STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey onsite on February 17, 18 and 23, 2021 and desk review on February 19, 22 and 24, 2021 with an exit conference via telephone on February 24, 2021.	D 000		
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 Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 5 residents sampled (#1, #2, #3, #4) including a resident who had six falls resulting in three emergency room (ER) (#2), a resident who had 13 falls within a five month period with four trips to the ER (#1), a resident who had two falls resulting in two ER (#4), and a resident with 3 undocumented falls, one of which resulted in an ER visit (#3). The findings are: Observations on 02/17/21 from 5:49am until 6:12am revealed: -At 5:49am there were 13 residents, 6 with walkers and 5 sitting in wheelchairs, with no staff in the TV room or on the hall. -At 5:56am a personal care aide (PCA) brought a resident in a wheelchair to the TV room; the PCA	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 1	D 270		

immediately left the TV room and returned to the 100 hall.
-At 6:01am a PCA brought a resident in a wheelchair to the TV room and immediately left the TV room.
-A male resident walking with the assistance of a wheeled walker left the TV room.
-A female resident walking with the assistance of a walker entered the TV room.
-There were 15 residents in the TV room with no staff.
-At 6:10am there were 17 residents in the TV room with no staff.
-At 6:12am a PCA brought a resident to the TV room and immediately left the TV room.
-Resident #6 attempted to stand from his wheelchair unassisted and then sat back down in his wheelchair.

Observations on 02/17/21 at 6:31am revealed:
-There was a female resident seated on the sofa at the back of the TV room; the resident was fully leaned over sleeping with her face on the seat cushion.
-There was a second female resident leaned forward in her wheelchair sleeping with her head on her knees.

Observations in the TV room on 02/17/21 between 6:34am - 6:38am revealed:
-There were 21 residents in the TV room.
-There was no staff present in the TV room.
-A resident stood up from his wheelchair holding onto the arm rest of the wheelchair.
-The maintenance staff, who was in the hall and was the closest staff to the TV room, was called to the attention of the resident standing from the wheelchair.
-The maintenance staff approached the resident and told the resident that he needed to sit down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 2	D 270		

-The maintenance staff left the TV room at 6:36am.
-A medication aide (MA) entered the tv room at 6:37am.
-The maintenance staff returned to the TV room with two glasses of orange juice, kneeled beside the resident who stood up from his wheelchair, and gave the resident the juice.

Observation of the hallway outside of the dining room on 02/17/21 at 6:40am revealed the supervisor beginning to line up residents in wheelchairs for meal service.

Observations of the TV room on 02/17/21 from 6:50am until 7:25am revealed:
-At 6:50am there were 24 residents in the TV room, with one PCA.
-At 7:01am the PCA left the TV room and returned at 7:05am pushing a resident in a wheelchair.
-At 7:08am two PCAs came into the TV room and relieved the previous shift PCA.

Interview with a PCA on 02/17/21 at 7:10am revealed:
-There was always to be a staff member in the TV room with the residents because they place high fall risk residents there for increased monitoring.
-If she had to leave the TV room she would be responsible for finding someone to take her place.
-Residents identified as high fall risk are placed on 15 minute checks.

Interview with a personal care aide (PCA) on 02/17/21 at 7:46am revealed:
-There were no specific residents staff had to monitor or check more frequently due to falls.
-Staff had to monitor all residents for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 3 Interview with a PCA on 02/18/21 at 8:56am revealed: -If she was the only staff in the TV room and if a resident needed her assistance to leave the TV room, she would call the supervisor. -"Usually" the MAs were "nearby or on the hall". Interview with a medication aide (MA) on 02/18/21 at 9:53am revealed: -After a resident had a fall, the MA checked the resident for injuries. -The MA put the resident on 24 hour monitoring for pain. -The MA documented in the communication book that the resident was put on 24 hour monitoring. -The MA also told the oncoming shift verbally that the resident was on 24 hour monitoring. Telephone interview with a MA on 02/19/21 at 3:40pm revealed: -Residents who were a "fall risk" and needed toileting assistance were usually put in the TV room after breakfast, lunch, and dinner so staff would "know where they are". -There was supposed to be a staff in the TV room to supervise the residents. -Sometimes there was not a staff in the TV room and residents were placed in the halls. -Staff had been instructed to put residents where the residents could be supervised, and staff could keep an eye on them. Interview with a second MA on 02/19/21 at 3:33pm revealed: -Staff usually placed fall risk residents in the TV room or the front activities room for close monitoring. -The TV room was used to place residents before and after meals.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 4	D 270		

-There was a "floater" staff member that was stationed in the TV room.
-The last time he recalled no "floater" being present in the TV room was approximately 3 days ago.
-When there was not enough staff or when the "floater" got called away residents are left unsupervised in the TV room.
-He was unsure of the total number of residents that would require a floater to be present but would guess 11 or 12.

Interview with a third MA on 02/23/21 at 11:28am revealed:
-Whenever a resident fell they were put on 24 hour acute monitoring.
-If the resident fell and did not have any injury, they would have been put on 24-hour acute monitoring.
-With acute monitoring MAs would have checked the resident's vital signs every shift.
-Staff documented on the acute monitoring form whenever a resident was on acute monitoring after a fall.

Interview with the Resident Care Coordinator (RCC) on 02/17/21 at 11:40am revealed:
-In the morning staff brought most residents to the hallway and TV room because the residents were already dressed and it was easier to see everyone in one room.
-Since the COVID-19 outbreak (December 2020) at the facility, there had been increased confusion with residents tripping over each other in the halls.
-If a resident fell staff were expected to monitor that resident more.
-Monitoring more meant the resident was usually kept up front in the hallway near the front desk.
-The approach to managing each resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 5	D 270		

not the same, it was individualized to the resident.
-Staff should always be in the TV room when residents were in the TV room.

Second interview with the RCC on 02/23/21 at 4:01pm revealed:
-When a resident fell the MA was responsible to check the residents vital signs and for any injuries.
-The MA was responsible for initiating the 24 hour acute monitoring form.
-There was an in house communication book where MAs documented which residents had a fall and were on acute monitoring.
-MAs also communicated verbally shift to shift which residents fell and were on acute monitoring.

1. Review of Resident #2's current FL-2 dated 10/15/20 revealed:
-Diagnoses included dementia, depression and hip pain.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #2's Care Plan dated 10/15/20 revealed:
-Resident #2 ambulated independently with staff supervision.
-Resident #2 used no ambulation devices.

Review of Resident #2's Licensed Health Professional Support (LHPS) review and evaluation completed on 01/20/21 revealed Resident #2 was independent in ambulation and transfers.

a. Review of an Incident/Accident Report for Resident #2 dated 12/23/20 revealed:
-Resident #2 fell from standing at 9:30pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 6	D 270		

-Resident #2 was evaluated by hospice and sent to the Emergency Room (ER) for evaluation.
-Resident #2's injuries included a knot on the back of the head and right elbow.

Review of Resident #2's hospitalization records dated 12/23/20 to 12/24/20 revealed:
-Resident #2 was transported to the ER because of an unwitnessed fall on 12/23/20.
-Resident #2 had an abrasion on the back of his head on the left side of his scalp and a skin tear to his left elbow.
-Resident #2's head CT scan on 12/23/20 showed a subtle collection of blood on the right frontal scalp.

Review of Resident #2's record revealed there was no 24-hour monitoring report for 12/24/20.

b. Review of an Incident/Accident Report for Resident #2 dated 12/27/20 revealed:
-Resident #2 fell from standing and hit his head at 6:00pm.
-Resident #2's injuries included a laceration to the back of his head and right elbow.

Review of Resident #2's hospitalization records dated 12/27/20 to 01/03/21 revealed:
-Resident #2 was transported to the ER because of a witnessed fall on 12/27/20.
-Resident #2 had a 1.5-inch laceration to the back side of his head.
-Resident #2's head CT scan on 12/28/20 showed a small right frontal scalp hematoma (decreased in size since previous exam) and small left parietal scalp hematoma (new since previous exam).
-Resident #2 was admitted to the hospital.
-Resident #2 was discharged from the hospital on 01/03/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 7	D 270		

c. Review of an Incident/Accident Report for Resident #2 dated 01/17/21 revealed:
-Resident #2 had a fall and sat down on his buttocks at 2:00pm.
-He was moving backwards, pulling a chair and fell.
-Resident #2 had no injuries noted.

d. Review of an Incident/Accident Report for Resident #2 dated 01/24/21 revealed:
-He had an unwitnessed fall in his room at 4:45am.
-He was sent to the ER for evaluation.
-His injury from the fall included a gash in the back of his head.
-The report was completed by the MA on duty.

Review of Resident #2's hospitalization records dated 01/24/21 to 01/25/21 revealed:
-He was transported to the ER because of an unwitnessed fall on 01/24/21.
-He had trauma to the back of his head.
-He received staples to his laceration.
-His head CT scan was negative for acute process.
-He was admitted for observation.
-His family member contacted the hospital medical staff and informed them the resident was on hospice and had a DNR order.
-He was discharged from the hospital on 01/25/21.

Review of Resident #2's record revealed there was no 72-hour monitoring report for 01/25/21.

e. Review of Resident #2's Incident/Accident Report dated 01/27/21 revealed:
-He stood up in TV room and fell at 10:28am.
-He hit the wall before hitting the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 8	D 270		

-He was placed back in the chair by facility staff.
-He showed no visible injuries at the time.
-He was placed on 24-hour monitoring.

f. Review of an Incident/Accident Report for Resident #2 dated 02/18/21 revealed:
-He was in the hallway and jumped out of his wheelchair at 7:45am.
-He hit the back of his head and had a skin tear.
-Hospice was notified of the fall and had planned to come assess the resident.
-He was placed on 24-hour monitoring awaiting hospice.

Observation of Resident #2 in his bedroom on 02/18/21 at 11:28am revealed:
-Two MAs were performing wound care to the back of Resident #2's head.
-The MAs stated that Resident #2 fell this morning
-The MAs were not able to provide details related to the fall.

Interview with a MA on 02/18/21 at 11:32am revealed:
-Resident #2 had a fall in the hallway outside of the TV room this morning before breakfast.
-She called the resident's family member and notified hospice of the fall.
-Resident #2 hit the back of his head and had a laceration.
-The fall was unwitnessed.
-The Business Office Manager (BOM) was able to play the video recording of the fall to see what happened.
-The RCC had instructed staff to keep Resident #2 in his room until he was evaluated.

Telephone interview with the RCC on 02/24/21 2:50pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 9	D 270		

-She had spoken with Resident #2's primary care provider (PCP) about adjustments to pain medication to help eliminate falls on 01/08/21.
-She worked with the PCP to make medication regimen changes to help reduce Resident #2's pain after the 01/08/21 fall.
-Resident #2 was placed in a wheelchair since his ambulation status declined in December of 2020.
-Staff would help Resident #2 transfer from the side of the bed to the wheelchair to reduce the risk of falls.
-She had worked with the hospice nurse to get a hospital bed ordered for Resident #2 after the fall on 02/18/21.

Telephone interview with Resident #2's hospice nurse on 02/23/21 at 4:45pm revealed the facility notified hospice of Resident #2's falls and the triage nurse would come to the facility to evaluate the resident.

