PRINTED: 07/18/2022 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	I I E D
		HAL042005	B. WING		R- 06/2	C 4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		LINA REST H RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	00 Initial Comments		D 000			
	annual and follow-up investigation on June with an exit conference 2022. The complaint	sure Section conducted an survey and complaint 21, 2022 to June 24, 2022 ce via telephone on June 24, investigation was initiated by epartment of Social Services				
D 067	10A NCAC 13F .0305	5(h)(4) Physical Environment	D 067			
	(h) The requirements exits are: (4) In homes with at determined by a physic to be disoriented or a accessible by resider sounding device that opened. The sound so that it can be heard be of remote sounding disorted panel for the sound sound sounding disorted panel for the sounding diso					
	reviews, the facility fa doors accessible to re with a sounding device safety of 2 sampled re	ns, interviews and record illed to ensure 2 of 9 exit esidents' use were equipped that activated for the esidents (#6, #7) who were liented (#6, #7) and with				

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

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SI COMPLE	
					R-0	
		HAL042005	B. WING		06/2	4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	CAROLINA REST HOME			OME ROAD		
	ROANOKE			27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 067	Continued From page	2 1	D 067			
D 067	Observations of the factor on 06/21/22 at 8:00ar 06/22/22 at 7:30 am, 06/23/22 at 5:45pm resurred and did not lintermittent observation (which led to an unfer facility) on 06/21/22 for revealed: -The door was unlock sounding alarm when Residents freely entersonking door to smol 1. Review of Resident of Carlonic airway obstruction heart disease. -She was ambulatory had wandering behave the confusion and wander never exhibited exit serviews it was determined interviewable.	acility's main entrance door m, 06/21/22 at 4:30pm, 06/22/22 at 5:45pm, and evealed the door was alarm when opened. ons of the smoking door need open field behind the rom 9:10am to 12:00pm ded and did not have a opened. ered and exited through the red and socialize. It #7's current FL-2 dated asthma, bronchiectesis, ction, diabetes mellitus, and riors. onal care aide (PCA) on evealed Resident #7 had ring behaviors but had eeking behaviors or eloped. as, interviews, and record nined that Resident #7 was	D 067			
	06/22/22 at 10:20am.					
	Refer to interview with on 06/22/22 at 10:30a	n the Director of Operations am.				
	Refer to interview with	n the Administrator on				

Division of Health Service Regulation

06/23/22 at 2:00pm.

STATE FORM R61411 If continuation sheet 2 of 130

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
			<u> </u>		1 00/2-4/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•	
CAROLIN	A REST HOME		OLINA REST H		
		ROANOKE	RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 067	Continued From page	e 2	D 067		
	Refer to interview with the facility's contracted primary care provider (PCP) on 06/23/22 at 10:46am.				
	2. Review of Resident #6's current FL-2 dated 03/25/22 revealed:				
	 -Diagnoses included advanced dementia with suicidal ideation. -She was ambulatory and constantly disoriented. Observation of Resident #6 on 06/21/22 at 				
		was ambulating in the hall			
	06/21/22 at 8:20am re	onal care aide (PCA) on evealed Resident #6 had but had never eloped.			
	9:05am revealed Res	nd PCA on 06/21/22 at sidents #6 had confusion and but had never exhibited exit eloped.			
		ns, interviews, and record nined that Resident #6 was			
	Refer to interview with 06/22/22 at 10:20am.	h a personal care aide on			
	Refer to interview with on 06/22/22 at 10:30a	h the Director of Operations am.			
	Refer to interview with 06/23/22 at 2:00pm.	h the Administrator on			
		h the facility's contracted (PCP) on 06/23/22 at			

Division of Health Service Regulation

10:46am.

STATE FORM R61411 If continuation sheet 3 of 130

STATEMENT OF DEPOCENCIES AND PLAN OF CORRECTION MALD42005 NAME OF PROVIDER OR SUPPLIER THE CARCILINA REST HOME THE CARCILINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 ROANOKE RAPIDS, NC 27870 PROVIDERS NAME OF CORRECTION. REQULATORY OR LOC IDENTIFYING INFORMATION) THE REQULATORY OR LOC IDENTIFYING INFORMATION) THE REQULATORY OR LOC IDENTIFYING INFORMATION) THE REPORT OF THE CARCILINA REST HOME ROAD THE CARCILINA REST HOME ROAD RESULT THE CARCILINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 PROVIDERS NAME OF CORRECTION. REQULATORY OR LOC IDENTIFYING INFORMATION) THE REPORT OF THE CARCILINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 PROVIDERS NAME AND OF CORRECTION. REQULATORY OR LOC IDENTIFY HAS INFORMATION. THE REPORT OF THE CARCILINA REST HOME ROAD THE REPORT OF THE REST HOME ROAD THE REST HOME	DIVISION	n Health Service Negu	ilation			1	
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Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 4 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R-C 06/24/2022	
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/2	
			OLINA REST H			
CAROLINA	A REST HOME		RAPIDS, NC			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 067	Continued From page	÷ 4	D 067			
	2:00pm revealed: -He was not aware of sounding alarms at al residents who had disbehaviorsHe and the DO shou rule and ensured the have doors with soun -The facility had neve outside of the building an extra measure of swandering residents. Interview with the faci care provider (PCP) or revealed: -He expected the faci having sounding alarmesident safetyHe expected facility soming in and out of the residents did not wan -Confused and disorie wandering behaviors and roads, get hit by a sounding alarmesidents get him to see the same residents and disorie wandering behaviors and roads, get hit by a sounding alarmesidents get him to see the same residents and disorie wandering behaviors and roads, get hit by a sounding alarmesidents get him to see the same residents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering behaviors and roads, get hit by a sounding alarmesidents wandering wandering alarmesidents wandering alarmesidents wandering alarmesidents wandering alarmesidents wandering w	Id have been aware of the facility was in compliance to ding alarms as expected. In had a resident wander go but sounding alarms were eafety for disoriented and lity's contracted primary on 06/23/22 at 10:46am lity to maintain compliance in ms on doors at all times for estaff to monitor who was the facility to ensure der off. In ented residents who had could wander into highways a vehicle, get lost, fall and miss care that they required				
D 137	10A NCAC 13F .0407 Qualifications	(a)(5) Other Staff	D 137			
	(a) Each staff person shall:(5) have no substant	Other Staff Qualifications at an adult care home atted findings listed on the Care Personnel Registry E-256;				

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 5 of 130

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUITIPI F	CONSTRUCTION	(X3) DATE S	URVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLI	
			20.25.110		_	
		HAL042005	B. WING		R-	C 4/2022
					1 00/2	7: 4044
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA			
CAROLINA	CAROLINA REST HOME			OME ROAD		
I			RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 137	Continued From page	5	D 137			
	This Rule is not met as evidenced by: TYPE B VIOLATION					
	facility failed to ensure					
	The findings are:					
	1. Review of Staff A's record revealed: -She was hired on 11/01/21 as a personal care aide (PCA) and began working as a medication aide (MA) on 02/16/22There was no documentation of that a Health Care Personnel Registry status check was done on or prior to the date of hire or thereafter.					
	Refer to interview with Coordinator (RCC) or					
	Refer to interview with (DO) on 06/22/22 at 4	n the Director of Operations :50pm.				
	Refer to interview with 06/23/22 at 2:00pm.	n the Administrator on				
	Refer to interview with residents at the facility	n the PCP for several y on 06/23/22 at 10:46am.				
	(MA). -There was no docum	115/22 as a medication aide entation of that a Health stry status check was done				

Division of Health Service Regulation

Refer to interview with the Resident Care

STATE FORM R61411 If continuation sheet 6 of 130

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF D	ROVIDER OR SUPPLIER	etheet And	DRESS, CITY, STA	TE ZID CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER				
CAROLIN	A REST HOME		OLINA REST H ERAPIDS, NC		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 137	Continued From page	e 6	D 137		
	Coordinator (RCC) or	n 06/22/22 at 3:58pm.			
	Refer to interview with (DO) on 06/22/22 at 4	h the Director of Operations 4:50pm.			
	Refer to interview with the Administrator on 06/23/22 at 2:00pm.				
	Refer to interview with the PCP for several residents at the facility on 06/23/22 at 10:46am.				
	3. Review of Staff C's record revealed: -She was hired on 07/30/18 as a MAThere was no documentation of that a Health Care Personnel Registry status check was done on or prior to the date of hire or thereafter.				
	Refer to interview with Coordinator (RCC) or	h the Resident Care n 06/22/22 at 3:58pm.			
	Refer to interview with (DO) on 06/22/22 at 4	h the Director of Operations 4:50pm.			
	Refer to interview with 06/23/22 at 2:00pm.	h the Administrator on			
	Refer to interview with residents at the facility	h the PCP for several y on 06/23/22 at 10:46am.			
	(RCC) on 06/22/22 at -A Health Care Perso check should have be hire.	sident Care Coordinator: 3:58pm revealed: nnel Registry (HCPR) status een done on staff on day of n in place to audit employee			
		ector of Operations (DO) on evealed she was unaware			

Division of Health Service Regulation

that a HCPR status needed to be done for

STATE FORM 6899 R61411 If continuation sheet 7 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL042005	B. WING		06/24/2022	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	CAROLINA REST HOME			OME ROAD		
	OLINA NA DV. OT		E RAPIDS, NC			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 137	Continued From page	e 7	D 137			
	personal care aides (PCA) but a HCPR should have been done on all medication aides upon hire.					
	2:00pm revealed: -The RCC and DO we new staffThe DO was respons HCPR status had bee -A HCPR status shou them starting work at -Not checking HCPR work at the facility corof the residents. Interview with the prin several residents at the 10:46am revealed:	ld be done on staff prior to the facility. status prior to staff starting uld jeopardize the well-being mary care provider (PCP) for the facility on 06/23/22 at				
	-Residents who lived increased risk for abuand were not always themselves.	se due to cognitive decline				
	-HCPR checks should	d have been done for all protect the residents in their				
	Refer to Tag D 338, 1 Resident Rights	0A NCAC 13F .0909				
	(Staff A, B, C) had a liprior to hire. This failuknowing if staff had since HCPR which was det welfare of the resider Violation.					
		131D-34 on June 23, 2022				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 8 of 130

Division c	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
CAROLINA REST HOME		OLINA REST H			
ROANOKE		E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 137	Continued From page	. 8	D 137		
D 101	Continued i form page	5 0	5 107		
	for this violation.				
	000000000000000000000000000000000000000				
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8,				
	2022.	IOT EXCEED August 6,			
	2022.				
D 130	10A NCAC 13F .0407	7(a)(7) Othor Staff	D 139		
D 139	Qualifications	(a)(1) Other Stall	D 139		
	Quamoutono				
	10A NCAC 13F .0407	Other Staff Qualifications			
	(a) Each staff person	at an adult care home shall:			
	(7) have a criminal ba	•			
	accordance with G.S.	114-19.10 and 131D-40;			
	This Dula is not mot	as suideneed by			
	This Rule is not met a TYPE B VIOLATION	as evidenced by.			
	THE B VIOLATION				
	Based on record revie	ews and interviews the			
	facility failed to ensure	e 2 of 5 sampled staff (Staff			
		inal background check			
	completed upon hire.				
	The findings are				
	The findings are:				
	1. Review of Staff A's	record revealed:			
		/01/21 as a personal care			
		n working as a medication			
	aide (MA) on 02/16/22				
		nentation that a criminal			
	•	as completed upon or before			
	hire, or thereafter.				
	Refer to interview with	n the Resident Care			
	Coordinator (RCC) or				
	220.4	. 00, <u>12, 22</u> at 0.00pm			
	Refer to interview with	n the Director of Operations			
	(DO) on 06/22/22 at 4	l:50pm.			
I				1	

Division of Health Service Regulation

Refer to interview with the Administrator on

STATE FORM R61411 If continuation sheet 9 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-(_
		HAL042005	B. WING		1	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		OLINA REST H			
			E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 139	Continued From page	9	D 139			
	06/23/22 at 2:00pm.					
	Refer to interview with the primary care provider (PCP) for several residents at the facility on 06/23/22 at 10:46am. 2. Review of Staff B's record revealed: -She was hired on 06/15/22 as a medication aide (MA)There was no documentation that a criminal background check was completed upon or before hire.					
	Refer to interview with Coordinator (RCC) or					
	Refer to interview with (DO) on 06/22/22 at 4	n the Director of Operations I:50pm.				
	Refer to interview with 06/23/22 at 2:00pm.	n the Administrator on				
		n the primary care provider idents at the facility on				
	(RCC) on 06/22/22 at -A criminal backgroundone on staff on day of	nd check should have been				
	06/22/22 at 4:50pm re -A criminal backgroun completed on staff wh	nd check was to be				

check.

Division of Health Service Regulation

facility without having a criminal background

STATE FORM 6899 R61411 If continuation sheet 10 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL042005			R-(C 4/2022
					1 06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CAROLINA	CAROLINA REST HOME		OLINA REST H E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 139	Continued From page	÷ 10	D 139			
	-She was not sure wh check was not perform must have been over	y a criminal background ned for Staff A and B; it ooked.				
	2:00pm revealed: -The RCC and DO we	ninistrator on 06/23/22 at ere responsible for hiring				
	criminal background of A criminal background of A criminal background staff prior to them states. Not checking a criminal to staff starting work a jeopardize the well-best linterview with the prince several residents at the 10:46am revealed: -Residents who lived increased risk for abuse.	eing of the residents. nary care provider (PCP) for the facility on 06/23/22 at the in a facility were at the se. checks checks should be althcare to protect the the sec.				
	The facility failed to e (Staff A and Staff B) h check completed prio resulted in the facility	not knowing if staff had was detrimental to the the residents and				
	The facility provided a accordance with G.S. for this violation.	a plan of protection in 131D-34 on June 23, 2022				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 11 of 130

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R-C 06/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		ROLINA REST H (E RAPIDS, NC			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETI	E
D 139	Continued From page	÷ 11	D 139			
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 8, 2022.					
D 164	10A NCAC 13F .0505 Diabetic Resident	Training On Care Of	D 164			
	Diabetic Residents An adult care home s the care of residents of unlicensed staff prior insulin as follows: (1) Training shall be p nurse, registered phat practitioner. (2) Training shall incl (a) basic facts about in the management of (b) insulin action; (c) insulin storage; (d) mixing, measuring for insulin administrati	diabetes and care involved f diabetes; g and injection techniques ion; evention of hypoglycemia including signs and initoring; universal ions; ions; ions;				
	This Rule is not met:	as evidenced by:				

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3

STATE FORM 6899 R61411 If continuation sheet 12 of 130

DIVISION	n Health Service Negu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	EIED
					R-	c
		HAL042005	B. WING		1	4/2022
		111/12012000	1		1 00/2	-7/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A DEST HOME	1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
			ļ	BEI IOIENOT)		
D 164	Continued From page	e 12	D 164			
		sampled who obtained				
	-	ars and administered insulin				
		nining on the care of diabetic				
		ce with the rule prior to				
	administering insulin	to residents.				
	The findings are:					
	The findings are:					
	Paview of Staff R's no	ersonnel record revealed:				
	•	06/15/22 as a medication				
	aide (MA).	00/13/22 as a medication				
	` '	nentation of diabetic care				
	training on file.	ieritation of diabetic care				
	training on the.					
	Review of a resident's	s June 2022 electronic				
		ation record (eMAR) with a				
	diagnosis of diabetes					
	•	for Novolog (short-acting				
		daily with meals at 8:00am				
	and 5:00pm.	adily min mode at 0.00dim				
	-Staff B documented	administration of the				
	Novolog to the reside					
	Interview with Staff B	on 06/24/22 at 3:27pm				
	revealed:	•				
	-The lead MA had spe	ent three days with her upon				
	-	nedication passes and				
	training her.	·				
		n 06/21/22, it was her fourth				
		medications to all residents,				
		agnosed with diabetes who				
	required insulin indep	endently.				
	-The lead MA had into	ermittently checked on her to				
	ensure she was doing	g okay, but she did not				
	supervise her medica	tion passes that day.				
		sulin on 06/21/22 without				
	supervision.					
	-She was still in traini	ng at the facility and had not				
		aining in the care of diabetic				
	residents and insulin	from the facility.				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 13 of 130

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
			DE00 0171/ 074	TE 7/2 0025	1 00/2 11/2022
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA		
CAROLIN	A REST HOME		OLINA REST H		
	Г	ROANOKE	RAPIDS, NC	2/8/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 164	Continued From page	e 13	D 164		
	revealed: -Staff B passed medic 06/21/22 while she w -She did not realized care training and did diabetic medications them because she the statusShe was not aware s supervise Staff B unti had been completed. Interview with the Dire 06/23/22 at 10:31am -She did not realize S administering insuling without supervision fr -The lead MA should	that Staff B required diabetic not supervise her pass to residents who required bught Staff B was off training she needed to continue to I her diabetic care training ector of Operations (DO) on revealed: staff B had been medications independently om the lead MA. have supervised Staff B il Staff B's diabetic care			
	2:00pm revealed: -It was the Resident 0 and the DO's respons training was complete recordsIt was the responsibi contact the pharmacy training to MAs as red -He expected MAs to properly prior to pass independentlyIt was important for N medication administra	Care Coordinator's (RCC) sibility to ensure all required ed and kept on file in staff lity of the RCC or DO to and the nurse to provide quired. be supervised and trained ing medications to residents MAs to have proper training ation training to ensure they ing medications to residents			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 14 of 130

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
04501111		1361 CA	ROLINA REST HOI	ME ROAD	
CAROLIN	A REST HOME	ROANO	(E RAPIDS, NC 27	7870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 164	Continued From page	e 14	D 164		
	care provider (PCP) of revealed: -He expected the facing to the MAs passing material -Proper training was in resident safety and administration. -Without proper training how to accurately follows:	ng, MAs would not know ow orders, what side effects to medications to look for, or			
D 243	10A NCAC 13F .0704 Information On Home	e(a)(1) Resident Contract, And	D 243		
	(a) An adult care hor administrator-in-charg with the resident or reinformation on the howhen changes are mastatement indicating the been received upon a required by this Rule by each person to whim the resident's recommendation shall inclus (1) the resident contrapplies: (A) the contract shall services and accommon different levels of sother charges or fees (B) the contract shall or conditions that the cannot meet pursuant.	and Resident Register ne administrator or ge shall furnish and review esponsible person me upon admission and ade to that information. A hat this information has admission or amendment as shall be signed and dated om it is given and retained d in the home. The ade the following: act to which the following specify rates for resident addations, including the cost ervice, if applicable, and any			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 15 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			7 50.E510. <u>_</u>		R-	С
		HAL042005	B. WING		1	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		OLINA REST H			
			E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 243	Continued From page	e 15	D 243			
D 243	administrator or admi resident or responsible the resident of resident of the resident of the resident of resident	nistrator-in-charge and the le person, a copy given to nsible person and a copy record; sponsible person shall be ny change is known, but not ore the change for rate he facility, of any changes in rovided an amended ment to the contract for ion to the established rates; and nthly adult care home rate to Special Assistance ed by the North Carolina mission and the North embly. accept payments for room d party, such as family ith community, if the untarily to supplement the rd for the added benefit of a ate or semi-private room in	D 243			
	suicidal ideationShe was constantly of	disoriented.				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 16 of 130

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL042005	B. WING		06/24/2022	
		TIALU42000			00/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
04501111	A DECT HOME	1361 CAF	OLINA REST H	OME ROAD		
CAROLIN	A REST HOME	ROANOK	E RAPIDS, NC	27870		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DE HOLLINGTY		
D 243	Continued From page	e 16	D 243			
	Review of Resident #6's Resident Register revealed she was admitted to the facility					
	04/04/22.					
		admissions policy revealed:				
		of \$4300.00 monthly would				
	be paid one month in					
		/ was signed by Resident #6				
		e Coordinator (RCC) on				
	04/04/22.					
	Review of Resident #	6's contract/facility				
	disclosure revealed:	,				
	-Resident #6's admiss	sion rate was \$4300.00				
	monthly.					
	-There was a handwr "prorated \$3870".	itten notation which stated,				
	-It was signed by Res 04/04/22.	sident #6 and the RCC on				
	Review of paperwork	provided by the facility				
	revealed a receipt dat	ted 04/12/22 stating				
	Resident #6 paid \$98	,900.00 for room and board.				
	Review of Resident #	6's record revealed there				
	was no new contract	stating that Resident #6				
		aying \$4300.00 monthly but				
	would pre-pay \$98,90	00.00 for 23 months of room				
	and board.					
		nt #6's family member on				
	06/23/22 at 11:26am					
		lent #6's room and board at				
		0.00 per month, but she did lity had taken money out of				
		t to pre-pay for 23 months of				
	room and board.	t to pre-pay for 23 months of				
		ity was taking \$4,300.00 out				
		ount each month to pay for				

Division of Health Service Regulation

her room and board.

