STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Alamance County Department of Social Services conducted a follow-up survey and a complaint investigation from June 14, 2022 to June 16, 2022 and June 20, 2022 with a desk review on June 17, 2022 and an exit on June 20, 2022.	D 000		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 201	Continued From page 1	D 201		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure aide hours met the minimum requirements for the Assisted Living (AL) section for 3 of 18 sampled shifts from 06/11/22-0/16/22.

The findings are:

Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including assisted living (AL) with a capacity of 46 beds and the special care unit (SCU) with a capacity of 48 beds.

Review of the facility's resident census report revealed the AL census was 21 from 06/11/22-06/16/22 which required 16 aide hours on first and second shifts and 8 hours on third shift.

Review of staff timecards dated 06/11/22 revealed:
-There was a total of 15.07 staff hours provided on first shift leaving a shortage of 0.93 hours.
-There was a total of 7.73 staff hours provided on second shift leaving a shortage of 8.27 hours.

Review of staff timecards dated 06/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 201	Continued From page 2	D 201		

revealed there was a total of 11.07 staff hours provided on second shift leaving a shortage of 4.93 hours.

Confidential interview with a resident revealed:
-One resident asked for assistance to go to the bathroom during the night of 06/13/22 (she did not recall the time) and not one ever came in and she soiled herself.
-She had to wait until the morning personal care aide (PCA) came in to assist her.
-When she stayed in a soiled brief, she would get a rash.

Confidential interviews with four other residents revealed:
-One resident stated not having assistance happened often.
-Another resident had not had a shower or "even a wash-up" in over a week.
-A third resident had not had a shower since last Monday, 06/06/22; it was impossible to get one.
-Three residents were told the staff did not have time.
-A fourth resident reported on Sunday night, 06/12/22, assistance was needed with changing the bed linens that were soiled and there were no staff to help.
-The staff did not have time to assist with baths and residents would go days without a bath.
-The first resident stated she had to get a bath on her own before and it scared her, because she thought she was going to fall.

Interview with a PCA on 06/15/22 at 9:02am revealed:
-There were three residents who physically had to have their incontinent changed.
-There were four residents who knew when they needed to be changed but needed some staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 201	Continued From page 3	D 201		

assistance.
-She assisted in the dining room during meals.
-She usually worked 7:00am-7:00pm.
-She had not personally talked to anyone in management about needing assistance with resident showers, but other PCAs had, and they were told they had all the PCAs needed based on the census.
-Some days it was really hard to get everything done because of other things that were going on, an example was yesterday, 06/14/22, she had four residents that had incontinence of stool and she could not do anything else.
-On Monday morning, 06/13/22, she found three named residents in soiled incontinent briefs.
-She was told there had only been one staff member working on the evening before, Sunday night, 06/12/22.

Interview with the facility's contracted primary care provider (PCP) on 06/15/22 at 11:40am revealed:
-She was concerned about a resident, who was confined to a wheelchair, was left in a soiled incontinent brief, and the resident was at risk for skin breakdown.
-If a resident who was confined to a wheelchair ever had a skin breakdown, it would be hard to heal because there would be constant pressure on that area.
-The residents were at risk for skin issues if they did not get showers; it was not hygienic and increased the residents' risk for infection.

Telephone interview with a medication aide (MA) on 06/20/22 at 1:39pm revealed:
-Residents had complained to her about not getting showers, not even a wash-up.
-She had helped the PCAs with incontinent care, but she did not have time to assist with showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 201	Continued From page 4	D 201		

-The PCA gave the residents showers whenever she got a chance, if she got a chance.
-She was told by management the AL was only required to have one MA and one PCA.
-All twenty-one of the residents needed reminders, even if they did not need hands-on assistance.
-Over half of the residents needed hands-on assistance with bathing.
-If there was at least one more PCA who worked 4-hours to help with showers, it would help.

Interview with the Resident Care Coordinator (RCC) on 06/20/22 at 9:10am revealed:
-Showers were scheduled for Mondays, Wednesdays, and Fridays for some residents and Tuesday, Thursday, and Saturday for other residents; on alternate days the residents got a "wash up."
-The PCA took the residents to the shower or assisted the resident at their sink, made sure the resident had what they needed to get washed up and assisted those that needed it.
-The AL was staffed with a MA and a PCA.
-The PCA was the only one who did showers on the AL.
-She had worked as a MA but she had not helped with resident showers.
-She thought they probably needed another PCA based on the residents' needs.
-It could be very overwhelming when they were short-staffed based on callouts.

Confidential interview with staff revealed she had never seen the RCC assist with personal care.

Interview with the Administrator on 06/20/22 at 6:07pm revealed:
-There was a shower and bath schedule and sheet for documenting showers and baths that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 201	Continued From page 5 was developed and should be documented on. -There were also skin assessment sheets the PCAs were required to fill out at bath time. -She was only aware of one resident who complained of not getting her shower. -There was a named resident in the AL who complained she did not get her baths for two weeks. -A PCA had told the named resident she would come back to get a bath but the PCA never came back to give the resident a bath. -At the time there were no shower sheets so there was no way to audit to see if the PCA had given the named resident a shower. -She hoped the PCAs did not falsify the new shower documents. -The RCC and the MAs should audit the new sheets for documentation and visually look at residents for appearance, cleanliness and hygiene to verify showers were being done. -She was concerned the facility was not taking care of the residents as they should be taken care of; she would think everyone [residents] wanted to be clean because it was a basic right and need.	D 201		
D 230	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge	D 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 6 is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications; (E) the resident's current medications; (F) a record of the resident's vaccinations and TB screening; (5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: (A) the regional long term care ombudsman; and (B) the protection and advocacy agency established under federal law for persons with disabilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure an orderly discharge and notification to the legal guardian of the reason for the discharge for 1 of 1 sampled residents (Resident #3) who was discharged to a local hospital after being sent to the emergency department for an evaluation. The findings are:	D 230		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 7	D 230		

Review of Resident #3's current FL2 dated 01/31/22 revealed:
-Diagnoses included type 2 diabetes and dementia.
-Resident #3 was intermittently disoriented.
-Resident #3 was verbally abusive.
-The level of care was Special Care Unit (SCU).

Review of Resident #3s Resident Register revealed:
-Resident #3 was admitted on 10/30/19.
-The discharge information had not been completed.

Review of Resident #3's care notes revealed:
-On 05/02/22, Resident #3 was fretting another resident.
-On 05/08/22, Resident #3 pulled three of his teeth.
-On 05/28/22, Resident #3 was pulling on another resident.
-On 05/30/22, Resident #3 had an altercation with another resident.
-On 06/01/22, Resident #3 pushed another resident on the floor.
-On 06/04/22, Resident #3 was agitated.
-On 06/05/22, Resident #3 was agitated/aggressive.
-On 06/08/22, Resident #3 had an altercation with another resident and was sent to the emergency department (ED) for behaviors.
-On 06/13/22, Resident #3 attacked another resident and was sent to the ED.

Interview with a personal care aide (PCA) on 06/16/22 at 1:24pm revealed she was told Resident #3 was not coming back to the facility.

Interview with the Administrator on 06/16/22 at 4:58pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 8	D 230		

-Resident #3 was still at the hospital.
-She had talked with the hospital's discharge planner and told them the facility could not take Resident #3 back.
-Within an hour of Resident #3 being sent to the hospital on 06/13/22, the hospital was trying to send him back to the facility.
-The psychiatry department had cleared Resident #3's involuntary commitment (IVC).
-She did not think the facility could meet Resident #3's needs because Veterans Administration residents could not get the medications and provider care he needed.

Telephone interview with a nurse at the local hospital ED on 06/17/22 at 3:02pm revealed:
-Resident #3 was in the ED and had been cleared from a medical standpoint and there was no reason the resident could not return to the facility's special care unit.
-They were told the facility would not allow the resident to return to the facility on 06/13/22.
-Resident #3 was still in the ED waiting on placement.

Telephone interview with a discharge planner at the local ED on 06/17/22 at 3:26pm revealed:
-The Administrator did not think it was safe for Resident #3 to return to the facility because he had choked another resident.
-Resident #3 had not had any issues with behaviors while in the ED.
-She was waiting to hear back from Resident #3's court-appointed guardian to work on placement for the resident since the facility refused his return.

Interview with the Memory Care Manager on 06/20/22 at 10:18am revealed:
-Resident #3 did not return to the facility after he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 9	D 230		

was sent out on 06/13/22.
-She thought the staff was told not to take Resident #3 back.
-She did not know who said to not take Resident #3 back, but it was not her.

Interview with the Administrator on 06/20/22 at 11:18am revealed:
-She told the hospital discharge planner on 06/14/22, Resident #3 could not return to the facility; she had not notified anyone else of the resident's discharge.
-She had received a message this am, (06/20/22) to call Resident #3's court-appointed guardian, but she had not had time to call.
-She knew the process for a normal discharge, a 30-day notice, but in Resident #3's case, it was an emergency discharge for his safety.
-When Resident #3's IVC was cleared that meant he was to return to the facility, but she had nothing new to manage his care.
-Without something to manage Resident #3, she could not prevent something from happening again.
-"If I do not have anything different, someone may get seriously hurt."
-Keeping both Resident #3 and the resident that agitated Resident #3, was not safe.
-She had not notified the county department of social services or anyone else about an emergency discharge for Resident #3.

Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed:
-When she was notified on 06/17/22 Resident #3 was at the hospital, she assumed he had been there since the 06/08/22 incident where he had been sent to the hospital after an altercation.
-She did not know Resident #3 had been sent to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 10	D 230		

the ED on 06/13/22.
-She was not notified by anyone at the facility Resident #3 had been discharged after being sent to the ED on 06/13/22.
-A staff member from the local ED informed her on 06/17/22, the facility staff had said Resident #3 was not allowed to return to the facility.
-She reached out to the facility on Friday, 06/17/22, but had not received a returned call as of today, 06/20/22.

Telephone interview with Resident #3's family member on 06/20/22 at 6:27pm revealed:
-A nurse at the local ED told her on Thursday, 06/16/22, Resident #3 had been involved in an altercation with another resident and was not allowed to return to the facility.
-She was worried about Resident #3 going somewhere else and her not knowing.
-She had always visited with Resident #3 weekly at the facility as well as her other family member.
-Her biggest fear was Resident #3 could not go back to the facility.

_____

The facility failed to provide a safe and orderly discharge for Resident #3 by not notifying his court-appointed guardian that the resident had been sent to the local emergency department (ED) for an evaluation and then would not allow the resident to return to the facility after he was deemed able to return to the same level of care by the physician in the ED, which resulted in Resident #3 remaining in the ED for 7 days without an appropriate placement. This failure was detrimental to the health, safety, and welfare of the resident which constitutes a Type B Violation.

_____

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on June 29, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 230	Continued From page 11 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 18, 2022.	D 230		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to provide personal care for 4 of 4 sampled residents (#1, #6, #7 and #8) related to incontinence care (#1, #6, #7) and grooming hair and changing clothes (#8). The findings are: 1. Review of Resident #1's current FL2 dated 03/08/22 revealed: -Diagnoses included alcohol induced dementia, muscle weakness, transient ischaemic attack (TIA) and venous thrombosis. -Resident #1 resided in the Special Care Unit (SCU). -Resident #1 was constantly disoriented and ambulatory.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 12 -Resident #1 was incontinent to bladder and bowl. -Resident #1 needed assistance with dressing and bathing. Review of Resident #1's care plan dated 06/15/22 revealed: -He was always disoriented. -He had significant memory loss and needed to be directed. -He required extensive assistance with toileting, grooming and bathing. Observations of Resident #1 on 06/14/22 at various times from 8:12am to 12:30pm revealed: -At 8:12am Resident #1 was laying asleep on a sofa in the common area of the SCU; he was covered by a blanket. -The personal care aides (PCAs) were bringing other residents into the common area; they were sitting in chairs and sofas in the common area. -At 8:20am, the PCAs began to take residents into the dining room; Resident #1 remained on the sofa asleep. -At 10:26am, a medication aide (MA) and a PCA attempted to wake Resident #1 and move him to his room. -Resident #1 refused to wake up or move from the sofa; the MA covered him back up with the blanket. -At 12:06pm, Resident #1 was on the sofa asleep with his bare feet hanging off the sofa and uncovered. -The MA came over to the sofa and sat Resident #1 up. -When the MA sat Resident #1 up, there was a large wet urine spot that covered one of the two cushions on the sofa. -Resident #1 had on a pair of flannel pajama bottoms and a white t-shirt; his t-shirt was wet on the back and side up to his arm pit.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13 -The MA stood Resident #1 up and his pajama bottoms were wet on the back and down his legs. -When the MA stood Resident #1 up, a puddle of urine formed on the floor where he was standing. -Resident #1 was walked back to his room; there was a trail of urine on the floor from the sofa to Resident #1's room. -A PCA went with Resident #1 to his room. -At 12:30pm, Resident #1 was eating lunch in the dining room in dry pajama bottoms and a dry white t-shirt. Observation of Resident #1 on 06/16/22 at 7:56am revealed: -He was asleep on his right side in his bed. -The sheets and bedding under him were wet with a large area of urine. -Resident #1's white t-shirt was wet past the small of his back. Interview with the MA on 06/14/22 at 12:14pm revealed: -Resident #1 would stay up all night and then fall asleep on the sofa sometime in the early morning hours. -Resident #1 would sleep until around 2:00pm or 3:00pm and then he would eat lunch. -Resident #1 was a "heavy wetter" and had to be changed after he slept because he would be soiled. -She and the PCA tried to move him to his room earlier but he started to swing at them, so they left him on the sofa. -She should have put a chuck pad under him, so he did not ruin the sofa. Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:30pm revealed: -She came in before 8:00am this morning and Resident #1's clothes were wet because his	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 14	D 269		

incontinent brief was so wet; that should have never happened.
-He should have been changed before his clothes got soiled; the staff knew he was a "heavy wetter".
-Staff should have checked him and changed him every two hours.
-She could tell by how soiled Resident #1 was that he had not been changed in the last two hours or longer; there was no way Resident #1's clothes got as soiled as they did in two hours.

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

Refer to interview with the primary care provider (PCP) on 06/15/22 at 11:15am.

Refer to interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am.

Refer to interview with another PCA on 06/16/22 at 9:01am.

Refer to interview with a third PCA on 06/16/22 at 1:20pm.

Refer to interview with a forth PCA on 06/16/22 at 1:56pm.

Refer to interview with a MA on 06/20/22 at 7:27am.

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:30pm.

Refer to interview with the Administrator on 06/20/22 at 5:38pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 15 2. Review of Resident #6's current FL-2 dated 06/08/22 revealed: -Diagnoses included vascular dementia, osteoporosis, hypertension and respiratory failure. -Resident #6 resided in the Special Care Unit (SCU). -Resident #6 was continent to bladder and bowel. -Resident #6 required assistance with bathing and dressing. Review of Resident #6's care plan revealed she did not have a care plan for review. Observations of Resident #6 on 06/14/22 at various times from 8:34am to 12:30pm revealed: -At 8:34am, there was a strong smell of urine in the hallway. -The smell was coming from room 315; Resident #6 and another resident resided in the room. -There was a personal care aide (PCA) dressing Resident #6's roommate and her bed sheets were stripped from the bed. -Resident #6's bed was closest to the door. -She was laying in the bed on her left side with her knees drawn up to her chest and her bottom close to the edge of the bed; her back was to the door. -Resident #6 had on a pink bathrobe and was not under the covers; she was asleep. -She did not have a chuck pad under her. -At 12:00pm, there was a strong smell of urine in room 305. -Resident #6 was in the same position on the bed and was asleep. -She had a large wet urine circle on the bedding under her; the circle covered the part of the bedding that hung down the side of the bed. -At 12:20pm, Resident #6 was asleep in the bed	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 16	D 269		

in the same position; a family member went into her room and came out to get a staff to assist her with Resident #6.
-There was a puddle of urine on the floor bedside the bed where Resident #6 was sleeping.
-A PCA and the family member got Resident #6 up and dressed.

Interview with Resident #6's family member on 06/14/22 at 12:40pm revealed:
-Resident #6 did not have on an incontinence brief; Resident #6 may have taken it off.
-Resident #6 was recently admitted to the facility.
-Resident #6 was diagnosed and treated with antibiotics for a urinary tract infection (UTI) prior to her admission to the facility.
-Resident #6 may have soiled the bed because she still had a UTI.
-Resident #6 was incontinent but would go to the bathroom if taken or prompted.

Interview with the medication aide (MA) on 06/14/22 at 12:42pm revealed:
-Resident #6 did not want to get up and eat breakfast so they left her in the bed asleep.
-She had checked on her before lunch, but she was still sleeping; she was sleeping so good she did not want to get up for lunch either.
-Resident #6 could go to the bathroom on her own but she still wore incontinent briefs.
-Resident #6 was a hard sleeper and could be "grumpy".

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

Refer to interview with the primary care provider (PCP) on 06/15/22 at 11:15am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 17	D 269		

Refer to interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am.

Refer to interview with another PCA on 06/16/22 at 9:01am.

Refer to interview with a third PCA on 06/16/22 at 1:20pm.

Refer to interview with a forth PCA on 06/16/22 at 1:56pm.

Refer to interview with a MA on 06/20/22 at 7:27am.

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:30pm.

Refer to interview with the Administrator on 06/20/22 at 5:38pm.

3. Review of Resident #7's current FL-2 dated 06/01/22 revealed:
-Diagnoses included vascular dementia and falls.
-Resident #7 resided in the Special Care Unit (SCU).
-Resident #7 was incontinent to bladder.
-Resident #7 was continent to bowel.
-Resident #7 required assistance with bathing.

Review of Resident #7's care plan revealed she did not have a care plan for review.

Observations of Resident #7 on 06/14/22 at various times from 8:42am to 12:03pm revealed:
-At 8:42am, Resident #7 was sitting in his wheelchair with a shirt on and incontinent briefs; he did not have on any pants.
-His incontinent brief was soiled and wet; a dark water ring was around the excess incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 18	D 269		

brief past the elastic at his legs.
-The room smelled of bowel movement and urine.
-Resident #7's bed was unmade and had two large urine stains each approximately 10 inches in diameter.
-There were several smears of fecal matter on the sheets.
-There was urine on the floor next to the bed.
-There were three chucks intertwined in the top sheet on the bed; there was fecal matter on the top sheet.
-There was a dry chuck balled up on the floor next to the foot of the bed.
-One chuck on the bed was soiled and the others were dry.
-At 12:03pm, Resident #7 was in a shirt and incontinent briefs only; his bed was unmade and had the same dirty sheets and chucks on it.

Observation of Resident #7 on 06/16/22 at 7:58am revealed:
-There were three large reddish-brown smears and circles on the bottom sheet and two of the pillows on the bed.
-Resident #7 did not have any dried blood or skin tears on his face, head, arms or hands.
-His nose did not have blood around his nostrils or on his face.
-He was partially dressed and sitting in his room in his wheelchair.