Telephone interview with the facility's Nurse Practitioner (NP) on 02/24/21 at 3:47pm revealed:
-Resident #2 ambulatory status declined in December 2020.
-Resident #2 was frequently placed in a wheelchair in the TV room for monitoring.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

2. Review of Resident #1's current FL2 dated 10/20/20 revealed:
-Diagnoses included dementia with behavioral disturbance, hypersensivity lung disease, vertigo, hypothyroidism, hypertension, Parkinson's Disease, fall risk and incontinence bladder.
-The resident was constantly disoriented and ambulatory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 10 Review of Resident #1's Care Plan dated 010/14/20 revealed: -The resident had significant loss of memory and must be directed. -The resident had a history of wandering behavior. -The resident needed extensive assistance with toileting, bathing, dressing. -The resident needed supervision with ambulation and transferring. -There was not any notation of the type of assistive device needed to help with ambulation. Observation of Resident #1 in his room on 02/17/21 at 5:59am to 6:03am revealed: -Resident #1 had a low bed. -He was lying on the floor beside his bed. -He tugged at his incontinence brief and tried to get up. -Two PCAs came to assist Resident #1 off of the floor and sat him up on his bed. Review of Report of Accident/Incident reports received for Resident #1 dated 10/19/20 revealed: -At 6:20am, Resident #1 was observed at the end of his bed. -Resident #1 had skin tear on his right arm. -The skin was cleaned, and Resident #1 was monitored for 24 hours. Review of Report of Accident/Incident reports received for Resident #1 dated 10/17/20 revealed: -At 8:00pm, Resident #1 was observed standing in the hall and had turned around, moved and fell over another resident's walker -Resident did not have any visible injuries and he was monitored for 24 hours.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 11 Review of Report of Accident/Incident reports received for Resident #1 dated 10/21/20 revealed: -At 10:45pm, Resident #1 had an unwitnessed fall. Resident #1 was observed on the floor in another resident's room. -Resident #1 had a cut over the left eye and skin tear on nose. -Resident #1 was monitored for 24 hours. Review of Report of Accident/Incident reports received for Resident #1 dated 11/30/20 revealed: -At 12:15am, Resident #1 had fallen in his room. -Resident #1 had gash over right eye, sent to the emergency room (ER). Review of Report of Accident/Incident reports received for Resident #1 dated 11/30/20 revealed: -At 12:15am, Resident #1 had an unwitnessed fallen in his room. -Resident #1 had gash over right eye, sent to the emergency room (ER). Review of Report of Accident/Incident reports received for Resident #1 dated 12/12/20 revealed: -At 2:20pm, Resident #1 was seated in the TV room and fell to the floor -Resident #1 did not have any visible injuries and was monitored for 24 hours. Review of Report of Accident/Incident reports received for Resident #1 dated 12/15/20 revealed: -At 12:32pm, Resident #1 was taken to the hospital at the recommendation his PCP for an evaluation due to a bump on left side of head.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 12	D 270		

Review of hospital emergency room records for Resident #1 dated 12/15/20 revealed:
-Resident #1 was admitted to the ER due to a fall.
-Resident #1 was discharged on 12/15/20.

Review of Report of Accident/Incident reports received for Resident #1 dated 12/17/20 revealed:
-At 12:01pm, Resident #1 was observed lying face down in his room
-Resident #1 had a hematoma to right forehead.
-Resident #1 was sent to the ER.

Review of hospital emergency room records for Resident #1 dated 12/17/20 revealed:
-Resident #1 was admitted to the ER due to a fall.
-Resident #1 had a hematoma on the right-side forehead.
-Resident #1 was discharged on 12/17/20.

Review of Report of Accident/Incident reports received for Resident #1 dated 12/23/20 revealed:
-At 7:25pm, Resident #1 was observed in the hall lying on his back.
-Resident #1 had a small cut on the back of his head.
-He was sent to the ER.

Review of hospital emergency room records for Resident #1 dated 12/23/20 revealed:
-Resident #1 was admitted to the ER due to a fall.
-Resident #1 was discharged on 12/23/20.

Review of Report of Accident/Incident reports received for Resident #1 dated 01/22/21 revealed:
-At 1:00pm, Resident #1 was observed on the floor in the TV room lying on his left side.
-He had a "big node" on the left side of his head,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 13	D 270		

he was sent to the ER.

Review of hospital emergency room records for Resident #1 dated 01/22/20 revealed:
-Resident #1 was transported to the local ER via emergency medical services (EMS) "without witnessed fall".
-Resident #1 had a bilateral frontal hematoma over left eye noted.
-Resident #1 was discharged on 01/23/21.

Review of Report of Accident/Incident reports received for Resident #1 dated 01/29/21 revealed:
-At 12:00pm, Resident #1 had an unwitnessed fall out of his wheelchair.
-Resident #1 had a large lump on the right side of his forehead.
-Resident #1 was monitored for 24 hours.

Review of the hospice progress notes on 01/29/21 revealed:
-The facility called and stated Resident #1 had a fall and hit his head.
-Resident #1 had a knot on the right side of his forehead.

Review of 24-hour monitoring report log did not have documentation of the 24-hour monitoring for Resident #1 for 10/17/20, 10/19/20, 10/21/20, 11/23/20, and 01/29/21.

Interview with a personal care aide (PCA) on 02/17/20 at 6:16am revealed:
-Resident #1 was a fall risk.
-She completed 5-10-minute checks on Resident #1 because he tried to get out of his bed on his own.
-She was assisting other Residents when Resident #1 was found on the floor on 02/17/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 14 at 6:03am. Interview with a second PCA on 02/18/21 at 2:12pm revealed: -Resident #1 walked without using a walker or a wheelchair when he first came to the facility. -Resident #1 later began using a walker and then used a wheelchair. -Resident #1 was a two person assist with transferring to wheelchair. -Resident #1 was a fall risk. -Resident #1 was given a low bed due to his falls. -Resident #1 had tried to get out of his bed on his own at different times. -She had completed 15-minute checks on Resident #1. -She did not document the 15-minute checks for Resident #1. -Resident #1 did not have a physician order for the 15-minute checks. -The 15-minute checks were standard for all residents. -She did not remember Resident #1's last fall. Telephone interview with a third PCA on 02/19/21 at 3:33pm revealed: -Resident #1 used a wheelchair. -Resident #1 had tried to stand on his own sometimes. -The PCA did not witnessed any of Resident #1 falls. -The PCA had assisted with getting Resident #1 off of the floor after a fall. -The PCA completed 15-minutes checks on Resident #1. -The PCA did not document the 15-minute checks for Resident #1. Interview with a MA on 02/18/21 at 9:52am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 15	D 270		

-Resident #1 was a fall risk.
-Resident #1 would be found on the floor.
-Resident #1 had placed himself on the floor on 02/17/21.
-The PCAs completed 15-minute checks.
-The 15-minute checks are not documented.
-Resident #1 did not have a physician order for routine checks.
-Resident #1 was provided a low bed because of his falls.
-Resident #1 did not have an alarm on his chair.

Telephone interview with a second MA on 02/19/21 at 2:09pm revealed:
-Resident #1 had walked around with the help of a walker.
-Resident #1's health started to decline, and he began using a walker.
-The PCA had to catch Resident #1 once before when he had fallen to the floor.
-Resident #1 always needed assistance in the mornings with transferring from his bed to his wheelchair.
-Resident #1 always tried to get out of his bed on his own.
-The PCA completed 15-minute checks on Resident #1.
-The 15-minute checks were standard for all residents.

3. Review of Resident #4's current FL-2 dated 07/19/20 revealed diagnoses included dementia, subarachnoid hemorrhage, transient ischemic attacks, cerebrovascular accident, muscle weakness, history of seizures, hypertension, diabetes type II, emphysema, and blindness.

Review of Resident #4's care plan dated 07/17/20 revealed:
-Resident #4's vision was very limited, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 16	D 270		

resident was legally blind.
-The resident had significant loss of memory and must be directed.
-The resident had a history of wandering behavior.
-The resident needed limited assistance with transferring, ensuring the resident's wheelchair was locked.
-The resident needed extensive assistance with toileting.
-The resident was totally dependent on staff for bathing, dressing, grooming, and ambulation.

Observations of Resident #4 on 02/17/21 at 5:51am revealed there were stitches running vertically down her forehead with swelling.

Interview with the personal care aide (PCA) on 02/17/21 at 5:51am revealed:
-The PCA was getting ready to take Resident #4 to the "TV room" until time for breakfast.
-The resident had an accident where she fell forward and hit her head.
-She believed the resident fell on Saturday (02/13/21).
-The wound required stitches.

Observations of Resident #4 on 02/17/21 between11:06am - 11:13am revealed:
-The resident was in a sitting position on the floor, leaning against the sofa, and asleep in the TV room.
-There were no staff present in the television room.
-A personal care aide/medication aide (PCA/MA) came into the television room and assisted Resident #4 after being prompted by surveyors.

Interview with the PCA/MA on 02/17/21 at 11:13am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 17	D 270		

-Two surveyors pointed out to her that Resident #4 was on the floor.
-Resident #4 was in the process of getting down on the floor, was sitting up on the floor, and asked the PCA/MA to help her (Resident #4) turn over.
-The PCA/MA called for another MA but saw the physical therapy staff and asked the physical therapy staff to help get Resident #4 up off the floor.

Interview with the physical therapy staff on 02/17/21 at 11:15am revealed:
-Resident #4 was on the floor in the TV room.
-It looked like Resident #4 was sleeping.
-When she arrived at Resident #4 in the TV room, the resident was laying on the floor on her right side.

Interview with a PCA on 02/17/21 at 11:43am revealed:
-If a resident had a recent fall the staff would place the resident at the front of the facility for monitoring.
-The TV room was one area in the facility "where we can look at everyone".

Interview with the PCA/MA on 02/17/21 at 2:35pm revealed:
-The PCAs were responsible to complete 15-minute "rounds" on all residents.
-The 15-minute resident rounds were done each shift.
-When she completed 15-minute rounds on residents, she checked to see where the residents were.

Interview with a second MA on 02/18/21 at 9:50am revealed:
-Resident #4 would try to stand up from a sitting position.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 18	D 270		

-Resident #4 could get up if she wanted to.
-She always had her "eyes on her" which meant she looked to see where the resident was "all the time".
-Resident #4 would sometimes fall after stumbling on her wheelchair and would be found on the floor.
-A "couple months ago" the resident tried to get out of bed into her wheelchair when the wheelchair slid away from the resident.
-One month ago, the resident slid off her wheelchair, got up, tried to sit back down in the chair and the chair slid from under the resident.
-Two weeks ago, the resident hit her head when she fell on the floor and required stitches to an open wound at the local hospital.
-She could not provide exact dates of the incidents.
-When an incident/accident occurred, the MA performed a body assessment of the resident, initiated 24-hour monitoring for complaints, completed an incident/accident report, and notified the Resident Care Coordinator (RCC), family member, oncoming shift, and faxed a copy of the incident/accident report to the Primary Care Provider (PCP).

Review of Incident /Accident Reports for Resident #4 revealed:
-On 02/17/21, the resident "sat herself on floor in TV room". Staff action taken was RCC notified, POA notified, and 24-hour monitoring.
-On 02/13/21, "resident had an unwitnessed fall in the TV room out of her wheelchair." Staff action taken was RCC notified, physician notified, POA notified. The resident was sent out to the emergency room (ER).
-On 02/04/21, "resident had an unwitnessed fall in the TV room from her wheelchair." Staff action taken was RCC notified, physician notified, POA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 19	D 270		

notified. The resident was sent out to the emergency room (ER).
-There was no documentation of increased supervision for Resident #4.

Review of 24-hour acute monitoring reports for Resident #4 revealed there were no 24-hour acute monitoring reports provided for the 02/17/21, 02/13/21, or 02/04/21 incident/accident.

Further review of the incident/accident report for Resident #4 dated 02/04/21 revealed:
-On 02/04/21 at 11:50am, Resident #4 had an unwitnessed fall in the television room from her wheelchair.
-The unwitnessed fall resulted in a gash to the resident's forehead.
-The resident was sent to the local hospital emergency room for treatment.

Review of the hospital ER notes for Resident #4 dated 02/04/21 revealed:
-Resident #4 was transported from the facility to the local hospital emergency room via emergency medical services (EMS) "after falling out of her wheelchair while asleep".
-"A portion of the history physical was limited due to baseline dementia".
-The resident "was turning out of the wheelchair and transfer to a stationary chair when she fell out of the chair onto the floor hitting her head on the ground, unsure if she had loss of consciousness".
-The resident sustained a small laceration/abrasion to the forehead.
-An x-ray of the head and spine revealed a soft tissue contusion over the right frontal bone.
-The resident was discharged back to the facility on 02/04/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 20	D 270		

Further review of the incident/accident report for Resident #4 dated 02/13/21 revealed:
-On 02/13/21 at 6:20am, Resident #4 had an unwitnessed fall in the television room out of her wheelchair.
-The unwitnessed fall resulted in a gash to the resident's forehead.
-The resident was sent to the local hospital emergency room for treatment.