STATE FORM 6899 R61411 If continuation sheet 17 of 130

	n nealth Service Negu	ialion	1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_ ا	_
			B. WING		R-	
		HAL042005	b. WING		06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
CAROLIN	A REST HOME		OLINA REST H			
		ROANOKE	RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	DATE
				,		
D 243	Continued From page	e 17	D 243			
	Observed the best of the state					
	•	nformed by the facility that				
	_	pre-pay that far in advance.				
		e aware by the facility that				
	they wanted Resident	t #6 to pre-pay for 23				
	months of room and b	poard she would not have				
	consented to it.					
	Interview with the RC	C on 06/22/22 at 3:16pm				
	revealed:	•				
	-She, the Director of 0	Operations (DO), and				
		he resident's bank and				
	closed her account.	no residente pariit ana				
		ative issued a cashiers'				
	•	the amount of \$98,900.00				
	_	room and board for Resident				
		oom and board for Resident				
	#6.					
	Intonvious with the DO	on 06/24/22 at 9:20 am				
		011 00/24/22 at 9.20 am				
	revealed:	- DOO D 40				
		e RCC, and Resident #6				
	went to the resident's	bank and closed ner				
	account.					
		ative issued a check to the				
	•	of \$98,900.00 for Resident				
	#6's room and board					
		esident #6 would pre-pay for				
		nd board was made by the				
	bank representative.					
	-Sometimes a contrac					
	residents pre-paid for	room and board depending				
	on whether the pre-pa	ayment was done before the				
		d to the facility or after the				
	resident was admitted	-				
		,				
	Interview with the Adr	ministrator on 06/24/22 at				
	10:39am revealed if a	a resident was pre-paying				
	room and board for m					
		ract to be completed and				
	signed by the residen					

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 18 of 130

	n rieaitii Service Regu	1	1		Т	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ובט
					R-0	_
		HAL042005	B. WING		1	4/2022
		11AE042003			1 00/2	4/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOK	E RAPIDS, NC	27870		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 243	Continued From page	. 19	D 243			
D 240	Continued From page	= 10	5 2 4 5			
	Based on observation	ns, interviews, and record				
	reviews it was determined Resident #6 was not					
	interviewable.					
D 273	10A NCAC 13F .0902	2(h) Health Care	D 273			
2 2.0	10/1140/10 10/ .0002	(b) Hoditi Garo				
	10A NCAC 13F .0902	Health Care				
		assure referral and follow-up				
	` '	nd acute health care needs				
	of residents.	id acute fleatiff care fleeds				
	or residerits.					
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	as evidenced by.				
	TIFE D VIOLATION					
	Rased on observation	ns, interviews, and record				
		illed to notify the primary				
		• •				
		or 2 of 5 sampled residents				
	, ,	esident with traumatic brain				
	injury that displayed f					
	, ,	r a resident with multiple				
		ars (FSBS) that were equal				
		per ordered parameters				
	(#1).					
	Tl 6:1:					
	The findings are:					
	Pavious of the facility	s modication policy roysolod:				
		s medication policy revealed: atments will be administered				
		e prescribing practitioner's				
	orders.	anatratad campatara				
		onstrated competency				
	according to state rule					
		ns and perform treatments.				
		cation errors or adverse				
		Il notify a physician or				
	appropriate health pro					
	supervisor, obtain fur	ther orders, and document				

Division of Health Service Regulation

in the resident's record.

STATE FORM 6899 R61411 If continuation sheet 19 of 130

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING		R-C	.
		HAL042005	B. WING) 1/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		ROLINA REST H			
	T		KE RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 19	D 273			
	O2/05/22 revealed: -Diagnosis included r traumatic brain injury spastic hemiplegia of cerebral vascular acc accident sequela and -There was no docum status. Review of Resident # 09/03/21 revealed: -There was no docum verbal aggressionThere was no docum behaviorHe was oriented and through gesturesHe required glasses -He required glasses -He required glasses -He had a lighter and she took it away from -There was no docum was notified of the incomplete of the incomplet	with loss of consciousness, right side as a late effect of ident, motor vehicle expressive aphasia. Inentation of orientation 3's current care plan dated mentation of physical or mentation of disruptive I was able to communicate stive device for ambulation. for limited vision. 3's progress note dated evealed: began fighting staff when him. Inentation Resident #3's PCP cident. 3's progress note dated evealed: member when she tried to from him. Inentation Resident #3's PCP cident.				

Division of Health Service Regulation

porch and tried to roll over a staff member's feet

STATE FORM 6899 R61411 If continuation sheet 20 of 130

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	JCTION (X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_			
			B. WING		R-	
		HAL042005	B. WING		06/2	4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAF	ROLINA REST H	OME ROAD		
CAROLIN	A REST HOME		E RAPIDS, NC			
				T		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 070	0 " 15	00	D 070			
D 273	Continued From page	e 20	D 273			
	and she moved his w	heelchair to avoid being run				1
	over.					ı
	-He hit the staff mem	ber in her stomach and a				ı
	second staff member	intervened, wheeling him to				ı
	his room.					ı
	-There was no docum	nentation Resident #3's PCP				ı
	was notified of the inc	cident.				
	Interview with Reside	nt #3 on 06/21/22 at 9:30am				
	revealed he hit a staff	f about 2 weeks prior.				
	I	onal care aide (PCA) on				I
	09/21/22 at 2:22pm re					I
		time when Resident #3				1
		n aide (MA) in the stomach.				1
	-She did not report th	•				1
		responsible for making				I
	notifications.					ı
	Interview with a medi	eation aide (MA) on				
	06/22/22 at 10:25am	, ,				ı
		ysically aggressive with staff				1
	when he did not get h					1
	_	ner in her stomach when she				1
		smoke with a nicotine				I
		but was unable to recall the				I
	date.	Tout was unable to recall the				
		inside and he grabbed her				ı
	by her wrist and woul					ı
	-A second staff memb					ı
	Resident #3 to let go	-				ı
		s note about episodes of				ı
		ted the incidents to the				
		s (DO) and the Resident				
		CC) but she did not notify				I
	the PCP.	50, Sat one did not notify				
	Interview with the Res	sident Care Coordinator				
	(RCC) on 06/22/22 at					
		rted to her that Resident #3				

STATE FORM 6899 R61411 If continuation sheet 21 of 130

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	
			B. WING		R-	
		HAL042005	B. WING		06/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAR	OLINA REST H	OMF ROAD		
CAROLIN	A REST HOME		E RAPIDS, NC			
			- KAFIDO, NC			T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	17.0	DEFICIENCY)		
D 273	Continued From page	e 21	D 273			
	hit her in the stomach	and grabbed her arm and a				
		ervene before Resident #3				
	would let her arm go.					
		y to hit staff when he did not				
	like what they said an					
	monthly.	d this occurred least				
	,	Resident #3's primary care				
		ware of the aggressive				
	behaviors.	ware or the aggressive				
		sident #3's PCP to report				
	behaviors in the past	•				
	-	ne date of last notification to				
	the PCP.	ie date of last flotification to				
	ille PCP.					
	Interview with the DO	on 06/22/22 at 4:20pm				
	revealed:	on 00/22/22 at 4.20pm				
		nsible for notifying Resident				
	#3's PCP if there was					
		ne PCP to be notified each				
	time Resident #3 was					
		Resident #3's PCP of the				
	behaviors but she tho					
	benaviors but sile the	ought he was aware.				
	Interview with the Po	gional Director on 06/22/22				
		he expected the RCC and				
	_	CP when residents display				
	aggressive behaviors	•				
	Tolonhono intonviouv	Posidont #2's primary care				
		Resident #3's primary care				
		/23/22 at 10:46am revealed:				
	-He was unsure of Re	esident #3 s history of				
	aggression.	all forms the afficient and an in-				
		all from the facility in January				
		was increased at that time				
		contact from the facility				
	since that time.	- ASC and a firm in a diagram of				
	-He expected to be no					
		y occurred so he could				
		s symptoms and behaviors.				
	-If he was notified of	on-going aggression, he				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 22 of 130

Division	of Health Service Regu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
					1
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		
CAROLIN	A REST HOME		ROLINA REST HO		
		ROANO	KE RAPIDS, NC 2	7870	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(*)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
1710		,	1,710	DEFICIENCY)	
D 070	0 " 15	00	D 070		
D 273	Continued From page	22	D 273		
	would have ordered a	PRN medication or			
	changed medications				
	Telephone interview v				
		n 06/23/22 at 11:40am			
	revealed:				
		story of being aggressive			
		managed in her home.			
	•	cility to notify his PCP when			
		ive behaviors so the PCP			
	do something about it	hing was wrong and could			
	do something about it				
	2. Review of Residen	t #1's current FL-2 dated			
	12/21/21 revealed dia	ignoses included insulin			
	dependent diabetes n	nellitus, hypertension,			
		ulmonary disease, peripheral			
	neuropathy, anxiety, a	and history of seizures.			
		1's physician orders dated			
		ere was an order for finger			
		SBS) three times daily (a			
	normal FSBS is betwe	een 70-140).			
	Review of Resident #	1's April 2022 electronic			
	medication administra				
	revealed:				
		or FSBS three times daily at			
	7:00am, 11:00am, and				
	-The resident's FSBS				
	obtained as ordered of				
	04/30/22 and ranged				
	-The resident's FSBS				
	follows: on $04/04/22$	64 at 8:00nm: 04/06/22 64			

Division of Health Service Regulation

at 8:00pm; 04/08/22, 69 at 8:00pm; 04/14/22, 66 at 8:00pm; 04/17/22, 64 at 8:00pm; 04/18/22, 61

STATE FORM 6899 R61411 If continuation sheet 23 of 130

Division (of Health Service Regu	ulation			FORM	IAPPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SI COMPLE	
		HAL042005	B. WING		R-06/2	C 4/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CAROLIN	IA REST HOME		ROLINA REST HO! KE RAPIDS, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 23	D 273			
	8:00pm; 04/20/22, 59 8:00pm; 04/22/22, 66 11:00am and 39 at 8: 8:00pm; 04/26/22, 48 -There was no docum PCP was notified of ti normal. Review of Resident # revealed: -There was an entry f 7:00am, 11:00am, an -The resident's FSBS obtained as ordered o 05/31/22 and ranged -The resident's FSBS follows: on 05/01/22,	the FSBS being below #1's May 2022 eMAR for FSBS three times daily at a second daily from 05/01/22 - from 45 - 455. Were documented as 65 at 8:00pm, 05/03/22, 54				
	at 11:00am; 05/04/22 66 at 8:00pm; 05/11/2	65 at 8:00pm, 05/03/22, 54 2, 60 at 11:00am; 05/05/22, 22, 65 at 8:00pm; 05/14/22, 3/22, 62 at 8:00pm; 05/19/22,				
	63 at 8:00nm: 05/21/	22 54 at 8:00nm: 05/26/22				

Review of Resident #1's June 2022 eMAR revealed:
-There was an entry for FSBS three times daily at

68 at 8:00pm; 05/31/22, 54 at 8:00pm.

7:00am, 11:00am, and 8:00pm.

50 at 11:00am; 05/27/22, 45 at 8:00pm; 05/30/22,

-There was no documentation that the resident's PCP was notified of the FSBS being below

-The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452.

-The resident's FSBS were documented as follows: on 06/03/22, 51 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/07/22, 54 at 8:00pm; 06/09/22, 57 at 11:00am; and 06/16/22, 54 at 8:00pm.

-There was no documentation that the resident's

Division of Health Service Regulation

normal.

STATE FORM R61411 If continuation sheet 24 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R-C 06/24/2022	
	ROVIDER OR SUPPLIER	1361 CAR	DRESS, CITY, STA DLINA REST H E RAPIDS, NC	OME ROAD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Review of Resident # was no documentation FSBS being below not linterview with the me 06/22/22 at 12:16pm - When Resident #1's administer the resident's ensure the FSBS can - She did not report for PCP when it occurred - FSBS that were low were unsafe for the refurther health issues at linterview with the Dirac 06/23/22 at 10:31am MAs to contact the Reguidance in care and assess the resident a medications as needed resident's record. Interview with the Adr 2:00pm revealed: - He expected the MA #1's primary care proobtain further guidance - It was a risk to the refuse FSBS that could lead a diabetic coma. Interview with Reside (PCP) on 06/23/22 at 10:06/23/22	l's record revealed there of PCP notification of ormal. dication aide (MA) on revealed: FSBS was low, she would not her glucose tablets then is FSBS in 1-2 hours to one up. W FSBS to Resident #1's if the did not know why, and remained untreated esident and could cause and complications. ector of Operations (DO) on revealed she expected the esident #1 PCP for further to notify him so he could not possibly adjust here and then document it in the ministrator on 06/23/22 at its to contact the Resident wider for any low FSBS to be for her care. Its identity is primary care provider in the wider sprimary care provider in the strength of the primary care provider in the	D 273			

Division of Health Service Regulation

-Resident #1 had diabetes mellitus and was

STATE FORM 6899 R61411 If continuation sheet 25 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		I	R-C / 24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CAROLIN	A REST HOME	1361 CAF	ROLINA REST H	OME ROAD		
CAROLINA	- REST HOME	ROANOK	E RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 25	D 273			
	dependent on insulin blood sugarsHaving low FSBS that cause harm or even of the cause harm or even or e	to help control and lower her at were left untreated could death to the resident. numerous occasions when S below normal was ne needed to assess the ner orders to care for the esident's medications, and ad follow up care to monitor				
	had aggressive behave #1's primary care problood sugars (FSBS) failure was detrimentated.	(PCP) for Resident #3 who viors and to notify Resident vider (PCP) of finger stick below normal. The facility's all to the health, safety, and dent and constitutes a Type				
	The facility provided a accordance with G.S. for this violation.	a plan of protection in 131D-34 on June 23, 2022				
	CORRECTION DATE VIOLATION SHALL N 2022.	FOR THE TYPE B IOT EXCEED August 8,				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	following in the reside (3) written procedures a physician or other li and (4) implementation of	ssure documentation of the				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 26 of 130

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL042005	B. WING		R-C 06/24/2	2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME	1361 CAR	DLINA REST H	OME ROAD		
- CAROLINA	- THE THOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
D 276	Continued From page	26	D 276			
	Rule.					
	ruic.					
	reviews, the facility fa implemented for 2 of 1 #5) including errors in hose (#1) and a conti- airway (CPAP) treatm The findings are: 1. Review of Residen 12/21/21 revealed: -Diagnoses included in mellitus, hypertension pulmonary disease, p	as, interviews, and record illed to ensure orders were 5 sampled residents (#1, at the use of compression nuous positive pressure lent (#5). It #1's current FL-2 dated ansulin dependent diabetes a, chronic obstruction eripheral neuropathy,				
	anxiety, history of seiz	zures.				
		mi-ambulatory and required				
	2 liters of oxygen (2L O2) at all times. Review of Resident #1's current care plan dated 12/21/21 revealed the resident required limited assistance with dressing.					
	01/21/22 revealed: -There was an order f wear as directed. (Co improve blood flow ar -There was no order f	or compression hose to mpression hose are used to deprevent blood clots.) for the resident to e of the compression hose.				
	Professional Support 04/19/22 revealed: -The resident was to her bilateral lower ext	wear compression hose to				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 27 of 130

DIVISION	of Health Service Regu	ialiuii				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMF	PLETED
						R-C
		HAL042005	B. WING		I	/24/2022
		TIALUTZUUU			1 00	12-112-022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
CAPOLIN	A REST HOME	1361 CAI	ROLINA REST HO	OME ROAD		
CAROLIN	A KLOT HOME	ROANOR	E RAPIDS, NC 2	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	27	D 276			
	morning and removed -The resident was abl of the compression he	e to self-administer the use				
	medication administrative revealed the compression	sion hose were				
	- 04/30/22.	nistered daily from 04/01/22				
	Review of Resident # revealed the compres documented as admir - 05/31/22.					
	Review of Resident # revealed the compres documented as admir - 06/20/22.					
	Observation of Reside 8:17am revealed she compression hose.					
	Observation of Reside 11:08am revealed she compression hose.	ent #1 on 06/23/22 at e was not wearing her				
	take them off herself, days her legs would s -She did not wear the day because she thou -There was only one lask her if she put the	ompression hose on and but only wore them on the swell. compression hose every aght they were too tight. MA who would occasionally compression hose on, the elp or assist her in putting				

Division of Health Service Regulation

-None of the other MAs would ask or look to see

STATE FORM 6899 R61411 If continuation sheet 28 of 130

Division of	of Health Service Regu	liation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						_
			B. WING		R-	
		HAL042005	B. WING		06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
CAROLINA	A REST HOME		OLINA REST H			
		ROANOKI	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				BETTOLENOTY		
D 276	Continued From page	e 28	D 276			
	Continuou i Tom page	3 20				
	if she was wearing the	em.				
	-She was not sure if t	he MAs documented her				
	use of the compression	on hose in her record.				
	•					
	Interview with the Dire	ector of Operations (DO) on				
	06/23/22 at 10:31am	. , ,				
		npetent enough to put on				
	and take off her comp					
		Diession nose				
	independently.	A - t				
	· · · · · · · · · · · · · · · · · · ·	As to verify the resident was				
	•	sion hose daily prior to				
	documentation of adr					
		As to encourage the use of				
	Resident #1's compre	ession hose and to				
	document the resider	nt's use of the compression				
	hose accurately.					
	Interview with Reside	nt #1's primary care provider				
	(PCP) on 06/23/22 at	: 10:46am revealed:				
	-He expected Reside	nt #1 to wear her				
	compression hose as	ordered.				
	-He did not provide R					
		because he expected the				
		compression hose were				
	worn daily as ordered					
	,	se were ordered for the				
	•					
	resident due to her pe					
		s to document the resident's				
	refusals of the compr	ession hose accurately.				
		h the RCC on 06/22/22 at				
	11:58am.					
	Refer to interview with	h the Director of Operations				
	(DO) on 06/23/22 at 1	10:31am.				
	Refer to interview with	h the Administrator on				
	06/23/22 at 2:00pm.					