Interview with Resident #7 on 06/20/22 at 11:00am revealed:
-His family bathed him once a day.
-He sheets were not changed every day; they were changed about every two to three days.
-He could dress himself and go to the bathroom with some help.

Interview with the Memory Care Manager (MCM)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 19 on 06/20/22 at 4:48pm revealed Resident #7 could be difficult to provide care for, but he should have never been left in a bed that was soiled with bowel movement. Refer to interview with the primary care provider (PCP) on 06/15/22 at 11:15am. Refer to interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am. Refer to interview with another PCA on 06/16/22 at 9:01am. Refer to interview with a third PCA on 06/16/22 at 1:20pm. Refer to interview with a forth PCA on 06/16/22 at 1:56pm. Refer to interview with a MA on 06/20/22 at 7:27am. Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:30pm. Refer to interview with the Administrator on 06/20/22 at 5:38pm. Attempted telephone interview with Resident #7's family member on 06/20/22 at 2:34pm was unsuccessful. 4. Review of Resident #8's current FL-2 dated 01/02/2022 revealed: -Diagnoses included type 2 diabetes, dementia with Lewy Bodies, cerebral infarction and hypertension. -Resident #8 resided in the Special Care Unit (SCU).	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 20 -She was intermittently confused and ambulatory. -She was continent to bladder and bowel. -She required assistance with bathing. Review of Resident #7's care plan revealed she did not have a care plan for review. Observation of Resident #8 on 06/14/22 at 8:45am revealed: -Resident #8's hair was shoulder length and so dirty it looked to be wet. -She had on a pink shirt and blue pants. Observation of Resident #8 on 06/15/22 at 7:56am revealed she had on the same pink shirt and blue pants as the day before and her hair was dirty. Interview with the medication aide (MA) on 06/14/22 at 8:45am revealed Resident #8's hair was not wet and always looked that way. Interview with Resident #8's family member on 06/20/22 at 9:48am revealed: -Resident #8 had reoccurring urinary tract infections (UTI) from sitting in soiled incontinent briefs. -She had visited with Resident #8 the day before, 06/19/22 and her incontinent brief was "very wet"; it was so wet it was visibly hanging down and her pants were sagging from the weight of the incontinent brief. -She was not sure how much assistance Resident #8 needed with bathing; she thought staff assisted her with washing her hair. -Resident #8's hair appeared greasy when she saw her on 06/19/22 and she noticed her hair was dirty on different visits. -Resident #8's room usually smelled so strong of urine that she could not visit with the resident in	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 21	D 269		

her room.
-She had a hard time with communicating with anyone at the facility because no one answered the telephone or returned her calls when they did answer the telephone.

Interview with a personal care aide (PCA) on 06/16/22 at 9:34am revealed:
-Resident #8 was stubborn and wanted to give herself a bath.
-Resident #8's hair was supposed to be washed at every bath; she was scheduled to have a bath three times a week.
-She would let Resident #8 put the shampoo on her hair and wash it; she just needed to be encouraged to let staff rinse her hair for her to get all the soap out.
-Resident #8 was scheduled to have a bath on second shift.
-She did not think Resident #8 was getting a bath regularly because her hair always looked dirty.

Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:48pm revealed:
-She was implementing a shower schedule with documentation, but it had just been introduced to the staff last week and had not been started.
-Each staff only had two residents a day to bathe or shower.
-Washing up a resident was only to be done in between showers and not in place of one.
-Staff had not complained to her about not having time to bathe residents.
-It did not take long to give a resident a shower.
-If Resident #8 was refusing to take a shower or was difficult to bathe, she should have been told so she could see what she could do to help make sure the resident had a bath.

Based on observations, interviews and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 22	D 269		

reviews it was determined Resident #8 was not interviewable.

Refer to interview with the primary care provider (PCP) on 06/15/22 at 11:15am.

Refer to interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am.

Refer to interview with another PCA on 06/16/22 at 9:01am.

Refer to interview with a third PCA on 06/16/22 at 1:20pm.

Refer to interview with a forth PCA on 06/16/22 at 1:56pm.

Refer to interview with a MA on 06/20/22 at 7:27am.

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:30pm.

Refer to interview with the Administrator on 06/20/22 at 5:38pm.

_____

Interview with the primary care provider (PCP) on 06/15/22 at 11:15am revealed:
-She would be concerned if residents were being left in soiled incontinent briefs for extended periods of time because it could cause urinary tract infections (UTIs) and put residents at risk for skin breakdown.
-She would be more concerned for the residents in the Special Care Unit (SCU) because they could not tell staff when they were soiled or needed to be changed.
-It was the responsibility of the facility to set the precedence for how often the residents should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 23 showered and changed. Interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am revealed: -She was the only PCA working in the SCU on 06/15/22; she did not know if anyone else was scheduled to help her. -The facility's scheduler/transport staff was helping her with resident care. -There were other times she had been the only PCA on the SCU, but this was the first time the facility's scheduler/transport staff had helped her. -Usually no one helped her when she was alone in the SCU. -The SCU residents required a lot of personal care assistance; it was a lot of work for one PCA. -She got 11 residents up by herself that morning and the facility's scheduler/transport staff got some up. -Some of the residents did not want to get up for breakfast. -Another PCA was scheduled to come in at 11:00am. -She had to strip the beds that were soiled overnight and remake them. -She had to get the residents dressed and toileted on her own this morning, 06/15/22. -She could not bathe the residents since she was alone, so she wiped them down with a wet cloth before getting them dressed. -The" heavy wetters" were always wet in the morning and needed their beds stripped. -Third and second shift staff checked on the residents at night but did not get them up to change their incontinent briefs or try to toilet them. -The "heavy wetter"s were always soiled in the morning and needed to be changed and cleaned up.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 24 Interview with another PCA on 06/16/22 at 9:01am revealed: -She had worked shifts where she came in at 3:00am and was scheduled to work twelve hours until 3:00pm. -She did rounds when she came in at 3:00am. -She had come in at 3:00am on more than one occasion and there was only a medication aide in the SCU. -Rounds consisted of going to the residents' rooms and turning on the light and checking to see if they were in the bed. -She did not get any residents up to encourage them to use the toilet when she came in at 3:00am. -If a resident was "very wet", she would change them, but she did not want to wake them if they were sleeping. -She would start to wake residents up at 5:00am; a few residents would refuse to get up so she would let them sleep. -She would come back later and ask the residents again if they wanted to get up; she would ask three times if they wanted to get up. -She would leave them in the bed if they did not want to get up for breakfast. -After breakfast, she would go back to the residents and ask them to get up again; most times she could get them up but some of the residents would continue to sleep until lunch time. -She did not toilet the residents that refused to get up for breakfast. -When she was there by herself, she did not give baths; when there were at least two PCAs, she could give three residents baths and so could the other PCAs. Interview with a third PCA on 06/16/22 at 1:20pm revealed: -One day last week, she thought Thursday,	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 25	D 269		

06/09/22, there were only 2 PCAs in the SCU working.
-One day when she worked, she was the only PCA in the building.
-She came in all the time on first shift and all the residents were soiled.
-There would have only been one staff on third shift in the SCU.
-She came in one day recently, she did not recall what day, but the MA was the only staff in the SCU.
-The residents' beds were "soaking wet" and she had to apologize to the residents.
-More than once the residents were soaking wet and the residents should not have to smell themselves.
-The residents apologized to the staff and the residents should not have to do that.
-She had been into resident rooms when the toilet was soiled and because it had not been cleaned, the resident had to sit on a dirty toilet and the residents' should not have to do that.

Interview with a fourth PCA on 06/16/22 at 1:56pm revealed:
-When she came in on first shift most of the residents would be soiled, including their pajamas and sheets.
-Third shift did not get anyone up to go to the bathroom or change them.
-She would try to get the "heavy wetters" up first because she knew they would be soiled and so would their beds.

Interview with a MA on 06/20/22 at 7:27am revealed:
-She had seen residents in the SCU double briefed.
-She thought it was one day last week when the first shift was short-staffed; maybe Friday,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 26 06/17/22. -That was not the first time she had seen residents double briefed. -A named resident was walking around in wet clothes. -She had to tell the PCAs to get residents out of wet clothing; it was not fair to the residents. Interview with the Memory Care Manager (MCM) on 06/20/22 at $;30pm revealed: -The staff were supposed to do rounds every two hours on each shift. -Residents were supposed to be changed every two hours. -Doubling adult incontinent briefs were not allowed and was a sign of laziness on staff's part. -Staff were supposed to encourage residents to use the toilet on all three shifts. -There was plenty of staff on all three shifts to change briefs and to toilet the residents. -Residents should be changed or toileted before their clothes got soiled. -She tried to get to the facility before 8:00am everyday and did rounds first thing herself to make sure the residents were up and toileted. -First shift had never complained to her about third shift not changing residents or about residents being soiled and soiled beds in the in the mornings. -If staff noticed a resident's clothes or bed was wet or soiled, they should be changed right away; residents should never be allowed to stay in soiled or wet beds or clothes. Interview with the Administrator on 06/20/22 at 5:38pm revealed: -The staff should check on residents every two hours and if the resident was soiled the staff should change them. -If the resident was known to get so soiled that	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 27	D 269		

their bedding and clothes would get soiled the staff should encourage the resident to get up and go to the bathroom.
-Double briefing was not allowed and staff should never double brief as a solution to wet clothes and beds.
-It was better for the resident to wake them up and have them go to the bathroom then to have them soil their clothes and the bedding.
-No resident should have to lay in a wet or soiled bed or stay in wet clothes or pajamas for any amount of time.
-Residents should be changed as soon as they were discovered wet or soiled and the peri area should be cleaned if needed.
-Wet sheets, bloody sheets, or sheets soiled from a bowel movement should be changed as soon as they were found.
-The reason for two-hour checks was to prevent residents from wetting their clothes and bedding and so residents did not lay in wet or soiled clothes and sheets.
-Two-hour checks were not documented.
-A new shower schedule and sheet was developed, and she thought that had started the previous week; the new shower sheet would require staff to document showers for residents.
-Each resident was scheduled a bath three times a week and each shift had to give baths so there were only a few baths scheduled each shift.
-There had been shifts when the SCU was short staffed and baths were not given but with the new showering and bathing schedule that would not happen anymore.
-When a resident refused a shower, the PCA should try again later: if the resident refused again the MA or the MCM should be told.
-Another PCA should offer to shower the resident that refused and the MCM should also get involved; the refusal should be documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 28 -She was concerned residents were left in wet clothes and wet or soiled bedding or not receiving scheduled baths because it could lead to skin irritations like rashes, skin breakdown and infections. _____ The facility failed to ensure assistance with personal care was provided for three residents who required personal care and assistance with toileting and changing incontinent briefs that became soiled and were left in soiled clothing, pajamas, soiled beds and sheets; and one resident who was left in soiled incontinent briefs and not assisted with bathing and had dirty hair and her clothes were not changed for two days. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/16/22. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 31, 2022.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 29 Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (#1 and #3) when it was known by staff that Resident #1, who had a history of dementia and was constantly disoriented, would wander into other residents' rooms, causing another resident to become agitated resulting in an altercation with Resident #3, who had a history of dementia and was intermittently disoriented, and on two other occasions there were altercations between the two residents resulted in Resident #1 being injured. The findings are: 1. Review of Resident #3's current FL2 dated 01/31/22 revealed: -Diagnoses included type 2 diabetes and dementia. -Resident #3 was intermittently disoriented. -Resident #3 was verbally abusive. -The level of care was Special Care Unit (SCU). Review of Resident #3's physician's orders dated 01/31/22 revealed documentation Resident #3 had behaviors and required redirection every shift. Review of Resident #3's care plan dated 01/19/22 revealed: -Resident #3 had wandering behaviors and was verbally abusive. -Resident #3 was independent with ambulation, dressing, and grooming. a. Review of Resident #3's care notes revealed on 05/02/22 Resident #3 was fretting another resident.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 30 Interview with a medication aide (MA) on 06/16/22 at 3:57pm revealed: -She documented Resident #3 was fretting another resident because he was trying to push another named resident. -The two residents were sitting in chairs in front of the nurse's station. b. Review of Resident #3's care notes revealed on 05/30/22 Resident #3 had an altercation with another resident. Review of a behavior notification to physician form completed on 05/30/22 revealed: -Resident #3 had an altercation with another resident on 05/30/22 at 5:30pm. -Resident #3 had made physical threats and physical contact with another resident. Telephone interview a with medication aide (MA) on 06/20/22 at 9:33am revealed: -She did not recall the specifics of the altercation with another resident she had documented, but it had to have been with another named resident because it was always with that resident. -Resident #3's altercations with the other resident usually happened between 3:00pm-5:00pm. -She was not given any instructions on what to do about Resident #3's behavior toward the other resident, just to keep an eye on the two residents. c. Review of Resident #3's care notes revealed on 06/01/22 Resident #3 pushed another resident on the floor. Interview with the first MA on 06/16/22 at 3:57pm revealed: -She documented Resident #3 pushed another resident.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 31 -Resident #3 pushed a named resident, but the resident did not fall. Interview with a personal care aide (PCA) on 06/16/22 at 9:26am revealed: -Resident #3's behaviors with another resident happened on 2nd shift. -The other resident was going to hit a staff member and Resident #3 reacted. -The other resident's behavior triggered Resident #3's behavior on 06/01/22.. Interview with the Memory Care Manager (MCM) on 06/20/22 at 10:18am revealed: -She was not in the facility on 06/01/22, but she had been made aware of the incident. -She was told Resident #3 pushed a named resident; the resident was not pushed to the floor. -She told the staff to redirect Resident #3, to keep him away from the other resident. Interview with the Administrator on 06/20/22 at 11:18am revealed: -She was told Resident #3 pushed another resident to the floor. -The resident had to be a named resident because Resident #3 got along with everyone else. -Staff were told to keep an eye on the two residents, to keep a closer eye on them. -Staff was told to especially keep an eye out for the named resident because he wandered and that triggered Resident #3. d. Review of Resident #3's care notes dated 06/04/22 and 06/05/22 revealed: -On 06/04/22, Resident #3 was agitated. -On 06/05/22, Resident #3 was agitated/aggressive.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 32 Telephone interview with another MA on 06/20/22 at 9:33am revealed: -She did not recall the specifics of the altercation with another resident she had documented, but it had to have been with another named resident, because it was always with that named resident -Resident #3's altercations with the other named resident usually happened between 3:00pm-5:00pm. -She was not given any instructions on what to do about Resident #3's behavior toward the other resident, just to keep an eye on the two residents. f. Review of Resident #3's care notes revealed on 06/08/22, Resident #3 had an altercation with another resident and was sent to the emergency department (ED) for behaviors. Review of a behavior evaluation form completed on 06/08/22 revealed: -The incident occurred on 06/08/22 at 3:10pm. -Resident #3 had an altercation with another resident. -Under the heading of physical/aggressive. Resident #3 was documented as hitting daily, kicking once or twice a week, grabbing onto other people once or twice a week, pushing once or twice a week, and hurting self or others daily. -Under the heading titled physical/non-aggressive, Resident #3 was documented as pacing and aimlessly wandering daily and general restlessness once or twice a week. -Under the heading of verbal/aggressive, Resident #3 was documented as screaming once or twice a week, and cursing or verbal aggression daily. Interview with the MCM on 06/20/22 at 10:18am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 33 -She was in the facility when Resident #3 choked another resident. -Resident #3 stated he was going to kill him. -She had heard Resident #3 say he was going to kill someone "plenty" of times. Interview with the Administrator on 06/20/22 at 11:18am revealed: -After the incident on 06/08/22, staff was to continue to monitor and redirect Resident #3. -She had reached out to Resident #3's guardian on 06/08/22 to change his primary care provider (PCP) and pharmacy from the VA to the facility's contracted PCP and pharmacy to better serve the resident's needs related to medications and provider services because it was difficult to get support from the VA because they were hard to reach. Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed: -She had not received any incident reports about Resident #3's behaviors. -She was first notified of Resident #3's altercation with another resident when the Administrator reached out to her on 06/08/22. -If she had known Resident #3 was having behaviors she would have looked at reasons, such as if the resident had a urinary tract infection, or if there had been a change in the resident's family member who lived at the facility, if there had been any staff changes, "just try to figure it out." -She would have expected to be notified of any behaviors with Resident #3. g. Review of Resident #3's care notes revealed on 06/13/22 Resident #3 attacked another resident and was sent to the ED.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 34 Review of an incident report dated 06/13/22 revealed: -The incident occurred at 12:10pm in the dining room. -Resident #3 did not have an injury. -Resident #3 had an altercation with another resident. -The incident was witnessed by staff. -Resident #3 was agitated. Interview with another PCA on 06/16/22 at 2:40pm revealed: -She was working on 06/13/22 and was in the dining room when a named resident did not want to sit down. -The named resident raised his hand as if he was going to hit the staff member. -Resident #3 thought the resident was going to hit the staff member, so he knocked the resident to the floor and hit the resident three more times in the head. Interview with the MCM on 06/20/22 at 10:18am revealed: -She was not at the facility when Resident #3 had an altercation with another resident on 06/13/22. -She did not recall when she was notified of the incident. -She was told Resident #3 was fighting the named resident again and was sent to the hospital. Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed: -She was not aware Resident #3 had an incident on 06/13/22 with another resident. -When she was notified on 06/17/22 Resident #3 was at the hospital, she assumed he had been	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35 there since the 06/08/22 incident where he had been sent to the hospital after an altercation. Confidential interview with staff revealed: -If management would have talked to the staff about ideas to know what triggered the behavior, what started it, and what calmed the behavior, all the altercations could have been avoided. -The facility staff could have done more to prevent Resident #3's altercations with the other resident. -The staff used to have stand-up meetings every day and they would know what went on during that shift, such as behaviors. -It would have helped to have had stand-up to discuss the residents because they could have shared any ideas that may have worked for Resident #3's behaviors. Interview with the same PCA on 06/16/22 at 9:26am revealed: -Resident #3 had behaviors since he moved into the facility. -Resident #3's family member lived at the facility, and he would pull on his family member. -Resident #3 did not like for others to provide care for his family member. -Resident #3 would holler at staff when they were providing care to his family member. -Resident #3 had a really strong grip. -Resident #3's behavior had gotten worse toward a named resident who recently moved into the facility. -If another resident was acting aggressive toward staff, Resident #3 would come to their defense. -Last year Resident #3 hit another resident in the face and the resident's face swelled up. -Once that resident's behaviors improved, there were no other altercations with Resident #3. -If Resident #3 was acting agitated, they would	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 36	D 270		

find the housekeeper, who would give Resident #3 something to do.
-She had never had a time the housekeeper was not there when Resident #3 was acting agitated.
-Several years ago, a supervisor told her to find something an agitated resident liked to do and keep them busy.
-Resident #3 did not get as agitated if he had something to do and would calm down too if he was busy.
-She had asked the MA if Resident #3 had any medication for behaviors and was told the resident did not have anything.
-Since May 2022, Resident #3 and one other resident had altercations; there were no altercations with other residents.
-She heard Resident #3 look toward the other resident and say, "I am going to get that [expletive]."
-The MA and the Administrator were told what was going on between Resident #3 and the other resident.
-The Administrator said she would take care of it.
-She had not been told of any interventions or suggestions on what to do to prevent behaviors between these two residents.