Review of the hospital ER notes for Resident #4 dated 02/13/21 revealed:
-Resident #4 was transported from the facility to the local hospital emergency room via EMS after an unwitnessed fall.
-The resident sustained a one-inch vertical laceration to the forehead.
-The resident complained of pain to the laceration site/head.
-The frontal scalp laceration was repaired with five stitches.
-The resident was discharged back to the facility on 02/13/21.

Telephone interview with a MA/PCA on 02/19/21 at 2:15pm revealed:
-She remembered when Resident #4 had a fall one day last week.
-She could not remember the exact day but was sure the fall occurred one day last week.
-She was standing at the medication cart outside the TV room when she heard a resident in the TV room say, "she fell".
-She did not see Resident #4 fall because she was preparing to administer medications.
-Staff were "in and out" of the TV room bringing residents in and going to get other residents.
-She remembered finding Resident #4 on the floor in her bedroom on an occasion when she administered the resident medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 21	D 270		

-Resident #4 had obtained a gash to her forehead twice due to falls from her wheelchair.
-A lot of Resident #4's falls were from her wheelchair.
-When she saw Resident #4 leaning forward in her wheelchair, she would instruct the resident to sit back, and would assist the resident to reposition in the wheelchair. Within 5 - 10 minutes, the resident would be leaning forward again and would require a reminder to sit up and back in the wheelchair.
-She had instructed the PCAs to sit residents who leaned on the couch, "if there's room".
-She could not recall if there was a staff in the TV room when Resident #4 fell.
-If the fall was unwitnessed, she would document unwitnessed fall on the incident/accident report.
-She had taken Resident #4 in the TV room and left her in the wheelchair.
-She would push the wheelchair in front of the couch or a chair so if the resident started to lean, she would not hit the floor. She just recently started doing that after Resident #4 had the second fall.
-Resident #4 was normally in the TV room when she came to work.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 02/24/21 at 3:50pm revealed:
-The facility tried to keep Resident #4 up in her wheelchair in the TV room.
-Use of the TV room was how the facility was able to provide close monitoring.
-The facility did not use lap buddies or restraints so that was why the facility tried to use physical therapy.
-The facility relied heavily on physical therapy for an intervention for residents with falls.
-Resident #4 had a fall resulting in a hematoma to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 22	D 270		

her head requiring stitches.
-Any head injury could result in concerns for bleeding or a fracture.

Telephone interview with Resident #4's family member on 02/23/21 at 3:35pm revealed:
-She was aware Resident #4 had fallen "a couple times" and sent out to the hospital.
-She had been contacted by the facility about three times.
-Resident #4 would slide out of the chair a lot of times.

Telephone interview with the Administrator on 02/24/21 at 2:30pm revealed she expected staff to always be in the TV room to supervise the residents.

4. Review of Resident #3's current FL-2 dated 05/01/20 revealed diagnoses included dementia, hypertension, coronary artery disease, degenerative joint disease, arthritis, cerebral vascular disease, bradycardia and chronic diastolic heart failure.

Review of Resident #3's current care plan dated 05/01/20 revealed:
-Resident #3 was disoriented most of the time and needed redirection from staff.
-Resident #3 ambulated independently, had wandering behaviors and needed supervision with ambulation.
-Resident #3 was continent of bowel and bladder and need limited hands on assistance with toileting hygiene.

Telephone interview with Resident #3's roommate on 02/19/21 at 1:54pm revealed:
-She woke up one night to use the bathroom and saw Resident #3 on the floor wrapped up in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 23	D 270		

sheet with feces on her.
-Resident #3 was laying on the floor beside her bed and bleeding from her head.
-Resident #3 fell another time in the bathroom.
-The staff cleaned her up and put her back in her bed.
-Resident #3 fell another time out the chair.
-Resident #3 was weak and the staff sat her up in the chair to eat.
-Resident #3 fell out of the chair and had bruises on her.
-She did not remember the dates but the falls happened when Resident #3 was sick at the end of December 2020 - beginning of January 2021.
-Resident #3 had diarrhea and could not get to the bathroom because she was so weak.
-Staff did not check on residents at night.
-It was hard to find staff to help residents at night.

Review of a text message from a family member to the Resident Care Coordinator (RCC) dated 12/19/20 at 8:28pm revealed the family member was concerned Resident #3 "fell a little bit ago."

Interview with the RCC on 02/23/21 at 4:01pm revealed:
-Regarding the text message dated 12/19/20 regarding Resident #3 having a fall, the personal care aide (PCA) should have gotten the medication aide (MA) to check Resident #3 for injuries and her vital signs.
-The MA would have been responsible for initiating the acute monitoring and verbally communicating the monitoring to the PCAs and oncoming shift.
-Monitoring documentation would have on the acute monitoring form by the MA each shift.

Upon request on 02/17/21, 02/18/21 and 02/23/21 an incident/accident report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 24 12/19/20 for Resident #3 was not available for review. Upon request on 02/23/21 a 24 acute monitoring form initiated on 12/19/20 for Resident #3 was not available for review. Review of an incident/accident report dated 12/22/20 at 3:50 (am/pm not specified) and a 24 hour acute monitoring form dated 12/22/20 for Resident #3 revealed: -Resident #3 had an unwitnessed fall and was found on the floor by her bed. -Resident #3 had a "quarter sized goose egg" on the right side of her head. -There was documentation Resident #3 was sent to the emergency room (ER) on 12/22/20 during first shift. -There was documentation of blood pressure (BP), heart rate (HR) and respiration rate (RR) checks and that Resident #3 was resting in her room with no complaints for second and third shifts. -There was no documentation of a fall or any intervention such as increased supervision to prevent falls and further injury. Review of an electronic mail (email) from a family member to the Administrator dated 01/03/21 revealed: -Resident #3's roommate checked on her through the night because Resident #3 had been sick and fell out of the bed, out of the chair and off the toilet. -Resident #3's roommate found the resident on the floor and was panicked and could not find staff. -The roommate contacted the family member to call the facility. -The family called the facility and there was no	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 25	D 270		

answer, called the RCC with no answer and Business Office Manager (BOM) with no answer.

Review of a text message from a family member to the RCC dated 01/03/21 at 12:47am revealed the family was concerned Resident #3 might have been hurt and staff at the facility had not answered the phone.

Telephone interview with a family member on 02/16/21 at 11:43am revealed:
-A resident called her about 4 weeks ago (early January 2021) and said Resident #3 was on the floor and the resident could not find staff to help Resident #3.
-The resident went to the hall looking for staff and yelling for staff to come and help but no one came.
-She called the facility but did not get an answer.
-She the RCC, but did not get an answer so she emailed the Administrator.
-After about 15 minutes the medication aide "popped up" to help Resident #3.

Interview with a MA on 02/17/22 at 10:10am revealed:
-She did not remember the date, but Resident #3's roommate did not come and find her for Resident #3.
-The roommate had her family member to call the facility.
-She went to Resident #3's room and found her lying on the floor with a blanket and a pillow.
-Resident #3 fell after that incident when she was sick towards the end of December 2020 or beginning of January 2021.
-Resident #3 fell and hit her head.
-She sent Resident #3 to the emergency room and completed and incident/accident report (12/22/20).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 26 -She was not working when Resident #3 returned from the ER. Interview with the RCC on 02/23/21 at 4:01pm revealed on 01/03/21, Resident #3 did not fall, but got herself on the floor to lay on the floor with a blanket and a pillow therefore there would not be an incident report. Review of an incident/accident report dated 12/28/20 at 11:40am revealed: -Resident #3 had chest pain. -Resident #3 was sent to the ER. -Resident #3's Guardian and PCP were notified. Review of Resident #3's EMS record dated 12/28/20 at 12:14pm revealed: -Staff reported Resident #3's O2 sats (oxygen saturation) had been in the 80's and the resident did not feel well. -Resident #3 was unsteady on her feet and required assistance. -Staff reported Resident #3 had several syncopal episodes "lately". Review of a hospital clinical note dated 12/28/20 at 1:15pm for Resident #3 revealed Resident #3 was admitted to the hospital for hydration and monitoring. Review of a hospital clinical note dated 01/01/21 at 1:28pm revealed Resident #3 was discharged from the hospital and returned to the facility on 01/01/21. Review of a 24 hour acute monitoring forms dated 01/01/21 through 01/04/21 for Resident #3 revealed: -There was documentation Resident #3's BP, HR and RR were checked and the resident had no	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 27	D 270		

complaints each shift.
-There was no documentation of a fall or any intervention such as increased supervision to prevent falls and further injury.

Interview with a second MA on 02/18/21 at 4:40pm revealed:
-She thought the acute monitoring forms dated 01/01/21 through 01/04/21 were for monitoring during the COVID-19 outbreak at the facility.
-A lot of the residents were not well and just stayed in the bed.
-Resident #3 might have fallen during the time of the monitoring (01/01/21 - 01/04/21) and did not have an injury so she was not sent out.

Interview with a PCA on 02/23/21 at 10:59am revealed:
-Resident #3 had diarrhea for at least 2 days when she was sick (December 2020).
-Resident #3 was not eating or drinking much and staff had to encourage the resident to drink fluids.
-She knew of one fall for Resident #3; it happened when the resident first got sick with COVID-19.
-Resident #3 was weak, tried to get to the toilet herself and fell in the bathroom.
-Resident #3 did not have any injuries and she assisted her back to bed.

Second interview with the second MA on 02/23/21 at 11:28am revealed:
-She was not working the days Resident #3 fell.
-Whenever Resident #3 fell she was put on 24 hour acute monitoring.
-If she fell and did not have any injury, she would have been put on 24-hour acute monitoring.
-With acute monitoring MAs would have checked Resident #3's vital signs every shift and taken her to the bathroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 28	D 270		

-Staff would have gone in every hour to ask Resident #3 if she needed to use the bathroom.
-Staff documented on the acute monitoring form whenever a resident was on acute monitoring after a fall.
-There should have been documentation of acute monitoring after each fall Resident #3 had.
-She did not know anything about missing 24 hour acute monitoring forms for Resident #3.

Interview with the RCC on 02/23/21 at 4:01pm revealed:
-When Resident #3 was sick in December 2020 through January 2021, she hardly got out of the bed.
-She did not have a response for Resident #3 having undocumented falls on 12/19/20 and 01/03/21 and if monitoring was done if there was no acute monitoring form initiated.

Review of Resident #3's record revealed:
-There were no care notes documented and no documentation of Resident #3 falling on 12/19/20, 01/03/21 and a third unknown date.
-There was no documentation of any intervention such as increased supervision to prevent further falls.

Review of a physical therapy plan of care dated 02/16/21 for Resident #3 dated 02/16/21 revealed:
-Resident #3 was evaluated for physical therapy needs on 02/16/21.
-Physical therapy was started on 02/16/21 for Resident #3 for generalized weakness, deconditioning and increased fall risk.
-Resident #3 had a fall on 12/22/20 and was sent to the ER after hitting her head resulting in a major decline in function.
-Diagnoses included muscle weakness,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 unsteadiness on feet and repeated falls. -Without therapy Resident #3 was at risk for falls, fractures, deconditioning and increased need for caregiver assistance. Attempted interview with Resident #3's previous PCP on 02/24/21 at 4:05pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. _____ The failure of the facility to provide supervision to residents (#1, #2, #3, #4) resulted in repeated falls and multiple emergency room visits and hospitalization. Resident #2 sustained six falls in three months with three of them resulting in hospital visits including lacerations to the head requiring staples. Resident #1 had 13 falls in a five month period with four of them resulting in hospital visits including instances of a hematoma to the head. Resident #3 sustained three undocumented falls with a head laceration and no interventions were implemented for fall prevention during a period of weakness during an acute illness. Resident #4 sustained two falls requiring hospital visits with a head contusion and two forehead lacerations, one of which required sutures. The facility's failure placed the residents at substantial risk of serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/21 for this violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2021.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 30	D 273		
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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to follow up on the health care needs for 2 of 5 sampled residents (#3 and #5) by not contacting the primary care provider (PCP) for difficulty breathing and ear pain and not following up with a gastroenterologist following an emergency room visit for rectal bleeding and scheduling a mammography appointment (Resident #5); and not contacting the PCP for an initial oxygen saturation level of 72% (Resident #3). The findings are: 1. Review of Resident #5's current FL-2 dated 05/04/20 revealed diagnoses included dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, bipolar disorder, hyperlipidemia, hypertension and a history of polyps. a. Review of a physician's orders form dated 11/02/20 for Resident #5 revealed: -There was an order to check BS before meals and at bedtime. -There was an order to check BS for any signs typical of hypoglycemia or any resident or family concerns of hypoglycemia. -There was an order for Proair HFA 2 puffs every	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 31	D 273		

6 hours.
-There was no order for an as needed inhaler and/or nebulizer treatment.

