER						
ERRABE	LLA NEWTON		N, NC 28658				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D935	Continued From page	e 98	D935				
		s March 2022 eMAR o documentation Staff F tions from 03/01/22 through					
	Review of a resident's April 2022 eMAR revealed there was no documentation Staff F administered medications from 04/01/22 through 04/20/22. Refer to interview with the BOM on 04/22/22 at 3:33pm.						
	Refer to interview wit 3:45pm.	h the RCC on 04/22/22 at					
	Refer to interview with the Administrator on 04/22/22 at 3:35pm.						
	Interview with the BC revealed:	DM on 04/22/22 at 3:33pm					
	hour MA training and	MAs required the 5/10/15 clinical skill check off to be iministering medications.					
	pre-employment pacl	ket together which included ur MA training and give to					
	clinical skills check of -After the 5/10/15 ho	nsible for getting the MAs ff completed by a nurse. ur training and clinical skills					
	give her the staff file process.	npleted then the RCC was to back for the final hiring					
	the 5/10/15 hour MA or that the agency M	she needed to have proof of training for the agency MAs A were required to have the					
	clinical skills check of medications.	ff prior to administering					
	Intonviow with the PC	C on 04/22/22 at 3:45pm					

Division of Health Service Regul STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		RECTION IDENTIFICATION NUMBER:		A. BUILDING:		PLETED
		HAL018036	B. WING		04/22/2022	
NAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
TERRABE	LLA NEWTON		DIO STATION ROA N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D935	Continued From pag	e 99	D935			
	staff records for proc training and the clinic -Previously, until Nov contact the facility co completion of the 5/1 the clinical skills chec administering medica -Since November 20 nurse to complete the -Since November 20 registry as passing the were cleared to pass -She was not aware skills check off prior to -There were no agen the facility because to those records. -She was not aware documentation requit the agency staff. Interview with the Ad 3:35pm revealed: -The BOM was respondent	vember 2021, she would ontracted nurse for 0/15 hour MA training and or ck off prior to a MA ations. 21, the facility did not have a e clinical skills check off. 21, if a MA was listed on the ne MA test, then the MA's				
	hour MA training and -The Health Wellnes	l the clinical skills check off. s Director (HWD) who was a le for all MA training and the				
	-A MA could not adm completion/verification training and the clinic	inister medications until on of the 5/10/15 hour MA cal skill check off.				
	staff records to show clinical skills check o administering medica					
		e agency MAs needed to te the clinical skill check off				

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL018036			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		04	/22/2022	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ERRABE	LLA NEWTON		DIO STATION ROAL N, NC 28658	D		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D935	Continued From page	e 100	D935			
	at the facility prior to administering medications. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). Refer to Tag D0344 10A NCAC 13F .1002(a) Medication Orders (Type B Violation).					
	•	10A NCAC 13F .0505 Diabetic Resident (Type SD				
	(Staff A, B, C, D, E a medications had com Training and 2 of the F) had completed the to administering med who failed to re-orde high blood pressure, depression, and pain thin the blood, and fa complete neurovascu resident developing a pressures prior to ad medication with para to ensure MAs met tr the administration of medication errors wh health, safety, and w constitutes a Type B	a and medications used to all to clarify orders to all to clarify orders to all to clarify orders to all to clarify orders to a blood clot and check blood ministering a blood pressure meters. The facility's failure raining requirements prior to medications resulted in all to the elfare of the resident and Violation.				
	accordance with G.S for this violation.	a plan of protection in . 131D-34 on April 22, 2022				
	CORRECTION DATE VIOLATION SHALL 1 2022.	E FOR THE TYPE B NOT EXCEED JUNE 7,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 04/22/2022	
		HAL018036				
AME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,		04	
	LLA NEWTON		DIO STATION ROA			
	LLA NEWTON	NEWTO	N, NC 28658			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC' TAG CROSS-REFERENCED TO DEFICIENT		TION SHOULD BE COM THE APPROPRIATE D/	