Interview with another PCA on 06/16/22 at 1:24pm revealed:
-There were times when Resident #3 was really nice and sweet, and other times when he was angry and would lash out.
-When Resident #3 saw another named resident, he would become aggressive.
-She tried to keep the two residents separated.
-Resident #3 was used to taking care of his family member and at times he would try to help her and other times he would call her stupid and grab her arms.
-When this happened, she would redirect him to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 37	D 270		

be gentle and give him tasks to do.
-There were times when Resident #3 was so angry he did not respond to redirection and she would ask the MA for medication and was told the resident did not have any.
-A named resident would go into Resident #3's room and she would hear him scream, "get out of my room."
-No one in management told them to do anything different for the altercations between Resident #3 and the other named resident; she just knew to keep them separated.
-She just wanted both residents to feel safe.

Interview with a housekeeper on 06/16/22 at 2:31pm revealed:
-Resident #3 liked to help clean, wipe off tables and sweep.
-When Resident #3 started throwing things away, like silverware, they stopped allowing him to clean tables.
-It seemed like Resident #3 started declining when they told him he could not help clean the dining room anymore.
-It made Resident #3 sad to not be able to help.
-Another named resident had behaviors, and Resident #3 was protective of the staff.

Interview with a PCA on 06/16/22 at 2:40pm revealed:
-She had learned at her previous job to keep residents separated and talk to them to prevent behaviors.
-No one had told her to do anything different for Resident #3.

Interview with a MA on 06/16/22 at 3:57pm revealed:
-As soon as a named resident moved into the facility, Resident #3 had a problem with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 38	D 270		

resident.
-Staff needed to keep the two residents separated to prevent altercations.
-On Saturday, 06/11/22, she observed Resident #3 staring at the named resident.
-She was concerned Resident #3 was going to hurt the other resident.
-She told the PCA to keep the two residents separated.
-The PCAs would ask for as needed (PRN) medication for Resident #3 but there was no PRN medication ordered.
-She had talked to a previous MCM about the need for PRN medication.
-The MCM told her all that could be done was "document it until it got worse."
-She documented Resident #3's behaviors to show his history of behaviors and how much happened.
-No one had provided direction on what to do related to Resident #3's behaviors.
-All they knew to do was to keep the two residents separated.
-No one had provided any ideas on what to do differently.

Interview with the MCM on 06/20/22 at 10:18am revealed:
-She did not know if there was a written policy/procedure related to behaviors and what to direct staff to do.
-If a resident was having behaviors, she would talk to the PCP to see if there were medications, or what could be done to prevent the behaviors.
-When she first saw Resident #3's behaviors she reviewed his record to see if he was receiving mental health services.
-She left a voicemail on 06/09/22 for Resident #3's mental health provider.
-She was aware of Resident #3's behavior on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 39	D 270		

06/01/22 but did not look at his chart until after the incident on 06/08/22.
-She had not given any direction to the staff to keep the other resident away from Resident #3 or discuss any interventions for staff to use to prevent behaviors between the two residents.

Interview with the Administrator on 06/16/22 at 4:58pm revealed:
-Every incident involving Resident #3 had been with another named resident.
-She did not know what it was with the other resident that triggered Resident #3.
-She had not ever seen Resident #3 do or say anything to any resident but the named resident.
-She told staff to keep the two residents separated.
-The MCM had reached out to Resident #3's mental health provider.
-Resident #3 liked to stay busy.
-Interventions for Resident #3 was to let him do the cleaning.
-Even if Resident #3 was busy, if the named resident came around, Resident #3 would get frustrated
-Resident #3 was only a problem when a named resident would come around.

Interview with another MA on 06/20/22 at 7:27am revealed no one had ever told her anything to do to prevent altercations between Resident #3 and another named resident.

Interview with the Administrator on 06/20/22 at 11:18am revealed:
-Resident #3 could be redirected with tasks such as cleaning the tables.
-She did not know if all the staff knew to redirect Resident #3 with these tasks, but she thought 75%-80% of the staff knew.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 40	D 270		

-The only direction given to staff was to monitor and redirect.
-She thought they did all they could to keep the residents safe.

Based on hospitalization on 06/13/22, Resident #3 was not available for interview.

Attempted interview with Resident #3's Veterans Administration (VA) PCP and the MH provider on 06/17/22 at 12:23pm was unsuccessful.

2. Review of Resident #1's current FL2 dated 03/08/22 revealed:
-Diagnoses included alcohol induced dementia, muscle weakness, transient ischaemic attack (TIA) and venous thrombosis.
-Resident #1 was constantly disoriented.
-Resident #1 had wandering behaviors.
-Resident #1 resided in the Special Care Unit (SCU)

Review of Resident #1's care plan dated 06/15/22 revealed:
-He was always disoriented.
-He had significant memory loss and needed to be directed.

Review of Resident #1's physician's visitation summary report dated 04/06/22 revealed:
-Resident #1 had dementia associated with alcoholism with behavioral disturbance.
-His cognitive deficit was stable and unchanged.
-Continue safety, supportive and pharmacological effort to target cognitive impairment and behaviors.
-His agitation was acute, and staff were to encourage participation in activities during the day to help with the behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 41	D 270		

Review of Resident #1's physician's visitation summary report dated 05/30/22 revealed:
-Resident #1's agitation had improved some.
-Continue safety, supportive and pharmacological effort to target cognitive impairment and behaviors.
-Staff were to encourage participation in activities during the day to prevent boredom and agitation.

Review of Resident #1's physician's visitation summary dated 06/13/22 revealed:
-Resident #1's sleep disturbance had worsened.
-His agitation had worsened.
-The staff were encouraged to provide daily activities for Resident #1 and redirection techniques were discussed.

Observation of Resident #1 on 06/15/22 at 8:05am revealed:
-He was asleep in the bed in room 307; Resident #1 resided in room 311 and he was in the wrong room.
-He was in the same pajama bottoms and white t-shirt from the day before.
-The PCA and MA tried to get him out of the bed, but he refused so get up, so they left him in the bed.

a. Review of Resident #1's care notes dated 05/30/22 revealed Resident #1 was hit by another resident.

Review of Resident #1's incident report dated 05/30/22 revealed:
-Resident #1 received punches to the head.
-Resident #1 was in the hallway when an unnamed staff witnessed another resident "went after" Resident #1.
-Resident #1 was not sent out to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 42	D 270		

Interview with a personal care aide (PCA) on 06/16/22 at 9:32am revealed:
-Another resident pushed Resident #1; she thought it was around 06/01/22.
-The same resident always showed aggression towards Resident #1.
-There was a previous incident where the same resident hit Resident #1 and gave him a blackeye.
-Resident #1 tried to avoid the other resident and would turn and walk the other direction when he saw the other resident coming his way.
-Resident #1 had swung at staff when they tried to get him to bathe or change his clothes, but he was never aggressive or tried to hit other residents.

Interview with the Memory Care Manager (MCM) on 06/20/22 at 10:18am revealed:
-She was aware Resident #1 was pushed to the floor by a named resident on 06/01/22.
-Resident #1 was not injured and not sent to the local hospital.
-When staff contacted her she instructed them to redirect the named resident in another direction from Resident #1.

b. Review of Resident #1's care notes dated 06/08/22 revealed:
-Resident #1 was choked by another resident and had redness around the neck.
-Resident #1 was sent to the local emergency department (ED).

Review of an incident report dated 06/08/22 revealed:
-Resident #1 had an altercation with another resident in Resident #1's room.
-Resident #1 had redness around his neck.
-Resident #1 was witnessed holding his neck as if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 43	D 270		

in pain.
-Resident #1 was transported to the local ED by emergency medical service (EMS) because he showed signs of pain.

Review of Resident #1's hospital after visit summary dated 06/08/22 revealed:
-The reason for the visit was assault victim.
-Resident #1 returned to the facility the same day, 06/08/22.

Interview with the same PCA on 06/16/22 at 9:21am revealed:
-Resident #1 did not sleep at night and would sleep in the mornings and wake up around 3:00pm.
-He would wake up and walk around the halls and get into everything.
-When the staff tried to keep Resident #1 awake in the mornings, he would constantly look for a place to lay down and sleep.
-Resident #1 would wander into other residents' rooms and lay down in their beds.
-Resident #1's behaviors had not gotten worse but the other resident's behaviors had worsened.

Interview with a second PCA on 06/16/22 at 1:56pm revealed:
-Resident #1 was in his room when another resident entered and began to choke Resident #1.
-The other resident did not like Resident #1 for some reason.
-Resident #1 walked a lot and fiddled with things but could be redirected.

Interview with the MCM on 06/20/22 at 10:18am revealed:
-On 06/08/22, Resident #1 was sent out to the local hospital after he was choked by a named

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44	D 270		

resident.
-Resident #1 had been choked by a named resident while in his own room.
-Resident #1 came from his room into the hall holding his neck; the named resident said he was going to kill Resident #1.
-Resident #1 was gasping for air and opening and closing his mouth while holding his neck so she decided he needed to be sent out.
-Resident #1 seemed to be having a hard time breathing.

c. Review of Resident #1's care notes dated 06/13/22 revealed:
-Resident #1 was hit by another resident.
-Resident #1 had a fall.
-Resident #1 was transported to the local ED by EMS.

Review of an incident report dated 06/13/22 revealed:
-Resident #1 was hit by another resident which resulted in Resident #1 falling.
-Resident #1 had a bump to his head.
-Resident #1 was transported to the local ED by EMS.
-Return status was noted as diagnosis was minor head injury.

Review of Resident #1's hospital after visit summary dated 06/13/22 revealed:
-He was seen for a head injury.
-He was diagnosed with a minor head injury.

Interview with a second PCA on 06/16/22 at 1:45pm revealed:
-On 06/13/22 Resident #1 would not sit down for lunch so she was trying to talk to him so he would sit down.
-Resident #1 raised his hands in the air as if he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45	D 270		

was going to hit her.
-A named resident who was behind her reached over her and hit Resident #1 in the head and Resident #1 fell to the ground.
-The named resident continued to repeatedly hit Resident #1 in the head while he was on the ground.
-She pushed the named resident away from Resident #1; the named resident walked away.
-Resident #1 and the other resident were sent to the local ED; Resident #1 returned that evening.

Interview with the MCM on 06/20/22 at 10:18am revealed:
-Resident #1 was hit again on 06/13/22 by the same named resident.
-Staff were told to keep the named resident and Resident #1 away from each other.
-She did not know what always triggered the named resident to hit Resident #1.
-Resident #1 was sent out to the hospital on 06/13/22 after he was hit by Resident #1.
-Resident #1 would fight with staff when they tried to get him to do anything or tried to do something for him.
-When Resident #1 tried to hit staff on 06/13/22, it triggered the named resident and he hit Resident #1.

_____

Interview with Resident #1's power of attorney (POA) on 06/15/22 at 10:59am revealed:
-Resident #1 was constantly being "beaten up" by another resident; it was always the same resident.
-Several times Resident #1 was sent to the hospital after the assault by the other resident.
-She was told the other resident hit Resident #1 and he had a black eye and a cut on his forehead.
-Resident #1 had been choked by the other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 46	D 270		

resident on another incident and was sent to the local hospital.
-She did not remember the dates of the incidents.
-Resident #1 had been sent to the local hospital this week because the same resident hit him in the back of the head.
-Resident #1 seemed happy; he did not understand what was going on.
-Staff would try to keep Resident #1 and the other resident apart.
-Not all staff knew to keep them apart and that would be when the other resident would go after Resident #1 and hit him.

Interview with Resident #1's primary care provider (PCP) on 06/15/22 at 11:15am revealed:
-She was aware of the altercations between Resident #1 and another resident.
-The facility notified her after each incident with the other resident.
-Resident #1 walked around a lot.
-Resident #1 needed structure and needed to be involved in activities.
-She did not want to increase any of his medications because she did not want him over sedated.
-She did not know what triggered the aggression towards Resident #1 by the other resident.
-She was concerned Resident #1's safety was at risk and the other resident may injure him.

Telephone interview with Resident #1's mental health provider on 06/20/22 at 2:47pm revealed:
-Resident #1 wanted to constantly move and he would fight to stay up at night and then finally fall asleep early in the day.
-She had discussed with staff about distractions like activities for Resident #1 and redirection.
-She was not notified after every incident with another resident unless there was an injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 47 Interview with a PCA on 06/16/22 at 9:21am revealed: -About a month ago a named resident started hitting Resident #1; he would see Resident #1 and he would become agitated and then aggressive. -She did not know why the named resident was aggressive towards Resident #1. -Resident #1 liked to walk around; he could be redirected if he became agitated, but it would take two staff sometimes. -Resident #1 required a lot of attention and patience from staff and was a "handful". -Resident #1 had to be watched because he would wander into other residents' rooms and get into things. -Resident #1 would urinate in random places or have a bowel movement and put his hands into it. -Resident #1 was known to hit staff but he had never hit a resident. Interview with a MA on 06/16/22 at 3:58pm revealed: -There was one resident that always had a problem with Resident #1. -Something about Resident #1 triggered agitation and aggression in the resident. -Resident #1 had been hit, choked and pushed by the one resident. -Staff had to keep Resident #1 and the other resident separated. -Resident #1 would just walk buy the other resident and the other resident would push Resident #1 for no reason. -Resident #1 walked around a lot and would walk into other residents' rooms; he was always touching things and moving chairs in the dining room.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 48 Interview with the Administrator on 06/20/22 at 11:18am revealed: -Resident #1 and a named resident had multiple altercations. -The named resident had pushed Resident #1 to the floor on one incident and Resident #1 had a skin tear on his elbow. -The named resident had an altercation with Resident #1 on 05/30/22 and on 06/01/22. -On 06/01/22, Resident #1 was pushed to the floor by the named resident but was not injured. -Staff were told to keep an eye on Resident #1 because he wandered. -Resident #1's constant wandering triggered the named resident. -On 06/08/22, the named resident choked Resident #1 while Resident #1 was in his own room. -Both residents were transported to the local ED. -The facility did all they could do to keep Resident #1 safe short of hiring a personal sitter for him. -The named resident was the aggressor and Resident #1 was the victim. Based on observations, interviews and record reviews it was determined Resident #1 was not interviewable. _____ The failure of the facility to provide supervision for a resident (#1) who wandered around the Special Care Unit (SCU), went into other residents rooms, urinated in random places, who needed to be kept occupied by staff, and constantly redirected and when he was not supervised, these behaviors would trigger another resident's aggression (#3). Staff failed to supervise the two residents which resulted in Resident #3 assaulting Resident #1 on two occasions and both residents were sent to the hospital which resulted in substantial risk of serious injury or	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 49 serious abuse to the residents and constitutes a type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/16/22 for this violation. THE CORRECTION DATE FOR THIS A2 VIOLATION WILL NOT EXCEED JULY 16, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up to meet the healthcare needs for 2 of 6 sampled residents (#3, #6) related to a resident needing a dental appointment and eye appointment (#3), and a resident, who had a foot disorder causing yellowed, curled, jagged, elongated nails and feet disfigurement and needed podiatry care (#6). The findings are: 1. Review of Resident #3's current FL2 dated 01/31/22 revealed: -Diagnoses included type 2 diabetes and dementia. -Resident #3 was intermittently disoriented. -Resident #3 wore glasses.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 50 -The level of care was Special Care Unit (SCU). a. Review of Resident #3's care notes revealed on 05/08/22 Resident #3 pulled three of his teeth. Review of Resident #3's after-visit summary with his Veterans Administration (VA) provider dated 05/12/22 revealed there was an order to schedule a dental appointment. Interview with a personal care aide (PCA) on 06/16/22 at 9:26am revealed: -Resident #3 had been complaining of his mouth hurting "days before" he pulled his teeth. -She noticed Resident #3 was not eating some of his favorite foods. -When she asked Resident #3 why he was not eating he complained of his mouth, jaw, and teeth hurting. -He had been complaining of mouth pain for about 2-weeks. -She had told a named medication aide (MA) and the MA told her it was hard to get an appointment with the VA and she had passed it on to a supervisor. Interview with another PCA on 06/16/22 at 1:24pm revealed: -Resident #3 handed her three teeth. -She gave the teeth to a MA. -Resident #3 had complained of his mouth hurting for about a week before his teeth fell out. -She was told Resident #3 went to the dentist after he pulled his teeth, but not before. -Resident #3's mouth pain may have contributed to his behaviors of agitation and aggression. Interview with the named MA on 06/16/22 at 3:57pm revealed: -No one had told her Resident #3 complained of	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 51	D 273		

mouth pain.
-The staff showed her the teeth Resident #3 had given the PCA.
-The teeth were from a partial, not the resident's actual teeth.
-Resident #3 had to go through the VA to get a dental appointment.

Interview with the same MA on 06/20/22 at 9:42am revealed:
-She accompanied Resident #3 on his appointment to the VA clinic on 05/12/22 and requested a referral to the dentist.
-It had been a long time since Resident #3 had seen the dentist.
-Resident #3 had asked to go to the dentist for about 3 months.
-Resident #3 could not describe why he wanted to go to the dentist.
-The after-visit summary was given to the Memory Care Manager (MCM) who was responsible for coordinating appointments.

Telephone interview with a nurse at the VA on 06/17/22 at 12:23pm revealed:
-To schedule a dental appointment, the facility staff would have to call the VA eligibility department first, then call the clinic to schedule an appointment.
-There was no dental appointment shown as scheduled in the VA system.

Interview with the previous MCM on 06/20/22 at 7:01am revealed:
-She was not aware Resident #3 complained of mouth pain.
-Resident #3 had never complained of mouth pain to her.
-When Resident #3 first moved in he was missing a tooth, but he never complained of any pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 52 Interview with the current MCM on 06/20/22 at 10:18am revealed: -She was not aware Resident #3 had any dental issues. -The incident on 05/08/22 was before her employment with the facility. Interview with the facility's scheduler/transport staff on 06/20/22 at 11:07am revealed: -The facility staff were supposed to give her a copy of after-visit summaries so she could coordinate follow-up appointments. -She reviewed her file for May 2022-June 2022 and had no information Resident #3 needed an appointment with a dentist. -If she had been given the discharge paperwork for 05/12/22 she would have scheduled Resident #3's appointment. -She reviewed her digital appointment calendar for Resident #3 and there were no appointments scheduled for the remainder of 2022. -The VA staff usually took about 3-4 days to talk to, and then it took about a month to get an appointment. Interview with the Administrator on 06/20/22 at 11:18am revealed: -She was aware Resident #3 was holding teeth on 05/08/22. -She assumed the teeth were his own. -The MCM was responsible for making appointments. -She was concerned an appointment had not been made for a dental consultation for Resident #3 whether it was his teeth or a partial. -Resident #3 may have been in pain, and that was why he was acting out. Telephone interview with Resident #3's	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 53	D 273		

court-appointed guardian on 06/20/22 at 3:31pm revealed:
-She had not been notified Resident #3 had any issues with his teeth and needed a dental appointment
-If she had known she would have been able to assist with scheduling an appointment.