Division of Health Service Regulation

Refer to interview with a pharmacist from the

STATE FORM 6899 R61411 If continuation sheet 29 of 130

DIVIDION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
			D. WING			-C
		HAL042005	B. WING		06/:	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			OLINA REST H	,		
CAROLINA	A REST HOME					
		ROANOK	E RAPIDS, NC	2/8/0		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
TAG	REGOLATORI GIVE	is is a second of the second o	TAG	DEFICIENCY)	111101111111111111111111111111111111111	
			+			
D 276	Continued From page	e 29	D 276			
	facility's contracted pl	harmacy on 06/22/22 at				
	2:45pm.	,				
	2 Peview of Residen	t #5's current FL-2 dated				
	02/26/22 revealed:	t #03 ourront i L-2 ualeu				
	-Diagnoses included	hypertension, anxiety,				
	•	oesophageal reflux disease,				
		glycemia, atrial fibrillation,				
	31 1 . 31	coronary artery disease,				
	depressive disorder,					
		bulatory with the use of a				
	walker.	ibulatory with the use of a				
		to use a CPAP machine				
		pnea) every night at bedtime				
	•					
	and remove in the mo	oming.				
	Review of Resident #	5's previous physician				
		2 revealed there was an				
		AP every night at bedtime				
	and remove in the mo					
		9.				
	Review of Resident #	5's April 2022 electronic				
	medication administra	The state of the s				
	revealed:					
		or CPAP every night before				
	bed and remove in th					
		mented as administered				
		1/22 - 04/16/22, 04/22/22,				
	and 04/26/22 - 04/30/					
		mented as not administered				
	_	2 and 04/23/22 - 04/25/22				
	medication.	eing unable to take the				
	medication.					
	Review of Resident #	5's May 2022 eMAR				
	revealed:	,				
		or CPAP every night before				
	bed and remove in the					
		mented as administered				

Division of Health Service Regulation

every night from 05/01/22 - 05/09/22, 05/12/22 -

STATE FORM 6899 R61411 If continuation sheet 30 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME	1361 CAR	DLINA REST H	OME ROAD		
CAROLINA	4 REST HOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	30	D 276			
	05/16/22, 05/19/22 - 0 05/31/22. -The CPAP was docu on 05/10/22 - 05/31/2 05/27/22 - 05/30/22 d unable to take the me Review of Resident # revealed: -There was an entry f bed and remove in th -The CPAP was docu every night from 06/0 06/10/22 - 06/13/22, a -The CPAP was docu on 06/06/22, 06/08/22	mented as not administered 2, 05/12/2 - 05/18/22, ue to the resident being edication. 5's June 2022 eMAR or CPAP every night before				
	#5's room on 06/23/2 was no CPAP machine Interview with Reside revealed: -Her CPAP machine Interview, but she could not someone at the facil was supposed to have recall whoShe had not been we night as ordered became	ity took the machine and e it fixed, but she could not earing her CPAP machine at				
	revealed: -She was not aware F brokenShe did not work nig	Resident #5's CPAP was ht shift and would not have				

Division of Health Service Regulation

would not have administered it to the resident.

STATE FORM 6899 R61411 If continuation sheet 31 of 130

Division	ot Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					l _	
			D WING		R-	
		HAL042005	B. WING		06/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE ZIP CODE		
TO WILL OF T	NOVIBER OR GOLF EIER		, ,	,		
CAROLIN	A REST HOME		ROLINA REST H			
		ROANOR	E RAPIDS, NC	27870		1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	INEGOLATORI ORT	EGC IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL	5,112
						
D 276	Continued From page	e 31	D 276			
		ector of Operations (DO) on				
	06/23/22 at 10:31am					
		hat Resident #5's CPAP				
	machine was broken					
		staff to report broken				
		she could correct the issue.				
		wear the CPAP at night				
	because she had slee					
	· · · · · · · · · · · · · · · · · · ·	o administer the CPAP as				
	ordered and docume	nt the administration				
	accurately.					
	Interview with Reside	ent #5's primary care provider				
	(PCP) on 06/23/22 at					
	, ,	I to wear the CPAP at night				
		hypertension, and poor				
	output.	riyperterision, and poor				
	•	ident's CPAP machine to be				
	available and in work					
		ing order. ie CPAP machine was not				
	being administered as	s ordered.				
	Defer to intensions with	h the RCC on 06/22/22 at				
	11:58am.	II the NCC on oo/22/22 at				
	11.Joann.					
	Pofor to intonvious with	h the Director of Operations				
		h the Director of Operations				
	(DO) on 06/23/22 at 1	10.3 fam.				
	Defer to intensions with	h the Administrator on				
		n the Administrator on				
	06/23/22 at 2:00pm.					
	Defende intensieus sid	h				
		h a pharmacist from the				
		harmacy on 06/22/22 at				[
	2:45pm.					
		00/00/00 11/ 50				
		C on 06/22/22 at 11:58am				
	revealed:					[
		to administer medications				
	and treatments accur	ately to residents per the				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 32 of 130

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		DLINA REST H			
			RAPIDS, NC		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	32	D 276			
	order then document medication and treatmedAR. -MAs were expected audits once per monti expected to look for emedications were in target orders to the eMAR, to treatments on hand. Interview with the Direct of the emedications were in target orders to the eMAR, to treatments on hand. Interview with the Direct of the emedications were in target orders to the eMAR, to treatments were not at a could a decline in the linterview with the Adr 2:00pm revealed: -He expected MAs to treatments accurately safety per the five rigital emedication and linterview with a pharm contracted pharmacy revealed when medicated in the safety of the respected as for the safety of the respected of the safety of the respected in the safety of the respected and the safety of the safety of the respected and the safety of the	the administration of the nents accurately on the sto perform medication cart h, but they were only expired medications and that he correct drawers. It is in place to perform audits and the resident's current to the medications and sector of Operations (DO) on revealed if medications and administered as ordered it resident's health status. In administer medications and readminister medications and readment documented accurately for disassessment. In acist from the facility's on 06/22/22 at 2:45pm ations or treatments were ordered could be detrimental sidents in which there could actions and not receiving the he diagnoses the				
D 296	·	(c)(7) Nutrition And Food	D 296			
	10A NCAC 13F .0904	Nutrition And Food Service				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 33 of 130 R61411

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		HAL042005	B. WING		1	, /2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLIN.	A REST HOME	1361 CARC	LINA REST H	OME ROAD		
			RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 296		are Homes: nave a matching therapeutic ician-ordered therapeutic	D 296			
	reviews, the facility fa diet menus were avai residents with therape	ns, interviews and record iled to ensure therapeutic lable for 2 of 2 sampled eutic diets (#1, #4) with an salt diet (#1, #4), and no				
	The findings are:					
	Observation of the kitchen on 06/22/22 at 8:00am revealed: -There was no therapeutic diet menu postedThere was a hand-written list of resident food preferences and general kitchen notes produced when the diet menu was requested of the Kitchen Manager.					
	12/21/21 revealed dia	t #1's current FL-2 dated agnoses included diabetes sion. (Hypertension is high				
		1's current diet order dated order for no concentrated salt diet.				
	revealed: -She was diagnosed	nt #1 on 06/21/22 at 8:17am with diabetes and the staff checked her fingerstick es daily.				

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 34 of 130

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING			-C 24/2022	
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA Rolina Rest H (E Rapids, NC	OME ROAD	1 001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 296	Refer to interview with Coordinator on 06/22 Refer to interview with on 06/22/22 at 4:20pr Refer to interview with 06/23/22 at 1:59pm. 2. Review of Residen 05/13/22 revealed: -Diagnoses included gastro-esophageal relater ordered diet was Refer to interview with 06/22/22 at 8:00am. Refer to interview with Coordinator on 06/22 Refer to interview with on 06/22/22 at 4:20pr Refer to interview with on 06/23/22 at 1:59pm. Interview with the Kito 06/22/22 at 8:00am relater to the KMShe was given the hipreferences by the preferences by the preferences.	h the Kitchen Manager on the Resident Care /22 at 3:15. the Director of Operations m. the Administrator on the #4's current FL-2 dated asthma and flux disease (GERD). Is no added salt. the Kitchen Manager on the Resident Care /22 at 3:15. the Director of Operations m. the Director of Operations m. the Administrator on chen Manager (KM) on evealed: y working independently as and-written list of residents'	D 296				

Division of Health Service Regulation

available for residents on a therapeutic diet.

STATE FORM 6899 R61411 If continuation sheet 35 of 130

Division of	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			_		_	•
			B. WING		R-	
		HAL042005	B. WING		06/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE		
•	-		ROLINA REST H	,		
CAROLINA	A REST HOME					
			E RAPIDS, NC	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	1,2002	100 IDENTIFY THIS IN S	IAG	DEFICIENCY)	WAI E	
			 			
D 296	Continued From page	e 35	D 296			
	She was not aware t	there needed to a congrete				
		there needed to a separate				
		at were ordered a special				
	diet.	9.1. £				
		no was responsible for				
	ensuring menus were					
		t of salt when cooking and				
	preparing meals.					
		sidents on no added salt				
	_	packets when the meal was				
	served.					
	-Residents on a no co	oncentrated sweets diet				
	were given sugar-free	e jello or sugar-free pudding				
	as a replacement who	en sweets were served at				
	mealtimes.					
	ı					
	Interview with the Res	sident Care Coordinator				
	(RCC) on 06/22/22 at	t 3:15pm revealed:				
	, ,	new to the role and was				
	trained by the previou					
		there should be a separate				
		u available in the kitchen.				
		r of Operations (DO) was				
	responsible for menus					
	responsible for mend	3 Were available.				
	Interview with the Dir	ector of Operations (DO) on				
	06/22/22 at 4:20pm re					
		sure the available menu was				
	followed daily.	ule tile avallable illellu was				
	•	a congrete therepoutic diet				
	menu should be avail	a separate therapeutic diet				
	·	hifted from her to the lead				
) when roles changed at the				
	end of 2021.	d 41 1 d NAA 41 DOO				
		d the lead MA or the RCC				
	the responsibility had	I moved to the lead MA.				
		ministrator on 06/23/22 at				
		menus were paid for and				
		e office and he expected the				
	DO and the RCC to e	ensure they were available			I	

STATE FORM 6899 R61411 If continuation sheet 36 of 130

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					R-C	:
		HAL042005	B. WING			/2022
		111/12012000			1 00/2-	- LULL
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A DECT LIGHT	1361 CAF	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOK	E RAPIDS, NC	27870		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				22.18.2.16.7		
D 296	Continued From page	e 36	D 296			
	and followed.					
D 338	10A NCAC 13F .0909	9 Resident Rights	D 338			
	10A NCAC 13F .0909					
		shall assure that the rights of				
	•	eed under G.S. 131D-21,				
		ents' Rights, are maintained				
	and may be exercise	d without hindrance.				
	This Rule is not met					
	TYPE A1 VIOLATION	l .				
	Daniel and internal	and as a said as discuss. Also				
		and record reviews, the				
		re resident rights were				
		to misappropriation of				
	resident (#3).	nd abuse and neglect of a				
	resident (#3).					
	The findings are:					
	The infalligs are.					
	1 Review of Residen	nt #6's current FL-2 dated				
	03/25/22 revealed:	it #00 darroint i E Z dated				
		advanced dementia with				
	suicidal ideation.	aavanooa aomoniia mar				
	-She was constantly	disoriented.				
	,					
	Review of Resident #	[‡] 6's Resident Register				
	revealed she was adi					
	04/04/22.	•				
	Review of Resident #	6's hospital history and				
	physical dated 03/23/					
		mitted to the hospital with a				
	diagnosis of dementia					
	-Resident #6's family	member had her				

Division of Health Service Regulation

involuntarily committed to the hospital because she had thrown away her medication and had made statements that she was going to get a gun

STATE FORM 6899 R61411 If continuation sheet 37 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			DLINA REST H	,		
CAROLIN	A REST HOME		RAPIDS, NC			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 338	Continued From page	e 37	D 338			
	and shoot herself or o	drive a car and crash it. nitted to the hospital with the				
	primary care provider stated that the reside unable to recall speci confused with dates a visit on 05/02/22Resident #6 was not directing the manage best interest and that	gned by Resident #6's (PCP) on 05/25/22 which nt had dementia and was fic important events and was and occurrences at her office capable of managing or ment of benefits in her own				
	member on 06/22/22 -The bank sent a lette account had been cloo-Resident #6 had aro account when it was element was not sure how removed from her bar was not capable of mand he did not approve removed from her accepted from her	er stating Resident #6's osed. und \$160,000 in her bank closed. v Resident #6's money was nk account because she laking decisions on her own ove to have the money count. Ory about what happened oney from the Resident Care and the Director of Operations ery time he talked to them. It let him move Resident #6 orecause they said the issue ourt. I's Power of Attorney (POA) e POA was not valid even				
	though the hospital he -Resident #6 had bills	onored the POA. s and a house that needed to				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 38 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		OOWII L	
			D WING		R-	_
		HAL042005	B. WING		06/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME	1361 CAR	OLINA REST H	OME ROAD		
ROANOKE		E RAPIDS, NC	27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	÷ 38	D 338			
	or maintain her house access to her moneyThere was a court do to settle the matter.	ate scheduled for 07/27/22				
	of Resident #6 on 06/	with a second family member /23/22 at 11:26am revealed: ng on her own before she				
	-Resident #6's other f	family member was bringing care of her while she was at				
	-There was a lot of co	ontention between Resident ily member for about a year				
		what led Resident #6 to be				
	-She had been contact	placed into the facility. cted by the facility and knew				
	put her money into a	dent #6's bank account and trust until guardianship could				
		lent #6's room and board at				
	not know that the faci	0.00 per month but she did lity had taken money out of t to pre-paid for 23 months				
	of room and board, w	t to pre-paid for 23 months hich totaled \$98,900.00. lity was taking \$4300.00 out				
		ount each month to pay for				
	· · · · · · · · · · · · · · · · · · ·	informed by the facility that pre-pay that far in advance.				
	-If she had been mad	e aware by the facility that				
		t #6 to pre-pay for 23 coard she would not have				
		ate stage dementia and she h longer the resident would				
	live.	in longer the resident would				

Division of Health Service Regulation

-Resident #6 was incompetent to make her own

STATE FORM R61411 If continuation sheet 39 of 130

Division	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL042005	B. WING		1	000
HAL042003					06/24/20	022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAF	ROLINA REST H	OME ROAD		
CAROLINA	A REST HOME		E RAPIDS, NC			
					1	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) OMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 000			—			
D 338	Continued From page	e 39	D 338			
	financial decisions.					
		nt for the court date on				
	-	e was petitioning the court				
	for guardianship of R					
	ioi guarulariship oi N	esident #0.				
	Interview with the DC	C on 06/22/22 at 2:16pm				
		C on 06/22/22 at 3:16pm				
	revealed:					
		mitted into the hospital				
		was found wandering in the				
	woods.					
		he hospital contacted her				
	and told her Resident	t #6 needed placement at				
	the facility.					
	-After Resident #6 wa	as admitted to the facility the				
	RCC and the DO tool	k Resident #6 to the bank				
	and closed her bank	account.				
	-The bank representa	ative gave them a cashier's				
	check for \$98,900 to	cover 2 years' worth of room				
	and board for Reside	nt #6.				
	-The money that was	left over after receiving the				
		olaced into Resident #6's				
	facility account.					
	•	acility had a facility account				
	which contained their	•				
		d \$1345.00 a month in				
		he and the DO took her to				
		n to remove that money from				
	-	ccount and place it into the				
	resident's facility acco					
	-Resident #6's family					
		with facility staff and when				
		erty, they had to make him				
	leave because of his	•				
		esident #6's family member				
	•	ved a lump sum from the				
		d that was when the family				
	member started gettir	-				
	-The facility had a law					
	documents provided	by the family member and				

Division of Health Service Regulation

were told they were falsified.