Review of a letter from Resident #5's PCP dated 12/22/20 revealed there was an order to add oxygen saturation (O2 sat) level and temperature checks during the night for Resident #5 due to COVID-19 infection, COPD and other health problems.

Review of a resident screening logs dated 12/18/20 through 12/31/20 revealed:
-Staff documented temperature and oxygen saturation (O2 sat) levels twice daily for all residents.
-There was no documentation of temperature and O2 sat results for Resident #5 on 12/22/20.
-There was no documentation of an O2 sat result during the night for Resident #5 from 12/22/20 through 12/31/20.

Upon request on 02/17/21 and 02/23/21 there were no resident COVID-19 symptom screening logs for Resident #5 dated 01/01/21 through 02/15/21.

Interview with the Resident Care Coordinator (RCC) on 02/23/21 at 4:01pm revealed:
-Staff had checked O2 sats on residents at night.
-She had worked at night and checked O2 sats on residents.
-When she checked Resident #5 the resident did not wake up or move.
-She did not see the letter from Resident #5's primary care provider (PCP) dated 12/22/20 to check the resident's O2 sat at night.

Telephone interview with Resident #5's Power of Attorney (POA) on 02/16/21 at 11:43am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 32 -Resident #5 was still experiencing shortness of breath from the COVID-19 infection in December 2020. -Resident #5 called a family member at 5:00am three weeks ago and said she was having difficulty breathing, shortness of breath and was sweating. -Resident #5 said she had told the medication aide (MA) and the MA told her to take a shower. -She called the MA at the facility and asked the MA if she had checked Resident #5's blood sugar (BS) and temperature. -The MA said Resident #5 was due for morning BS check in 2 more hours. -The MA checked Resident #5's BS and temperature and both were fine. -The POA was concerned the MA did not think to check vital signs and a BS and just told Resident #5 to take a shower. -Resident #5 saw her cardiologist on 02/16/21 who said rhonchi were still present in the resident's lungs and might have been residual from the COVID-19 infection. (Rhonchi is a low pitched rattling sound heard with listening to lungs through a stethoscope and are usually caused by obstruction or secretions in larger airways.) -She was taking Resident #5 to an appointment with her PCP later in the day on 02/16/21 for a further evaluation. Interview with a MA on 02/18/21 at 10:10am revealed: -She was working on 01/27/21 when Resident #5 came to her with complaints of difficulty breathing. -Resident #5 came to her and said she was sweating; she told Resident #5 if she was hot to take a shower. -Resident #5 said she was not hot but could not breathe.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 33	D 273		

-She gave Resident #5 a "breathing treatment."
-Resident #5 called her Power of Attorney (POA) and the POA then called the MA.
-The POA asked the MA to check Resident #5's blood sugar (BS) and temperature.
-Resident #5's BS was 155 and her temperature was 96.6 degrees Fahrenheit (F).
-Resident #5 did not complain of low BS, she only said she could not breathe and was sweating.
-She did not see any sweating and thought Resident #5 was hot.
-After giving Resident #5 a breathing treatment, checking her blood sugar and temperature, the resident called her POA and went and sat in the TV room.
-She did not contact Resident #5's primary care provider (PCP) about the resident's episode of difficulty breathing and sweating because Resident #5 had just been upset and calmed down after talking to her POA and sitting in the TV room.

Telephone interview with Resident #5 on 02/19/21 at 1:54pm revealed:
-She was very winded/short of breath on 01/27/21; it was the same feeling but worse with her POA that morning (02/19/21).
-On 01/27/21 she was not hot, she was sweating, and the sweat was "running off me."
-The MA did not come down to her room on 01/27/21, the MA sent a personal care aide (PCA).
-The PCA told her to go to the medication cart at the TV room.
-The MA checked her blood sugar and put the "thing" (oxygen saturation meter) on her finger; she did not remember the result.
-The MA did not give her any medications.

Telephone interview with a second MA on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 34	D 273		

02/19/21 at 3:32pm revealed:
-Resident #5 did not have an as needed breathing treatment; she did have a scheduled inhaler for 6:00am, 12:00pm, 6:00pm and 12:00am.
-No one had reported Resident #5 being short of breath to him; he had not seen Resident #5 short of breath.

Review of Resident #5's December 2020 electronic medication administration record (eMAR) revealed:
-There was no documentation of an order for and/or administration of an as needed inhaler and/or nebulizer treatment.
-There was an entry for ProAir 2 puffs every 6 hours scheduled for 6:00am, 12:00pm, 6:00pm and 12:00am.
-There was documentation the 6:00am dose was administered on 01/27/21.

Interview with the RCC on 02/18/21 at 4:48pm revealed:
-Resident #5 would tell her POA something was wrong and then tell her (RCC) something different.
-She thought Resident #5 was having a hot flash the morning of 01/27/21 because Resident #5 said she was hot.
-The episode was not documented because staff followed protocol.
-Resident #5's temperature was checked, and the result was 97.6 degrees F.

Telephone interview with the RCC on 02/22/21 at 12:41pm revealed:
-If a resident complained of shortness of breathe, staff were expected to give as needed medication first.
-Every concern did not go through the PCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 35 -If the as needed medication did not work or there was no order for an needed medication, then she contacted the PCP. Telephone interview with the RCC on 02/24/21 at 9:51am revealed: -She arrived early to work the morning of 01/27/21 and the MA reported Resident #5 was feeling hot. -The MA reported telling Resident #5 to sit in front of her fan or take a shower. -The MA checked Resident #5's BS which was 155, and temperature which was 97.7. -When she saw Resident #5 that morning, the resident was not complaining of anything; she did not have any shortness of breath. -The incident on the morning of 01/27/21 was not reported to Resident #5's PCP because the resident was upset and anxious and calmed down. -If Resident #5 was short of breath that morning, the MA would have sent the resident to the ER. -When Resident #5 got anxious her breathing would get heavy and staff would sit the resident down to calm down and the heavy breathing went away. -Resident #5's heavy breathing was situational due to her anxiety. -If Resident #5 was feeling short of breath and the MA gave the resident her inhaler and that "fixed it, then the situation was handled" and staff did not need to contact the PCP. -Between 01/27/21 and 02/15/21 staff did not see Resident #5 with difficulty breathing or shortness of breath. -She told Resident #5's POA about any concerns staff had and the POA contacted the resident's providers. -The last time she tried to contact Resident #5's PCP was on 10/15/20.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 36 Review of an email dated 01/23/21 at 11:58am from Resident #5's POA to the Administrator and RCC revealed: -Resident #5's medical appointment on 02/03/21 with her PCP were local appointments. -The POA was asking for contact from RCC and/or Administrator to confirm whether the facility was taking Resident #5 to her local appointments or was she (POA). Telephone interview with Resident #5's POA on 02/22/21 at 8:01am revealed: -The email dated 01/23/21 refers to not being able to take Resident #5 to medical appointments. -She was tested for COVID-19 and still could not take Resident #5 to medical appointments. -Getting Resident #5 to medical appointments and being able to be there during the appointments "got complicated." -On 01/25/21 she "got frustrated and agreed to do what she had to do" to take care of Resident #5. -She decided to reschedule the PCP appointment for 02/16/21 for Resident #5 and then quarantine the resident at her home as the facility requested. -Resident #5 did not go to the 02/03/21 appointment with her PCP due to needing to make arrangements to quarantine the resident in the POA's home for 10 days. Review of a PCP office visit form for Resident #5 dated 02/16/21 revealed: -Resident #5 was seen for shortness of breath, COPD, type 2 diabetes mellitus, laboratory orders and headache. -Resident #5 had an abnormal chest x-ray with orders for an antibiotic injection on 02/17/21, oral antibiotics for 5 days and nebulizer treatments 4	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 37	D 273		

times daily as needed for shortness of breath and/or wheezing.
-There was an order for referral to a neurologist for evaluation and treatment of headaches.

Upon request on 02/17/21, 02/23/21 and 02/24/21, documentation of Resident #5's complaints on 01/27/21 and contact with Resident #5's POA and PCP regarding the events on the morning of 01/27/21, were not available for review.

Refer to telephone interview with a medication aide (MA) on 02/19/21 at 3:32pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm.

Refer interview with the Administrator on 02/23/21 at 5:12pm.

b. Review of an incident/accident report for Resident #5 dated 10/01/20 at 11:00am revealed:
-Resident #5 was sent to the emergency room (ER) for complaints of rectal bleeding and lower abdominal pain.
-Resident #5's Power of Attorney (POA) and primary care provider (PCP) were contacted.

Review of ER triage notes dated 10/01/20 at 12:15pm for Resident #5 revealed:
-Resident #5 was sent to the ER for complaints of bright red blood with wiping after bowel movements for one week.
-Resident #5 also reported left lower abdominal pain, headache and bilateral ear pain.

Review of Resident #5's ER laboratory results dated 10/01/20 at 1:00pm revealed Resident #5 tested positive for fecal occult blood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 38	D 273		

Review of a PCP encounter summary for Resident #5 dated 10/05/20 revealed:
-The PCP spoke with a medication aide (MA) about a referral for Resident #5 to a gastroenterologist for rectal bleeding.
-The PCP provided contact information for the gastroenterologist's office for appointment scheduling.

Review of a progress note dated 02/18/21 for Resident #5 revealed:
-The Resident Care Coordinator (RCC) documented that she received a message from Resident #5's POA regarding making an appointment for the resident to see a gastroenterologist.
-The RCC spoke with a representative at a local gastroenterologist's office on 10/06/20.
- A local gastroenterologist's office was not seeing residents of assisted living facilities.
-The RCC notified Resident #5's POA.

Review of a letter from Resident #5's PCP dated 10/12/20 revealed the letter directed that due to rectal bleeding, it was an emergency for Resident #5 to be seen by her gastroenterologist in the month of October 2020.

Interview with the RCC on 02/23/21 at 4:01pm revealed:
-She saw the letter dated 10/12/20 from Resident #5's PCP for an emergency gastroenterologist appointment.
-The POA left messages for her (RCC) to schedule the gastroenterologist appointment.
-She attempted to schedule the appointment, but one local gastroenterologist was not seeing residents of assisted living facilities (ALF).
-She let the POA know the gastroenterologist was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 39	D 273		

not seeing residents from ALF.
-She tried a second gastroenterologist, but they needed more paperwork from Resident #5's previous gastroenterologist and the POA had to get the paperwork.

Review of an electronic mail (email) from Resident #5's gastroenterologist to Resident #5's POA and forwarded to the RCC and Administrator dated 01/22/21 revealed Resident #5 was overdue for a follow up colonoscopy and follow up for rectal bleeding/ER visit in October 2020.

Telephone interview with Resident #5's POA on 02/16/21 at 11:43am revealed:
-As soon as the COVID-19 restrictions started in March 2020, residents were not able to leave the facility unless it was an emergency.
-She made all of Resident #5's medical appointments.
-There had been difficulties getting Resident #5 seen by a gastroenterologist locally following an ER visit for rectal bleeding in October 2020.
-One gastroenterologist declined due the extent of treatment required and a second declined due to Resident #5 living in an assisted living facility.
-A third appointment was canceled because the RCC told the provider the rectal bleeding had stopped.
-Resident #5 had a history of recurring colon polyps and needed treatment by a gastroenterologist every 2 years.
-The RCC told her in October 2020 if she took Resident #5 out of the area to see a gastroenterologist, she would have to quarantine the resident in her home for 14 days per Centers for Disease Control (CDC) guidelines.
-Follow up appointments were further delayed by Resident #5 contracting COVID-19 in December 2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 40	D 273		

Telephone interview with a nurse at Resident #5's gastroenterologist's office on 02/23/21 at 3:23pm revealed:
-The only communication they had was with Resident #5's POA.
-Resident #5 was last seen in the office for a procedure in September 2019.
-Resident #5 was last seen via a telehealth visit on 02/16/21.
-It depended on what was going on physically but, Resident #5 should be seen in the office at least annually.