Telephone interview with Resident #3's family member on 06/20/22 at 6:27pm revealed:
-She usually saw Resident #3 at least once a week.
-She had noticed Resident #3 having difficulty chewing and eating.
-Resident #3 would point to his teeth and make an agonizing face.
-She spoke to the previous MCM about Resident #3 needing a dental appointment.
-She did not recall when she spoke to the previous MCM about an appointment.
-Resident #3 had eaten soup on 06/12/22 because it was easy for him to eat.

Review of Resident #3's electronic medication administration record (eMAR) revealed:
-On 05/01/22, Resident #3 weighed 171 pounds (lbs).
-On 06/01/22, Resident #3 weighed 168lbs.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry for ibuprofen 600mg three times daily as needed for pain.
-Ibuprofen was not documented as administered at anytime during the month when Resident #3 had complained of mouth pain.

Based on hospitalization on 06/13/22, Resident #3 was not available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 54	D 273		

Attempted interview with Resident #3's VA provider on 06/17/22 at 12:23pm was unsuccessful.

b. Review of Resident #3's after-visit summary with his Veterans Administration (VA) provider dated 05/12/22 revealed there was an order to schedule an eye appointment.

Telephone interview with Resident #3's family member on 06/20/22 at 6:27pm revealed:
-She usually saw Resident #3 at least once a week.
-She was visiting with Resident #3 back in November 2021 when he broke his eyeglasses.
-She let the previous MCM know the eyeglasses had been broken and Resident #3 needed an eye appointment.
-She also notified the previous MCM on the same day, Resident #3 was complaining of being dizzy and having a headache.
-The previous MCM told her the earliest appointment she could get scheduled for Resident #3 to see an eye doctor was for June 2022.
-Resident #3 could not see without his glasses.
-Someone at the facility had given him a pair of glasses that she thought belonged to someone else, but those were lost at some point.
-At first Resident #3 talked about it all the time, but he had stopped talking about his glasses over time.

Interview with a personal care aide (PCA) on 06/16/22 at 2:40pm revealed Resident #3 had complained of headaches; she did not know what was causing the headaches.

Interview with a medication aide (MA) on 06/20/22 at 9:42am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 55	D 273		

-Resident #3 had asked to go to the eye doctor about 7-months ago.
-She had contacted the VA to get an eye appointment last year (she did not recall the date) and was told she had to get the appointment through Resident #3's PCP at the VA.
-She did not know why an appointment was not requested before 05/12/22.
-The after-visit summary was given to the previous MCM who was responsible for coordinating appointments.

Telephone interview with a nurse at the VA on 06/17/22 at 12:23pm revealed:
-To schedule an eye appointment, the facility staff would have to call the VA eligibility department first, then call the clinic to schedule an appointment.
-There was no eye appointment shown as scheduled in the VA system.

Interview with the previous MCM on 06/20/22 at 7:01am revealed she was not aware Resident #3 had complained of any visual issues.

Interview with the current MCM on 06/20/22 at 10:18am revealed:
-She was not aware Resident #3 had any issues with his vision and needed an eye appointment.
-The order dated 05/12/122 for an eye appointment was before her employment with the facility.

Interview with the facility's scheduler/transport staff on 06/20/22 at 11:07am revealed:
-The facility staff were supposed to give her a copy of after-visit summaries so she could coordinate follow-up appointments.
-She reviewed her file for May 2022-June 2022 and had no information Resident #3 needed an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 56	D 273		

appointment with an eye doctor.
-If she had been given the discharge paperwork for 05/12/22 she would have scheduled Resident #3's appointment.
-She reviewed her digital appointment calendar for Resident #3 and there were no appointments scheduled for the remainder of 2022.
-The VA staff usually take about 3-4 days to talk to, and then it took about a month to get an appointment.

Interview with the Administrator on 06/20/22 at 11:18am revealed:
-She was not aware Resident #3 had been referred to an eye doctor.
-The eye referral should have been followed up on.
-The MCM was responsible for making appointments.
-She was concerned an appointment had not been made for the eye doctor for Resident #3.

Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed:
-She had not been notified Resident #3 had any issues with his eyes and needed an appointment
-If she had known she would have been able to assist with scheduling the appointment.

Based on hospitalization on 06/13/22, Resident #3 was not available for interview.

Attempted interview with Resident #3's VA PCP on 06/17/22 at 12:23pm was unsuccessful.

2. Review of Resident #6's current FL-2 dated 06/08/22 revealed:
-Diagnoses included vascular dementia, osteoporosis, hypertension and respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 57	D 273		

failure.
-Resident #2 resided in the Special Care Unit (SCU).

Review of Resident #6's primary care provider's (PCP) encounter note dated 06/08/22 revealed:
-The PCP had a face to face encounter with Resident #6 at the facility on 06/08/22 to establish care.
-Resident #6 recently moved into the facility after a hospital admission.
-Resident #6 was diagnosed with vascular dementia but remained alert and oriented.
-Per facility, family requests a podiatry referral for ongoing overgrown toenail issues.
-Staff deny any concerns for Resident #6 other than needing medications.

Review of a physician's order dated 06/09/22 revealed an order for podiatry services for Resident #6 having a diagnosis of onychauxis (a nail disorder causing toenails to grow abnormally thick, may become curled and turn white or yellow; overgrowth or thickening of the nail can cause discoloration due to dried blood underneath the nail plate); the physician specified a certain local foot and ankle center for Resident #6's care.

Observation of Resident #2 on 06/15/22 during the morning tour of the SCU revealed:
-The resident was laying on the bed with her feet up.
-The resident's feet were a mottled pale gray and pink color.
-Her toes were curled with rounded tips covered with thick white and yellowed, curled, jagged and elongated nails.
-The soles of the feet and the bases of the big toes were calloused with circles of dry skin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 58	D 273		

-The nails of the big toes were 1/4 inch-thick, 1/2 inch past the tip of the toe and curled under having a scoop appearance under the nail.

A second observation of Resident #6 on 06/16/22 at 1:40pm revealed:
-The resident was seated in a chair in the common room and wearing socks and slippers over her feet.
-Resident #6 wanted to show her feet and removed her socks and slippers.
-The resident's feet were a pale purple and light gray color with dry skin.
-When she stood, her toes curled under and her toenails scraped the floor.

Interview with Resident #6 on 06/16/22 at 1:42pm revealed:
-The resident took care of her own toenails, trimming them as needed.
-She did not think her toenails needed trimming yet.
-Her big toenails were longer than the others and she filed them in an upside "V" shape.
-The resident wore socks and slippers on her feet because they were comfortable.
-Her toenails did not scrape her socks when she put them on or took them off.

Interview with a personal care aide (PCA) on 06/16/22 at 10:16am revealed:
-She did personal care and gave residents showers three times a week.
-Staff were assigned to do a skin assessment to look for bruises, skin tears and look at and clean fingernails and toenails.
-She looked at Resident #6's feet and toenails this morning when she was getting her up for breakfast.
-Resident #6's toenails were too long; they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 59	D 273		

needed trimming.
-Resident #6 did not complain her toenails were too long; she put on socks and slippers herself.
-The facility used to have a podiatrist that came to do nail care, but she had not seen the podiatrist since January 2022.
-She did not know why the podiatrist stopped coming.
-She did not know if the facility tried to get another podiatrist to come or send residents out for care.
-She had a concern about Resident #6's nails being too long and notified the medication aide (MA).
-She did not know who was responsible for ensuring residents had routine nail care.

Review of the Resident Assessment Tool for admission on 06/03/22 for Resident #6 revealed she was to have assistance with skin care 2 days a week which included washing her face and hands and feet care.

Interview with a MA on 06/20/22 at 10:13am revealed:
-When a new resident was admitted, the Memory Care Manager (MCM) met with the resident and talked with the family to determine the needs of the resident.
-When Resident #6 was admitted, her responsible person (RP) requested the resident have a podiatry appointment as her toenails were long and skin was growing out to the end of her toenails.
-She told Resident #6's RP the facility did not have on-site podiatry care since the PCP group had not had a podiatrist to come quarterly since December of last year (2021).
-She had not seen Resident #6's toenails since admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 60	D 273		

-She was not aware of a podiatry referral order or podiatry appointment scheduled for Resident #6.
-She was not aware if the MCM contacted a podiatrist for care for Resident #6.

Interview with the MCM on 06/20/22 at 9:30am revealed:
-During Resident #6's admission process, the RP made a request for the resident to have a podiatrist appointment as the resident had been in the hospital before admission to the facility and did not see a podiatrist.
-The RP was given facility admission documents to sign and she made a request for On-Site Services for podiatry.
-She faxed a request to the PCP group requesting a podiatrist come to the facility to see Resident #6.
-The request was made on the day of admission (06/03/22).
-The PCP group was responsible for providing Resident #6's podiatry care.
-She had not seen a podiatrist from the PCP group at the facility in several months.
-The MCM was responsible for processing Resident #6's new admission documents.
-The MCM was responsible for processing Resident #6's physician orders.
-She had not seen an order dated 06/09/22 for referral for podiatry care for Resident #6.
-She was not aware of an order to take Resident #6 to a podiatrist for foot care.

Interview with the RP for Resident #6 on 06/16/22 at 4:35pm revealed:
-Resident #6 started complaining about the look of her toenails several months ago; she wanted to trim her own toenails.
-Resident #6 had been in the hospital for a month

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 61	D 273		

before her admission to the facility (06/03/22) and did not have her toenails trimmed.
-She was told the facility had podiatry care for residents every 3 months with the PCP podiatrist and requested the service for Resident #6 on the day of admission (6/03/22).
-She met and talked with the PCP about Resident #6's feet and toes when the PCP came to the facility (06/09/22) for the initial visit and assessment of Resident #6.
-The PCP wrote an order for a referral to a local podiatrist group for Resident #6 to have an appointment for care.
-She had not heard anything about a scheduled appointment for Resident #6 to date.

Interview with the PCP on 06/16/22 at 11:29am revealed:
-She met and assessed Resident #6, as a new patient, at the facility on 06/09/22.
-The resident's RP requested a podiatry consult from the facility for Resident #6 but the facility had not contacted her about a referral order appointment for her family member.
-She assessed Resident #6's feet and toes and wrote an order for podiatry services for the resident on 06/09/22.
-The PCP's agency had not had podiatry services available since last December 2021.
-She wrote a referral order for Resident #6 to see a local foot and ankle podiatrist that day (06/09/22) and told the RP she would be contacted by the facility or the podiatrist office about an appointment date and time for Resident #6.

Interview with the clinical coordinator of the referred podiatry group on 06/17/22 at 1:40pm revealed:
-There was no documentation for Resident #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 62 -Resident #6 was not listed as a current patient. -When the referral order was received an appointment could be made within a week. Second interview with the clinical coordinator of the referred podiatry group on 06/20/22 at 8:27am revealed no appointment had been requested for Resident #6 to date. Interview with the Administrator on 06/20/22 at 2:50pm revealed: -The Administrator was new to the facility, but she was working the day Resident #6 was admitted, 06/03/22. -The RP was present and requested a podiatry consult for Resident #6 on the New Patient Registration form. -The form was e-mailed and faxed to the PCP group who had been providing podiatry services to residents at the facility. -The facility had not received a response to the request, upon admission, for podiatry services for Resident #6. -She was not aware if the MCM or the Resident Care Coordinator (RCC) received any information regarding an appointment for podiatry services. -She or the MCM had not contacted the PCP group for another podiatry service for Resident #6. -She was not aware the PCP group had not had podiatry services since December 2021. -The MCM should have established care with an available podiatry service for Resident #6 and other residents requiring podiatry services. _____ The facility failed to schedule appointments and follow-up on referrals for two residents, including Resident #3, who had requested to see a dentist, was complaining of mouth pain for several weeks, was observed having difficulty eating and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 63 had lost 3 pounds during the time period he had complained of mouth pain, was not administered any pain-relieving medication, had teeth broken from a partial, and after the resident's primary care provider (PCP) wrote an order on 05/12/22 to schedule an appointment with a dentist, the appointment was not scheduled; and Resident #3 broke his glasses and complained of being dizzy and having headaches by not wearing his glasses in November 2021 and the resident's family member requested an appointment, but the appointment had not been scheduled six months later when the PCP wrote an order on 05/12/22 to schedule an eye appointment, and the appointment was still not scheduled; and a resident (#6) who had a foot disorder causing disfigured curling toes with thickened toenails and an order for a podiatry appointment that was not scheduled causing the resident to walk with bent toes and long toenails. This failure resulted in a substantial risk for physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/22. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2022.	D 273		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 64	D 315		

require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure activities were provided daily that engaged the residents, resulting in increased agitation by a resident who had altercations with another resident and who was ordered participation in facility activities by the physician (#1).

The findings are:

Review of the June 2022 SCU Activity Calendar revealed:
-On all Mondays, morning exercise was scheduled for 9:30am (there was no stop time); from 10:45am-12:30pm, class office hours for the Activity Director was scheduled, and a pastor was scheduled for 1:00pm (there was no stop time).
-On Wednesdays, 06/01/22, 06/08/22, 06/15/22 and 06/22/22 music was scheduled at 9:30am (there was no stop time), outside time was scheduled for 11:00am (there was no stop time) and combo games were scheduled for 1:00pm.
-On Tuesday 06/14/22 music was scheduled at 9:30am and 11:00am on 06/16/22; there were no stop times.
-Outside time and porch time were scheduled at 11:00am (there was no stop time) for 13 days during the month.
-Bingo was scheduled at 3:00pm (there was no stop time) seven days during the month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 65 -Combo group games were scheduled at 1:00pm (there was no stop time) four days during the month. Observation of the Special Care Unit (SCU) on 06/14/22 at 9:30am revealed: -The common area, dining room and nurses' station in the SCU were in one open area. -The common area had two sofas and multiple chairs and a television; the common area was visible from the dining room. -The common area and the dining room were visible from the nurses' station. -The Activity Director came into the unit and turned on a radio that was in the common area and then left the unit. -There were twelve residents sitting in the common area; nine of the residents were asleep in the common area. -One resident was walking around the unit; another resident sat in a chair and was working a puzzle book and a third resident was sitting in the dining room adjacent to the common area. Observation of the SCU on 06/14/22 at 2:07pm revealed: -Two residents were waiting at the exit door to the SCU to go to the Assisted Living (AL) unit of the facility to participate in a strawberry shortcake making activity. -The two residents were excited about going to the activity on the AL unit. -There were six residents asleep in the common area and the television was on. -Two residents were wandering the area in front of the nurses' station. -There were three residents sitting at a table in the dining room together, but they were not engaging with each other and a fourth resident sat at a table alone.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 66 Observation of the SCU on 06/15/22 at 9:30am revealed: -There were fifteen residents sitting in the common area; some were sleeping and some were awake. -There were two residents sitting together at a table in the dining room area and a third resident was sitting in her wheelchair in the middle of the dining room. -None of the residents were engaging with each other. -The Activity Director came into the unit and turned on the radio and left the SCU; she did not interact with any of the residents or staff. Observation of the SCU on 06/15/22 at 1:15pm revealed: -There was one resident in the dining room at a table with a bingo card. -The Activity Director was calling bingo to the resident; there were no other residents participating in the activity. -The Activity Director was cueing the resident when she needed to cover a spot on the bingo card. -There were eight residents sitting in the common area and the television was on; seven of the residents were asleep. -There were two residents walking around the area. Based on oberservations on 06/14/22 and 06/15/22 at various times revealed no activities were observed according to the activity calendar in the SCU. Review of Resident #1's current FL-2 dated 03/08/22 revealed: -Diagnoses included alcohol induced dementia,	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 67	D 315		

muscle weakness, venous thrombosis, muscle weakness and transient ischemic attack (TIA).
-Resident #1 resided in the Special Care Unit (SCU).
-Resident #1 was constantly disoriented and ambulatory.

Review of Resident #1's care plan dated 06/15/22 revealed:
-Diagnoses included alcohol-induced persisting dementia and dementia in other diseases classified elsewhere with behavioral disturbance.
-He was always disoriented.
-He had significant memory loss and needed to be directed.

Review of Resident #1's physician's visit summary dated 04/06/22 revealed:
-The plan of treatment for Resident #1's acute agitation included providing and encouraging participation in the facility's activities when they were offered.
-Resident #1's primary care provider (PCP) noted Resident #1 was usually seen wandering the halls in the SCU when she visited.
-The PCP discouraged daytime napping and recommended finding things for him to do during the day to help with agitation and slow cognitive decline.
-The PCP noted she had not observed activities in the SCU on the visit on 04/06/22 or on any previous visits to the SCU.
-Under the orders section of the notes was an order to facilitate activities throughout the day to keep the resident occupied.

Review of Resident #1's physician's visit summary dated 05/30/22 revealed the plan of treatment for Resident #1's acute agitation included providing activities and tasks for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 68	D 315		

Resident #1 to perform during the day to prevent boredom and agitation opportunities.

Review of Resident #1's physician's visit summary dated 06/13/22 revealed the plan of treatment for Resident #1's acute agitation was to continue daily activities.

Review of Resident #1's care notes from 05/30/22 to 06/13/22 revealed:
-On 05/30/22, Resident #1 was hit by another resident.
-On 06/08/22, Resident #1 was choked by another resident and had redness around the neck; Resident #1 was sent to the local emergency department.
-On 06/13/22, Resident #1 was hit by another resident and had a fall; Resident #1 was transported to the local emergency department (ED) by emergency medical services (EMS).

Interview with Resident #1's PCP on 06/15/22 at 11:15am revealed:
-The residents in the SCU would benefit from a stricter activity schedule.
-She had not observed activities being conducted in the SCU; she had only seen the Activity Director passing snacks to the residents.
-The facility wanted the PCP to order more and more medications for agitation and she told them there needed to be more structure and activities to keep the residents busy and occupied.
-The residents sat around in the common area and got bored, so they acted out.
-The activities in the SCU would have to be planned for the SCU residents; they could not participate in the same activities as the AL residents.
-The activities in the SCU needed to be centered around residents with dementia and engage them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 69	D 315		

so they would participate.
-If there were activities centered around the SCU residents, there would be less agitation; the residents wanted something to do too.
-Resident #1 walked around a lot and became agitated.
-She had repeatedly asked the staff to encourage Resident #1 to participate in activities, but she never saw any activities to participate in.