STATE FORM 6899 R61411 If continuation sheet 40 of 130

	Division of Health Service Regu	lation		
	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
				R-C
		HAL042005	B. WING	06/24/2022
	NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
CAROLINA REST HOME		1361 CAROLINA REST HOME ROAD		
	CANOLINA NEST HOME	ROANOKE	RAPIDS, NC 27870	

CAROLINA REST HOME ROANOKE RAPIDS, NC 27870						
(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 40	D 338				
	-There was a court date set for 07/27/22 and					
	another family member was petitioning for					
	guardianship of Resident #6.					
	Interview with the DO on 06/24/22 at 9:20am revealed:					
	-On 04/12/22 she, the RCC, and Resident #6					
	went to the resident's bank and withdrew all her					
	money from her account.					
	-The bank representative asked how much					
	monthly room and board at the facility was for					
	Resident #6 and the bank representative					
	encouraged them to pre-pay 23 months of room					
	and board for Resident #6.					
	-The bank issued a cashier's check for					
	\$98,900.00 for Resident #6's room and board for					
	23 months.					
	-The \$98,900.00 was placed into the facility's					
	operational account.					
	-She did not remember if she made the					
	Administrator aware of the account closure and					
	transfer of funds before or after the bank					
	transaction occurred.					
	-The remainder of Resident #6's money was					
	placed into Resident #6's facility account.					
	-On 05/04/22, she, the RCC, and Resident #6					
	went to the resident's bank and withdrew the					
	resident's Social Security money totaling					
	\$1340.00 from the resident's personal bank account and transferred it into Resident #6's					
	facility account.					
	-On 06/01/22, the RCC and Resident #6 went to					
	the resident's bank and withdrew her Social					
	Security check for \$1340.00 from the resident's					
	personal bank account and transferred it into					
	Resident #6's facility account.					
	-It was typical for some residents to pre-pay for					
	room and board at the facility and the number of					
	months they pre-paid varied depending on what					
	the resident's families wanted to do.					

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 41 of 130

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D C
		HAI 042005	B. WING		R-C
		HAL042005			06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1361 CAF	ROLINA REST H	OME ROAD	
CAROLIN	A REST HOME	ROANOK	E RAPIDS, NC	27870	
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 338	Continued From page	Δ Δ 1	D 338		
	Continuou i rom page	· · ·			
	-	erview with the DO on			
	06/24/22 at 12:05pm				
		dent #6 were deposited on			
		sident #6's facility account			
	and one into the oper				
		nately \$163,000.00 was			
	•	ent #6's facility account and			
	a \$98,900.00 check w				
	facility's operational a				
	-She later received a				
	representative that sh	ne had issued a check for			
	the wrong amount an	d needed the \$163,000.00			
	check returned.				
	-	refund to the bank in the			
	T	00 and then the bank issued			
		or around \$64,000.00.			
		o be deposited into Resident			
	#6's facility account.				
	-She could not find a				
	\$64,000.00 was depo	sited into the facility			
	account.				
	-The \$64,000.00 show	uld have been deposited into			
	•	account on 04/14/22 but she			
	did not deposit the \$6	4,000.00 check into the			
		as off work that day and she			
		d deposited the money into			
	Resident #6's facility	account.			
		gional Director on 06/23/22			
	at 3:20pm revealed:				
	•	the money from Resident			
		cause they were concerned			
		amily member's motives			
	related to her funds.				
	-She called the local I				
	, ,	ike an adult protective			
	, , ,	on Resident #6 and was			
	told to let the courts d	lecide what needed to be			

STATE FORM 6899 R61411 If continuation sheet 42 of 130

Division of	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						0
			B. WING		R-	
		HAL042005	B. WING		06/2	24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		OLINA REST H			
		ROANOKI	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DAIL
				22.18.2.18.17		
D 338	Continued From page	e 42	D 338			
	Continuou i rom page	<i>,</i>				
	-Pre-paying room and	d board for 23 months was a				
	random number of me	onths that was picked by the				
	facility.					
	-					
	Telephone interview v	with the Administrator on				
	06/23/22 at 2:00pm re					
		with Resident #6's family				
	member wanting her	•				
		was aware that Resident #6				
	_	n of money in her account				
	_					
		ted the facility and made				
	them aware.	9 9 ()				
	-The facility did not no	ormally like to handle				
	resident's money.					
	-	d the county DSS to get				
		ey should do with Resident				
		they were concerned about				
	her family member's	motives related to her funds.				
	-Resident #6's money	y was in her facility account				
	until completion of the	e pending court case.				
	-The facility should no	ot have done a pre-payment				
		m and board for Resident #6				
		w how long the resident				
	might live.	3				
	-Normally the facility	sent a monthly bill to				
	,	idents paid for that month				
	only.	idente para for triat month				
		the remaining balance back				
	to Resident #6 after the					
	guardian was establis					
	•					
		sident #6's money was in				
	Resident #6's facility					
		00.00 of Resident #6's				
	l	to the facility's operational				
	account.					
		/ the pre-payment was taken				
	out of Resident #6's a	account and put into the				
	facility's operational a	account.				

Division of Health Service Regulation

-There was a hand-written ledger card that was kept by the facility to show how much money

STATE FORM 6899 R61411 If continuation sheet 43 of 130

Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL042005	B. WING		R-C 06/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	
04501111		1361 CAI	ROLINA REST HO	OME ROAD	
CAROLINA	A REST HOME	ROANOR	KE RAPIDS, NC 2	27870	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGULATORT OR	LOCIDENTII TING INI ONWATION)	TAG	DEFICIENCY)	UAIL 57112
D 338	Continued From page	e 43	D 338		
	remained in Resident	#6's facility account as well			
		98,900.00 was left in the			
	facility's operational a	ccount.			
	Cocond tolonhone int	and an unith the Administrator			
	on 06/24/22 at 10:39a	erview with the Administrator			
	-Resident #6 was not				
		ility withdrew the money			
	from her account so h	ner family member could not			
		ner money over to him.			
		0.00 of Resident #6's			
	money was deposited	<u>-</u>			
	came up with that nur	but he did to know how they			
	•) was deposited into the			
		scount that left a balance of			
	\$64,556.62 that was t	to be deposited into			
	Resident #6's facility				
	_	no record of the \$64,556.62			
	being deposited into I	Resident #6's facility			
	accountThe Regional Director	or, the DO, and the RCC had			
	access to resident's fa				
		uld not have been placed in			
		nal account because the			
	operational account s	hould not be co-mingled			
	with resident funds.				
		of a resident at the facility			
	pre-paying room and advance before.	board 23 months in			
	-The entire \$163,00.0	N should have been			
		ent #6's facility account and			
		should have been made for			
	her room and board.				
	Third Adams 1. 1. 1	Secretary Alexander Control			
	Third telephone intervolution 06/24/22 at 2:51pr	view with the Administrator m revealed:			

around \$64,000.00.

-The RCC and DO were at the bank with Resident #6 when the bank issued a check for

STATE FORM 6899 R61411 If continuation sheet 44 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CAROLIN	A REST HOME	1361 CARG	DLINA REST H	OME ROAD	
		ROANOKE	RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	2 44	D 338		
	-He was told by the Dissued was in a plain on the DO's desk by the what happened to the The \$64,000.00 check Resident #6's facility The facility was waitito see if the \$64,000.1 and to cancel that characteristics of the check was new bank to cancel that characteristics of the Check was cast Sheriff's Office to file. Telephone interview woo 6/23/22 at 3:28pm reshe was told by the stoput Resident #6's reguardianship was est She did not know that \$98,900.00 of Reside facility's operational and She was petitioning the guardian of Resident awarded guardianship was est awarded guardianship wardent awarded guardianship wardent warded state of the DO's was petitioning the state of the DO's was petitioning the guardian of Resident awarded guardianship	O that the check that was envelope and was placed the RCC and no one knew e check after that. It was never deposited into account. In a call from the bank of the check was ever cashed. It was need, he would ask the neck and reissue a new one. In the check and reissue a new one wealed: It was a report. It with a county attorney on evealed: It was a recount until ablished for the resident. It the facility had put the resident was placed. It was not the resident was the facility had put the resident was placed. It was not the resident was not the resident was placed. It was not the resident wa			
	06/23/22 at 10:46am -Resident #6 had a hi cognitive issues.	story of dementia and			
	Resident #6 was inca financesThe paperwork was at the facilityHe did not think it wa months of care for Re	or in May 2022 stating that pable of handling her own provided to him by someone as wise to pre-pay for 23 stident #6 because of her			
	advanced age and he -Any financial decisio	er diagnosis. ns that were being made for			

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 45 of 130

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED
					F	R-C
		HAL042005	B. WING			/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZIP CODE		
TO THE OT THE	NOVIDEN ON OUT FIELD		OLINA REST H			
CAROLIN	A REST HOME		E RAPIDS, NC			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	2 45	D 338			
	Resident #6 should b	e made by a Health Care				
		acility because the facility				
		making financial decisions				
	for Resident #6.	a facility was a saturalline				
		ne facility was controlling				
		resident's family member or				
		of money was withdrawn				
	from the resident's ac					
		terest that the facility had				
		oom and board so far in				
	advance.					
	Attempted telephone	interview with the bank				
	representative on 06/					
	unsuccessful.					
		ns, interviews, and record				
	interviewable.	nined Resident #6 was not				
	2 Review of Residen	t #3's current FL-2 dated				
	02/05/22 revealed:	t #0 3 dancine i E-2 dated				
	-Diagnosis included r	ight sided weakness,				
	, ,	with loss of consciousness,				
		right side as a late effect of				
	cerebral vascular acc accident sequela and	•				
	-	nentation of orientation				
	status.					
	Review of Resident #	3's current care plan dated				
	09/03/21 revealed:					
		nentation of physical or				
	verbal aggression.					
	 There was no document behavior. 	nentation of disruptive				
		was able to communicate				
 -He was oriented and was able to communicate through gestures. 						

Division of Health Service Regulation

-He required an assistive device for ambulation.

STATE FORM R61411 If continuation sheet 46 of 130

Division of	of Health Service Regu	ılation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU COMPLE	
			B. WING		R-(
		HAL042005	B. WING		06/24	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A DEST HOME	1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOK	E RAPIDS, NC	27870		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 338	Continued From page	÷ 46	D 338			
	-He required glasses	for limited vision.				
		ector of Operations (DO) on evealed there were no sion or behaviors.				
	05/30/22 at 6:20pm re -Resident #3 was ent	tering the building from the				
	back porch and tried to roll over a staff member's feet and she moved his wheelchair to avoid being run over.					
		ber in her stomach and a intervened, wheeling him to				
	revealed:	ent on 06/21/22 at 8:48am				
		dent #3 outside smoking and him go back inside the				
	-Resident #3 hit Staff	A and then Staff A hit				
	glasses.	nes in the face, breaking his				
	2:48pm revealed:	nd resident on 06/21/22 at				
	the nursing staff, but	or complaint, she would tell she would not complain to				
	anything about it.	ause they would not do				
	weeks ago as they er	A hit Resident #3 about two ntered the dining room from				
	the smoking area out	side. #3 in the head three times				
	leaving the resident w	vith a bruised face and a				
	black eye. -She was not sure if a	any other staff members				

witnessed the incident, but several other residents had witnessed the incident.

STATE FORM 6899 R61411 If continuation sheet 47 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					С		
		HAL042005	B. WING		06/2	4/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
CAROLIN	A REST HOME		OLINA REST H				
		ROANOKI	RAPIDS, NC	27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 338	Continued From page	: 47	D 338				
D 338	-She did not report the because Staff A shoul and managementShe did not think rep have been beneficialShe was concerned about the assault aga any staff got in trouble about retaliation agair for talking which could linterview with a third 3:20pm revealed: -Some staff had "bad" and would talk down aggressivelyResident #3, who wa history of aggressive supposed to be smok -About two weeks aggresident #3 hit Staff back giving him a blad glassesShe did not report the assumed the staff had thought the AdministrationidentShe did not want to swas worried the staff they were held accourreported them. Interview with a fourth 2:48pm revealed: -She witnessed Staff.	e incident to anyone Id have reported the incident orting the incident would about saying too much inst Resident #3 because if e, she would be concerned not herself or other residents in make life difficult for them. Tresident on 06/21/22 at The attitudes toward residents to them disrespectfully and instance wheelchair bound, had a behavior and was not ing. To, she witnessed Staff A tell not allowed to smoke, and if A had a fight. A first, then Staff A hit him is to anyone because she id already done so and ator already knew about the say too much because she would retaliate against her if intable and found out she The resident on 06/21/22 at A hit Resident #3 about	D 338				
		e dining room. supposed to be smoking ng the resident inside.					

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 48 of 130

Division of Health Service Regulation					APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ′		COMPLI		
			-			_
		HAL042005	B. WING		R-	.C 24/2022
		HAL042005			06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME	1361 CAF	ROLINA REST H	OME ROAD		
OAROLINA	A REOT HOME	ROANOK	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG	NEGOE/WORK ORE	iso BENTIL TINO IN GRAMMION	IAG	DEFICIENCY)	W. C.	
D 338	Cantinual Francisco	. 40	D 338			
D 330	Continued From page		D 336			
		set and the resident and				
	Staff A began yelling a					
		A first then she heard Staff				
	A say, "Oh no, you're					
		lent #3 three times in the				
	head.	ised in the face and his				
	glasses were broken in -She did not report the					
		have done any good and				
	would not be taken se	, ,				
		staff would retaliate against				
	the residents for talking					
	making them have to	wait longer than they should				
	for things they need o	or treat them disrespectfully.				
	-There were no other	staff around when Resident				
	#3 was hit.					
	3:20pm revealed:	esident on 06/21/22 at				
	•	Posidont #2 three times in				
		Resident #3 three times in ne in from smoking in the				
	dining room.	ie iii iioiii siiiokiiig iii tiie				
	•	Il Resident #3's family				
		it #3 had hit a staff member				
		ck and they would replace				
		our days after the incident.				
		ck and blue bruises on his				
	face.					
		activities Director (AD) say				
	that it should not have					
		ivities Director (AD) on				
	06/22/22 at 11:12am	revealed:	1			

-She had heard from staff that Resident #3 had been physically aggressive but had never

-She was attempting to locate Resident #3's missing eyeglasses when a resident reported to her the eyeglasses were broken during a fight

witnessed any aggression.

STATE FORM 6899 R61411 If continuation sheet 49 of 130

Division of Health Service Regul	lation				
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					0
1141 040005		B. WING		R-	
	HAL042005			06/2	24/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	1361 CAR	OLINA REST H	OME ROAD		
CAROLINA REST HOME	ROANOK	E RAPIDS, NC	27870		
OVA) ID SUMMARY ST/	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(>1.).2	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			DEFICIENCY)		
D 338 Continued From page	. 10	D 338			
2 coo Continued From page	. 43				
between a staff memb					
-She did not know wh	en the altercation had				
occurred.					
	ne resident had told her to				
_	out she did not remember				
what the date was an	d the reporting was not				
documented.					
	nt #3 on 06/21/22 at 9:30am				
revealed:	_				
-He hit a staff about 2	•				
-The staff member the	<u> </u>				
shoulder but did not h					
	staff in the smoking area to				
witness the staff hittin	~				
-He did not report the	incident to anyone.				
Observation of Reside	ont #2 on 06/21/22 of				
Observation of Reside					
9:30am revealed there	his face or shoulder area.				
swelling observed on	This face of shoulder area.				
Telephone interview w	with Resident #3's				
	n 06/23/22 at 11:40am				
revealed:	100/20/22 at 11.40am				
	ported that he was ever hit				
by staff.	ported that no was ever the				
•	ther resident that he gave				
	te and Resident #3 became				
	f attempted to redirect him				
back into the building.					
-The resident did not					
	by staff during that incident				
	sident #3 or was abusive in				
any way during the in					
any way daming the in	5.45.11.				
Interview with a perso	onal care aide (PCA) on				
06/21/22 at 2:22pm re					
	d a medication aide (MA) in				

Division of Health Service Regulation

the stomach.

-She could not remember the date of the incident

STATE FORM 6899 R61411 If continuation sheet 50 of 130

Division (of Health Service Regu	ulation			FORM	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HAL042005	B. WING		R- 06/2	-C 24/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	IA REST HOME	1361 CAF	ROLINA REST H	OME ROAD		
	-	ROANOK	E RAPIDS, NC	27870		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	= 50	D 338			
	before when the MA v back inside to stop hir she was in the front she heard Resident # derogatory name and -The MA was wheelin when she arrivedShe saw Resident #3 from himShe did not witness the smoking area. Interview with a second 3:19pm revealed: -Resident #3 used to missing a few weeks -She was not aware if -She was not aware if -She was not aware of for Resident #3. Interview with a medic 06/22/22 at 10:25am -Resident #3 has a ni orderedHe kicked her in her he could not smoke were	portion of the facility when #3 calling the MA a d she responded. In the man and strying to get the building a strying to get the MA away the MA strike Resident #3 at what happened outside in and PCA on 06/21/22 at have glasses but they went ago. If they were broken or lost, of any incident of aggression dication aide (MA) on revealed: It is to mach when she told him with the patch on, inside and he grabbed her lid not let go.				

the event.

Resident #3 to let go of her wrist.

with his wheelchair.