Interview with the RCC on 02/18/21 at 4:48pm revealed:
-Resident #5 told her POA she was having black stools.
-She monitored Resident #5 for 2 days and saw nothing.
-Resident #5 had a follow up telehealth visit with her PCP that the POA canceled.
-The facility was not doing outside medical appointments unless it was an emergency.

Upon request on 02/18/21 and 02/23/21 documentation of monitoring of rectal bleeding for Resident #5 for October 2020 and contact with Resident #5's POA and PCP were not available for review.

Attempted interview with a local gastroenterologist's office for Resident #5 on 02/23/21 at 3:47pm was unsuccessful.

Attempted interview a second local gastroenterologist's office for Resident #5 on 02/23/21 at 3:44pm was unsuccessful.

Refer to telephone interview with a medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 41	D 273		

aide (MA) on 02/19/21 at 3:32pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm.

Refer interview with the Administrator on 02/23/21 at 5:12pm.

c. Telephone interview with Resident #5 on 02/19/21 at 1:54pm revealed:
-She told the Resident Care Coordinator (RCC) several times she needed ear drops because her ears were hurting; she did not remember when she told the RCC.
-One day she was desperate for relief from her ear pain and asked a provider who was at the facility help her; she did not remember when that happened.
-Her ears hurt before the COVID-19 outbreak in December 2020 and still hurt.

Telephone interview with Resident #5's Power of Attorney (POA) on 02/16/21 at 11:43am revealed:
-Resident #5 had longstanding issues with her ears and needed drops for cleaning and pain and had to have her ears cleaned at the physician's office.
-Resident #5 had been complaining of ear pain off and on for the past 4 months.

Telephone interview with Resident #5's POA on 02/19/21 at 1:54pm revealed:
-She was not able to take Resident #5 to see her otolaryngologist (ear specialist) because the office was out of the area.

Review of emergency room (ER) discharge instructions dated 10/01/20 for Resident #5 revealed:
-Resident #5 was diagnosed with a right ear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 42	D 273		

ache.
-There were no instructions for follow up or new orders.

Telephone interview with Resident #5's POA on 02/22/21 at 8:01am revealed there was no follow up with Resident #'s PCP or otolaryngologist from the resident's 10/01/20 ER visit where she had complained of right ear pain.

Interview with the RCC on 02/23/21 at 4:01pm revealed:
-She was not aware Resident #5 had complaints of ear pain on 10/01/20.
-She did not have a direct response for the notation of an ear ache on Resident #5's ER discharge instructions.

Review of an electronic mail (email) from Resident #5's POA to the Administrator and the RCC dated 11/02/20 revealed:
-Resident #5 had complained of her right ear hurting for several weeks and now the left ear had started to hurt.
-Resident #5 continued to ask for ear drops.
-Resident #5 said she had spoken to the Administrator and RCC about her ear pain and getting ear drops.

Review of an email dated 01/06/21 at 11:56am from Resident #5's Power of Attorney (POA) to the Administrator and RCC revealed:
-Resident #5 had been calling the POA 6 to 8 times a day with complaints of her ears hurting.

Telephone interview with a MA on 02/19/21 at 3:32pm revealed:
-Resident #5 had ear pain sometimes.
-Resident #5's had medicine for ear pain, but it had been discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 43 -He did not remember the dates. Telephone interview with a Registered Nurse from Resident #5's otolaryngologist's office on 02/24/21 at 2:35pm revealed: -Staff were expected to contact the office with any concerns about Resident #5; the only contact had been with the resident's POA. -Resident #5 had a cholesteatoma in her ear which can cause chronic ear drainage and if untreated can lead to hearing loss. (Cholesteatoma is a type of inner ear cyst that causes persistent ear aches and can cause dizziness, facial muscle weakness and hearing loss.) -Resident #5 was usually seen in the office for cleaning and debridement of her ears. -Resident #5 was last seen in March 2020. Telephone interview with the RCC on 02/22/21 at 12:41pm revealed: -If a resident complained of an ear ache and there was nothing on the eMAR, then the MA notified the RCC and RCC contacted the PCP for an order. -With Resident #5, the resident called her POA and POA contacted the PCP. -She did not document her contact with a PCP unless she was told to do something specific by the PCP. Telephone interview with the RCC on 02/24/21 at 9:51am revealed: -She told Resident #5's POA about any concerns staff had and the POA contacted the resident's providers. -The Cortisporin ear drops order was changed to a scheduled dosing frequency by someone at Resident #5's otolaryngologist's office. -The Debrox ear drops were discontinued by the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 44	D 273		

facility's previous contracted PCP.
-She was not sure if the previous contracted PCP saw Resident #5 about her ear pain.

Review of an email dated 01/22/21 at 11:56am from Resident #5's POA to the RCC and the Administrator revealed:
-She (POA) had scheduled an appointment for Resident #5 on 02/15/21 with her otolaryngologist.
-Resident #5 was overdue for a recheck from an ear infection, ear cleaning and her yearly checkup.

Review of an otolaryngologist office visit note for Resident #5 dated 02/15/21 revealed:
-Resident #5 was seen for ear draining and nasal drainage.
-There were orders to start Atrovent nasal spray and baby oil drops to right ear immediately. (Atrovent nasal spray is used to decrease nasal secretions.)

Upon request on on 02/17/21 and 02/23/21, documentation of contact with Resident #5's otolaryngologist, PCP, and/or POA regarding continued complaints of ear pain from December 2020 through February 2021 were not available for review.

Refer to telephone interview with a medication aide (MA) on 02/19/21 at 3:32pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm.

Refer interview with the Administrator on 02/23/21 at 5:12pm.

d. Review of a gynecological office visit form for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 45 Resident #5 dated 11/10//20 revealed a referral order for an annual mammography examination. Telephone interview with Resident #5's Power of Attorney (POA) on 02/22/21 at 8:01am revealed Resident #5 had not had a mammography exam since 11/10/20. Interview with the Resident Care Coordinator (RCC) on 02/23/21 at 4:01pm revealed: -She knew about the mammography referral dated 11/10/20 for Resident #5. -The referral order got "lost in the shuffle" and was not followed up on. Telephone interview with the transportation staff on 02/19/21 at 4:35pm revealed: -He scheduled residents' medical appointments and transported residents to and from appointments. -Some referral appointments were documented on office visit forms and some staff told him about. -He had not been doing outside medical appointments due to COVID-19 restrictions at the facility. -He had just resumed office visits that were medically necessary one week ago. -Medically necessary was like being seen for a hernia or heart palpitations, not for an annual eye exam or dental checkup. -He had to ask the Administrator if a resident was able to leave the facility for a particular appointment. Refer to telephone interview with a medication aide (MA) on 02/19/21 at 3:32pm. Refer to interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 46	D 273		

Refer interview with the Administrator on 02/23/21 at 5:12pm.

2. Review of Resident #3's current FL-2 dated 05/01/20 revealed diagnoses included dementia, hypertension, coronary artery disease, degenerative joint disease, arthritis, cerebral vascular disease, bradycardia and chronic diastolic heart failure.

Review of an undated standing order for all residents by the facility's contracted primary care provider (PCP) revealed:
-An order to check temperatures and oxygen saturation (O2 sat) levels daily.
-An order to send the resident to the emergency room (ER) if the temperature result was over 101 degrees Fahrenheit (F) and/or the O2 sat level was less than 85%.

Review of a resident screening logs dated 12/18/20 through 12/31/20 revealed:
-Staff documented temperature and O2 sat levels twice daily for residents.
-On 12/18/20 between 10:00am and 11:00am, Resident #3's O2 sat level was documented as 72% and a recheck of 92%.
-There were no times documented on the entries.

Review of Resident #3's record revealed there were no care notes documented.

Telephone interview with a medication aide (MA) on 02/24/21 at 4:12pm revealed:
-He worked the evening of 12/18/20 but did remember Resident #3 having an O2 sat result of 72% on 12/18/20.
-If that happened, the MA would let the Resident Care Coordinator (RCC) know and the RCC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 47	D 273		

would have contacted the resident's primary care provider (PCP).

Upon request on 02/23/21 and 02/24/21 documentation of notification to Resident #3's PCP of the O2 sat result of 72% on 12/18/20 was not available for review.

Review of a PCP visit note dated 12/18/20 for Resident #3 revealed:
-Resident #3 was being seen for follow up on insomnia, vascular dementia and depressive disorder.
-There were no vital signs documented on the visit note.
-There was documentation Resident #3 tested positive for COVID-19 on 12/16/20.
-There was no documentation staff reported Resident #3 was experiencing symptoms of COVID-19.
-There was no documentation staff reported Resident #3 had an initial O2 sat of 72% on 12/18/20.

Review of an incident/accident report dated 12/28/20 at 11:40am revealed:
-Resident #3 had chest pain.
-There was documentation Resident #3's O2 sat level was 90% and her temperature was 98 degrees F.
-Resident #3 was sent to the emergency room (ER).
-Resident #3's Guardian and PCP were notified.

Review of Resident #3's emergency medical service (EMS) record dated 12/28/20 at 12:14pm revealed:
-Staff reported Resident #3's O2 sats had been in the 80's and the resident did not feel well.
-Resident #3 had tested positive for COVID-19 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 48	D 273		

12/16/20 and began having symptoms of cough and shortness of breath on 12/17/20.
-Resident #3 was unsteady on her feet and required assistance.
-Staff reported Resident #3 had several syncopal episodes "lately".

Review of an ER triage note dated 12/28/20 at 12:50pm for Resident #3 revealed:
-Resident #3 was sent to the ER for an evaluation of low O2 sats related to a positive COVID-19 status.
-Resident #3's O2 sat was 98% on arrival to the ER.

Review of a hospital clinical note dated 12/28/20 at 1:15pm for Resident #3 revealed:
-Resident #3 was admitted to the hospital for hydration and monitoring.

Review of a hospital clinical note dated 01/01/21 at 1:28pm revealed Resident #3 was discharged from the hospital and returned to the facility on 01/01/21.

Interview with the RCC on 02/23/21 at 4:01pm revealed:
-When Resident #3 was sick with COVID-19 she hardly got out of the bed.
-She had talked to someone at the hospital about when to send residents to the hospital.
-She "kind of did and kind of did not" contact residents' PCPs.
-She told Resident #3's PCP for the O2 sat of 72% on 12/18/21, no matter what was written in the visit note.