Telephone interview with Resident #1's mental health provider on 06/20/22 at 2:47pm revealed:
-Resident #1 had behaviors related to his dementia.
-When she visited Resident #1, she had discussed with staff about distracting Resident #1.
-He constantly wanted to move and to wander around.
-He would benefit from scheduled activities to keep him busy; it would decrease his agitation and calm him down to have activities he could do.
-The last time she had seen him, he was in the dining room repeatedly rearranging the chairs around the tables; it was keeping him busy and he was calm.

Interview with the Activity Director on 06/15/22 at 2:40pm revealed:
-She provided activities for the AL and the SCU.
-She prepared separate activities calendars for the AL and the SCU.
-She passed snacks to the residents in the SCU two times a day but did not count that as activity time.
-She provided more than 14 hours of activities for the AL and the SCU each week.
-The AL residents demanded most of her time.
-She tried to get the AL residents and the SCU residents to engage with each other in group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 70	D 315		

activities.
-Combo group games were conducted in the AL and residents were brought from the SCU to participate.
-She combined other activities with the AL residents and the SCU residents on the AL unit of the facility.
-Not all of the residents from the SCU could come and participate in the activities on the AL unit; only about six residents on the SCU were able to go to the activities on the AL unit.
-The residents in the SCU loved music and she thought listening to the music in the morning was engaging enough for them.
-Some of the SCU residents enjoyed going outside but she had canceled the outside time today, 06/15/22, due to the extreme heat; she did not schedule another activity for that time.
-She did reminisce activities and games with the SCU residents; there was not a lot of activities they could participate in.
-Most of her activities were 30 minutes to one hour.
-The residents on the SCU favorite activity was tossing and bouncing a beach ball; the SCU residents also enjoyed going to the combined activities on the AL unit even though not all of them could participate.
-She did not know there was a recommendation from Resident #1's PCP for encouraging participation in activities.
-If the residents in the SCU participated in activities it would benefit them and their cognition.
-She was not aware staff were trying to keep two residents busy by providing tasks for them to do; she had not considered tasks like wiping tables or sweeping as part of the activities calendar.

Confidential interview with a staff revealed:
-Staff complained to management so many times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 71	D 315		

about the residents not having anything to do in the SCU.
-The Activities Director would sometimes bring a ball to the SCU for the residents to hit.
-After an activity, the residents seemed calmer.
-They had expressed concern so much and nothing was ever done so they just stopped talking about it.

Interview with a personal care aide (PCA) on 06/16/22 at 9:21am revealed:
-Resident #1 was always getting into things; he was a handful to supervise.
-Resident #1 liked to walk around.
-Staff tried to keep an eye on Resident #1 because another resident would hit him if he walked near the other resident.
-Resident #1 had been aggressive with staff and attempted to hit them.
-Resident #1 required a lot of attention and redirection.
-It was hard to keep Resident #1 busy; there just was not enough staff.
-She was not aware Resident #1 had an order to participate in activities.
-She told the Memory Care Manager (MCM) and the Administrator that Resident #1 was a handful and gave ideas for activities to keep him and other residents busy, but nothing was ever done.
-She had given the Activity Director suggestions for activities, but they were never done.
-The residents in the SCU sat around a lot and got bored.
-The staff requested the Activity Director do more activities in the SCU, but she did not come over until they pushed her.
-Sometimes she would get balloons and blow them up for the residents to throw and bounce around; the residents seemed much calmer after they played with the balloons.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 72 -During the morning music, she would dance and some of the residents would join her; they seemed calmer after they danced. -If there had been activities for Resident #1 to keep him busy from the start he would not have had altercations. Interview with another PCA on 06/16/22 at 1:24pm revealed: -The residents did not have activities to do. -The residents needed activities. Interview with a third PCA on 06/16/22 at 1:56pm revealed: -She would give Resident #1 something to do to occupy his time; she had brought him something to color one time and it pleased him and kept him calm. -Resident #1 was easy to please with an activity. -Resident #1 liked to walk around a lot but was always into something and going into other residents' rooms. -Resident #1 just needed something to do to keep him busy and away from the other resident who he agitated. Interview with a medication aide (MA) on 06/16/22 at 4:12pm revealed: -Resident #1 would push chairs around in the dining room; he would move chairs for hours. -He was like a two-year-old and needed constant attention. -He liked to dance and would dance with her when she had time. -He walked around a lot and wandered into other residents' rooms. -He would go behind the nurses' station and get into things behind the station. -The SCU activities did not keep him entertained so the staff did their best to do it for him.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 73 -She was not aware of an order to involve him in activities, but it made since because he was always into things. Confidential interview with a resident in the SCU revealed: -She would like to have things to do like a daily exercise class; they did not have exercises. -The only area to go outside was the smoking area. -They got irritated easily because they had to be at the facility. -It would help them feel better to have meaningful activities. -They could do things like for a children's hospital, go shopping at a thrift store, buy stuffed animals and clean them up and donate them. Interview with the MCM on 06/20/22 at 4:27pm revealed: -Staff had complained to her about the residents having nothing to do. -She had not observed all activities due to lack of time. -She had overheard bingo being done. -She did not think the activities on the activity calendar were appropriate for the SCU. -The residents were not participating in the activities. -There were two PCAs that would dance and play with a beach ball with the residents. -The residents would participate with the two PCAs and had fun; they were in a much better mood after the PCAs played with them. -She thought if the activities were geared towards the residents' abilities and needs in the SCU, they would benefit from an activities program. -She had read last week in Resident #1's notes about recommending increased activities. -Resident #1 liked to walk around and wandered.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 74 -He would benefit from an activity depending on what was offered to him and how his day was going. Interview with the Administrator on 06/20/22 at 5:38pm revealed: -She had done very little observations in the SCU for activities. -The Activity Director gave her the calendar every month. -The residents in the SCU were pretty high functioning and could do more interesting and interactive activities. -She knew the Activity Director took some of the SCU residents to the AL unit to participate in activities. -She understood the importance of activities that were designed with the SCU residents in mind. -She was concerned the residents in the SCU were not getting fulfillment, interaction and joy from the activities that were currently being done in the SCU. -Lack of activities and fulfillment for the residents could contribute and lead to boredom, depression, and behavior issues. -She was not aware Resident #1 had an order for participation in activities, but she could see where it would help him with his behaviors. _____ The facility failed to offer daily activities to the residents who resided in the SCU, including a resident (#1) who had an order to encourage participation in activities, due to the resident's restlessness and wandering which frustrated another resident, resulting in an altercation between the two residents. The facility's failure to promote active involvement in activities was detrimental to the safety and welfare of the residents, which constitutes a Type B Violation. _____	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 75 The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 06/16/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 31, 2022.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received dignity and respect for a resident (#7) who had to stay in his room because he did not have clean pants to wear and the Administrator who had behaviors while reprimanding staff in front of residents and upsetting the residents. The findings are: 1. Review of Resident #7's current FL-2 dated 06/01/22 revealed: -Diagnoses included vascular dementia and falls. -Resident #7 resided in the Special Care Unit (SCU). -Resident #7 was incontinent to bladder. -Resident #7 was continent to bowel. -Resident #7 required assistance with bathing. Observations of Resident #7 on 06/14/22 at various times from 8:42am to 12:03pm revealed: -At 8:42am, Resident #7 was sitting in his	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 76	D 338		

wheelchair with a shirt on and incontinent briefs; he did not have on any pants.
-At 12:03pm, Resident #7 was still in a shirt and incontinent briefs only.

Observation of Resident #7 on 06/16/22 at 7:57am revealed:
-He was seated in his wheelchair with a zippered jacket, wearing an incontinent brief and no pants on.
-There were no clothes in his wardrobe and there was only a single sock in his dresser.

Interview with Resident #7 on 06/16/22 at 7:57am revealed:
-He did not have any clean pants to wear.
-A personal care aide (PCA) had taken his pants and was washing them.
-He thought he only had two pairs of pants to wear.
-He wanted to go to breakfast but he had to wait for his pants to be washed and dried.
-He did not know if anyone was going to bring him clean pants so he could go to breakfast.
-He had to wait in his room and could not leave without pants.
-He did not have pajamas to wear either.

Interview with Resident #7 on 06/20/22 at 11:00am revealed:
-He had to wait for his pants to be washed before he could leave his room a couple of times a week.
-He would sit in his room without any pants on until his were cleaned.
-It took about half a day for his pants to be washed.
-He did not go to meals or out of his room because he did not have pants to wear.
-He was told by staff he had to wait in his room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 77 until his pants were cleaned. Interview with a PCA on 06/16/22 at 8:00am revealed: -Resident #7 only had a couple of pairs of pants and no pajamas. -His pants were wet, so she took them to the laundry and was washing them. -He would have to wait in his room while they washed and dried. -She would take him his breakfast. -He stayed in his room most of the time anyway. Interview with the Memory Care Manager (MCM) on 06/16/22 at 9:00am revealed: -He was recently admitted to the facility and his family brought him in; she did not know what the family had provided. -The facility staff did his laundry. -There were no extra clothes for any residents at the facility. -He would have to stay in his room until his clothes were washed. Interview with the Administrator on 06/16/22 at 9:00am revealed: -She was not aware until that moment that Resident #7 did not have more than two pairs of pants. -The only thing the facility could do was to reach out to the family and let them know Resident #7 did not have enough clothes. -The facility was not responsible for providing or purchasing clothes for Resident #7; the only time they purchased clothing for residents was when the family put money in the account for them to make the purchases. -Unfortunately he would have to stay in his room until his clothes were washed.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 78 Attempted interview with Resident #7's family on 06/20/22 at 2:34pm was unsuccessful. 2. Confidential interview with a staff revealed: -She was on the Assisted Living (AL) unit and heard a commotion in the Special Care Unit (SCU), so she went to the SCU to see what was going on. -When she got to the SCU the Administrator was yelling at a named personal care aide (PCA) in the dining room. -It was during lunch time so the dining room in the SCU was full of residents. -The Administrator used swear words towards the named PCA. -The named PCA walked from the dining room to the nurses' station; the Administrator followed the named PCA to the nurses' station and continued to yell. -The nurses' station in the SCU was in a large open area next to the dining room so the residents could still hear the Administrator yelling. -The named PCA left the building and went to the parking lot; the Administrator followed the named PCA outside. -The staff went back to the AL side of the facility because she did not want to get caught up in it. -She did not notice if any of the residents were upset because she was watching the Administrator and the named PCA. Confidential interview with two staff revealed: -Management was disrespectful to staff in front of the residents on the SCU. -When staff called anyone in management including the Administrator, Resident Care Coordinator (RCC), and Memory Care Manager (MCM), they did not respond even if staff called or text them multiple times.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 79 Interview with a PCA on 06/14/22 at 5:05pm revealed: -About a week and a half ago, at dinner time, the Administrator started yelling at a PCA on the SCU. -There was a group of PCAs in the kitchen getting plates to serve to residents who were in the dining room. -The Administrator came to the door of the kitchen that lead to the dining room where residents were waiting for dinner to be served. -The Administrator started yelling and using profanity at the PCA. -The PCA went to the parking lot to cool off and returned to finish her shift. -The Administrator was so loud that one of the residents said something and began to cry while a few other residents started to leave the dining room. Interview with another PCA on 06/16/22 at 9:07am revealed: -About a week or so ago during a mealtime she had been in the bathroom behind the nurses' station in the SCU when she heard yelling. -She came out of the bathroom and heard the Administrator yelling at staff; the Administrator was in the kitchen but walked over to the area between the nurses' station and the dining room. -The Administrator was still yelling and loud. -She asked the Administrator not to "go off" or yell at the staff in front of the residents; the Administrator said she did not care about anyone's feelings. -A resident was watching the Administrator and was visibly upset; the resident yelled "can you stop yelling". -The Administrator continued to yell at the staff even after the resident asked her to stop. -The dining room was full of residents; she did	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 80	D 338		

not know if any other residents were upset.
-She sat down and began to feed a resident.

Interview with a third PCA on 06/16/22 at 1:20pm revealed:
-She witnessed a recent confrontation between a PCA and the Administrator on the SCU.
-The residents were in the dining room eating and were getting upset when they heard the staff hollering.
-Four named residents got up and left the dining room without finishing their food.
-One resident hollered, "shut up."
-All the residents looked distraught during the incident.

Interview with a fourth PCA on 06/16/22 at 1:45pm revealed:
-About a week ago the Administrator came into the dining room and began to yell at a PCA; it was during mealtime.
-The Administrator yelled at another PCA on Sunday, 06/12/22, when the PCA was in the dining room at mealtime.
-Some of the residents did not like loud noises and would get upset when the Administrator would come in and yell at staff.
-One resident had asked the Administrator to stop yelling while she was eating.
-The Administrator had used profanity once when she was yelling at staff in front of the residents.
-Staff asked the Administrator not to confront them and yell at them in front of the residents, but she continued to do it.
-One resident did not like loud noises and had to be calmed down by another PCA because the Administrator was yelling in the dining room; he started to fidget and wanted to leave the dining room.
-The Administrator would continue to yell at staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 81	D 338		

even after staff and residents would ask her not to.

Interview with a medication aide (MA) on 06/16/22 at 4:41pm revealed:
-She had witnessed the Administrator get loud and yell at staff twice; both times were during mealtimes and in front of residents.
-She did not hear profanity, but the Administrator was screaming on both occasions.
-She only recalled one resident getting upset enough to react; the resident told the Administrator to stop yelling.
-She checked on the resident after the incident to be sure the resident was okay; the resident said she was okay but did not like the Administrator coming into the dining room and yelling at staff.

Interview with the MCM on 06/20/22 at 4:03pm revealed:
-She had not witnessed the Administrator yelling at staff in front of residents.
-No one had complained or reported to her about the Administrator yelling in front of residents.
-It had been reported to her by staff that the Administrator was out of line with them and they were offended but staff never told her about anything happening in front of residents.

Interview with the Administrator on 06/20/22 at 5:05pm revealed:
-There had been times where she had to reprimand staff on the floor; if she saw them doing something wrong she was going to correct it.
-If she stopped and removed the staff from the floor, she would be taking away from the residents and their care.
-She had addressed the staff over something during mealtime a couple of weeks ago; the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 82 residents were in the dining room. -She was correcting the staff in the kitchen adjacent to the dining room, she was not in the dining room. -One of the staff was in the dining room and was upset and got loud and started to yell in front of the residents. -She walked away and went into the MCM's office, but she could still hear staff talking loudly about the situation while they were in the dining room with the residents. -She went back into the dining room and said something else to the staff so they would stop talking about it in front of the residents. -One resident overheard the confrontation in the dining room when she went back in and the resident spoke up and said "be quiet". -She stopped once the resident said something because she did not want to upset the residents. -No other residents got upset and there was no profanity used. -There had been other times she had to have conversations with staff to correct them while on the floor, but she did not use profanity and she did not upset residents during those conversations either. Attempted interview with a resident on 06/16/22 at 2:50pm was unsuccessful.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 83 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO A TYPE A2 VIOLATION Based on these findings, the previous Type A2 violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 residents, (#1, #2, #3, and #4) related to two medications used to treat behaviors (#3), an inhaler and a nasal spray (#4) an ammonia reducer and a topical steroid cream (#1), and a laxative and a pain reliever (#2). The findings are: 1. Review of Resident #3's current FL2 dated 01/31/22 revealed: -Diagnoses included type 2 diabetes and dementia. -The level of care was Special Care Unit (SCU). Review of Resident #3's care notes revealed: On 05/02/22, Resident #3 was fretting another resident. -On 05/08/22, Resident #3 pulled three of his teeth. -On 05/28/22, Resident #3 was pulling on another resident. -On 05/30/22, Resident #3 had an altercation. -On 06/01/22, Resident #3 pushed another resident on the floor. -On 06/04/22, Resident #3 was agitated. -On 06/05/22, Resident #3 was agitated/aggressive.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 84 -On 06/08/22, Resident #3 had an altercation with another resident and was sent to the emergency department (ED) for behaviors. -On 06/13/22, Resident #3 attacked another resident and was sent to the ED. a. Review of Resident #3's after visit summary with his Veterans Administration (VA) provider dated 05/12/22 revealed there was an order for Trazadone 25mg (used to treat behaviors and depression) every morning. Review of Resident #3's May 2022 electronic medication administration record (eMAR) revealed: -There was no entry for Trazadone 25mg from 05/12/22-05/31/22. -There was no documentation Trazadone 25mg was administered from 05/12/22-05/31/22. Review of Resident #3's June 2022 eMAR revealed: -There was an entry for Trazadone 50mg, take one-half tablet (25mg) every morning with a scheduled administration time of 8:00am; the start date was 06/09/22. -There was no documentation Trazadone 25mg was administered from 06/01/22-06/08/22. -Trazadone 25mg was documented as administered from 06/10/22-06/13/22 at 8:00am. -There were exceptions documented from 06/14/22-06/15/22 when Resident #3 was in the ED. Observation of Resident #3's medication on hand on 06/15/22 at 4:54pm revealed: -There was a prescription bottle dated 05/14/22 for Trazadone 50mg with the directions to administer one-half tablet every morning; 45 tablets were dispensed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 85 -There were 25 and ½ tablets available for administration. -There were 19 and ½ tablets that could not be accounted for based on the documentation on Resident #3's eMAR. Interview with the Memory Care Manager (MCM) on 06/20/22 at 10:18am revealed: -When she was first made aware Resident #3 was having behavior issues, she looked to see if he had a medication order used to treat behaviors and left a voicemail for Resident #3's MH provider. -On 06/09/22, she saw Resident #3's prescription bottle of Trazadone 25mg dated 05/14/22 on the medication cart, found the order dated 05/12/22 in the record, and faxed the order to the facility's contracted pharmacy to be profiled for the eMAR. -The order was written for Resident #3's Trazadone 25mg daily and she did not know why someone had not noticed the order. -Orders were entered into the eMAR by a manager. -When the medication was delivered to the facility, the MA should have let someone know the medication needed to be put into the eMAR and approved so the medication could have been administered. -Not receiving his Trazadone may have been part of the resident's issues with behaviors. Telephone interview with a representative from the facility's contracted pharmacy on 06/17/22 at 10:30am revealed: -Trazadone 25mg was entered on the eMAR for Resident #3 on 06/09/22 after an order was received. -The date of the order for Trazadone 25mg was 05/12/22, but the order was not received at the pharmacy until 06/09/22.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 86 -The order was sent from the facility. -When orders were received, they were entered into the system, and a manager would have to approve the order at the facility. Telephone interview with a representative from the VA on 06/16/22 at 8:37am revealed: -Once an order was received at the pharmacy, it took 2-3 days to process the order and mail the prescription. -He did not know how long it took the mailed prescription to arrive at the facility. -A 90-day supply of Trazadone 50mg, one half a tablet, was dispensed on 05/14/22 for Resident #3; 45 whole tablets were dispensed. -There was no documentation anyone from the facility had contacted the pharmacy. -All pharmacy calls were documented, and the last call from the facility regarding Resident #3 was on 04/14/22. Review of the medication delivery manifest for Resident #3's Trazadone revealed there was no delivery notification for Resident #3's Trazadone dispensed on 05/14/22. Interview with a medication aide (MA) on 06/20/22 at 10:03am revealed: -When medications were delivered, a delivery receipt was filed in a notebook. -The forms were supposed to be dated and signed by the MA who received the medication. -There was no delivery receipt for Resident #3's Trazadone dispensed on 05/14/22. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/09/22 at 10:36am revealed: -Trazadone would be used to treat mood and aggression.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 87	D 358		

-Trazadone 25mg would have been a starting dose and would have been tapered up for the maximum benefit.
-If the Trazadone 25mg was administered as ordered, there would have been some improvement in behavior.