-Resident #3's glasses fell off of his face when he was being aggressive and he rolled over them

-She reported the incident to the DO, the RCC and to the MA but she was unsure of the date of

-She denied hitting or pushing Resident #3 at any

STATE FORM R61411 If continuation sheet 51 of 130

Division of Health Service Regulation				IAPPROVED		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLI	ETED	
					R-	_
		HAL042005	B. WING		1	4/2022
NAME OF D	20,4555 05 01 551 155				1 00/2	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
CAROLINA	A REST HOME		ROLINA REST H Œ RAPIDS, NC			
	OLIMANA DV OT		<u> </u>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 338	Continued From page	: 51	D 338			
	time.					
	Interview with the RC	C on 06/22/22 at 3:15pm				
	revealed:					
		rted to her that Resident #3				
		and grabbed her arm.				
	 The staff member represented to the incident 					
	•	hitting Resident #3 had				
	been made to her unt	_				
	-She and the DO wou	lld be responsible for				
	investigating any alleg	gations of abuse and				
		made to DSS, family, and				
		onal Registry (HCPR) after				
	-	completed if found to be				
	true.	ICPP report made				
	-There had been no H	on she became aware of on				
		investigation was not				
	complete.	conganon mac not				
	-	conducting investigation				
	when she became RC	CC in August or September				
	2021.					
	Second interview with	n the DO on 06/21/22 at				
	3:30pm revealed:					
		ff member and a second				
		ned to release the staff				
	member from his gras					
	-She was not able to					
	prior.	was two to three weeks				
	•	dent occurred on the back				
	porch where residents					

-Resident #3 wore glasses and an MA told her Resident #3 needed new glasses but did not say

-She did not ask the MA why he a new pair and she did not ask what happened to the pair he

why he needed a new pair.

STATE FORM 6899 R61411 If continuation sheet 52 of 130

Division of Health Service Regulation					FURIV	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	ETED	
					R-	-C
		HAL042005	B. WING		1	24/2022
					1 00/2	,
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
CAROLINA	A REST HOME		ROLINA REST H			
			KE RAPIDS, NC			T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 338	Continued From page	- - 52	D 338			
		glasses were broken during				
	the incident with staff.					
	Third interview with th	20 DO on 06/22/22 of				
	4:20pm revealed:	le DO 011 00/22/22 at				
	-She and the RCC we	ere responsible for				
		gation when an abuse				
	allegation was reporte	_				
		of any report of a staff				
		lent #3 prior to 06/21/22.				
	_	eport made to the HCPR for				
	the allegation reported	d to her on 06/21/22 at				
	3:30pm because the i	•				
	complete, and she did	d not know if it was				
	necessary.					
	 -She was responsible to the HCPR. 	e for making the notification				
	-She was trained by t	he previous manager how to				
	_	s and who to report to but				
		ny investigation of an abuse				
	allegation since taking					
		d out to the Regional Director				
		ator for guidance regarding				
	the allegation of abus	e.				
	Interview with the RD	on 06/21/22 at 1:41pm				
	revealed:	511 56/2 1/22 at 11 1 pm				
	She came to the faci	ility once per month to assist				
		nd of residents to ensure the				
	facility ran according	to expectations and the				
	residents were happy	· ·.				
	-She had never heard	d any complaints or				

concerns that residents were in fear of retaliation from facility staff, but she had to sometimes "coax" concerns out of the residents because

-Any allegations of abuse should have been

-The Administrator may not have shared any concerns regarding abuse with her unless there

they were hesitant to tell her things.

reported to the Administrator.

STATE FORM R61411 If continuation sheet 53 of 130

PRINTED: 07/18/2022 FORM APPROVED

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	A. BUILDING:						
		HAL042005	B. WING			R-C 6/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
0450111	A DEST HOME	1361 CAI	ROLINA REST HOI	ME ROAD			
CAROLIN	A REST HOME	ROANOR	E RAPIDS, NC 27	870			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 338	Continued From page	e 53	D 338				
	was a question about -She had not received abuse for Resident #3 -The Director of Oper be responsible for inv Second interview with 5:33pm revealed: -The RCC and the DC conducting investigation and notifying the Heat -The RCC and the DC had to be notified with an allegation of abuse investigation was continuously to the continuous and the continuous to	how to handle the situation. d report of allegation of 3. ations and the RCC would restigating reports of abuse. The RD on 06/22/22 at O were responsible for ions of allegations of abuse atth Care Personnel Registry. O were not aware the HCPR nin 24 hours of learning of					
	provider (PCP) on 06 -He was not aware of episodes of aggressic -He had received a ca 2022 and medication -He expected to be no aggression when they manage Resident #3' Interview with the Adr 1:59pm revealed he wallegation of abuse pr The facility failed to phad dementia and wa financial decisions, fro resulted in the misapp making financial decisions.	on or an allegation of abuse. all from the facility in January was increased at that time. otified of episodes of y occurred so he could s symptoms and behaviors. ministrator on 06/23/22 at was not aware of any rior to 06/21/22. rotect a resident (#6), who as unable to make her own					

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 54 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
HAL042005			B. WING			R-C 5/ 24/2022
	ROVIDER OR SUPPLIER A REST HOME	1361 CA	DDRESS, CITY, STATE ROLINA REST HOI KE RAPIDS, NC 27	ME ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	facility's operational a facility without conser and not being able to the resident's money resident (#3) from phyresulted in bruises of glasses being broken resulted in exploitation a Type A1 Violation. The facility provided a accordance with G.S. an addendum on 06/2 CORRECTION DATE	account for the benefit of the nt from the resident's family account for \$64,556.62 of and failed to protect a ysical abuse by staff which the face and the resident's. The facility's failure n and abuse and constitutes a plan of protection in 131D-34 on 06/21/22 and 24/22 for this violation.	D 338			
D 358	(a) An adult care hor preparation and admi prescription and nonby staff are in accorda (1) orders by a licens which are maintained (2) rules in this Sectiand procedures. This Rule is not met Based on observation reviews, the facility famedications as order residents (#1, #5) inc medications ordered blood sugar (FSBS) prescription and procedures.	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: ns, interviews, and record iled to administer	D 358			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 55 of 130

DIVISION	n Health Service Negu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		-		_	_	
			5 14/11/0		R-	С
		HAL042005	B. WING		06/2	24/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE ZIP CODE		
TO TWIL OF TH	TO VIDER ON OUT FEET		, ,	,		
CAROLINA	A REST HOME		OLINA REST H			
		ROANOKE	RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR L	230 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	JAIL	DATE.
				,		
D 358	Continued From page	e 55	D 358			
		flux medications (used to				
	treat acid reflux) (#5).					
	The findings are :					
	Review of the facility's	s medication policy revealed:				
	-Medications and trea	tments will be administered				
	in accordance with the	e prescribing practitioner's				
	orders.					
	-Staff who have demo	onstrated competency				
	according to state rule	es may prepare and				
	•	ns and perform treatments.				
		or adverse reactions, the				
		n or appropriate health				
		pervisor, obtain further				
	-	t in the resident's record.				
	orders, and documen	till the resident's record.				
	1 Paview of Pasiden	t #1's current FL-2 dated				
	12/21/21 revealed:	t#13 current 1 L-2 dated				
		inculin dependent diabetes				
	_	insulin dependent diabetes				
	mellitus, hypertension					
	pulmonary disease, p					
	anxiety, and history o					
		mi-ambulatory and required				
	2 liters of oxygen (2L	O2) at all times.				
		t #1's physician orders				
	dated 01/21/22 revea	. = -:-				
		for FSBS three times daily.				
		for glucose 4 grams, chew				
		S less than or equal to 80				
	every ten minutes unt	til FSBS was greater than or				
	equal to 100, use twice	ce daily or more often as				
	clinically indicated. (G	Slucose tablets are used to				
	increase FSBS when					
		•				
	Review of Resident #	1's April 2022 electronic				
	medication administra					
		·/				1

Division of Health Service Regulation

-There was an entry for FSBS three times daily at

STATE FORM 6899 R61411 If continuation sheet 56 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	HAL042005	B. WING	R-C 06/24/2022			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1361 CAROLINA REST HOME ROAD

CAROLINA REST HOME ROANOKE RAPIDS, NO (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	DDOU/DEDIG DLAM OF CODDECTION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	DDOV/DEDIC DI ANI OF CODDECTION
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
D 358 Continued From page 56 D 358	
7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 04/01/22 - 04/30/22 and ranged from 39 - 319. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The resident's FSBS less than or equal to 80 were documented as follows: on 04/04/22, 78 at 11:00am and 64 at 8:00pm; 04/06/22, 64 at 8:00pm; 04/07/22, 79 at 8:00pm; 04/08/22, 69 at 8:00pm; 04/17/22, 64 at 8:00pm; 04/14/22, 66 at 8:00pm; 04/17/22, 64 at 8:00pm; 04/19/22, 48 at 8:00pm; 04/20/22, 59 at 8:00pm; 04/19/22, 48 at 8:00pm; 04/22/22, 66 at 8:00pm; 04/22/22, 50 at 8:00pm; 04/25/22, 61 at 11:00am and 39 at 8:00pm; 04/25/22, 61 at 8:00pm; 04/26/22, 48 at 8:00pm; 04/25/22, 68 at 11:00am and 39 at 8:00pm; 04/28/22, 68 at 11:00am; 04/30/22, 78 at 11:00am; and all other FSBS were documented as greater than 80. -The glucose tablets were documented as administered twice daily at 8:00am and 8:00pm from 04/01/22 - 04/18/22 at 10:00pm, 04/23/22 at 12:32pm, and 04/24/22 at 11:11am for FSBS less than 80. -There were 4 of 21 opportunities in which the glucose tablets were administered in reference to ordered parameters in which the glucose tablets were not administered in reference to ordered parameters in which the FSBS were never rechecked. -There were 17 of 21 opportunities in which the FSBS were less than or equal to 80 and the FSBS were never rechecked.	

STATE FORM 6899 If continuation sheet 57 of 130 R61411

CAROLINA REST HOME

Division of Fleath Service Regu	ialion			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	HAL042005	B. WING	R-C 06/24/2022	
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
0.000	1361 CARO	LINA REST HOME ROAD		

PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 358 D 358 Continued From page 57

ROANOKE RAPIDS, NC 27870

Review of Resident #1's May 2022 eMAR revealed:

- -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm.
- -The resident's FSBS were documented as obtained as ordered daily from 05/01/22 05/31/22 and ranged from 45 455.
- -There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm.
- -The Novolog was documented as administered from 05/01/22 05/03/22 twice daily, 05/04/22 at 8:00am, 05/05/22 05/06/22 twice daily, 05/11/22 at 8:00pm, and 05/12/22 05/31/22 twice daily.
- -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm.
- -The resident's FSBS were documented as follows: on 05/01/22, 65 at 8:00pm, 05/03/22, 54 at 11:00am and 76 at 8:00pm; ; 05/04/22, 60 at 11:00am; 05/05/22, 66 at 8:00pm; 05/11/22, 65 at 8:00pm; 05/13/22, 72 at 8:00pm; 05/14/22, 57 at 11:00am; 05/18/22, 62 at 8:00pm; 05/19/22, 63 at 8:00pm; 05/20/22, 72 at 8:00pm; 05/21/22, 54 at 8:00pm; 05/25/22, 70 at 11:00am; 05/26/22, 50 at 11:00am and 70 at 8:00pm; 05/27/22, 45 at 8:00pm; 05/28/22, 75 at 11:00am; 05/29/22, 74 at 8:00pm; 05/30/22, 68 at 8:00pm; 05/31/22, 54 at 8:00pm; all other FSBS were documented as greater than 80.
- -The glucose tablets were documented as administered twice daily from 05/01/22 05/31/22 regardless of FSBS values.
- -There were 4 of 21 opportunities in which the glucose tablets were administered per parameters for FSBS less than 80 but the FSBS were never rechecked.

-There were 17 of 21 opportunities in which the

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 58 of 130

	Division of Ficalin Oct vice regu	alion		
I	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
ı	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
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ı				R-C
ı		HAL042005	B. WING	06/24/2022
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ı	NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STATE, ZIP CODE	

CAPOLINA PEST HOME

1361 CAROLINA REST HOME ROAD

CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870						
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			
Continued From page 58	D 358					
glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked.						
-There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pmThe resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pmThe Novolog was documented as administered from 06/01/22 - 06/21/22 twice dailyThere was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pmThe resident's FSBS were documented as						
follows: on 06/01/22, 79 at 11:00am, 06/03/22, 51 at 8:00pm; 06/04/22, 72 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/07/22, 54 at 8:00pm; 06/09/22, 5763 at 11:00am and 76 at 8:00pm; 06/10/22, 80 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/16/22, 54 at 8:00pm; 06/20/22, 72 at 11:00am; all other FSBS were documented as greater than 80. -The glucose tablets were documented as administered twice daily from 06/01/22 - 06/12/22, 06/14/22, 06/17/22 - 06/21/22, and on 06/13/22 at 8:00am, 06/15/22 at 8:00pm, and 06/16/22 at 8:00am, regardless of FSBS values. -There was no documentation that the resident's FSBS were rechecked every ten minutes for values less than 80. -There was no documentation that the glucose tablets were administered every ten minutes for FSBS that continued to be less than 80.						
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked. Review of Resident #1's June 2022 eMAR revealed: -There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm. -The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452. -There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm. -The Novolog was documented as administered from 06/01/22 - 06/21/22 twice daily. -There was an entry for glucose 4 grams, chew two tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm. -The resident's FSBS were documented as follows: on 06/01/22, 72 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/04/22, 72 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/01/22, 72 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/01/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/01/22, 54 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/01/22, 54 at 8:00pm; 06/12/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/01/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/01/22, 72 at 8:00pm; 06/01/22, 80 at 8:00pm; 06/01/22 at 8:00pm; of FSBS were rechecked every ten minutes for values less than 80. -There was no documentation that the glucose tablets were administered every ten minutes for	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIES) (EACH DEFICIES) (EACH DEFICIENCIES) (EACH DEFICIES) (EACH DEFICE) (EACH DEFICIES	ROANOKE RAPIDS, NO 27870 SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 58 glucose tablets were not administered in reference to ordered parameters in which the FSBS were less than or equal to 80 and the FSBS were never rechecked. Review of Resident #1's June 2022 eMAR revealed: - There was an entry for FSBS three times daily at 7:00am, 11:00am, and 8:00pm The resident's FSBS were documented as obtained as ordered daily from 06/01/22 - 06/21/22 and ranged from 51 - 452 There was an entry for Novolog 40 units twice daily at 8:00am and 5:00pm The resident's FSBS were documented as administered from 06/01/22 - 06/21/22 lwice daily There was an entry for glucose 4 grams, chew to tablets for a FSBS less than or equal to 80 every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as clinically indicated at 8:00am and 8:00pm The resident's FSBS were documented as clinically indicated at 8:00am and 6:00pm The resident's FSBS were documented as elilows: on 06/01/22, 79 at 8:00pm; 06/06/22, 55 at 8:00pm; 06/06/22, 72 at 8:00pm; 06/10/22, 80 at 8:00pm; 06/06/22, 72 at 8:00pm; 06/10/22, 80 at 8:00pm; 06/10/22, 72 at 8:00pm; 06/10/22, 80 at 8:00pm; 06/10/22, 20 at 8:00am and 76 at 11:00am and 76 at 11:00am; and 10 ther FSBS were documented as administered twice daily from 06/01/22 - 06/11/22 -			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 59 of 130 R61411

Division o	<u>of Health Service Regu</u>	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
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		11/12042000			1 00/24/2	UZZ
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A DEST HOME	1361 CAF	ROLINA REST H	OME ROAD		
CAROLINA REST HOME RO		ROANOK	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
IAG			i AG	DEFICIENCY)		
D 358	Continued From page	- 50	D 358			
D 330			D 330			
		opportunities in which the				
	glucose tablets were					
	•	less than 80 but the FSBS				
	were never rechecked	a. opportunities in which the				
	glucose tablets were	• •				
	_	parameters in which the				
		or equal to 80 and the				
	FSBS were never rec	•				
	Review of Resident #	t1's record revealed there				
	was no documentatio	on that any of her FSBS were				
	ever rechecked.					
	linkam ilavy vyikla Daniela	ant #4 am 00/24/22 at 0:47am				
		ent #1 on 06/21/22 at 8:17am				
	revealed:	with diabetes and the staff				
		checked her FSBS three				
	times daily.	SHECKER HELL ODG HILCO				
		ecial diet and did not know if				
	she had low blood su					
		3				
	Interview with the me	dication aide (MA) on				
	06/22/22 at 12:16pm	revealed:				
	-MAs were expected	to administer medications				
	accurately per param	eters as ordered for resident				
	safety.					
	-Resident #1 was only	• • •				
	_	tabs when her FSBS were				
	less than 80 per para					
		FSBS was low, she would				
		nt her glucose tablets then s FSBS in 1-2 hours to				
	ensure the FSBS can					
		nt the resident's FSBS				
		low FSBS, she did not know				
	why.	ow i obo, she did not know				
		ked the FSBS it would have				
	been documented on					

resident's progress notes.