Attempted interview with Resident #3's previous PCP on 02/24/21 at 4:05pm was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 49 Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. Refer to telephone interview with a medication aide (MA) on 02/19/21 at 3:32pm. Refer to interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm. Refer interview with the Administrator on 02/23/21 at 5:12pm. _____ Telephone interview with a medication aide (MA) on 02/19/21 at 3:32pm revealed: -The MAs let the Resident Care Coordinator (RCC) know about any health care concerns for residents. -The RCC was responsible for contacting the resident's primary care provider (PCP). -He usually notified the RCC by text message. -MAs documented concerns in a communication book kept at the front desk Interview with the Resident Care Coordinator (RCC) on 02/18/21 at 4:48pm revealed: -She was the only one who called the primary care providers (PCPs). -Medication aides (MAs) might fax documents to the PCP's office, but they did not call the PCP. -Staff did not document care notes for residents in order to prevent documentation errors. -MAs documented on incident reports which were faxed to the PCP's office. Interview with the Administrator on 02/23/21 at 5:12pm revealed: -Staff notified the Resident Care Coordinator (RCC) or her directly with any resident concerns. -Any issues outside the RCC's scope of practice	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 should have been followed up with the resident's primary care provider (PCP) such as needing medical attention. -The RCC was normally in communication with the facility's contracted PCP daily. _____ The facility failed to notify the primary care provider (PCP) of the health care needs for 2 of 5 sampled residents (#3 and #5) related to one resident (#5) who had chronic obstructive pulmonary disease (COPD) and a recent diagnosis of COVID-19 and presented with difficulty breathing resulting in delayed treatment for residual pneumonia, not following up with a gastroenterologist following an emergency room visit for rectal bleeding resulting in a 5 month delay in evaluation; not contacting the PCP for an initial oxygen saturation level of 72% for Resident #3 with a documented hospitalization 10 days later for hypoxia and syncope. These failures were detrimental to the health, safety and wellbeing of Resident #5 and Resident #3 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/23/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2021.	D 273		
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.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 51 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#5) had a reasonable response from the Administrator and Resident Care Coordinator related to coordination of medical and mental health appointments; the freedom to have her Power of Attorney (POA) present at appointments in the community without having to quarantine the resident for 10 days in the POA's home following any in office medical vist the POA was present for; and the freedom of choice of medical provider. The findings are: a. Review of the facility's COVID-19 Action Plan updated 12/13/21 revealed: -All medical appointments would be performed via telehealth unless there was written documentation from the physician that it was a medical emergency for the resident to be seen in the office. -The facility would transport all residents to and from appointments if medical attention was needed on an emergency/necessary case. -All family members were encouraged to work with medical providers to arrange telehealth visits for appointments. -If a family member transports a resident to an appointment, the resident would have to quarantine for 7 days at home following the appointment. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities dated 05/29/20 revealed: -Residents should be encouraged to wear a cloth	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 52	D 338		

face mask (if tolerated) whenever they around others including whenever they leave their rooms or leave the facility.
-There was no guidance or directive to quarantine a resident away from the facility following a medical appointment.

Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in long term care facilities dated October 2020 revealed:
-Residents regularly leaving the facility for medically necessary purposes should wear a face mask whenever they leave their room, including when the leave they facility.
-Residents regularly leaving the facility for medically necessary purposes should be assigned a private room if possible.

Review of Centers for Medicaid and Medicare Services (CMS) guidance for long-term care facilities dated 11/19/20 revealed:
-Residents returning to the facility should be screened and monitored for signs and symptoms of COVID-19.
-Residents should be tested for COVID-19 if signs or symptoms of appear or their family reports possible exposure to COVID-19 while outside the facility.
-Residents should be placed on transmission-based precautions if signs or symptoms of appear or their family reports possible exposure to COVID-19 while outside the facility.
-The facility should consider testing for COVID-19 and initiating transmission-based precautions for residents away from the facility for more than 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 53	D 338		

Review of Resident #5's current FL-2 dated 05/04/20 revealed diagnoses included dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, bipolar disorder, hyperlipidemia, hypertension and a history of polyps.

Telephone interview with Resident #5's Power of Attorney (POA) on 02/16/21 at 11:43am revealed as soon as the COVID-19 restrictions started in March 2020, residents were not able to leave the facility unless it was an emergency.

Review of a telemedicine primary care provider (PCP) visit note dated 10/15/20 for Resident #5 revealed:
-The PCP conducted the telemedicine visit with Resident #5's POA via phone.
-Resident #5 was not available for the visit due to not being able to leave the facility for COVID-19 prevention per the POA.
-Resident #5 could only leave the facility for medical emergency treatment per the POA.

Interview with the Resident Care Coordinator (RCC) on 02/23/21 at 4:01pm revealed:
-She scheduled the follow up appointment for 10/15/20 with Resident #5's PCP.
-The appointment was a telehealth visit in which the PCP was supposed to call the facility's number.
-She called the PCP's office and was told the PCP called the POA's number.
-She told Resident #5's POA the facility would take the resident for emergency in person medical visits otherwise appointments were via telehealth per CDC, NC DHHS and local health department COVID-19 guidelines.

Review of an email dated 01/23/21 at 11:58am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 54	D 338		

from Resident #5's POA to the Administrator and RCC revealed:
-Resident #5's medical appointments on 02/03/21 with her PCP and 02/04/21 with her cardiologist were local appointments.
-Resident #5's appointment with her otolaryngologist on 02/15/21 was out of the area (90 minutes away).
-The POA was asking for contact from RCC and/or Administrator to confirm whether the facility was taking Resident #5 to her local appointments or was she (POA).
-The POA was getting a COVID-19 test to "satisfy the facility."

Review of an email from the RCC dated 01/25/21 at 3:33pm revealed:
-The recipients of the email were not identified.
-The POA was going to reschedule all of Resident #5's appointments including the appointment on 01/27/21 with her mental health provider (MHP).
-The POA agreed to quarantine Resident #5 for 10 days after her last appointment.
-Resident #5 would be able to return to the facility after the 10 days as long as the resident did not exhibit any signs or symptoms of COVID-19.

Telephone interview with Resident #5's POA on 02/22/21 at 8:01am revealed:
-The email dated 01/23/21 refers to not being able to take Resident #5 to medical appointments.
-She was tested for COVID-19 and still could not take Resident #5 to medical appointments.
-Getting Resident #5 to medical appointments and being able to be there during the appointments "got complicated."
-On 01/25/21 she "got frustrated and agreed to do what she had to do" to take care of Resident #5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 55	D 338		

-She decided to reschedule all the appointments together over a few days, planned to take Resident #5 to all the appointments and then quarantine Resident #5 at her home.
-Resident #5 needed a lot of assistance which was hard for her to do alone.
-Resident #5 needed blood sugar checks 4 times a day, had scheduled insulin in the morning and evening and had sliding scale insulin with the blood sugar checks.
-Resident #5 needed some assistance with bathing and dressing due to fatigue and shortness of breath.
-Resident #5 did not go to the 02/03/21 appointment with her PCP or the 02/04/21 appointment with her cardiologist.
-Between 02/15/21 and 02/19/21, Resident #5 had seen her PCP, Cardiologist, endocrinologist, otolaryngologist, MHP and had a telehealth gastroenterologist visit.
-She planned to return Resident #5 to the facility on 02/22/21 since hearing from the local Ombudsman regarding the facility's quarantine policy.
-She had already scheduled the grouped appointments and picked up Resident #5 with all her belongings prior to getting the response from the Ombudsman.

Review of an email from the Administrator to Resident #5's POA and the RCC revealed:
-The date of the email was "4 days ago" (February 2021).
-During the time Resident #5 was out of the facility it was considered a leave of absence.
-Insurance allowed residents to be out of the facility for 14 days.

Interview with the RCC on 02/18/21 at 4:48pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 56	D 338		

-She told the POA the facility would take Resident #5 to medical office appointments but the POA wanted to be in the room with the resident.
-Her "first priority was keeping residents safe" from COVID-19.
-The medical exam rooms were too small for the physician, resident, staff and POA to maintain social distancing.
-She offered virtual access to Resident #5's POA during office visits if the facility transported the resident, but the POA declined.
-Resident #5 had not left the facility for six months; the resident did not have medical needs where she needed to be seen outside the facility.

Review of a signed statement with the facility's letterhead dated 02/15/21 revealed:
-Resident #5's POA was taking Resident #5 out of the facility for nonmedical emergency physician appointments.
-Resident #5's POA agreed to monitor Resident #5 for fever, cough and shortness of breath.
-Resident #5's POA agreed to contact Resident #5's PCP and seek medical treatment immediately if the symptoms occurred.
-Once Resident #5 had been without symptoms for 10 days the resident was able to return the facility.
-If Resident #5 was exposed within the 10 day quarantine through an emergency room visit, social gathering or physician's office visit, the 10 day quarantine would restart.
-The statement was signed by Resident #5's POA and the RCC.

Interview with the Administrator on 02/23/21 at 5:12pm revealed:
-The facility's policy was to not send a resident out for medical appointments unless it was an emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 57	D 338		

-She and the RCC had offered to add Resident #5's POA virtually to any appointment the facility took her to.
-She knew now she could not ask resident family members to quarantine residents after leaving the facility for medical appointments and that family members had the right to take residents to and from medical appointments.
-She had not followed up with Resident #5's POA regarding the quarantine and medical appointments.

Upon request on 02/18/21, 02/22/21 and 02/23/21 documentation of the facility's response to coordinate medical appointments with Resident #5's POA were not available for review.

b. Review of an electronic physician's prescription order dated 09/17/20 for Resident #5 revealed an order for Debrox 5 drops into both ears twice daily for up to 4 days; may repeat as needed for excessive ear drops. (Debrox ear drops are used to remove ear wax.)

Review of an electronic physician's prescription order dated 09/24/20 for Resident #5 revealed an order to discontinue Debrox as needed signed by the facility's previous contracted primary care provider (PCP).

Telephone interview with Resident #5's POA on 02/16/21 at 11:43am revealed Resident #5 did not see the facility's contracted PCP.

Interview with the RCC on 02/18/21 at 4:48pm revealed Resident #5 saw the facility's contracted PCP for some things like treatment for COVID-19 in December 2020.

Telephone interview with Resident #5's POA on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 58 02/19/21 at 1:54pm revealed: -She was aware and had approved the facility's contracted PCP to see Resident #5 during the COVID-19 outbreak (December 2020). -She did not know the facility's contracted PCP had written an order to discontinue the Debrox ear drops on 09/24/20. Telephone interview with the facility's current contracted primary care provider (PCP) on 02/22/21 at 12:41pm revealed she did see Resident #5. Attempted telephone interview with the facility's previous contracted PCP on 02/24/21 at 4:05pm was unsuccessful. [Refer to 10A NCAC 13F .0902(b) Health Care]	D 338		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S.	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 59	D 433		

131D-21);
(D) the home's grievance procedures; and
(E) civil rights statement;
(4) resident assessment and care plan;
(5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;
(6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;
(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.
When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure documentation of contact with the physician services and from hospital providers related to illness, change in condition and accidents for 4 of 5 sampled residents (#2, #3, #4 and #5).

The findings are:

1. Review of Resident #5's current FL-2 dated 05/04/20 revealed diagnoses included dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, bipolar disorder, hyperlipidemia, hypertension and a history of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 60 polyps. Review of Resident #3's record revealed: -There were no care notes documenting acute health care issues related to complaints of difficulty breathing and shortness of breath in January 2021. -There were no copies of letters from Resident #5's primary care provider (PCP) with order for an emergency gastroenterology follow up appointment (10/12/20) and to monitor oxygen saturation levels during the night (12/22/20). -There were no care notes documenting acute health care issues related to rectal bleeding and monitoring in October 2020. -There were no care notes documenting acute health care issues related to ear pain and interventions from October 2020 through February 2021. -There was no documentation of contact with Resident #5's PCP, mental health provider (MHP) and/or Power of Attorney (POA) for acute health care concerns such as difficulty breathing, rectal bleeding, ear pain and behavior concerns. -There was no documentation of Resident #5's visit(s) with PCP, MHP and otolaryngologist. -There was no documentation of the facility's efforts to coordinate access to medical providers and follow up appointments for Resident #5. [Refer to Tag 273, 10A NCAC 13F .0902(b) example 1] Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/22/21 at 12:41pm. Refer to telephone interview with the Administrator on 02/22/21 at 12:41pm. 2. Review of Resident #3's current FL-2 dated	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 61	D 433		

05/01/20 revealed diagnoses included dementia, hypertension, coronary artery disease, degenerative joint disease, arthritis, cerebral vascular disease, bradycardia and chronic diastolic heart failure.

Review of Resident #3's record revealed:
-There were no care notes documenting falls and interventions on 12/19/20, 01/03/21 and a third fall with an unknown date.
-There were no care notes documenting acute health care issues during Resident #3's COVID-19 infection in December 2020.
-There was no documentation of contact with Resident #3's primary care provider (PCP) for acute health care concerns such as diarrhea, weakness, and an oxygen saturation level of 72% on 12/18/20.

Upon request on 02/17/21, 02/18/21 and 02/23/21 an incident/accident report dated 12/19/20 for Resident #3 was not available for review.

Upon request on 02/23/21 a 24 acute monitoring form initiated on 12/19/20 for Resident #3 was not available for review.