Telephone interview with the facility's primary care provider (PCP) on 06/17/22 at 10:59am revealed:
-She was familiar with Resident #3.
-Resident #3 was known to have aggressive behaviors.
-Trazadone was used to help with behaviors.
-If Resident #3 had been administered Trazadone, especially in the morning, it would have "chilled" his behaviors.

Interview with the first MA on 06/16/22 at 3:57pm revealed:
-She accompanied Resident #3 to a mental health (MH) appointment at the VA on 05/12/22.
-She told the MH provider everything that was going on with Resident #3 and his behaviors and there were two new medications ordered.
-The medications ordered on 05/12/22 had not been received and she reached back out to the MH provider (she thought it was 05/25/22) and was told they would get the medications delivered ASAP (as soon as possible).
-This all happened before "a lot of stuff started happening" last week; Resident #3 became more physical with another resident.

Interview with the first MA on 06/20/22 at 3:25pm revealed:
-She administered medication by looking at the resident's eMAR.
-She matched the eMAR to the medication she was going to administer to make sure the medication matched the eMAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 88 -She then popped the medication that was scheduled and observed the resident take the medication. -After the resident took the medication she then went to the eMAR and signed off on the eMAR to document the medication as administered. Interview with a second MA on 06/20/22 at 7:27am revealed: -She administered medication to Resident #3. -She administered medication based on the eMAR. -If the medication was not on the eMAR she did not administer it. -Resident #3 did not have any medications ordered for behaviors. -She did not recall administering Resident #3's Trazadone. -She did not know Resident #3 had Trazadone. -If Resident #3 had received his Trazadone as ordered the medication may have helped with his behaviors or shown the medication needed to be adjusted. Review of Resident #3's June 2022 eMAR revealed the second MA had not documented administering Trazadone 25mg to the resident. Interview with the Administrator on 06/16/22 at 4:58pm revealed: -She was aware there had been a delay in Resident #3 receiving his Trazadone because of difficulty getting the medication filled at the resident's VA pharmacy. -She had reached out to Resident #3's court-appointed guardian on 06/08/22 because the facility staff was having such a problem getting Resident #3 the medications and care he needed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 89 Interview with the Administrator on 06/20/22 at 11:18am revealed: -Resident #3 needed medication to help with his behaviors. -Medication was not her first choice, but it would have helped. -The facility staff had caught the issue with the Trazadone and the medication was being administered. -Trazadone should have been added to Resident #3's eMAR when it was ordered on 05/12/22. -When the medication was delivered, the MA should have asked for the order since there was a communication gap. -If Resident #3 had been administered his daily Trazadone, the medication would have helped his behaviors. Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed: -She was not aware the facility had an issue with obtaining Resident #3's medication from the VA pharmacy until the Administrator reached out to her on 06/08/22. -On 06/08/22, the provider requested Resident #3 use the facility's contracted pharmacy due to problems obtaining medication from the VA. -She completed the paperwork and returned the forms to the Administrator the next day -If she had been contacted about issues with Resident #3 obtaining his medications, she would have intervened immediately. -She could have obtained Resident #3's medication from a backup pharmacy. -She would have expected Resident #3's medication to be administered no later than the next day after the medication was ordered, especially for medication ordered for behaviors since this was a concern.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 90	D 358		

Based on interviews, observation of medications on hand, and review of Resident #3's eMAR, it could not be determined if Resident #3 received Trazadone 25mg, including the correct dose or time of administration.

Attempted interview with Resident #3's VA MH provider on 06/17/22 at 12:23pm was unsuccessful.

b. Observation of Resident #3's medication on hand on 06/15/22 at 4:54pm revealed:
-There was a bottle of Trazadone 50mg dated 06/01/22 with the directions to administer one-half tablet every day as needed for agitation; 45 tablets were dispensed.
-There were 40 tablets available for administration.

Review of Resident #3's physician's orders revealed there was no order for Trazadone 25mg as needed (PRN) for agitation.

Review of Resident #3's June 2022 eMAR revealed there was no entry for Trazadone 25mg prn.

Review of the medication delivery manifest for Resident #3's Trazadone revealed:
-There was a delivery notification for Trazadone 50mg dispensed on 06/01/22; it was not signed or dated.
-There were no other delivery notifications for Resident #3's Trazadone.

Interview with a medication aide (MA) on 06/20/22 at 10:03am revealed:
-When medications were delivered, a delivery receipt was filed in a notebook.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 91	D 358		

-There was a delivery receipt for Resident #3's PRN Trazadone 25mg with a dispensed dated of 06/01/22, but it was not dated or signed.
-The forms were supposed to be dated and signed by the MA who received the medication.

Telephone interview with a representative from the facility's contracted pharmacy on 06/20/22 at 10:07am revealed they did not have an order for Resident #3's Trazadone 25mg every day as needed for agitation.

Telephone interview with a representative from the VA on 06/16/22 at 8:37am revealed:
-Once an order was received at the pharmacy, it took 2-3 days to process the order and mail the prescription.
-He did not know how long it took the mailed prescription to arrive at the facility.
-Trazadone 50mg, one half a tablet, was dispensed on 06/01/22 for Resident #3; 45 whole tablets were dispensed.

Interview with a personal care aide (PCA) on 06/16/22 at 9:26am revealed she had asked the MA if Resident #3 had any PRN medication for behaviors and was told the resident did not have anything.

Interview with a MA on 06/16/22 at 3:57pm revealed:
-The PCAs would ask for PRN medication for Resident #3 when he was agitated, but there was no PRN medication ordered.
-She had talked to a previous MCM about the need for PRN medication.
-The MCM told her all that could be done was "document it until it got worse."

Interview with the Administrator on 06/20/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 92 11:18am revealed if Resident #3 had been administered his PRN Trazadone, the medication would have helped his behaviors. Based on interviews, observation of medications on hand, and review of Resident #3's eMAR, it could not be determined if Resident #3 received Trazadone 25mg PRN, including the correct dose, time of administration, or effectiveness of the medication. Attempted interview with Resident #3's VA MH provider on 06/17/22 at 12:23pm was unsuccessful. c. Review of Resident #3's after visit emergency department (ED) summary revealed: -On 06/08/22, Resident #3 was seen for homicidal and aggressive behavior. -There was an order to start Seroquel 25mg (used to treat mood disorders) twice a day. Review of a care note dated 06/09/22 revealed: -Resident #3 returned to the facility around 11:00am. -Resident #3 was administered Seroquel 25mg at 10:30am before leaving the ED. -Resident #3 had a prescription for Seroquel 25mg and it has been faxed to both pharmacies and placed in the resident's record. Review of Resident #3's care notes revealed on 06/13/22 Resident #3 attacked another resident and was sent to the ED. Telephone interview with a medication aide (MA) on 06/20/22 at 1:39pm revealed: -She faxed Resident #3's prescription to the facility's current pharmacy and the pharmacy the facility was switching to.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 93 -She did not fax Resident #3's prescription for Seroquel to the resident's Veterans Administration (VA) pharmacy; she did not know she needed to. Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed there was no entry for Seroquel 25mg twice daily. Observation of Resident #3's medication on hand on 06/15/22 at 4:54pm revealed there was no Seroquel 25mg available to be administered. Telephone interview with a representative from the VA pharmacy on 06/16/22 at 8:37am revealed: -There was no order for Seroquel 25mg received at the pharmacy for Resident #3. -There was no documentation anyone from the facility had contacted the pharmacy to inquire about the Seroquel. -If the facility had not received Resident #3's Seroquel in 4-5 days after faxing the prescription, he would have expected the facility to call and check on the status of the prescription. -All pharmacy calls were documented, and the last call from the facility was on 04/14/22. Review of an electronic email from the mental health provider (MH) from the ED dated 06/17/22 at 2:27pm revealed: -He saw Resident #3 on 06/08/22 in the ED. -He ordered Seroquel for agitation and aggression. -The medication would have decreased outbursts of impulsive aggression in Resident #3. -If the medication had been administered, it may have prevented readmission to the ED because aggression was the reason for the readmission. -Seroquel had been administered to Resident #3	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 94 in the ED and it had been helpful and tolerated. Telephone interview with a representative from the facility's contracted pharmacy on 06/17/22 at 10:30am revealed: -An order for Seroquel 25mg twice daily was received from the ED on 06/09/22 and was profiled for Resident #3. -Resident #3's prescriptions were filled at the VA pharmacy, but they entered the information into the eMAR system for the facility. -Once the order was entered, it would pop up for the order to be approved at the facility. -She could not see if the order had been approved. -If Seroquel was not listed on Resident #3's eMAR, the order was either not approved or was discontinued. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/09/22 at 10:36am revealed: -Seroquel was used to treat agitation, aggression, and behaviors. -Seroquel would take up to four weeks to reach maximum benefit. -If Resident #3's Seroquel had been administered as ordered, there would have been an improvement in his behaviors, even if administered for a short period. Telephone interview with the facility's primary care provider (PCP) on 06/17/22 at 10:59am revealed: -She was familiar with Resident #3. -Resident #3 was known to have aggressive behaviors. -If Resident #3 had been administered Seroquel after the ED visit on 06/08/22, he would have at least been calmer.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 95 Interview with the Memory Care Manager (MCM) on 06/20/22 at 10:18am revealed: -Resident #3 had an altercation and was sent to the ED on 06/08/22. -She was not at the facility when the resident returned to the facility. -The MA who was working should have reviewed the ED discharge papers and sent any order to Resident #3's VA pharmacy. -She was concerned Resident #3's order for Seroquel was not faxed to the correct pharmacy because he needed the medication for his aggression. Interview with the Administrator on 06/20/22 at 11:18am revealed: -She did not know Resident #3 had an order for Seroquel that had not been filled. -If Resident #3 had a prescription for Seroquel, it should have been faxed to the resident's VA pharmacy. -The prescription would have been sent to the facility's contracted pharmacy to be profiled and then wait on the medication to be delivered from Resident #3's VA pharmacy. -The MCM was responsible for reviewing the ED discharge papers. -If she had known Resident #3 had an order for Seroquel, she would have reached out to Resident #3's court-appointed guardian, to expedite getting the medication filled. -She felt she would have been able to have the medication filled within 1-2 days had she known. Telephone interview with Resident #3's court-appointed guardian on 06/20/22 at 3:31pm revealed: -She was not aware the facility had an issue with obtaining Resident #3's medication from the VA pharmacy until the Administrator reached out to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 96	D 358		

her on 06/08/22.
-On 06/08/22, the provider requested Resident #3 use the facility's contracted pharmacy due to problems obtaining medication from the VA pharmacy.
-She completed the paperwork and returned the forms to the Administrator the next day
-If she had been contacted about issues with Resident #3 obtaining his medications, she would have intervened immediately.
-She could have obtained Resident #3's medication from a backup pharmacy.
-She would have expected Resident #3's medication to be administered no later than the next day after the medication was ordered, especially for medication ordered for behaviors since this was a concern.

Based on hospitalization on 06/13/22, Resident #3 was not available for interview.

Refer to interview with the medication aide (MA) on 06/20/22 at 3:10pm.

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm.

2. Review of Resident #4's current FL-2 dated 02/10/22 revealed diagnoses included major depressive disorder, hyperlipidemia, chronic systolic hypertension, hyperlipidemia, and osteoarthritis.

a. Review of Resident #4's signed physician's orders dated 04/25/22 revealed an order for an Ellipta inhaler [used to treat chronic obstructive pulmonary disorder (COPD)and asthma] inhale one puff every day.

Review of Resident #4's April 2022 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 97	D 358		

medication administration record (eMAR) revealed:
-There was an entry for Ellipta 100mcg/actuation, inhale one puff daily with a scheduled administration time of 9:00am.
-Ellipta was documented as administered from 04/01/22-04/30/22; there were no exceptions documented.

Review of Resident #4's May 2022 eMAR revealed:
-There was an entry for Ellipta 100mcg/actuation, inhale one puff daily with a scheduled administration time of 9:00am.
-Ellipta was documented as administered from 05/01/22-05/04/22, 05/06/22-05/18/22, and 05/20/22-05/31/22.
-There was an exception documented on 05/05/22 and 05/19/22 as resident refused.

Review of Resident #4's June 2022 eMAR revealed:
-There was an entry for Ellipta 100mcg/actuation, inhale one puff daily with a scheduled administration time of 9:00am.
-Ellipta was documented as administered from 06/01/22-06/07/22, and 06/09/22-06/12/22.
-There was an exception documented on 06/08/22 as the resident refused.
-There was no documentation the Ellipta inhaler was administered on 06/13/22-06/14/22; there were no exceptions documented.

Observation of Resident #4's medication on hand on 06/14/22 at 10:21am revealed:
-There was an Ellipta inhaler with a dispense date of 12/27/21; twenty-one puffs were remaining in the inhaler.
-The Ellipta dispensed on 12/27/21 was not dated when the inhaler was opened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 98	D 358		

-There was a second Ellipta inhaler with a dispense date of 06/11/22; the inhaler had not been opened.

Telephone interview with a representative from the facility's contracted pharmacy on 06/14/21 at 2:26pm revealed:
-Resident #4's Ellipta was dispensed on 08/30/21,12/27/21, 03/02/22, and 06/11/22.
-Each dispensing was a 30-day supply based on the order to inhale one puff daily.

Interview with Resident #4 on 06/15/22 at 3:12pm revealed:
-She was not sure why she was ordered the Ellipta inhaler but thought it was to help with her breathing.
-She was not administered her Ellipta inhaler every day; it depended on which medication aide (MA) was working.
-She did not notice a difference if she missed doses of her Ellipta.

Interview with Resident #4's primary care provider (PCP) on 06/16/22 at 3:08pm revealed:
-Resident #4 was ordered Ellipta to help with her breathing secondary to COPD.
-If Resident #4's Ellipta was not administered as ordered she could experience an exacerbation of COPD.
-It was important for Resident #4 to receiver Ellipta as ordered because the resident also had bad congestive heard failure (CHF) and her lungs could not tolerate an exacerbation.
-She expected Resident #4's medication to be administered as ordered.

Interview with a MA on 06/16/22 at 3:51pm revealed:
-She administered Resident #4's Ellipta when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 99	D 358		

worked.
-Resident #4 had never refused Ellipta.
-Ellipta inhalers lasted for 30-days.
-Resident #4's Ellipta dated 12/27/21 should be empty.
-If Resident #4's Ellipta was not being used up monthly, it was not being administered correctly.

Interview with the Resident Care Coordinator (RCC) on 06/20/22 at 8:00am revealed:
-Ellipta was an inhaler that contained 30 inhalations.
-She did not know why an Ellipta with a dispense date of 12/27/21 would still be on the cart with medication remaining as it should have been used up and reordered.
-She was concerned Resident #4's Ellipta had not been administered correctly.
-She had not had a chance to do a cart audit since she started to work at the facility "a couple of weeks ago."

Interview with the Administrator on 06/20/22 at 12:20pm revealed:
-If Resident #4 had medication still available from a medication dispensed in December 2021, it appeared the medication had not been administered as ordered.
-Resident #4's Ellipta was ordered for a reason, and she expected the medication to be administered and documented.
-She was concerned without the Ellipta being administered correctly, Resident #4's breathing and care were not being managed.

b. Review of Resident #4's signed physician's orders dated 04/25/22 revealed an order for Fluticasone nasal spray (used to relieve symptoms of rhinitis such as sneezing and a runny, stuffy nose) spray into each nostril twice a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 100	D 358		

day.

Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone instill 1 spray in each nostril twice a day with a scheduled administration time of 9:00am and 8:00pm.
-Fluticasone was documented as administered from 04/01/22-04/30/22; there were no exceptions documented.
-There were 120 sprays documented as administered.

Review of Resident #4's May 2022 eMAR revealed:
-There was an entry for fluticasone instill 1 spray in each nostril twice a day with a scheduled administration time of 9:00am and 8:00pm.
-Fluticasone was documented as administered at 9:00am from 05/01/22-05/04/22, 05/06/22-05/18/22, 05/20/22-05/29/22, and 05/31/22.
-There was an exception documented on 05/05/22 as resident refused, on 05/19/22 as resident out of the facility, and on 05/30/22 as awaiting pharmacy delivery at 12:30pm.
-Fluticasone was documented as administered at 8:00pm from 05/01/22-05/31/22; there were no exceptions documented.
-There were 118 sprays documented as administered.

Review of Resident #4's June 2022 eMAR revealed:
-There was an entry for fluticasone instill 1 spray in each nostril twice a day with a scheduled administration time of 9:00am and 8:00pm.
-Fluticasone was documented as administered at 9:00am from 06/01/22-06/07/22 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 101	D 358		

06/09/22-06/14/22; there was an exception on 06/08/22 as the resident refused.
-Fluticasone was documented as administered at 8:00pm from 06/01/22-06/13/22; there were no exceptions documented.
-There were 50 sprays documented as administered.

Observation of Resident #4's medication on hand on 06/14/22 at 10:21am revealed:
-There was a bottle of Fluticasone nasal spray with the direction to instill one spray in each nostril twice daily with a dispense date of 05/30/22.
-There was documentation the bottle was opened on 06/09/22.

Telephone interview with a representative from the facility's contracted pharmacy on 06/14/21 at 2:26pm revealed:
-Resident #4's Fluticasone was dispensed on 01/14/22, 03/18/22, and 05/30/22.
-Each dispensing was a 30-day supply (120 metered spray) based on the order to use two sprays in each nostril twice daily for a total of 4 sprays per day.

Interview with Resident #4's primary care provider (PCP) on 06/16/22 at 3:08pm revealed:
-Resident #4 was ordered Fluticasone to help with allergies, including a runny nose.
-Fluticasone was a medication that had to be administered consistently to be effective.
-She expected Resident #4's medication to be administered as ordered.