STATE FORM 6899 R61411 If continuation sheet 60 of 130

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME ROANOKE RAPIDS, NO 27870 PROPRIOR (EACH DEPCICIONO' MUST BE RECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 60 -She did not report low FSBS to Resident #1's PCP when it occurred, she did not know whyShe was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the orderFSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed: -She was not sure that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe was concerning that MAs were not following parameter orders for Resident #1 regarding low FSBSLow FSBS that were left untreated could cause the resident adverse health effects such as coma or d'eath.	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME 1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 (RAH) DE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 60 -She did not report low FSBS to Resident #1's PCP when it occurred, she did not know whyShe was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the orderFSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58m revealed: -She was not aware that Resident #1's glucose tabs were being igiven twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe expected MAs to administer medications per ordered parameters and to notify the resident \$PCP of any FSBS less than 80 for further guidanceIt was concerning that MAs were left untreated could cause the resident adverse health effects such as come	74101244	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
MANE OF PROVIDER OR SUPPLIER CAROLINA REST HOME 1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 [(X4) ID SUMMARY STATEMENT OF DEFICIENCIES) ((EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) CONTINUED FROM INCOME. D 358 Continued From page 60 -She did not report low FSBS to Resident #1's PCP when it occurred, she did not know whyShe was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the orderFSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator ((RCC) on 08/22/22 at 11:58am revealed: -She was not aware that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidanceIt was concerning that MAs were not following parameter orders for Resident #1 regarding low FSBSLow FSBS that were left untreated could cause the resident adverse health effects such as coma			HAL042005	B. WING		1	_
CAPULNA REST HOME CAPUL C	NAME OF P	ROVIDER OR SUPPLIER		DRESS CITY STA	TE ZIP CODE	1 00,2	
CAROLINA REST HOME ROANOKE RAPIDS, NC 27870	NAIVIL OF T	TOVIDER OR SOLT ELER		, ,	,		
EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 Continued From page 60 She did not report low FSBS to Resident #1's PCP when it occurred, she did not know why. She was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the order. -FSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidanceIt was concerning that MAs were not following parameter orders for Resident #1' regarding low FSBSLow FSBS that were left untreated could cause the resident adverse health effects such as coma	CAROLINA	A REST HOME					
-She did not report low FSBS to Resident #1's PCP when it occurred, she did not know whyShe was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the orderFSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed: -She was not aware that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidanceIt was concerning that MAs were not following parameter orders for Resident #1 regarding low FSBSLow FSBS that were left untreated could cause the resident adverse health effects such as coma	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
PCP when it occurred, she did not know why. -She was not sure why Resident #1's glucose tabs were not being administered per parameters as ordered but thought it might be due to a misunderstanding in the order or just missed reading the order. -FSBS that were low and remained untreated were unsafe for the resident and could cause further health issues and complications. Interview with the Resident Care Coordinator (RCC) on 06/22/22 at 11:58am revealed: -She was not aware that Resident #1's glucose tabs were being given twice daily at 8:00am and 8:00pm instead of every 10 minutes as needed for FSBS less than 80 until greater than 100She expected the MAs to read the order carefully prior to medication administration to ensure safe administration of medication to residents as orderedShe expected MAs to administer medications per ordered parameters and to notify the resident's PCP of any FSBS less than 80 for further guidanceIt was concerning that MAs were not following parameter orders for Resident #1 regarding low FSBSLow FSBS that were left untreated could cause the resident adverse health effects such as coma	D 358	Continued From page	e 60	D 358			
Interview with the Director of Operations (DO) on 06/23/22 at 10:31am revealed: -She was not aware that Resident #1's glucose tablets were being administered twice daily despite the FSBS parameter orderShe expected MAs to follow the administration		-She did not report loop PCP when it occurred she was not sure what tabs were not being as ordered but though misunderstanding in the reading the orderFSBS that were low were unsafe for the refurther health issues at linterview with the Refurch of the refurcher health issues at linterview with the Refurch of the refurcher health issues at linterview with the Refurch of the refurcher was not aware to tabs were being given 8:00pm instead of every for FSBS less than 80. She expected the Maprior to medication and administration of medication o	w FSBS to Resident #1's d, she did not know why. By Resident #1's glucose administered per parameters at it might be due to a sche order or just missed and remained untreated esident and could cause and complications. Sident Care Coordinator at 11:58am revealed: That Resident #1's glucose are twice daily at 8:00am and the ery 10 minutes as needed at 10 until greater than 100. The store and the order carefully deministration to ensure safe dication to residents as a considering and to notify the ers a				

Division of Health Service Regulation

recheck her FSBS every ten minutes to continue

STATE FORM R61411 If continuation sheet 61 of 130

DIVISION	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			D. MING		R-C		
		HAL042005	B. WING		06/24/2022		
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE			
10 10 1	NOVIDEN ON OUT FIEN						
CAROLIN	A REST HOME		OLINA REST H				
		ROANOK	E RAPIDS, NC	27870			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD			
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE		
				DETICIENCY)			
D 358	Continued From page	e 61	D 358				
	giving the glucose tab						
	-It was a safety conce	ern to learn that Resident					
	#1's FSBS were going	g untreated because					
	untreated low FSBS						
		nospitalization or diabetic					
	coma.						
	Coma.						
	Interview with the Adr	ministrator on 06/23/22 at					
	2:00pm revealed:	Timistrator on ourzorzz at					
	•	a to administer Posident					
		s to administer Resident					
		accurately per parameters.					
	•	s to contact the Resident					
		vider for any low FSBS to					
	obtain further guidand						
	-It was a risk to the re	esident to have untreated low					
	FSBS that could lead	to adverse health events or					
	a diabetic coma.						
		nacist from the facility's					
		on 06/22/22 at 2:45pm					
	revealed:						
	-Resident #1 should of	only be administered					
	glucose tablets for FS	SBS that are 80 or below.					
	-The resident's FSBS	should be rechecked every					
	ten minutes when the	FSBS were 80 or below					
	and she should be give	ven glucose tablets every 10					
		S were greater than 100.					
		As to administer glucose					
		parameters as ordered.					
	•						
		S remain less than 80 and					
		d to adverse health issues to					
	include a diabetic con	na.					
	Interview with Posido	nt #1's primary care provider					
	(PCP) on 06/23/22 at						
		petes mellitus and was					
		to help control and lower her					
	blood sugars.						
	-Having low FSBS tha	at were left untreated with					

Division of Health Service Regulation

the glucose tablets as ordered could cause harm

STATE FORM 6899 R61411 If continuation sheet 62 of 130

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
CAROLIN	A DEST HOME	1361 CA	ROLINA REST HO	ME ROAD		
CAROLINA REST HOME ROANOK		KE RAPIDS, NC 2	7870			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page or even death to the resident's glucose table and to notify him of an immediately after addresident #1 had FSB concerning because he resident, provide further ensure the resident had the FSBS more close. Refer to interview with on 06/22/22 at 12:16pt. Refer to interview with 11:58am. Refer to interview with 106/23/22 at 2:00pm. Refer to interview with facility's contracted ple 2:45pm. Refer to interview with (PCP) on 06/23/22 at at at 12:16pt.	e 62 esident. s to administer the olets accurately as ordered by FSBS less than 80 ministering the glucose ess low FSBS. umerous occasions when S less than 80 was be needed to assess the eler orders to care for the esident's medications, and ad follow up care to monitor by. In the medication aide (MA) om. In the RCC on 06/22/22 at the Director of Operations 10:31am. In the Administrator on the parmacy on 06/22/22 at the the primary care provider the primary care provider.	D 358		RIATE DATE	
		led: for FSBS three times daily. for glucose 4 grams, chew				

two tablets for a FSBS less than or equal to $80\,$ every ten minutes until FSBS was greater than or equal to 100, use twice daily or more often as

STATE FORM 6899 If continuation sheet 63 of 130 R61411

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					R-	-C
		HAL042005	B. WING		1	24/2022
					1	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CAROLINA	A REST HOME		COLINA REST H			
ROANOKE		E RAPIDS, NC	<u>27870 </u>		1	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	- 63	D 358			
D 000						
		Glucose tablets are used to				
	increase FSBS when	they are too low.)				
	Daview of Docident #	141- Azzil 2000 - Instrunia				
	medication administra	t1's April 2022 electronic				
	revealed:	ation record (elviAit)				
		for FSBS three times daily at				
	7:00am, 11:00am, an	_				
		S were documented as				
	obtained as ordered of					
	04/30/22 and ranged					
	_	for glucose 4 grams, chew				
		S less than or equal to 80				
		til FSBS was greater than or				
		ce daily or more often as				
	clinically indicated at					
	-The glucose tablets	were documented as aily from 04/01/22 - 04/18/22				
		04/30/22 regardless of FSBS				
	values.	14/30/22 Togardio33 01 1 323				
		f 60 opportunities that the				
		administered to the resident,				
		due to not being required or				
		ood sugars were greater				
	than 80 and within no	ormal parameters.				
		··· 0000 MAD				
	Review of Resident #	:1's May 2022 eMAR				
	revealed:	for FSBS three times daily at				
	7:00am, 11:00am, an					
		S were documented as				
	obtained as ordered of					
	05/31/22 and ranged	•				
		for glucose 4 grams, chew				
	two tablets for a FSB	S less than or equal to 80				
	every ten minutes unt	til FSBS was greater than or				
	'='	ce daily or more often as				
	clinically indicated at	8:00am and 8:00pm.				

-The glucose tablets were documented as administered twice daily from 05/01/22 - 05/31/22

STATE FORM R61411 If continuation sheet 64 of 130

Division of Fleatin Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
					R-C
		HAL042005	B. WING		06/24/2022
			•		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET AD			TE, ZIP CODE	
CAROLIN	A DECT LIGHT	1361 CAR	OLINA REST H	OME ROAD	
CAROLINA REST HOME ROANOKE		E RAPIDS, NC	27870		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 358	Continued From page	e 64	D 358		
	regardless of FSBS v	alues			
		60 opportunities that the			
		administered to the resident,			
		due to not being required or			
	needed, when her blo	ood sugars were greater			
	than 80 and within no	rmal parameters.			
		•			
	Review of Resident #	1's June 2022 eMAR			
	revealed:				
	-There was an entry f	or FSBS three times daily at			
	7:00am, 11:00am, and				
		were documented as			
	obtained as ordered of	•			
	06/21/22 and ranged				
	_	or glucose 4 grams, chew			
	two tablets for a FSBS	S less than or equal to 80			
	every ten minutes unt	til FSBS was greater than or			
		ce daily or more often as			
	clinically indicated at	•			
	-The glucose tablets v				
	administered twice da				
		6/17/22 - 06/21/22, and on			
	·	•			
		06/15/22 at 8:00pm, and			
		regardless of FSBS values.			
		f 41 opportunities that the			
		administered to the resident,			
	instead of being held	due to not being required or			
	needed, when her blo	ood sugars were greater			
than 80 and within normal parameters.					
		•			
	Interview with Reside	nt #1 on 06/21/22 at 8:17am			
	revealed:				
		with diabetes and the staff			
	_				
		checked her FSBS three			
	times daily.	:-1 -1:-4			
	-She was not on a sp	eciai diet.			
	Interview with the me				
	06/22/22 at 12:16pm	revealed:			

Division of Health Service Regulation

-MAs were expected to administer medications

STATE FORM 6899 R61411 If continuation sheet 65 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION (X3) DATE COMP		
			A. BOILDING		R-	_
		HAL042005	B. WING		1	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME	1361 CAF	OLINA REST H	OME ROAD		
OAROLIN	A REOT HOME	ROANOK	E RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 65	D 358			
D 358	accurately per param safetyResident #1 was only administered glucose less than 80 per para -She was not sure what tabs were not being a as ordered but though misunderstanding in the reading the order. Interview with the Residence (RCC) on 06/22/22 at -She was not aware to tabs were being giver 8:00pm instead of every for FSBS less than 80 -She expected the Maprior to medication and administration of medication and administration of medication and the sexpected MAs to per ordered parameter resident's PCP of any further guidanceIt was concerning the parameter orders for administration of the control of the sexpected MAs to the	eters as ordered for resident y supposed to be tabs when her FSBS were meters. y Resident #1's glucose administered per parameters nt it might be due to a the order or just missed sident Care Coordinator and 11:58am revealed: hat Resident #1's glucose ntwice daily at 8:00am and ery 10 minutes as needed of until greater than 100. As to read the order carefully deministration to ensure safe lication to residents as of administer medications ers and to notify the of FSBS less than 80 for at MAs were not following Resident #1 regarding glucose tablets for FSBS. ector of Operations (DO) on revealed: hat Resident #1's glucose liministered twice daily fameter order. of follow the administration 's glucose tablets accurately	D 358			
	-She was not aware t tablets were being ad despite the FSBS par -She expected MAs to order for Resident #1 as written per parame	hat Resident #1's glucose Iministered twice daily rameter order. o follow the administration 's glucose tablets accurately				

Division of Health Service Regulation

2:00pm revealed he expected the MAs to

STATE FORM R61411 If continuation sheet 66 of 130

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL042005	B. WING		R-0	C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	TE ZIP CODE		
		ROLINA REST H				
CAROLIN	A REST HOME		E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 66	D 358			
	administer Resident # accurately per parame	t1's glucose tablets				
	contracted pharmacy revealed: -Resident #1 should of glucose tablets for FS -She expected the MA	SBS that are 80 or below. As to administer glucose				
Interview with Resident #1's primary care provider (PCP) on 06/23/22 at 10:46am revealed: -Resident #1 had diabetes mellitus and was dependent on insulin to help control and lower her blood sugarsHe expected the MAs to administer the resident's glucose tablets accurately as ordered per parameters.						
	Refer to interview with on 06/22/22 at 12:16p	n the medication aide (MA) om.				
	Refer to interview with 11:58am.	n the RCC on 06/22/22 at				
	Refer to interview with (DO) on 06/23/22 at 1	n the Director of Operations 0:31am.				
	Refer to interview with 06/23/22 at 2:00pm.	n the Administrator on				
		n a pharmacist from the narmacy on 06/22/22 at				

Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.

c. Review of Resident #1's physician orders dated

STATE FORM R61411 If continuation sheet 67 of 130

PRINTED: 07/18/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, ,	SURVEY PLETED	
			B. WING			₹-C
		HAL042005	B. WING		06	/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
CAROLIN	A REST HOME		ROLINA REST HOI			
	T	ROANOK	E RAPIDS, NC 27	⁷ 870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 67	D 358			
		ere was an order for Humulin sulin), inject 40 units twice 7:00pm.				
	paperwork dated 02/0 order to discontinue to administering Novolo to lower FSBS) 40 under the Review of Resident # revealed: -There was an entry to daily at 8:00am and 5 or The Novolog was do from 05/01/22 - 05/03 8:00am, 05/05/22 - 05 at 8:00pm, and 05/12 or The Novolog was do	for Novolog 40 units twice 5:00pm. ccumented as administered 8/22 twice daily, 05/04/22 at 5/06/22 twice daily, 05/11/22 ct/22 - 05/31/22 twice daily.				
	8:00am and 5:00pm, 5:00pm, 05/09/22 at 8:00am a 8:00am due to the pa the medication awaiti pharmacy. -There were 10 of 62 resident's Novolog wa	and 5:00pm, and 05/11/22 at titlent being unable to take				
	revealed she was dia the staff gave her ins	ent #1 on 06/21/22 at 8:17am gnosed with diabetes and ulin and checked her FSBS sometimes she ran out of				
	06/22/22 at 12:16pm	dication aide (MA) on revealed MAs were er medications accurately				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 68 of 130

Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R-C 06/24/2022	
NAME OF B	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIR CODE	1 00/2 11/2022	
			ROLINA REST H			
CAROLINA REST HOME		KE RAPIDS, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 68	D 358			
	per parameters as ord	dered for resident safety.				
	(RCC) on 06/22/22 at	sident Care Coordinator 11:58am revealed she ninister insulin as ordered				
	Interview with a pharm contracted pharmacy revealed: -Resident #1 should of glucose tablets for FS -She expected the MA	nacist from the facility's on 06/22/22 at 2:45pm				
	(PCP) on 06/23/22 at -Resident #1 had dial dependent on insulin blood sugars. -He expected the MA	nt #1's primary care provider 10:46am revealed: betes mellitus and was to help control and lower her s to have on hand and nt's insulin accurately as				
	Refer to interview with on 06/22/22 at 12:16p	n the medication aide (MA) om.				
	Refer to interview with 11:58am.	n the RCC on 06/22/22 at				
	Refer to interview with (DO) on 06/23/22 at 1	n the Director of Operations 0:31am.				
	Refer to interview with 06/23/22 at 2:00pm.	n the Administrator on				
		n a pharmacist from the narmacy on 06/22/22 at				

2:45pm.

Refer to interview with the primary care provider

STATE FORM 6899 R61411 If continuation sheet 69 of 130

Division of Health Service Regulation								
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
				R-C				
		HAL042005	B. WING		06/24/2022			
		11/12/04/2003			1 00/24/2022			
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE				
CAROLINA REST HOME 1361 CAROLINA REST HOME ROAD								
OAROLINA	A KLOT HOME	ROANOR	E RAPIDS, NC	27870				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(-/			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI				
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	VAIL 5/112			
			+					
D 358	Continued From page	e 69	D 358					
	(PCP) on 06/23/22 at	10:46am						
	(. 6.) 6 66/26/22 4.5							
	2. Review of Residen	it #5's current FL-2 dated						
	02/26/22 revealed:							
	-Diagnoses included	hypertension, anxiety,						
	hypothyroidism, gastr	roesophageal reflux disease,						
	hyperlipidemia, hyperglycemia, atrial fibrillation, diastolic heart failure, coronary artery disease, depressive disorder, and neuropathy. -The resident was ambulatory with the use of a							
	walker.							
	a. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for Aspirin 81mg (used as a low-dose blood thinner) once							
	daily.							
	Review of Resident #5's previous physician orders dated 02/23/22 revealed there was an order for Aspirin 325mg daily. Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed:							
	-There was an entry f	for Aspirin 325mg to be						
	administered daily.							
	-The Aspirin 325mg v							
	,	om 04/01/22 - 04/16/22,						
	•	and 04/26/22 - 04/30/22.						
		for Aspirin 81mg to be						
	administered daily.							
	Davious of Davidant #	45'a May 2022 aMAD						
	Review of Resident # revealed:	os way zuzz elviAK						
		for Aspirin 325mg to be						
	administered daily.	or Aspiriti sesting to be						
	-The Aspirin 325mg v	vas documented as						
		om 05/01/22 - 05/31/22.						
	-	for Aspirin 81mg to be						
	THOIS WAS NO CHUY I	or replini o iring to be	1					

administered daily.

STATE FORM 6899 R61411 If continuation sheet 70 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI E	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:				
				R-C		
HAL042005			B. WING		06/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			OLINA REST H	,		
CAROLIN	A REST HOME		E RAPIDS, NC			
	OUR MAR DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 358	Continued From page 70		D 358			
D 000	Continued From page 70		D 550			
	Review of Resident #	5's June 2022 eMAR				
	revealed:					
	_	or Aspirin 325mg to be				
	administered daily.					
	-The Aspirin 325mg w					
	administered daily from 06/01/22 - 06/21/22There was no entry for Aspirin 81mg to be administered daily.					
	Observation of Resident #5's medications on					
	hand on 06/23/22 at 9:48am revealed:					
	-There was a bottle of Aspirin 325mg available for administrationThere was no Aspirin 81mg available for					
	administration.					
	Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication orders.					
		ponsibility to fax a resident's				
	updated FL-2 to the p	ild not see that document.				
		edication order or FL-2 was				
		nacy, the MA would not				
		nges in medication orders or				
		correct when administering				
		it was the pharmacy's				
		te the eMAR with current				
	orders.					
		C on 06/22/22 at 11:58am				
	revealed:					
	-She did not send upo					
		cians orders every six				
	months, because she did not think updated FL-2					

orders.