Upon request on 02/17/21, 02/18/21 and 02/23/21 an incident/accident report dated 01/03/21 for Resident #3 was not available for review.

[Refer to Tag 270, 10A NCAC 13F .0901(b) example 5]

[Refer to Tag 273, 10A NCAC 13F .0902(b) example 2]

Refer to telephone interview with the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 62	D 433		

Care Coordinator (RCC) on 02/22/21 at 12:41pm.

Refer to telephone interview with the Administrator on 02/22/21 at 12:41pm.

4. Review of Resident #4's current FL-2 dated 07/19/20 revealed diagnoses included dementia, subarachnoid hemorrhage, transient ischemic attacks, cerebrovascular accident, muscle weakness, history of seizures, hypertension, diabetes type II, emphysema, and blindness.

Observations of Resident #4 on 02/17/21 at 5:51am revealed there were stitches running vertically down her forehead with swelling.

Interview with a Medication Aide (MA) on 02/17/21 at 2:23pm revealed:
-All orders were placed in the Resident Care Coordinator's (RCC) box.
-The RCC reviewed the information before she filed the information in the resident's record.
-When a resident had a same day hospital visit, each shift was supposed document on a 24-hour monitoring report.
-When a resident had an overnight hospital stay, there was supposed to be documentation from each shift on a 72-hour monitoring report.
-Once the monitoring reports were completed, the monitoring report was placed in a drawer for the RCC.

Interview with the RCC on 02/18/21 at 4:48pm revealed:
-She was the only one who filed documents in the resident record.
-She was responsible for contacting physicians.
-She only documented physician contacts when the physician gave new orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 63 Interview with the RCC on 02/23/21 at 4:45pm revealed: -Twenty-four hour and 72-hr monitoring reports would be in the resident record. -The MA on duty was responsible to initiate the monitoring reports. Review of Resident #4's record revealed: -There was no documentation of an injury requiring suturing to the residents' forehead. -There were no hospital discharge notes for any hospital visits. -There were no 24-hour monitoring reports for 02/04/21 or 02/13/21. Telephone interview with the county Department of Social Services on 02/19/21 at 11:37am revealed: -She received a faxed copy of an incident report for Resident #4 dated 02/13/21 documenting the resident had an unwitnessed fall and sustained a laceration to the forehead and was sent to the hospital emergency room -She received a faxed copy of an incident report for Resident #4 dated 02/04/21 documenting the resident had an unwitnessed fall and sustained a "gash" to the forehead and was sent to the hospital emergency room. Review of the incident/accident report for Resident #4 dated 02/13/21 received from the county Department of Social Services revealed: -On 02/13/21 at 6:20am, Resident #4 had an unwitnessed fall in the television room out of her wheelchair. -The unwitnessed fall resulted in a gash to the resident's forehead. -The resident was sent to the local hospital emergency room for treatment.	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 64 Review of hospital emergency room records received from the local hospital for Resident #4 dated 02/13/21 revealed: -Resident #4 was transported from the facility to the local hospital emergency room via EMS after an unwitnessed fall. -The resident sustained a one-inch vertical laceration to the forehead. -The resident complained of pain to the laceration site/head. -The frontal scalp laceration was repaired with five sutures. -The resident was discharged back to the facility on 02/13/21. Review of hospital emergency room records received from the local hospital for Resident #4 dated 02/04/21 revealed: -Resident #4 was transported from the facility to the local hospital emergency room via emergency medical services (EMS) "after falling out of her wheelchair while asleep". -A description of the incident in the emergency department note revealed the resident "was turning out of the wheelchair and transfer to a stationary chair when she fell out of the chair onto the floor hitting her head on the ground, unsure if she had loss of consciousness". -The resident sustained a small laceration/abrasion to the forehead. -An x-ray of the head and spine revealed a soft tissue contusion over the right frontal bone. -The resident was discharged back to the facility on 02/04/21. Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/22/21 at 12:41pm. Refer to telephone interview with the Administrator on 02/22/21 at 12:41pm.	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 65 5. Review of Resident #2's current FL-2 dated 10/15/20 revealed diagnoses included dementia, depression, and hip pain. Observation of Resident #2 in his bedroom on 02/18/21 at 11:28am revealed: -Two medication aides (MAs) were performing wound care to the back of the resident's head. -Resident #2 had a laceration to the back of his head from a fall earlier in the morning. Review of Resident #2's record revealed: -There was no documentation of an injury requiring wound care to the resident's head. -There were no hospital discharge notes for Resident #2's hospitalization 12/24/20, 01/03/21, or 01/25/21. -There was no 24-hour monitoring report for 12/24/20 -There was no 72-hour monitoring report for 01/25/21. -There were no primary care provider (PCP) visit notes for the 01/26/21 visit. Telephone interview with the county Department of Social Services on 02/19/21 at 11:30am revealed: -She did not receive a copy of an incident report dated 12/23/20 for Resident #2. -She had received a copy of an incident report dated 12/27/20 for Resident #2. -She did not receive a copy of an incident report dated 01/24/21 for Resident #2. Review of Resident #2's hospitalization records received from the local hospital dated 12/23/20 to 12/24/20 revealed: -Resident #2 was transported to the ER because of an unwitnessed fall on 12/23/20. -Resident #2 had an abrasion the left posterior	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 66 scalp and a skin tear to his left elbow. Review of Resident #2's hospitalization records received from the local hospital dated 12/27/20 to 01/03/21 revealed: -Resident #2 was transported to the ER because of a witnessed fall on 12/27/20. -Resident #2 had a 1.5-inch laceration to his posterior scalp. -Resident #2 was admitted to the hospital and discharged from the hospital on 01/03/21. Review of Resident #2's hospitalization records dated 01/24/21 to 01/25/21 revealed: -Resident #2 was transported to the ER because of an unwitnessed fall on 01/24/21. -Resident #2 received staples to his laceration. -Resident #2 was admitted for observation. -Resident #2 was discharged from the hospital on 01/25/21. Refer to telephone interview with the Resident Care Coordinator (RCC) on 02/22/21 at 12:41pm. Refer to telephone interview with the Administrator on 02/22/21 at 12:41pm. _____ Telephone interview with the Resident Care Coordinator (RCC) on 02/22/21 at 12:41pm revealed: -Staff did not document notes for residents unless the resident was sent to the hospital. -All notes related to provider orders and outcomes of appointments were documented in an in house communication book. -Staff did not document in resident records. -Staff documented on incident/accident forms so that everyone who needed to see the report had a copy such as the RCC, PCP and Administrator. -PCP visit notes were not kept in the residents'	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 433	Continued From page 67 records to keep them from going missing. -If a resident had a physical complaint and there was nothing on the electronic medication administration record, then the medication aide (MA) notified the RCC and RCC contacted the PCP for an order. -She did not document her contact with PCP's unless she was told to do something specific by the PCP. Telephone interview with the Administrator on 02/22/21 at 12:41pm revealed: -Staff documented shift notes in the communication book and communicated verbally during stand up at shift change. -Everything was documented on incident reports. -If a resident fell 5 times there would have been 5 incident reports whether the resident was sent to the emergency room (ER) or not. -There was documentation on the incident report form of who staff notified.	D 433		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 68 department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Center for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding proper use of face masks by staff, resident screening, staff screening, visitor screening, and social distancing of residents. The findings are: Review of NC DHHS Best Practices for Infection Prevention in Long Term Care Facilities dated 02/10/21 revealed: -Follow CDC guidance for appropriate selection and use of personal protective equipment (PPE). -Modify facility layouts and procedures to support social distancing. Review of NC DHHS Guidance on Visitation, Communal Dining and Indoor Activities for Larger Residential Settings dated 12/22/20 revealed: -Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms). -Social distancing at least six feet between persons. -The facility must conduct daily screening for	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 69	D 612		

temperature check, presence of symptoms, and known exposure to COVID-19 of all residents and staff.
-Ensure 6 feet of space between each individual and each table during dining.
-If possible, space should be designating 6 feet of separation between tables.

Review of the CDC's Considerations for Memory Care Units in Long-term Care Facilities dated 05/12/20 revealed:
-Facilities should limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area.
-Gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.
-Try to keep residents' environment and routine as consistent as possible while still reminding and assisting them with social distancing.

Review of the CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities (ALF) dated 05/29/20 revealed:
-ALFs should refer to guidance from state and local officials when making decisions about relaxing restrictions including restoring communal dining.
-Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building.
-Personnel should wear a facemask at all times while they are in the facility.
-Facemasks are personal protective equipment (PPE) and are often referred to as surgical masks or procedure masks.
-Cloth face coverings are not PPE and should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 70	D 612		

NOT be worn instead of facemask if more than source control is required.
-Encourage social (physical) distancing.
-Instead of communal dining, consider delivering meals to rooms, creating a 'grab n' go' option for residents, or staggering mealtimes to accommodate social distancing while dining (e.g. a single person per table).
-Remind residents to remain at least 6 feet apart from others when they are outside their room.
-Designate one or more facility employees to ensure all residents have been asked at least daily about fever and symptoms consistent with COVID-19.

Review of NC DHHS Strategies to Optimize Personal Protective Equipment- Facemasks dated August 2020 revealed cloth face masks are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown.

Review of the facility's COVID-19 Action Plan updated 12/13/20 revealed visitors will be screened for fever and other symptoms associate with COVID-19 (fever equal to or greater than 100F, cough, shortness of breath, sore throat, muscle aches, chills or new onset of less of smell or taste).

Review of the facility's COVID-19 Visitation Policy revealed staff must wear a surgical face mask.

Review of the facility's resident roster revealed the facility's current census was 55 residents.

1. Observation of the front entrance door of the facility on 02/17/21 at 5:31am revealed:
-One sign that stated: "Face Masks Required Prior to Entry".
-A second sign that state: "Face Coverings are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 71 Required: Non-Medical Masks, Bandanas, Scarves and Cloth Can Be Used". Observation of the medication aide (MA) who greeted the surveyors at the front entrance on 02/17/21 at 5:32 am revealed she was wearing a cloth face covering. Observation on 02/17/21 at 6:16am revealed there were three personal care aides (PCA) wearing cloth masks and assisting residents to the TV room. Observation of two personal care aides (PCA) performing resident care in a resident's room on 02/17/21 at 5:53am revealed: -The PCAs assisted the resident with dressing and hygiene care. -Both PCAs wore cloth face coverings. Observation of two MAs performing resident care on 02/18/21 at 11:28am revealed: -The MAs performed wound care on Resident #2. -Both MAs wore cloth face coverings. Observation of two PCAs on 02/18/21 at 2:37pm revealed: -The PCAs took a resident to the bathroom for toileting and personal care. -Both PCAs wore cloth face coverings. Observation of a medication aide (MA) on 02/23/21 at 10:47am revealed the MA wore a cloth face covering. Observations of the facility's personal protective equipment (PPE) supply on 02/17/21 at 1:30pm revealed three full boxes of 2,000 disposable face masks.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 72 Interview of a PCA on 02/17/21 at 6:25am revealed: -The facility would give them surgical masks to wear if they asked for a mask. -She chose to wear a cloth mask. -She was never instructed that she could not wear a cloth mask by management. Interview with the Resident Care Coordinator (RCC) on 02/17/21 at 1:34pm revealed: -She thought that staff could wear cloth masks while working in the facility. -She was not aware that it was in the Center for Disease Control (CDC) guidance that staff could not wear cloth masks while performing personal care. -The facility received guidance from the CDC regarding PPE. Telephone interview with the Business Office Manager (BOM) on 02/22/21 at 1:17pm revealed: -She received emailed guidance on 12/17/20 from the local health department (LHD) that included the CDC link related to proper usage of PPE. -She could not recall specifically what the PPE guidance was related to cloth masks versus surgical masks. -She shared the information regarding proper use of PPE with the RCC and Administration when it was sent by the LHD. Interview with a MA on 02/23/21 at 11:47am revealed: -Staff could wear their own cloth face coverings while working inside the facility. -She had not been instructed to wear a surgical face mask inside the facility. -She thought it was fine "as long as you have on a mask".	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 73 Interview with the Administrator on 02/23/21 at 4:52pm revealed: -She was not aware that staff could not wear cloth face masks alone. -She was not able to recall specifically what the guidance was on cloth face masks. -The facility received guidance on PPE from the CDC, North Carolina Department of Health and Human Services (NC DHHS), and LHD. Telephone interview with a Registered Nurse from the LHD on 02/22/21 at 8:53am revealed the facility was sent guidance via email on 12/17/20 which included proper PPE usage under CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities. 2. a. Observation on 02/17/21 at 5:32am revealed the medication aide (MA) invited the surveyors into the facility without performing any screening per NC DHHS and CDC guidelines. Observation of the front entrance on 02/17/21 at 5:32am revealed: -There was a handheld thermometer on the ledge by the door. -There was no sign in book or screening log at the front entrance. Observation on 02/17/21 at 1:20pm revealed the Resident Care Coordinator (RCC) invited the surveyors into the facility without performing any screening per NC DHHS and CDC guidelines. Interview with a MA on 02/17/21 at 5:44am revealed -The facility staff usually checked visitors' temperatures. -She was "thrown off" with the surveyor coming to	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 74	D 612		

the facility and forgot to check their temperatures.
-Visitor's temperatures were taken but they were not asked screening questions.
-She did not know why visitors were not asked screening questions.
-Visitor's temperatures were not documented.