Interview with Resident #4 on 06/15/22 at 3:12pm revealed:
-She was ordered a nasal spray because of allergies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 102 -She was not administered her nasal spray every day; it depended on which medication aide (MA) was working. -She was supposed to use her nasal spray twice a day. -She felt better when she used the nasal spray twice a day. Interview with a MA on 06/16/22 at 3:51pm revealed: -She administered Resident #4's Fluticasone when she worked. -Resident #4 had never refused her Fluticasone. -She did not know how long a bottle of Fluticasone lasted. -She did not know why Resident #4's Fluticasone was not ordered monthly if each dispensing was for a one-month supply. Interview with the Resident Care Coordinator (RCC) on 06/20/22 at 8:00am revealed: -Fluticasone was a nasal spray; she did not know how long each bottle would last. -She did not know why Resident #4's Fluticasone had not been ordered monthly if the medication only lasted one month based on Resident #4's order. -She was concerned Resident #4's Fluticasone had not been administered correctly. -She had not had a chance to do a cart audit since she started to work at the facility "a couple of weeks ago." Interview with the Administrator on 06/20/22 at 12:20pm revealed: -Resident #4's Fluticasone was ordered for a reason, and she expected the medication to be administered and documented. -She was concerned without the Fluticasone being administered correctly, Resident #4's care	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 103 was not being managed. Refer to the interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm. Refer to the interview with the Administrator on 06/20/22 at 5:22pm. 3. Review of Resident #1's current FL-2 dated 03/08/22 revealed: -Diagnoses included alcohol induced dementia, muscle weakness, venous thrombosis, muscle weakness and transient ischemic attack (TIA). -Resident #1 resided on the Special Care Unit (SCU). a. Review of Resident #1's current FL-2 dated 03/08/22 revealed there was an order for lactulose (used to treat liver disease) 10g/15ml (45ml or 30g) administered twice daily. Review of Resident #1's signed physician orders dated 05/11/22 revealed an order for lactulose solution 10g/15mL administer 45ml(30g) twice daily. Review of Resident #1's April 2022 e MAR revealed: -There was an entry for lactulose solution 10g/15ml administer 45mL(30g) twice daily at 8:00am and 8:00pm. -There was documentation lactulose 45mL(30g) was administered at 8:00am 30 of 30 opportunities from 04/01/22 to 04/30/22. -There was documentation lactulose 45mL(30g) was administered at 8:00pm 30 of 30 opportunities from 04/01/22 to 04/30/22. Review of a physicians visit note for Resident #1	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 104 dated 04/06/22 revealed: -Under a note for elevated liver enzymes there was documentation the physician was unsure if there was chronic or acute elevation. -Ammonia was within normal levels. -Lactulose remained on the eMAR. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for lactulose solution 10g/15ml administer 45mL(30g) twice daily at 8:00am and 8:00pm. -There was documentation lactulose 45mL(30g) was administered at 8:00am 31 of 31 opportunities from 05/01/22 to 05/31/22. -There was documentation lactulose 45mL(30g) was administered at 8:00pm 31 of 31 opportunities from 05/01/22 to 05/31/22. Review of Resident #1's 06/01/22 to 06/14/22 eMAR revealed: -There was an entry for lactulose solution 10g/15ml administer 45mL(30g) twice daily at 8:00am and 8:00pm. -There was documentation lactulose 45mL(30g) was administered at 8:00am 14 of 14 opportunities from 06/01/22 to 06/14/22. -There was documentation lactulose 45mL(30g) was administered at 8:00pm 13 of 13 opportunities from 06/01/22 to 06/14/22. Observation of Resident #1's medication on hand on 06/14/22 at 10:59am revealed: -There was a 473ml bottle of lactulose solution 10g/15mL. -The dispense date was 05/15/22 and the bottle was three-fourths full. -The bottle was opened but there was not an open date noted on the bottle.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 105 Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/15/22 at 10:31am revealed: -There was a current order for lactulose 10g/15ml administer 45ml or 30g twice daily. -The last two dispense dates for lactulose 10g/15ml were 02/28/22 and 05/15/22; a five-day supply was dispensed on each date. -Lactulose was not on an autofill schedule; the facility had to submit a request for refill from the pharmacy. -Lactulose was used to remove ammonia from the liver to treat hepatic encephalopathy (loss of brain function when the liver does not remove toxins from the blood). -An outcome of not administering the lactulose as ordered could be untreated liver disease and the risk of complications of hepatic encephalopathy due to increased ammonia levels. Interview with Resident #1's primary care provider (PCP) on 06/15/22 at 11:15am revealed: -Resident #1 was ordered lactulose to lower ammonia levels. -Resident #1's ammonia levels were checked on 04/02/22 and were 41 micromol/L which was within normal range. -Possible outcomes of Resident #1's lactulose not being administered as ordered could be increased ammonia levels and encephalopathy of the brain which could cause increased confusion. -She expected the facility to follow the orders for lactulose as written for Resident #1. Interviews with a medication aide (MA) on 06/14/22 at 10:59am and 3:50pm revealed: -Resident #1 did not refuse his medications including the lactulose. -The lactulose smelled bad, but she would mix it with a beverage, and he would drink it without a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 106	D 358		

problem.
-She administered his lactulose every day as ordered.
-She did not know why there was a 3/4 full bottle from 05/15/22 available for administration.

Interview with another MA on 06/20/22 at 3:10pm revealed:
-She administered Resident #1's lactulose as ordered when she worked.
-Resident #1 did not refuse the lactulose.
-She poured the lactulose into a small measured medication cup and administered it during his meals; he would drink it while he was eating.
-She did not know why there was still a 3/4 full bottle of lactulose from 05/15/22; she did not know how long the bottle of lactulose should have lasted.
-The lactulose was not on an autofill schedule but had to be ordered from the pharmacy by the MAs before it ran out.

Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm revealed:
-She was not aware Resident #1 had an almost full bottle of lactulose that was dispensed on 05/15/22.
-Based on his current order there should have not been any left; the dose should not have lasted more than seven days if it had been administered as ordered.
-Resident #1 was not administered his lactulose based on the amount of lactulose that remained in the bottle.
-Documentation of administration of a medication without administering the medication was considered a medication error.
-She expected the MAs to administer Resident #1 his medication as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 107 Interview with the Administrator on 06/20/22 at 5:22pm revealed: -She expected the MAs to administer all medication as ordered, including Resident #1's lactulose. -If Resident #1 had a full bottle of lactulose available for administration from 05/15/22 then he was not administered the medication as ordered. Based on dispense dates it was derterminded Resident #1 was not administered his lactulose solution 10g/15ml fifty-five doses from 05/17/22 to 06/14/22. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm. Refer to interview with the Administrator on 06/20/22 at 5:22pm. b. Review of Resident #1's current FL-2 dated 03/08/22 revealed there was an order for hydrocortisone (used to reduce itching related to skin rashes) 1% topical cream, apply to face once every twelve hours. Review of Resident #1's signed physician orders dated 05/11/22 revealed an order for hydrocortisone cream 1% ; apply topically to rash on face every twelve hours at 8:00am and 8:00pm. Review of Resident #1's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocortisone cream	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 108 1%; apply topically to rash on face every twelve hours at 8:00am and 8:00pm. -There was documentation hydrocortisone cream was applied at 8:00am 30 of 30 opportunities from 04/01/22 to 04/30/22. -There was documentation hydrocortisone cream was applied was administered at 8:00pm 30 of 30 opportunities from 04/01/22 to 04/30/22. Review of Resident #1's May 2022 eMAR revealed: -There was an entry for hydrocortisone cream 1%; apply topically to rash on face every twelve hours at 8:00am and 8:00pm. -There was documentation hydrocortisone cream was applied at 8:00am 31 of 31 opportunities from 05/01/22 to 05/31/22. -There was documentation hydrocortisone cream was applied at 8:00pm 31 of 31 opportunities from 05/01/22 to 05/31/22. Review of Resident #1's 06/01/22 to 06/14/22 eMAR revealed: -There was an entry for hydrocortisone cream 1%; apply topically to rash on face every twelve hours at 8:00am and 8:00pm. -There was documentation hydrocortisone cream was applied at 8:00am 14 of 14 opportunities from 06/01/22 to 06/14/22. -There was documentation hydrocortisone cream was applied at 8:00pm 13 of 13 opportunities from 06/01/22 to 06/14/22. Review of Resident #1's physician's visitation summary dated 05/30/22 revealed: -Resident #1 was treated for unspecified atopic dermatitis on his face and along his hairline. -Continue with hydrocortisone cream to face twice daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 109	D 358		

Observation of Resident #1's medication on hand on 06/14/22 at 10:59am revealed:
-There was a one-ounce tube of hydrocortisone 1% cream dispensed on 05/15/22.
-The tube was full and did not have an opened date documented on the tube.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/15/22 at 10:31am revealed:
-There was a current order for hydrocortisone 1% cream apply topically to rash on face every twelve hours.
-The last two dispense dates for the hydrocortisone cream were 02/28/22 and 05/15/22; a seven to ten-day supply was dispensed each date.
-About 1gm of hydrocortisone cream should have been applied for each administration and the cream would have only lasted seven to ten days depending on how much was applied each time.
-Hydrocortisone cream was not on an autofill schedule; the facility had to submit a request for refill from the pharmacy.
-Hydrocortisone cream was used to treat a rash or dermatitis on the skin.
-An outcome of not applying the hydrocortisone cream as ordered could be continued skin irritation including itching and scratching that could aggravate the condition.

Interview with Resident #1's primary care provider (PCP) on 06/15/22 revealed:
-Resident #1 was ordered hydrocortisone 1% cream for a rash on his face.
-Hydrocortisone cream calmed the skin down so there was not irritation and scratching.
-A possible outcome of the hydrocortisone cream not applied as ordered could be worsening of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 110	D 358		

rash, increased scratching and infection.
-She expected the facility staff to apply the hydrocortisone cream to Resident #1 as ordered.

Interviews with a medication aide (MA) on 06/14/22 at 10:59am and 3:50pm revealed:
-She applied Resident #1's hydrocortisone cream to his face after he woke up in the mornings.
-Resident #1 did not refuse his medications and would let her apply the cream.
-She did not know why there was still a full tube from 05/15/22 available for administration; maybe there was another tube that was used first.

Interview with another MA on 06/20/22 at 3:10pm revealed:
-She applied Resident #1's hydrocortisone cream to his face after his bath; Resident #1 was bathed every day.
-Resident #1 let her apply the cream to his face without resistance but she did not know about the other MAs.
-She did not date the tubes as she opened them.
-She did not know why there was still a full tube of hydrocortisone cream from 05/15/22; she did not know how long the tube of hydrocortisone cream should have lasted.
-The hydrocortisone cream was not on an autofill schedule and had to be ordered from the pharmacy by the MAs before it ran out.
-She had not ordered the hydrocortisone cream from the pharmacy.

Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm revealed:
-She was not aware Resident #1 had a full tube of hydrocortisone 1% cream that was dispensed on 05/15/22.
-Based on his current order there should have not been any left; the dose should not have lasted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 111	D 358		

more than a week or two if it had been administered as ordered.
-Resident #1's hydrocortisone cream was not applied as ordered based on the amount that remained in the tube.
-Documentation of administration of a medication without administering the medication was considered a medication error.
-She expected the MAs to administer Resident #1 his medication as ordered.

Interview with the Administrator on 06/20/22 at 5:22pm revealed:
-She expected the MAs to administer all medication as ordered, including applying creams like Resident #1's hydrocortisone 1% cream.
-If Resident #1 had a full tube of hydrocortisone cream available for administration from 05/15/22 then he was not administered the medication as ordered.

Based on dispense dates it was determinded Resident #1 was not administered his hydrocortisone 1% cream fifty-seven doses from 05/16/22 to 06/14/22

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

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm.

Refer to interview with the Administrator on 06/20/22 at 5:22pm.

4. Review of Resident #2's current FL-2 dated 01/18/22 revealed diagnoses included unspecified dementia, and hypertension.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 112 a. Review of a signed physician order for Resident #2 dated 02/09/22 revealed an order for Tylenol (use to relieve pain) 325mg three tablets take three times daily. Review of a signed physician order for Resident #2 dated 04/1/22 revealed an order to discontinue previous order of Tylenol 325mg three tablets three times a day and begin Tylenol 325mg take two tablets three times daily. Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tylenol 325mg three tablets scheduled three times daily at 8:00am, 12:00pm and 8:00pm. -Tylenol 325mg take three tablets was documentation as administered at 8:00am from 04/01/22 to 04/04/22. -Tylenol 325mg take three tablets was documentation as administered at 12:00pm from 04/01/22 to 04/03/22. -There was an entry for Tylenol 325mg take three tablets three times daily scheduled at 8:00am, 12:00pm and 8:00pm -Tylenol 325mg take three tablets was documentation as administered at 8:00pm from 04/01/22 to 04/03/22. -There was an entry for Tylenol 325mg take two tablets three times daily scheduled at 8:00am, 12:00pm and 8:00pm. -Tylenol 325mg take two tablets three times daily was documentation as administered beginning at 12:00pm from 04/03/22 to 04/30/22. Review of Resident #2's May 2022 eMAR revealed: -There was an entry for Tylenol 325mg take two tablets three times daily scheduled at 8:00am,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 113	D 358		

12:00pm and 8:00pm.
-Tylenol 325mg was documented as administered at 8:00am, 12:00pm and 8:00pm 31 of 31 opportunities from 05/01/22 to 05/31/22.

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry for Tylenol 325mg take two tablets three times daily scheduled at 8:00am, 12:00pm and 8:00pm
-Tylenol 325mg was documented as administered at 8:00am 14 of 14 opportunities from 06/01/22 to 06/14/22.
-Tylenol 325mg was documented as administered at 12:00pm and 8:00pm 13 of 13 opportunities from 06/01/22 to 06/14/22.

Observation of Resident #2's medication on hand on 06/15/22 at 3:01pm revealed there was no Tylenol 325mg available for administration.

Observation of the facility's house stock medication on 06/20/22 at 3:10pm revealed:
-There were five bottles of generic over the counter brand Tylenol on hand.
-Each bottle contained one hundred acetaminophen 500mg tablets.

Telephone interview with a pharmacist from Resident #2's contracted pharmacy on 06/17/22 at 10:58am revealed:
-Tylenol 325mg was last dispensed from the pharmacy on 02/12/22; 300 tablets were dispensed.
-Resident #2's medication was not on an autofill, so the facility had to contact the pharmacy to reorder any medication for Resident #2.
-The facility ordered Tylenol 325mg two tablets scheduled three times daily on 06/14/22.
-The Tylenol ordered by the facility on 06/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 114	D 358		

would be sent via mail and would take a few days to arrive at the facility; the facility should have ordered medications for Resident #2 before they ran out.
-He did not know why Resident #2 was ordered Tylenol but it was usually used to treat for moderate to chronic pain.
-An outcome of Resident #2's Tylenol not administered as ordered could be increased pain and discomfort.

Telephone interview with a pharmacist from Resident #2's backup pharmacy on 06/17/22 at 11:30am revealed:
-They had entered the order for Resident #2's Tylenol 325mg onto the eMAR for the facility.
-Resident #2's current order was Tylenol 325mg take two tablets scheduled three times daily.
-They had never dispensed Tylenol 325mg for Resident #2.

Interview with a medication aide (MA) on 06/20/22 at 3:10pm revealed:
-She used the house stock of Tylenol to administer to Resident #2 for his scheduled Tylenol 325mg two tablets twice a day.
-She always used the house stock of Tylenol to administer Resident #2's Tylenol three times daily because his contracted pharmacy did not always supply it when needed.
-She had ordered Resident #2's Tylenol from both his contracted pharmacy and his back up pharmacy.
-Resident #2's contracted pharmacy would dispense the Tylenol in a large bottle.
-Resident #2's backup pharmacy would dispense Tylenol for Resident #2 in a large bubble package if it were dispensed from there; she did not think the backup pharmacy had ever dispensed Tylenol for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 115 -There was always plenty of house stock Tylenol to administer to Resident #2. -She did not know what the dosage was for Resident #2's Tylenol, she thought it was the same as the house stock. Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm revealed: -She knew Resident #2's Tylenol was two 325mg tablets three times a day. -Resident #2 should have had a bubble package of Tylenol 325 or a bottle of Tylenol 325mg dispensed for a scheduled medication. -The facility's house stock of Tylenol was a 500mg and was the incorrect dosage. -If the MAs were using the house stock with the wrong dosage then it was a medication error. -She did not think the house stock Tylenol was being administered to Resident #2 by the MAs because the facility's house stock would have been depleted. -She expected the MAs to administer medications as ordered. Interview with the Administrator on 06/20/22 at 5:22pm revealed: -She expected the MAs to administer all medication as ordered, including Resident #2's Tylenol 325mg. -Resident #2's scheduled medications should have been ordered from his pharmacy. -The MAs should not have used the house stock of Tylenol to administer to Resident #2 because it was the incorrect dosage. Attempted telephone interview with Resident #2's primary care provider on 06/17/22 at 10:51am was unsuccessful. Based on observations, interviews and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 116	D 358		

reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm.

Refer to interview with the Administrator on 06/20/22 at 5:22pm.

b. Review of Resident #2's current FL-2 dated 01/18/22 revealed there was an order for Senna glycoside (used to treat constipation) 8.6-50mg twice daily.

Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Senna glycoside 8.6-50mg two tablets scheduled twice daily at 8:00am and 8:00pm.
-Senna glycoside was documented as administered at 8:00am and 8:00pm 30 of 30 opportunities from 04/01/22 to 04/30/22.

Review of Resident #2's May 2022 eMAR revealed:
-There was an entry for Senna glycoside 8.6-50mg two tablets scheduled twice daily at 8:00am and 8:00pm.
-Senna glycoside was documented as administered at 8:00am and 8:00pm 31 of 31 opportunities from 05/01/22 to 05/31/22.

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry for Senna glycoside 8.6-50mg two tablets scheduled twice daily at 8:00am and 8:00pm.
-Senna glycoside was documented as administered at 8:00am 14 of 14 opportunities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 117	D 358		

from 06/01/22 to 06/14/22.
-Senna glycoside was documented as administered at 8:00pm 13 of 13 opportunities from 06/01/22 to 06/14/22.

Observation of Resident #2's medication on hand on 06/15/22 at 3:01pm revealed there was no Senna glycoside 8.6-50mg available for administration.

Telephone interview with a pharmacist from Resident #2's contracted pharmacy on 06/17/22 at 10:58am revealed:
-Senna glycoside 8.6-50mg had never been dispensed from the pharmacy.
-They did not have an order for Senna glycoside 8.6-50mg for Resident #2.

Telephone interview with a pharmacist from Resident #2's backup pharmacy on 06/17/22 at 11:30am revealed:
-They did not have an order for Senna glycoside 8.6-50mg for Resident #2.
-Senna glycoside 8.6-50mg had never been dispensed from the pharmacy.

Interview with a medication aide (MA) on 06/20/22 at 3:10pm revealed:
-Resident #2 had run out of his Senna glycoside 8.6-50mg the day before.
-She administered his medications as ordered and if he had an order for the medication it should be on the cart.
-She could order medication from the pharmacy or the Memory Care Manager (MCM) could order it.
-Resident #2 was never constipated that she was aware of.