Division of Health Service Regulation

orders needed to be sent to the pharmacy as new

STATE FORM 6899 R61411 If continuation sheet 71 of 130

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 (X4) ID PREFIX TAG CROCHINA REST HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 71 -She was responsible to compare current orders to new orders for any changes as soon as new orders were receivedResidents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. Interview with Resident #5's primary care provider	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
CAROLINA REST HOME ROANOKE RAPIDS, NC 27870 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 71 She was responsible to compare current orders to new orders for any changes as soon as new orders were receivedResidents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. 1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870 PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOUL			HAL042005	B. WING			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 71 -She was responsible to compare current orders to new orders for any changes as soon as new orders were received. -Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason. (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D 358 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OMPLETI TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OMPLETI TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DATE OMPLETI TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1361 CAROLINA REST HOME ROAD						
-She was responsible to compare current orders to new orders for any changes as soon as new orders were receivedResidents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE
(PCP) on 06/23/22 at 10:46am revealed: -He expected medications to be administered accurately as ordered per the FL-2 dated 02/26/22. -He expected updated medication orders to be faxed to the pharmacy as soon as possible to ensure accurate eMARs for MAs could administer medications to residents safely and accurately. -Medication errors could cause serious consequences such as drug interactions, withholding treatment for a diagnosis the medication was prescribed for, potential unwanted side effects, electrolyte abnormalities, and increased risk of falls. Refer to interview with the medication aide (MA) on 06/22/22 at 12:16pm. Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am. Refer to interview with the Administrator on 06/23/22 at 2:00pm. Refer to interview with a pharmacist from the facility's contracted pharmacy on 06/22/22 at 2:45pm.	D 358	-She was responsible to new orders for any orders were received -Residents needed to as ordered because the prescribed the residence reason. Interview with Reside (PCP) on 06/23/22 at -He expected medical accurately as ordered 02/26/22He expected updated faxed to the pharmace ensure accurate eMA medications to reside -Medication errors consequences such a withholding treatment medication was prescunwanted side effects and increased risk of Refer to interview with on 06/22/22 at 12:16g Refer to interview with (DO) on 06/23/22 at 12:00pm. Refer to interview with 06/23/22 at 2:00pm. Refer to interview with facility's contracted place.	to compare current orders changes as soon as new. be administered accurately he resident's PCP nt the medications for a sent #5's primary care provider 10:46am revealed: tions to be administered diper the FL-2 dated dimedication orders to be y as soon as possible to a large and accurately. In the safely and accurately. In the safely and accurately. In the safely and accurately. It for a diagnosis the cribed for, potential as, electrolyte abnormalities, falls. In the medication aide (MA) orm. In the RCC on 06/22/22 at the head of the head	D 358			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 72 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING	B. WING		C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
CAROLIN	A REST HOME		OLINA REST H E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	b. Review of Residen 02/26/22 revealed the fluticasone 50mcg (us one spray in each nost revealed: Review of Resident # orders dated 02/23/22 order for fluticasone 5 nostril daily as neede Review of Resident # medication administrate revealed: -There was an entry f spray in each nostril c-There was no entry f spray in each nostril s-The fluticasone was administered. Review of Resident # revealed: -There was an entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was an entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spray in each nostril c-There was no entry f spra	the primary care provider 10:46am. It #5's current FL-2 dated are was an order for sed for seasonal allergies), stril daily. 5's previous physician 2 revealed there was an 60mcg, one spray in each d. 5's April 2022 electronic ation record (eMAR) or fluticasone 50mcg one daily as needed. or fluticasone 50mcg one daily. not documented as 5's May 2022 eMAR or fluticasone 50mcg one daily as needed. or fluticasone 50mcg one	D 358			

Division of Health Service Regulation

administered.

STATE FORM 6899 R61411 If continuation sheet 73 of 130

DIVISION	n nealth Service Negu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					R-	_
		HAL042005	B. WING		1	4/2022
		HAL042005	1	-	06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOK	E RAPIDS, NC	27870		
240.15	CLIMMADY CT				<u> </u>	245)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 358	Continued From page	. 72	D 358			
D 330	Continued From page	e 73	D 336			
	Observation of Residen	ent #5's medications on				
	hand on 06/23/22 at 9	9:48am revealed the				
	fluticasone was availa	able for administration as				
	ordered.					
	Interview with the me	dication aide (MA) on				
	06/22/22 at 12:16pm	, ,				
	•	ny the eMAR matched the				
		nysician orders instead of				
	the current FL-2 med	•				
	-It was the RCC's res	ponsibility to fax a resident's				
	updated FL-2 to the p					
		uld not see that document.				
		nedication order or FL-2 was				
		macy, the MA would not				
		nges in medication orders or				
		ncorrect when administering				
		it was the pharmacy's				
		te the eMAR with current				
	orders.	te the emak with current				
	orders.					
	Interview with the PC	C on 06/22/22 at 11:58am				
	revealed:	O 011 00/22/22 at 11.30am				
	-She did not send upo	dated EL-2s to the				
		cians orders every six				
		e did not think updated FL-2				
		·				
		sent to the pharmacy as new				
	orders.	to compare current anders				
	•	e to compare current orders				
	· ·	changes as soon as new				
	orders were received	•				
		be administered accurately				
	as ordered because t	_				
	•	nt the medications for a				
	reason.					
		ent #5's primary care provider				
	(PCP) on 06/23/22 at	: 10:46am revealed:				

Division of Health Service Regulation

-He expected medications to be administered

STATE FORM 6899 R61411 If continuation sheet 74 of 130

Division of	Division of Health Service Regulation						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL042005	B. WING		R-C 06/24/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE			
CAROLIN	A REST HOME		ROLINA REST HO (E RAPIDS, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	SHOULD BE COMPLETE		
D 358	Continued From page	ontinued From page 74					
	accurately as ordered 02/26/22He expected updated faxed to the pharmace ensure accurate eMA medications to reside -Medication errors consequences such a withholding treatment medication was presounwanted side effects and increased risk of Refer to interview with on 06/22/22 at 12:16g. Refer to interview with 11:58am. Refer to interview with (DO) on 06/23/22 at 2:00pm. Refer to interview with 66/23/22 at 2:00pm. Refer to interview with facility's contracted place 2:45pm. Refer to interview with (PCP) on 06/23/22 at c. Review of Residen 02/26/22 revealed the ranitidine 300mg (use night before bed.	d per the FL-2 dated d medication orders to be ey as soon as possible to ARs for MAs could administer ents safely and accurately. Fould cause serious as drug interactions, as drug interactions, as tor a diagnosis the cribed for, potential as, electrolyte abnormalities, falls. In the medication aide (MA) and the Administrator on The The Primary care provider at 10:46am. The The The Administrator The The The The The The Administrator The					

medication administration record (eMAR) revealed there was not an entry for ranitidine

STATE FORM 6899 R61411 If continuation sheet 75 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL042005		B. WING		R-C 06/24/2022		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
CAROLIN	A REST HOME		DLINA REST H RAPIDS, NC			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 75	D 358			
	300mg every night be	fore bed.				
	300mg every night before bed. Review of Resident #5's May 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Review of Resident #5's June 2022 eMAR revealed there was not an entry for ranitidine 300mg every night before bed. Observation of Resident #5's medication on hand on 06/23/223 at 9:48am revealed there was no ranitidine 300mg available for administration. Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication ordersIt was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that documentIf a resident's new medication order or FL-2 was					
	know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current orders					
	orders. Interview with the RCC on 06/22/22 at 11:58am revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new ordersShe was responsible to compare current orders to new orders for any changes as soon as new					

Division of Health Service Regulation

orders were received.

STATE FORM 6899 R61411 If continuation sheet 76 of 130

Division of Health Service Regulatio			1		Tour =	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LANC	J JOHN LOTION	IDENTIFICATION NOWIDER.	A. BUILDING: _			
					R-C	
		HAL042005	B. WING		06/24/2022	2
NAME OF D	DOVIDED OD SUDDI IED	OTDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		, ,			
CAROLINA	CAROLINA REST HOME			OME ROAD		
	ROANO			27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	, , , ,	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
IAG		200.022	IAG	DEFICIENCY)		
D 358	Continued From page 76		D 358			
	-Residents needed to be administered accurately as ordered because the resident's PCP prescribed the resident the medications for a reason.					
	Interview with Reside	ent #5's primary care provider				
	(PCP) on 06/23/22 at					
	-He expected medica	tions to be administered				
	accurately as ordered	d per the FL-2 dated				
	02/26/22.					
	-He expected update	d medication orders to be				
		y as soon as possible to				
	ensure accurate eMA	Rs for MAs could administer				
	medications to reside	ents safely and accurately.				
	-Medication errors co	uld cause serious				
	consequences such a					
	withholding treatment					
	medication was preso					
		s, electrolyte abnormalities,				
	and increased risk of	falls.				
	D (() () ()					
		h the medication aide (MA)				
	on 06/22/22 at 12:16p	piii.				
	Refer to intoniow with	h the RCC on 06/22/22 at				
	11:58am.	II the NCC on 00/22/22 at				
	11.Juaiii.					
	Refer to interview with	h the Director of Operations				
	Refer to interview with the Director of Operations (DO) on 06/23/22 at 10:31am.					
	(20) 511 50120122 dt	.0.0				
	Refer to interview with	h the Administrator on				
	06/23/22 at 2:00pm.					
	Refer to interview with	h a pharmacist from the				
		harmacy on 06/22/22 at				
	2:45pm.	•				

Division of Health Service Regulation

Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.

STATE FORM 6899 R61411 If continuation sheet 77 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	HAL042005 B. WING			R-C 06/24/2022		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/24/2022	
CAROLIN	A REST HOME		OLINA REST H			
ROANOK			E RAPIDS, NC	2/8/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	Έ
D 358	Continued From page	e 77	D 358			
	d. Review of Resident #5's previous physician orders dated 02/23/22 revealed an order for omeprazole 20mg (used to prevent acid reflux) daily.					
	Review of Resident #5's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for omeprazole 20mg dailyThe omeprazole 20mg was documented as administered daily from 04/01/22 - 04/16/22, 04/19/22 - 04/24/22, and 04/26/22 - 04/30/22.					
	Review of Resident #5's May 2022 eMAR revealed: -There was an entry for omeprazole 20mg dailyThe omeprazole 20mg was documented as administered daily from 05/01/22 - 05/31/22.					
	Review of Resident #5's June 2022 eMAR revealed:There was an entry for omeprazole 20mg dailyThe omeprazole 20mg was documented as administered daily from 06/01/22 - 06/21/22.					
	Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -She was not sure why the eMAR matched the resident's previous physician orders instead of the current FL-2 medication ordersIt was the RCC's responsibility to fax a resident's updated FL-2 to the pharmacy because medication aides would not see that documentIf a resident's new medication order or FL-2 was not faxed to the pharmacy, the MA would not know there were changes in medication orders or that the eMAR was incorrect when administering medications because it was the pharmacy's responsibility to update the eMAR with current					

orders.

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 78 of 130

Division of	of Health Service Regul	lation			1 Ortiv	ATTROVED	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R- 06/2	C 4/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE			
			ROLINA REST H				
CAROLIN	A REST HOME	ROANOK	E RAPIDS, NC	27870			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	HOULD BE COMPLETE		
D 358	Continued From page	: 78	D 358				
	revealed: -She did not send upor pharmacy, only physic months, because she orders needed to be sordersShe was responsible to new orders for any orders were receivedResidents needed to medications accurate resident's PCP preson medications for a reason linterview with Reside (PCP) on 06/23/22 at -He expected medications accurately as ordered 02/26/22He expected updated faxed to the pharmacy ensure accurate eMA medications to reside -Medication errors conconsequences such a withholding treatment medication was preson unwanted side effects and increased risk of Refer to interview with on 06/22/22 at 12:16pt	cians orders every six did not think updated FL-2 sent to the pharmacy as new to compare current orders changes as soon an new be administered ly as ordered because the ribed the resident the son. Int #5's primary care provider 10:46am revealed: tions to be administered I per the FL-2 dated I per the FL-2 dated I medication orders to be y as soon as possible to Rs for MAs could administer nts safely and accurately. uld cause serious as drug interactions, for a diagnosis the cribed for, potential s, electrolyte abnormalities, falls. In the medication aide (MA)					

11:58am.

Refer to interview with the Director of Operations

(DO) on 06/23/22 at 10:31am.

STATE FORM 6899 R61411 If continuation sheet 79 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		_
		HAL042005	B. WING		R- 06/2	C 4/ 2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		DLINA REST H			
	- TOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 79		D 358			
	Refer to interview with 06/23/22 at 2:00pm.	h the Administrator on				
		h a pharmacist from the harmacy on 06/22/22 at				
	Refer to interview with the primary care provider (PCP) on 06/23/22 at 10:46am.					
	Interview with the medication aide (MA) on 06/22/22 at 12:16pm revealed: -New medication orders were to be faxed to the pharmacy by the MAs or the RCC as soon as possible.					
	-The pharmacy entered the orders onto the resident's eMARWhen the medications arrived at the facility, it was the MAs responsible to compare the original order to the eMAR to the medication on hand for					
	accuracy prior to approved the order and administering the medication. -MAs were responsible to compare the medication on hand to the resident's task list and the eMAR for accuracy prior to administering the medication, then document the administration					
	monthly and documer where they were.	R. nedication cart audits once nted them but was not sure ts included comparing an				
		nedications on hand and the				
	revealed:	C on 06/22/22 at 11:58am				
		responsible to fax new the pharmacy as soon as ng the orders.				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 80 of 130

Division of	Division of Health Service Regulation					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		R-C	
		HAL042005	I B. WING		06/2	4/2022
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CAROLIN	A REST HOME		OLINA REST HO E RAPIDS, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	SHOULD BE COMPLETE	
D 358	Continued From page	ontinued From page 80				
	the resident's eMAR a responsible to review accuracy before approved the medications a medication order, it we compare the original hand and the eMAR for There was no processon check the according to the MA approved the MAs were expected accurately to resident document the administ accurately on the eMAR of the medications were in total the transfer of the eMAR, the series of the eMAR, the eMAR prior to administration orders would not be emaled to the eMAR orders would not know medications accurated.	vas the MA's responsibility to order with the medication on for accuracy. So in place to have a second curacy of the orders after her the order. To administer medications to sper the order then stration of the medication CAR. To perform medication cart th, but they were only expired medications and that the correct drawers. So in place to perform audits ing the resident's current to the medications on hand. Dector of Operations (DO) on revealed: To administer medications medication; right medication, and route. To compare medications to ministration for resident entered onto the eMAR, and how to administer				

2:00pm revealed:

Interview with the Administrator on 06/23/22 at

STATE FORM 6899 R61411 If continuation sheet 81 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING			C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CAROLINA	CAROLINA REST HOME 1361 CARO ROANOKE			OME ROAD 27870		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	reflected accurately o -He expected MAs to accurately as ordered five rightsHe expected medica documented accurate assessment. Interview with a pharm contracted pharmacy revealed: -MAs were responsible accurately as ordered	administer medications I for resident safety per the tion administration to be ely for proper evaluation and macist from the facility's on 06/22/22 at 2:45pm le to administer medications I.				
	accurately as ordered. -MAs were expected to compare the medications being administered to the eMAR to ensure accuracy prior to administration. -When medications are not administered as ordered could be detrimental to the safety of the residents in which there could be drug to drug interactions and not receiving the proper treatment for the diagnoses the medication was prescribed for.					
	care provider (PCP) of revealed: -He expected the MA: medications to reside -He expected orders to resident eMARsHe expected to be not	lity's contracted primary on 06/23/22 at 10:46am s at the facility to administer onts accurately and safely. To be reflected accurately on otified when errors or from medications occurred.				
D 367	10A NCAC 13F .1004 Administration	(j) Medication	D 367			
	10A NCAC 13F .1004	Medication Administration				

Division of Health Service Regulation

(j) The resident's medication administration

STATE FORM 6899 R61411 If continuation sheet 82 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL042005	B. WING		1	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		OLINA REST H			
			RAPIDS, NC			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 82	D 367			
	record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record					
	accurate for 2 of 5 sa	ation records (eMAR) were mpled residents (#1, #5)				
	•	ompression hose (#1), and nner, a nasal spray, acid				
	The findings are:					
	reflux medications, and a CPAP treatment (#5). The findings are: Review of the facility's medication policy revealed: -Medications and treatments will be administered in accordance with the prescribing practitioner's ordersStaff will document administration of medications on the eMAR after observing the resident take the					

Division of Health Service Regulation

-The eMAR will be updated and changed when

STATE FORM 6899 R61411 If continuation sheet 83 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		DLINA REST H			
	OUN MAN DV OT		RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	e 83	D 367			
	medication or treatme prescribing practitione					
	12/21/21 revealed:	t #1's current FL-2 dated				
	mellitus, hypertension, chronic obstruction pulmonary disease, peripheral neuropathy,					
	anxiety, history of seizures, and a history of illegal drug use. -The resident was semi-ambulatory and required					
	2 liters of oxygen (2L	O2) at all times.				
	Review of Resident # 01/21/22 revealed:	1's physician orders dated				
	wear as directed.	or compression hose to				
	-There was no order f self-administer the us	or the resident to e of the compression hose.				
	Review of Resident # medication administra	1's April 2022 electronic ation record (eMAR)				
	revealed the compression hose were documented as administered daily from 04/01/22 - 04/30/22.					
	Review of Resident # revealed the compres documented as admir - 05/31/22.					
	Review of Resident #1's June 2022 eMAR revealed the compression hose were documented as administered daily from 06/01/22 - 06/20/22.					
	•	ent #1 on 06/21/22 at 8:17 her compression hose.				