Interview with the RCC on 02/17/21 at 1:20pm revealed:
-She did not screen the surveyors after they returned from lunch off campus because she was told that they did not have to.
-She could not remember who told them they did not have to re-screen visitors when they returned.
-All visitors were screened with temperature checks and COVID-19 symptom checks.
-Visitor screenings were not documented.
-She was not aware that visitor screening needed to be documented.

Interview with the Administrator on 02/23/21 at 4:52pm revealed:
-All visitors were screened with temperature checks and COVID-19 symptom checks.
-Visitor screenings were not documented.
-She was not aware that visitor screening needed to be documented.
-She was not aware that visitors needed to be re-screened upon return to the facility if they were off-campus.
-The facility received guidance from the local health department (LHD) including information from the CDC and NC DHHS related to COVID-19 guidelines.

Telephone interview with the local health department Registered Nurse on 02/22/21 at 8:53am revealed:
-The facility was provided with COVID-19 guidance on 12/17/20 via email which included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 75 CDC's Considerations for Memory Care Units in Long-term Care Facilities and CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities. -The facility was not provided with guidance to stop visitor screenings at any time. -Visitors screening should include temperature check and symptom screenings. b. Interview with a personal care aide (PCA) on 02/17/21 at 7:47am revealed: -Staff temperatures were taken at the start of each shift. -She did not think that staff temperatures were recorded. -She did not remember being asked about symptoms of COVID-19 prior to the start of her shift. Interview with the transportation staff on 02/17/21 at 10:02am revealed: -Staff's temperatures were being taken at the start of each shift since March of 2020. -Staff temperatures were not documented. -Staff were not screened for COVID-19 symptoms or exposure at the start of each shift. Interview with the RCC on 02/17/21 at 1:32pm revealed: -Staff's temperatures were checked at the start of each shift. -The facility did not document staff's temperature checks. -She was not aware that staff screening needed to be documented. Observation of a medication aide (MA) entering the facility on 02/23/21 at 10:48am revealed: -The MA entered through the front door. -The MA did not perform a temperature check	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 76	D 612		

until prompted by the surveyor.

Interview with the MA on 02/23/2021 at 10:48am revealed she did not have to recheck her temperature because she had checked her temperature earlier in the morning when she reported to work.

Interview with the Administrator on 02/23/21 at 4:52pm revealed:
-Staff's temperatures were being taken at the start of each shift since March 2020.
-Staff temperatures were not being documented.
-Staff screenings including symptom screening for COVID-19 were not being completed because she was not aware that it had to be done.
-She was not aware that staff screenings needed to be documented.
-The facility received guidance from the local health department (LHD) including information from the CDC and NC DHHS related to COVID-19 guidelines.

Telephone interview with the local health department Registered Nurse on 02/22/21 at 8:53am revealed:
-The facility was provided with COVID-19 guidance on 12/17/20 via email which included CDC's Considerations for Memory Care Units in Long-term Care Facilities and CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities.
-The facility was not provided with guidance to stop staff screenings at any time.
-Staff screenings should include temperature check and symptom screening.

c. Review of resident screening forms revealed:
-There were daily temperature and oxygen saturation results dated 12/16/20 to 12/31/20 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 77	D 612		

all residents.
-There were no daily temperature and oxygen saturation results available for review prior to 12/16/20 or after 12/31/20.

Interview with the transportation staff on 02/17/21 at 10:02am revealed:
-Residents' temperatures were taken daily during the facility's COVID-19 outbreak from 12/17/20 until mid-January 2021.
-Residents' temperatures were not taken prior to the facility outbreak in December 2020 or after the quarantine time period ended in January 2021.
-Residents were not being screened for signs and symptoms of COVID-19.

Interview with RCC on 02/23/21 at 12:50pm revealed:
-On 12/16/20, resident's temperatures were taken by herself and the Administrator.
-On 12/17/20, the facility started taking temperature and oxygenation saturations of all the residents until the end of the quarantine period mid-January 2021.
-Prior to the December 2020 outbreak, the RCC and the Administrator would "randomly spot check 3 or 4 residents' temperatures" since March 2020.
-The random spot checks of residents' temperatures were not documented.
-Residents' temperatures and symptom screenings for COVID-19 were not completed daily prior to the outbreak 12/16/20.
-The facility stopped daily screening after the quarantine period in January 2021 because they were not aware that they had to continue to perform them.

Interview with the Administrator on 02/23/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 78	D 612		

4:52pm revealed:
-She and the RCC performed random checks of residents' temperatures prior to December 2020.
-The random checks of residents' temperatures prior to the December 2020 facility outbreak were not documented.
-She felt the random resident temperature checks would help identify early symptoms of COVID-19.
-Temperature and oxygen levels were recorded from the start of the facility outbreak on 12/18/20 until the end of the quarantine period.
-She was not aware that she had to continue with daily resident screening after the quarantine period ending mid-January 2021.
-The facility received guidance from the local health department (LHD) including information from the CDC and NC DHHS related to COVID-19 guidelines.

Telephone interview with the local health department registered nurse on 02/22/21 at 8:53am revealed:
-The facility was provided with COVID-19 guidance on 12/17/20 via email which included CDC's Considerations for Memory Care Units in Long-term Care Facilities and CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities.
-The facility was not provided with guidance to stop resident screening after the completion of quarantine in mid-January 2021.
-The facility should continue to screen residents as directed in the COVID-19 guidance from the CDC and NC DHHS.

3. Observation of the TV room on 02/17/21 at 7:25am revealed 25 residents seated closer than 6 feet in distance from each other.

Observation of the first breakfast service in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 79	D 612		

dining room on 02/17/21 at 7:42am revealed:
-There were 16 residents in the dining room.
-The residents were seated 2, 3, or 4 to a table.
-Residents were directed where to sit by staff.
-At the tables where 4 residents were seated, they were separated by approximately 2 feet of space.
-The residents were not separated by 6 feet in distance.

Observation of the second breakfast service in the dining room on 02/17/21 at 8:19am revealed:
-There were 32 residents in the dining room.
-There were 6 staff members in the dining room.
-The residents were seated 3 or 4 per table.
-Residents were directed where to sit by staff.
-At the tables where 4 residents were seated, they were separated by approximately 2 feet of space.
-The residents were not separated by 6 feet in distance.

Observation of the TV room on 02/18/21 at 6:31am revealed there were 22 residents seated closer than 6 feet apart.

Observation of the 200 hall entrance on 02/17/21 at 7:04am revealed 4 residents seated closer than 6 feet apart in the hallway.

Observation of the TV room on 02/18/21 at 7:14am revealed there 23 residents seated closer than 6 feet apart.

Observation of the TV room on 02/18/21 at 11:25am revealed 30 residents and 1 staff member seated less than 6 feet in distance from each other.

Observation of hallway outside of the TV room on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 80 02/23/21 at 11:57am revealed: -Residents using wheelchairs were placed by staff members in a line outside the dining room. -Residents were waiting to go into the dining room for the second lunch service. -Residents were not separated by at least 6 feet in distance. Observations of the TV room on 02/23/2021 from 11:30am - 11:35am revealed: -There were 19 residents in the TV room. -There were three residents seated on the sofa positioned to the left of the entry to the TV room. -The three residents were not wearing face coverings. -A staff member approached the three residents in the TV room at 11:33am and greeted the residents. -There was no prompting from the staff to encourage and redirect the residents to social distance. -A second staff entered the TV room at 11:35am. -There was no prompting from the second staff to encourage and redirect the residents to social distance. Observation of residents on 02/23/21 between 11:54am - 12:10pm revealed: -A staff was positioning the residents in wheelchairs outside the dining room in a line. -The wheelchairs were lined up within four floor tile squares of each other (approximately four feet). Interview with the transporter on 02/23/21 at 11:54am revealed: -There was no specific distance between each wheelchair when positioning the resident wheelchairs in a line outside the dining room. -He was trying to be more efficient in getting the	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 81	D 612		

residents who used walkers out of the TV room first and into the dining so there would not be a trip hazard.
-It was hard to keep residents social distanced in the facility.

Interview with two additional staff members standing in the hall by the TV room and dining room on 02/23/21 at 12:06pm revealed residents were usually lined up in the hall before meals.

Observation of the second lunch service in the dining room on 02/23/21 at 12:00pm revealed:
-Residents were placed at dining table by staff.
-There were tables of 3 or 4 residents.
-Residents were not separated by at least 6 feet in distance.

Telephone interview with the Business Office Manager (BOM) on 02/22/21 at 1:17pm revealed she received emailed guidance on 12/17/20 from the local health department (LHD) that included the Center for Disease Control (CDC) link related to social distancing.

Interview with the Administrator on 02/23/21 at 4:52pm revealed:
-The facility received guidance on COVID-19 from the Center for Disease Control (CDC), North Carolina Department of Health and Human Services (NC DHHS), and local health department (LHD) including guidance on social distancing.
-During the facility's quarantine period from 12/17/20 to mid-January 2021 the residents ate in their rooms.
-The front activity room was sometimes used as a second dining area to space apart the residents during meal service.
-The front activity room was sometimes used as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 612	Continued From page 82 an area for residents to spread out during the day rather than using the TV room. Telephone interview with a Registered Nurse from the LHD on 02/22/21 at 8:53am revealed: -The facility was sent guidance via email on 12/17/20 including social distancing during communal dining and group activities. -The facility should continue to observe social distancing guidelines when resuming communal dining and group activities. _____ The failure of the facility to adhere to the Center for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) recommendations and guidance regarding proper use of face masks by staff; to perform COVID-19 screenings for residents, visitors and staff; and to ensure social distancing of residents placed the residents at increased risk for transmission and infection from COVID-19. The facility's failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/24/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2021.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 83	D912		

adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care and infection prevention.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 4 of 5 residents sampled (#1, #2, #3, #4) including a resident who had six falls resulting in three emergency room (ER) (#2), a resident who had 13 falls within a five month period with four trips to the ER (#1), a resident who had two falls resulting in two ER (#4), and a resident with 3 undocumented falls, one of which resulted in an ER visit (#3). [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)]

2. Based on observations, interviews and record reviews, the facility failed to follow up on the health care needs for 2 of 5 sampled residents (#3 and #5) by not contacting the primary care provider (PCP) for difficulty breathing and ear pain and not following up with a gastroenterologist following an emergency room visit for rectal bleeding and scheduling a mammography appointment (Resident #5); and not contacting the PCP for an initial oxygen saturation level of 72% (Resident #3). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026054	A. BUILDING: _____ B. WING _____	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE MANOR	231 TREETOP DRIVE FAYETTEVILLE, NC 28311

(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 84 (Type B Violation)] 3. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Center for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding proper use of face masks by staff, resident screening, staff screening, visitor screening, and social distancing of residents. [Refer to Tag 612 10A NCAC 13F .1801(c) Infection Prevention & Control Program (Type B Violation)]	D912		