Interview with the MCM on 06/20/22 at 4:03pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 118 revealed: -Resident #2's Senna glycoside should have been ordered from the back up pharmacy if the contracted pharmacy did not dispense it. -The back up pharmacy should have received the order from his FL2 or a signed physician's order. -She was concerned he was not receiving his medication as ordered because it was ordered for a reason. -Senna glycoside was a laxative and she was concerned Resident #2 might have experienced constipation from the medication not being administered. -She expected the MAs to administer the medications as ordered and if a medication was not available for administering, they should have contacted the pharmacy for a refill. -If it was not available for administering and it was documented all this time as administered then she considered it a medication administration error. Interview with the Administrator on 06/20/22 at 5:22pm revealed: -She expected the MAs to administer all medication as ordered, including Resident #2's Senna glycoside. -Resident #2's scheduled medications should have been ordered from his pharmacy. -The MAs should not have reordered the medication or questioned why it was on the eMAR but not on the cart. Attempted telephone interview with Resident #2's primary care provider on 06/17/22 at 10:51am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 119 Refer to interview with the MCM on 06/20/22 at 4:03pm. Refer to interview with the Administrator on 06/20/22 at 5:22pm. _____ Interview with the Memory Care Manager (MCM) on 06/20/22 at 4:03pm revealed: -Cart audits had not been done since she started working at the facility three weeks ago. -The MAs should do audits daily on the medication cart. -The MAs were inventorying, counting and documenting medications that were available for administration on a printout of the signed physician orders. -The MAs should have caught missing medication when they did the cart audits and inventory counts. -There was training scheduled for the MAs related to medication cart audits, but it had not begun. Interview with the Administrator on 06/20/22 at 5:22pm revealed: -If medication was not administered as ordered there could be terrible outcomes and deadly errors. -None of the medication errors should have happened; steps were in place to prevent the errors and steps should have been taken to prevent errors from happening. -The cart audit process had been developed by the MCM, but she did not think it had begun. -The MAs should conduct cart audits weekly so that every medication for every resident on the cart could be reconciled. -The audits should be turned into the MCM for her to verify the audit numbers.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 120 -The only way the MCM would be able to ensure medications had been administered as ordered would be by doing a medication reconciliation. -A medication reconciliation would look at the amount of medication on hand and compare the amount on hand with the electronic medication administration record (eMAR). _____ The facility failed to ensure medications were administered as ordered for 4 of 5 sampled residents for record review including errors related to a resident (#3) not receiving a medication used to treat aggressive behaviors as ordered resulting in the resident having an altercation with another resident and was sent to the emergency department (ED) for behaviors and the ED mental health provider ordered an additional medication to treat behaviors and was also not administered as ordered and resulted in another altercation with a resident and five days later a second ED admission for behaviors; a resident (#4) who had a history of chronic obstructive pulmonary disease and allergies was not administered her inhaler and nasal spray as ordered; a resident (#1) who had alcohol induced dementia and was ordered an ammonia reducer and had aggitation which could have resulted from increased ammonia levels and who was also ordered a cream for a rash to his face that was not administered as ordered; and a resident (#2) who had an order for Tylenol 375mg but was administered 500mg three times daily. The facility's failure to administer medications as ordered placed the residents at substantial risk of physical harm and neglect which constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/22 for this violation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 14 of 18 shifts sampled from 06/11/22-06/16/22. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including a special care unit (SCU) with a capacity of 48 beds. Review of the facility's resident census report revealed the SCU census was 33 from 06/11/22-06/16/22 which required 33 aide hours on first and second shifts and 26.4 hours on third shift. Review of staff timecards dated 06/11/22 revealed: -There was a total of 24 staff hours provided on	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 122	D 465		

first shift leaving a shortage of 9 hours.
-There was a total of 12.51 staff hours provided on second shift leaving a shortage of 20.49 hours.
-There was a total of 8.0 hours provided on third shift leaving a shortage of 18.4 hours.

Review of staff timecards dated 06/12/22 revealed:
-There was a total of 8 staff hours provided on first shift leaving a shortage of 25 hours.
-There was a total of 17.89 staff hours provided on second shift leaving a shortage of 15.11 hours.

Review of staff timecards dated 06/13/22 revealed:
-There was a total of 8 staff hours provided on first shift leaving a shortage of 25 hours.
-There was a total of 13.71 staff hours provided on second shift leaving a shortage of 19.29 hours.
-There was a total of 16 hours provided on third shift leaving a shortage of 10.4 hours.

Review of an incident report dated 06/13/22 revealed:
-The incident occurred at 12:10pm in the dining room.
-A resident, who was agitated, had an altercation with another resident.
-The incident was witnessed by staff.

Interview with a PCA on 06/16/22 at 2:40pm revealed:
-When she came in on 06/13/22, she was the only PCA in the SCU at 7:00am.
-If there was more staffing, incidents would not have happened with resident-to-resident altercations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 123 Review of staff timecards dated 06/14/22 revealed: -There was a total of 18 staff hours provided on first shift leaving a shortage of 15 hours. -There was a total of 28.14 staff hours provided on second shift leaving a shortage of 4.86 hours. -There was a total of 12.12 hours provided on third shift leaving a shortage of 14.28 hours. Review of staff timecards dated 06/15/22 revealed there was a total of 22.75 hours provided on third shift leaving a shortage of 3.65 hours. Review of staff timecards dated 06/16/22 revealed: -There was a total of 18.45 staff hours provided on second shift leaving a shortage of 14.55 hours. -There was a total of 14.11 hours provided on third shift leaving a shortage of 12.29 hours. Interviews with a personal care aide (PCA) on 06/15/22 at 7:50am and 8:59am revealed: -She was the only PCA working in the SCU on 06/15/22; she did not know if anyone else was scheduled to help her. -The facility's scheduler/transport staff was helping her with resident care. -There were other times she had been the only PCA on the SCU, but this was the first time the facility's scheduler/transport staff had helped her. -Usually no one helped her when she was alone in the SCU. -The SCU residents required a lot of personal care assistance; it was a lot of work for one PCA. -She got 11 residents up by herself that morning and the facility's scheduler/transport staff got some up. -Some of the residents did not want to get up for	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 124	D 465		

breakfast.
-Another PCA was scheduled to come in at 11:00am.
-She had to strip the beds that were soiled overnight and remake them.
-She had to get the residents dressed and toileted on her own this morning, 06/15/22.
-She could not bathe the residents since she was alone, so she wiped them down with a wet cloth before getting them dressed.
-The" heavy wetters" were always wet in the morning and needed their beds stripped.
-Third and second shift staff checked on the residents at night but did not get them up to change their incontinent briefs or try to toilet them.
-The "heavy wetter"s were always soiled in the morning and needed to be changed and cleaned up.

Confidential interview with a staff revealed there were altercations with residents on the SCU because there was not enough staff assistance.

Confidential interview with another staff revealed:
-There was no way the residents were being taken care of with one medication aide (MA) and one personal care aide (PCA) in the SCU.
-Staffing was a huge problem at the facility.
-The facility should not move any more residents into the facility until they could get more staff.

Confidential interview with a third staff revealed:
-Residents in the SCU were not getting the help they needed.
-Sometimes the residents could not get a shower even when they needed it.

Confidential interview with a fourth staff revealed:
-The SCU needed at least three PCAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 125	D 465		

-There were times when she worked there were no PCAs.
-Management knew the SCU only had one person working at various times.
-Sometimes the SCU would have one staff for several hours and then other staff would come in.

Interview with another PCA on 06/16/22 at 9:26am revealed:
-If there were more staff, the staff could keep a better eye on the residents (supervise).
-It was hard to care for the residents and keep an eye on them when there were only two staff.

Interview with a PCA on 06/16/22 at 1:20pm revealed:
-One day last week, she thought on 06/09/22, there were only 2 PCAs in the SCU working.
-One day recently she was the only PCA in the building (she did not recall the date).
-She came in all the time on the first shift and all the residents would be wet; there would only be one person who worked on the third shift in the SCU.
-She came in one day recently, she did not recall what day, but the MA was the only staff in the SCU; the residents' beds were soaking wet, and she had to apologize to the residents.
-More than once the residents were soaking wet and the residents should not have to smell themselves.
-The residents apologized to the staff when they had soiled their briefs and the residents should not have to do that.

Interview with a MA on 06/16/22 at 3:57pm revealed:
-She usually worked 7:00am-7:00pm.
-The SCU had one, two, or three PCAs working.
-About three weeks ago, she worked with 1-2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 126	D 465		

PCAs
-One time recently she was the only staff from 3:00pm-6:00pm.
-She called management and was told someone would be in at 7:00pm.

Telephone interview with a MA on 06/17/22 at 12:47pm revealed:
-She worked 7:00pm-7:00am.
-The facility had staffing issues.
-There were times there were two PCAs in the SCU but three PCAs were needed based on the census.
-It took her 2-4 hours to complete her medication pass and she had other responsibilities, including processing medications that were delivered on her shift.
-She also assisted with laundry for the residents and cleaning.
-Third shift staff also did the linens from the 1st and 2nd shifts.
-She had not assisted the PCAs with any personal care.

Interview with another MA on 06/20/22 at 7:27am revealed:
-Staff came to work and just left when they wanted to.
-She had worked by herself at least 7 hours before.
-She had been late doing medication passes because she was doing personal care for the residents.

Telephone interview with a third MA on 06/20/22 at 1:39pm revealed:
-When the SCU was fully staffed, there were better outcomes.
-Staff did not show up when they were scheduled to work.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 127	D 465		

-Staff were on their personal phones during work.
-Sometimes she did not know where the staff was and what they were doing.

Interview with the MCM on 06/20/22 at 4:03pm revealed:
-She did not prepare the schedule; the Administrator did.
-She did not know how many staffing hours the SCU required.
-She saw staff standing around on their phones so the SCU could not have been short if they had time to play on their phones.
-She did not remember the SCU being short when she worked Monday through Friday; she worked eight hours a day.
-Her hours were counted as a PCA on the floor if there was a staff shortage.
-She had helped to get residents up in the mornings, but she had not worked as a PCA since she began three weeks ago because the SCU had not been short PCAs.
-She had worked on the medication cart administering medications, but she could not recall when.
-Staff had not came to her to complain about being short staffed or asked for help so she had not helped with residents.

Interview with the Administrator on 06/20/22 at 5:51pm revealed:
-She prepared the schedule for the facility staff, including the SCU.
-There was always coverage and enough hours for MAs and PCAs when she did the schedule, but staff called off or came in late or left early and it would affect the staffing hours on the SCU schedule.
-She knew there were supposed to be more staffing hours in the SCU than she had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 128	D 465		

running but she did not know what to do to prevent the shortages created by staff.
-Staff would fail to notify her they were calling off, leaving early or coming in late and she would not know about the shortage of hours until she did the timecards.
-She had worked as a MA last week and the week before.
-She had worked the overnight shift in the SCU as a PCA over a weekend from Friday to Sunday two weeks ago.
-She had done laundry, changed residents' incontinent briefs, bathed two residents a day and made beds.
-She was concerned residents might not be properly taken care of due to the staff shortages in the SCU.

Refer to Tag D0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation).

Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2Violation).

_____

The facility failed to ensure there was enough staff on the Special Care Unit (SCU) to meet the required staffing hours and the needs of the residents. There were not enough staff members present on the unit to properly supervise residents with behaviors on 06/13/22, which resulted in an altercation between two residents and one was sent to the hospital to be evaluated. The facility's failure resulted in a substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation.

_____

The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on June

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 129 20, 2022 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2022.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 130 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure that 5 of 5 sampled staff (Staff A, B, C, D and E) completed the required 6 hours of orientation training within the first week of working in the Special Care Unit (SCU) and 20 hours of training within the first 6 months of working in the SCU. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -Staff A was hired on 03/01/21. -There was no documentation Staff A completed 6.0 hours of special care unit (SCU) training in her first week of employment. -There was no documentation Staff completed 20 hours of SCU training during her first 6 months of employment. -There was documentation Staff A completed 3.5 hours of SCU training in November 2021. -There was documentation Staff A completed 3.9 hours of SCU training in April 2022. Attempted interview with Staff A on 6/20/22 at 4:12pm was unsuccessful. Refer to interview with the Administrator on 06/20/22 at 6:25pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 12/22/21. -There was no documentation Staff B completed 6.0 hours of SCU training in her first week of employment.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 131 -There was no documentation Staff B completed 20 hours of SCU training during her first 6 months of employment. -There was documentation Staff B completed 3.4 hours in April 2022. -There was documentation Staff B completed 3.0 hours of SCU training in May 2021. -There was documentation Staff B completed 1.0 hour of SCU training in June 2021. -There was documentation Staff B completed 1.0 hour of SCU training in July 2021. -There was documentation Staff B completed 1.0 hour of SCU training in October 2021. Interview with Staff B on 06/20/22 at 4:15pm revealed: -She was transferred from a sister facility last December 2021. -She was asked by the Memory Care Manager (MCM) to work the SCU but not told she needed to have SCU training to work with the residents. -When the last Administrator came to the facility, she was told she needed to take the computer classes to work in the SCU and she was assigned the training. -She was not aware of the number of hours of SCU training she needed and did not think to ask since the MCM assigned the classes. -She completed the assigned trainings but was not asked to do more. -She was needed to work in the SCU due to the shortage of staff. -If they had more staff to work in the SCU, they could take better care of the residents and staff could complete their SCU training. Refer to interview with the Administrator on 06/20/22 at 6:25pm. 3. Review of Staff C's, personal care aide (PCA),	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 132	D 468		

personnel record revealed:
-Staff C was hired on 07/19/19.
-There was no documentation Staff C completed 6.0 hours of SCU training in her first week of employment.
-There was no documentation Staff C completed 20 hours of SCU training during her first 6 months of employment.
-There was no documentation of SCU training prior to 04/24/22.
-There was documentation Staff C completed 3.9 hours of SCU training in April 2022.
-There was documentation Staff C completed 0.75 hours of SCU training in June 2022.

Attempted interview with Staff C on 06/20/22 at 4:40pm was unsuccessful.

Refer to interview with the Administrator on 06/20/22 at 6:25pm.

4. Review of Staff D's, personal care aide (PCA), personnel record revealed:
-Staff D was hired on 01/15/19.
-There was no documentation Staff D completed 6.0 hours of SCU training in her first week of employment.
-There was no documentation Staff D completed 20 hours of SCU training during her first 6 months of employment.
-There was no documentation of SCU training prior to 05/01/22.
-There was documentation Staff D completed 3.4 hours of SCU training in May 2022.

Interview with Staff D on 06/20/22 at 4:45pm revealed:
-She had some SCU training since starting to work at the facility and was given a listing of classes to do by computer when the class

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 133	D 468		

popped up on the screen.
-She could not choose the classes; the decision was made by the corporation management.
-She was never told how many hours of SCU training were required before working in the SCU and afterwards.
-She was not given the time to do the classes at work because of the lack of staff to care for residents.

Refer to interview with the Administrator on 06/20/22 at 6:25pm.

5. Review of Staff E's, personal care aide (PCA), personnel record revealed:
-Staff E was hired on 08/16/21.
-There was no documentation Staff E completed 6.0 hours of SCU training in her first week of employment in August 2021.
-There was no documentation Staff E completed 20 hours of SCU training during her first 6 months of employment.
-There was no documentation Staff E had any SCU training before working with SCU residents.

Interview with Staff E on 06/20/22 at 5:00pm revealed:
-Staff E starting work on the Assisted Living Unit before going to the SCU.
-She was given a list of computer classes to complete that were chosen by the MCM and Administrator.
-She was never told she had to have SCU training and did not know how many hours of SCU training were needed but she was not given the time to do the classes as she was doing resident care during her shift.

Refer to interview with the Administrator on 06/20/22 at 6:25pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 134 Interview with the Administrator on 06/20/22 at 6:25pm revealed: -Staff were not specifically hired to work in the SCU. -All staff were cross trained to work on the AL and the SCU. -When a new hire started working, they were educated using a computer training system based on the roles of the PCA and MA positions for AL and the SCU. -The training system was automated to show the classes each staff completed. -The corporate office was aware of the lack of training hours staff received by reading the reports. -She was constantly trying to have staff on the SCU complete their hours of training. -They had not offered group training to staff due to the need for staff to be on the floor for resident care. -Staff could not be pulled away from their assigned duties for resident care to do training classes. -With a lack of training, the SCU staff may not be as knowledgeable of the care needed for the SCU residents and understanding of their behaviors. Refer to Tag D0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation). Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2Violation). The facility failed to ensure that five staff (A, B, C, D and E) working in the Special Care Unit received their 6 hours of SCU orientation trainig	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 135 within one week of starting work in the SCU and 20 hours of SCU trainig within the first 6 months of working in the SCU which led to staff not having the required training and skills to care for residents' needs and behaviors which was deterimental to the safety and welfare of the residents who resided in the SCU and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on June 29, 2022 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 18, 2022.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, activities program, personal care and supervision, discharge of residents, and special care unit staff orientation and training. . The findings are:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 136 1. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up to meet the healthcare needs for 2 of 6 sampled residents (#3, #6) related to a resident needing a dental appointment and eye appointment (#3), and a resident, who had a foot disorder causing yellowed, curled, jagged, elongated nails and feet disfigurement and needed podiatry care (#6). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 14 of 18 shifts sampled from 06/11/22-06/16/22. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type A2 Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to provide personal care for 4 of 4 sampled residents (#1, #6, #7 and #8) related to incontinence care (#1, #6, #7) and grooming hair and changing clothes (#8). [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure activities were provided daily that engaged the residents, resulting in increased agitation by a resident who had altercations with another resident and who was ordered participation in facility activities by the physician (#1). [Refer to Tag D315, 10A NCAC 13F .0905 Activities Program (Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 137 5. Based on interviews and record reviews, the facility failed to ensure an orderly discharge and notification to the legal guardian of the reason for the discharge for 1 of 1 sampled residents (Resident #3) who was discharged to a local hospital after being sent to the emergency department for an evaluation. [Refer to Tag D230, 10A NCAC 13F .0702 Discharge Of Residents (Type B Violation). 6. Based on record reviews and interviews, the facility failed to ensure that 5 of 5 sampled staff (Staff A, B, C, D and E) completed the required 6 hours of orientation training within the first week of working in the Special Care Unit (SCU) and 20 hours of training within the first 6 months of working in the SCU. [Refer to Tag D468, 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to ensure all residents were free from neglect related to medication administration personal care and supervision. The findings are: 1. Based on observations, interviews and record	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001148	A. BUILDING: _____ B. WING _____	R 06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOUSE	2766 GRAND OAKS BOULEVARD BURLINGTON, NC 27215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 138 reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 residents, (#1, #2, #3, and #4) related to two medications used to treat behaviors (#3), an inhaler and a nasal spray (#4) an ammonia reducer and a topical steroid cream (#1), and a laxative and a pain reliever (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (#1 and #3) when it was known by staff that Resident #1, who had a history of dementia and was constantly disoriented, would wander into other residents' rooms, causing another resident to become agitated resulting in an altercation with Resident #3, who had a history of dementia and was intermittently disoriented, and on two other occasions there were altercations between the two residents resulted in Resident #1 being injured. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		