Division of Health Service Regulation

Observation of Resident #1 on 06/23/22 at

STATE FORM 6899 R61411 If continuation sheet 84 of 130

	<u>of Health Service Regu</u>					
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COME	PLETED
					١,	2 C
		HAI 04200E	B. WING			R-C
		HAL042005			100	/24/2022
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
0.1.001.11		1361 CA	AROLINA REST HO	ME ROAD		
CAROLIN	A REST HOME	ROANO	KE RAPIDS, NC 27	870		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
				52.10.2.1		
D 367	Continued From page	e 84	D 367			
	44.00	w wina b				
		e was not wearing her				
	compression hose.					
	Interview with Reside	nt #1 on 06/23/22 at				
	11:08am revealed:	111 #1 011 00/23/22 at				
		ompression hose on and				
	, ,					
	•	As would ask or look to see				
	if she was wearing the	em.				
	-She was not sure if t	he MAs documented her				
	use of the compression	on hose in her record.				
	Interview with the Dire	ector of Operations (DO) on				
		- ·				
	-					
	_	As to verify the resident was				
		sion hose daily prior to				
	documentation of adr	ninistration.				
	-She expected the Ma	As to encourage the use of				
	Resident #1's compre	ession hose and to				
	document the resider	nt's use of the compression				
	hose accurately.					
	Internieus sitte De 11	m4 #41a maina ama				
	, ,					
	•					
	1 - 1 ie did Hot provide R	CSINCIIL#I WILLI A	1			1
	self-administer order	because he expected the				
	take them off herself, days her legs would so she did not wear the day because she thouther was only one ask her if she put the she was wearing the she was not sure if the use of the compression of the c	but only wore them on the swell. compression hose every aght they were too tight. MA who would occasionally compression hose on. As would ask or look to see em. he MAs documented her on hose in her record. ector of Operations (DO) on revealed: mpetent enough to put on oression hose As to verify the resident was sion hose daily prior to ministration. As to encourage the use of ession hose and to on the compression hose and to on the compression hose and to on the compression the compression that the compressi				

worn daily as ordered.

-The compression hose were ordered for the resident due to her peripheral edema.

STATE FORM 6899 If continuation sheet 85 of 130 R61411

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		S) DATE SURVEY COMPLETED	
		HAL042005	B. WING		l l	R-C / 24/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	ΓΕ, ZIP CODE			
CAROLIN	A REST HOME	1361 CAF	ROLINA REST HO	OME ROAD			
CAROLIN	A REST HOWE	ROANOK	E RAPIDS, NC 2	27870		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D 367	Continued From page	2 85	D 367				
		s to document the resident's ession hose accurately.					
	Refer to interview witl on 06/22/22 at 12:16p	n the medication aide (MA) om.					
	Refer to interview witl 11:58am.	n the RCC on 06/22/22 at					
	Refer to interview witl (DO) on 06/23/22 at 1	n the Director of Operations 0:31am.					
	Refer to interview with the Administrator on 06/23/22 at 2:00pm.						
		n a pharmacist from the narmacy on 06/22/22 at					
	Refer to interview witl (PCP) on 06/23/22 at	n the primary care provider 10:46am.					
	02/26/22 revealed dia hypertension, anxiety gastroesophageal ref hyperglycemia, atrial	, hypothyroidism, lux disease, hyperlipidemia, fibrillation, diastolic heart y disease, depressive					
	02/26/22 revealed the	t #5's current FL-2 dated ere was an order for Aspirin dose blood thinner) once					
		5's previous physician 2 revealed there was an ng daily.					
	Review of Resident #	5's April 2022 electronic					

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 86 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL042005	B. WING		R-C 06/24/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CAROLINA	A REST HOME	1361 CAR	OLINA REST H	OME ROAD	
OAROLINA	A REOT HOME	ROANOK	E RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 86	D 367		
	medication administrate revealed: -There was an entry from administered daily. -The Aspirin 325mg wadministered daily from 04/19/22 - 04/24/22, and administered daily. Review of Resident # revealed: -There was an entry from administered daily. -The Aspirin 325mg wadministered daily. -There was no entry from administered daily. Review of Resident # revealed: -There was no entry from administered daily. Review of Resident # revealed: -There was an entry from administered daily. -There was an entry from administered daily. -There was no entry from administered daily. Observation of Resident # revealed: -There was no entry from administered daily. Observation of Resident # revealed: -There was no entry from administered daily. Observation of Resident # revealed: -There was no entry from administered daily. Observation of Resident # revealed: -There was no entry from administered daily. Observation of Resident # revealed: -There was no entry from administered daily.	ation record (eMAR) or Aspirin 325mg to be vas documented as m 04/01/22 - 04/16/22, and 04/26/22 - 04/30/22. or Aspirin 81mg to be 5's May 2022 eMAR or Aspirin 325mg to be vas documented as m 05/01/22 - 05/31/22. or Aspirin 81mg to be 5's June 2022 eMAR or Aspirin 81mg to be vas documented as m 06/01/22 - 06/21/22. or Aspirin 81mg to be vas documented as m 06/01/22 - 06/21/22. or Aspirin 81mg to be ent #5's medications on 0:48am revealed: f Aspirin 325mg available for a 81mg available for dication aide (MA) on			
	06/22/22 at 12:16pm				

Division of Health Service Regulation

resident's previous physician orders instead of

the current FL-2 medication orders.

STATE FORM R61411 If continuation sheet 87 of 130

PRINTED: 07/18/2022 FORM APPROVED

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
			B. WING		R-C	
		HAL042005	B. WING		06/24/2	2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
			ROLINA REST H			
CAROLIN	A REST HOME		(E RAPIDS, NC			
			E RAPIDS, NC			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		DATE
IAG		,	l lAG	DEFICIENCY)		
D 367	7 Continued From page 87		D 367			
	It was the BCC's res	ponsibility to fax a resident's				
	updated FL-2 to the p					
	I	uld not see that document.				
		redication order or FL-2 was				
	I	macy, the MA would not				
		nges in medication orders or				
		correct when administering				
		it was the pharmacy's				
		te the eMAR with current				
	orders.					
	Intervious with the DC	C on 06/22/22 of 11/59om				
		C on 06/22/22 at 11:58am				
	revealed:	d-4- d El O- 4- 4				
	-She did not send upo					
		cians orders every six				
		e did not think updated FL-2				
		sent to the pharmacy as new				
	orders.	to compare current orders				
		to compare current orders				
	to new orders for any	be administered accurately				
	as ordered because t	<u> </u>				
		nt the medications for a				
	reason.	in the medications for a				
	Teason.					
	Interview with Reside	nt #5's primary care provider				
	(PCP) on 06/23/22 at					
	` '	tions to be administered				
	accurately as ordered					
	02/26/22.					
		d medication orders to be				
		y as soon as possible to				
	•	Rs for MAs could administer				
		ents safely and accurately.				
	-Medication errors co	•				
	consequences such a					
	withholding treatment					
	_	_				
	medication was preso	cribed for, potential				

Division of Health Service Regulation

and increased risk of falls.

unwanted side effects, electrolyte abnormalities,

STATE FORM 6899 R61411 If continuation sheet 88 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
					R-0	2
		HAL042005	B. WING		06/24	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		ROLINA REST H			
	· · · · · · · · · · · · · · · · · · ·	ROANOP	E RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	÷ 88	D 367			
	Refer to interview witl on 06/22/22 at 12:16p	n the medication aide (MA) om.				
	Refer to interview with 11:58am.	n the RCC on 06/22/22 at				
	Refer to interview witl (DO) on 06/23/22 at 1	n the Director of Operations 10:31am.				
	Refer to interview with the Administrator on 06/23/22 at 2:00pm.					
		n a pharmacist from the narmacy on 06/22/22 at				
	Refer to interview witl (PCP) on 06/23/22 at	n the primary care provider 10:46am.				
	02/26/22 revealed the	sed for seasonal allergies),				
	orders dated 02/23/22	5's previous physician 2 revealed there was an 50mcg, one spray in each d.				
	medication administrative revealed: -There was an entry for spray in each nostril of the spray in each	or fluticasone 50mcg one daily as needed. or fluticasone 50mcg one scheduled daily.				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 89 of 130

DIVISION	of Fleatill Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_ ا	0
			B. WING		R-	_
		HAL042005	B: Wiite		06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		1361 CAR(DLINA REST H	OME ROAD		
CAROLINA	A REST HOME		RAPIDS, NC			
			TAPIDO, NO			
(X4) ID	_	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 367	Continued From page	÷ 89	D 367			
	Review of Resident #	5's May 2022 eMAR				
	revealed:	0 0 may 2022 0mm				
		or fluticasone 50mcg one				
	spray in each nostril of					
	' '	for fluticasone 50mcg one				
	spray in each nostril s					
	-The fluticasone was					
	administered.	not documented as				
	administered.					
	Review of Resident #	5's June 2022 eMAR				
	revealed:	03 dane 2022 civil at				
		or fluticasone 50mcg one				
	spray in each nostril of					
	• •	for fluticasone 50mcg one				
	spray in each nostril s					
	-The fluticasone was	-				
	administered.	not documented as				
	administered.					
	Observation of Boold	ent #5's medications on				
	hand on 06/23/22 at 9					
		able for administration as				
		able for administration as				
	ordered.					
	Interview with the med	dication aida (MA) on				
	06/22/22 at 12:16pm	` ,				
	· · · · · · · · · · · · · · · · · ·					
		ny the eMAR matched the				
	· ·	nysician orders instead of				
	the current FL-2 medi					
		ponsibility to fax a resident's				
	updated FL-2 to the p					
		uld not see that document.				
		edication order or FL-2 was				
		macy, the MA would not				
		nges in medication orders or				
		correct when administering				
		it was the pharmacy's				
		te the eMAR with current				
	orders.					

Division of Health Service Regulation

Interview with the RCC on 06/22/22 at 11:58am

STATE FORM R61411 If continuation sheet 90 of 130

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R-C	
		HAL042005	B. WING		06/24	1/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		1361 CAI	ROLINA REST H	OME ROAD		
CAROLIN	A REST HOME	ROANOR	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
iAG		,	IAG	DEFICIENCY)		
D 367	Continued From page	200	D 367			
D 001			2 007			
	revealed:	d-4- d El O- 4- 4-				
	-She did not send upo					
		cians orders every six did not think updated FL-2				
		sent to the pharmacy as new				
	orders.					
	-She was responsible	to compare current orders				
	to new orders for any	changes.				
		be administered accurately				
	as ordered because t					
	•	nt the medications for a				
	reason.					
		nt #5's primary care provider				
	(PCP) on 06/23/22 at					
	accurately as ordered	tions to be administered				
	02/26/22.	r per trie i L-2 dated				
		d medication orders to be				
	faxed to the pharmac	y as soon as possible to				
		Rs for MAs could administer				
		nts safely and accurately.				
	-Medication errors co					
	consequences such a					
	withholding treatment medication was preso					
		s, electrolyte abnormalities,				
	and increased risk of					
						
		n the medication aide (MA)				
	on 06/22/22 at 12:16p	om.				
	Defer to interview	the BCC on 06/22/22 at				
	11:58am.	n the RCC on 06/22/22 at				
	i i .ooaiii.					
	Refer to interview with	n the Director of Operations				
	(DO) on 06/23/22 at 1					

06/23/22 at 2:00pm.

Refer to interview with the Administrator on

STATE FORM 6899 R61411 If continuation sheet 91 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL042005	B. WING		R-C 06/24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CAROLIN	A REST HOME	1361 CAR	OLINA REST H	OME ROAD	
CAROLINA	A REST HOME	ROANOK	E RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	91	D 367		
		n a pharmacist from the narmacy on 06/22/22 at			
	Refer to interview with (PCP) on 06/23/22 at	n the primary care provider 10:46am.			
	c. Review of Resident #5's current FL-2 dated 02/26/22 revealed there was an order for ranitidine 300mg (used to treat acid reflux) every night before bed.				
	orders dated 02/23/22	5's previous physician 2 revealed there was no 0mg every night before bed.			
	medication administra	ot an entry for ranitidine			
	Review of Resident # revealed there was no 300mg every night be	ot an entry for ranitidine			
	Review of Resident # revealed there was no 300mg every night be	ot an entry for ranitidine			
	on 06/23/223 at 9:48a	ent #5's medication on hand am revealed there was no lable for administration.			
		` ,			

Division of Health Service Regulation

the current FL-2 medication orders.

-It was the RCC's responsibility to fax a resident's

STATE FORM 6899 R61411 If continuation sheet 92 of 130

	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF D		OTDEETAD		TE 7/D 00DE	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	•	
CAROLIN	A REST HOME		OLINA REST H		
	T		E RAPIDS, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 92	D 367		
<i>D</i> 307	updated FL-2 to the pmedication aides would are sident's new mot faxed to the phank know there were chait that the eMAR was in medications because responsibility to updatorders. Interview with the RC revealed:	oharmacy because ald not see that document. sedication order or FL-2 was macy, the MA would not sees in medication orders or secorrect when administering it was the pharmacy's te the eMAR with current acc on 06/22/22 at 11:58am	<i>D</i> 307		
	revealed: -She did not send updated FL-2s to the pharmacy, only physicians orders every six months, because she did not think updated FL-2 orders needed to be sent to the pharmacy as new orders.				
	to new orders for any -Residents needed to as ordered because t	be administered accurately			
	(PCP) on 06/23/22 at -He expected medical accurately as ordered 02/26/22He expected update faxed to the pharmace ensure accurate eMA medications to reside -Medication errors co consequences such a withholding treatment medication was prese	tions to be administered d per the FL-2 dated d medication orders to be y as soon as possible to acks for MAs could administer ents safely and accurately. uld cause serious as drug interactions, t for a diagnosis the cribed for, potential s, electrolyte abnormalities,			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 93 of 130

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL042005	B. WING		R-C 06/24/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E. ZIP CODE	1 00/2 11/2022
			ROLINA REST HO	•	
CAROLIN	A REST HOME		(E RAPIDS, NC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
D 367	Continued From page	93	D 367		
	Refer to interview with on 06/22/22 at 12:16p	n the medication aide (MA) om.			
	Refer to interview witl 11:58am.	n the RCC on 06/22/22 at			
	Refer to interview witl (DO) on 06/23/22 at 1	n the Director of Operations 0:31am.			
	Refer to interview witl 06/23/22 at 2:00pm.	n the Administrator on			
		n a pharmacist from the narmacy on 06/22/22 at			
	Refer to interview witl (PCP) on 06/23/22 at	n the primary care provider 10:46am.			
	02/26/22 revealed an	at sleep apnea) every night			
	orders dated 02/23/22	5's previous physician 2 revealed there was an AP every night at bedtime orning.			
	medication administrative revealed:	,			
	bed and remove in the CPAP was docu	or CPAP every night before e morning. mented administered every 04/16/22, 04/22/22, and			
	-The CPAP was docu on 04/18/22 - 04/21/2	mented as not administered 2 and 04/23/22 - 04/25/22 sing unable to take the			

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 94 of 130

Division o	<u>of Health Service Regu</u>	ılation				
STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			D WING		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
IVAIVIL OI II	NOVIDEN ON OUT LIEN					
CAROLIN	A REST HOME		ROLINA REST H			
		ROANOI	KE RAPIDS, NC	27870		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	V (X5)	
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE DATE	
				DEFICIENCY)		
D 367	Continued From page	a 0/1	D 367			
D 307	Continued From page	5 94	5007			
ļ	medication.					
	Review of Resident #	5's May 2022 eMAR				
ļ	revealed:	oo may 2022 om a t				
ļ		for CPAP every night before				
ļ	bed and remove in th	, ,				
ļ		•				
ļ		umented administered every				
ļ		05/09/22, 005/12/22 -				
	· ·	05/26/22, 05/28/22, and				
	05/31/22.					
	-The CPAP was docu	ımented as not administered				
	on 05/10/22 - 05/11/2	22, 05/17/22 - 05/18/22,				
		due to the resident being				
	unable to take the me					
	Review of Resident #	45's June 2022 eMAR				
	revealed:	-0 3 Udilo 2022 0.1				
		for CPAP every night before				
	I -					
	bed and remove in th	•				
ļ		umented administered every				
ļ	night from 06/01/22 -					
	·	and 06/17/22 - 06/20/22.				
ļ	-The CPAP was docu	ımented as not administered				
		2 - 06/09/22, 06/14/22 -				
	06/16/22 due to the re	esident being unable to take				
	the medication.					
	Observation of Resid	ent #5's medication on hand				
	on 06/23/22 at 9:48ar	m revealed there was no				
	CPAP machine availa					
	Or 7 traditino availe	able to the resident.				
ļ	Interview with Poside	ent #5 on 06/23/22 at 9:55am				
ļ		:111 #3 011 00/23/22 at 9.33a111				
	revealed:					
	_	had been broken for some				
ļ	time, but she could no					
ļ	-Someone at the facil	lity took the machine and				
ļ	was supposed to hav	e it fixed, but she could not				
ļ	recall who.					

-She had not been wearing her CPAP machine at

night as ordered because it was broken.

STATE FORM 6899 R61411 If continuation sheet 95 of 130

DIVISION	n Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL042005	B. WING		06/24/2022	2
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CAROLINA	A REST HOME		ROLINA REST H			
		ROANOK	E RAPIDS, NC	27870	<u> </u>	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	/-	(5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		PLETE ATE
1710		,	17.0	DEFICIENCY)		
D 267	Oti	. 05	D 367			
D 367	Continued From page	95	D 367			
	Interview with an MA	on 06/23/22 at 9:55am				
	revealed:					
		lesident #5's CPAP was				
	broken.					
		ht shift and would not have as broken because she				
		ras proken because sne histered it to the resident.				
	would not have admir	istered it to the resident.				
	Interview with the Dire	ector of Operations (DO) on				
	06/23/22 at 10:31am					
		hat Resident #5's CPAP				
	machine was broken	and unavailable.				
	-She expected facility	staff to report broken				
	equipment to her so s	she could correct the issue.				
	-The resident had to v	wear the CPAP at night				
	because she had slee					
	•	o administer the CPAP as				
	ordered and documer	nt the administration				
	accurately.					
	Interview with Decide	nt #Ela primary agra provider				
	(PCP) on 06/23/22 at	nt #5's primary care provider				
	` ,	to wear the CPAP at night				
		hypertension, and poor				
	output.	hypertension, and poor				
	•	ident's CPAP machine to be				
	available and in worki					
		e CPAP machine was not				
	being administered as					
	-He expected the MA	s to administer and				
	document the adminis	stration of the CPAP				
	accurately.					
	5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6					
		h the medication aide (MA)				
	on 06/22/22 at 12:16p	om.				
	Refer to interview with	h the RCC on 06/22/22 at				
ı	I VOICE TO HITCH VICAN MILE	ii iiio 1100 oii oo/22/22 at	1	1	l l	

Division of Health Service Regulation

11:58am.

STATE FORM 6899 R61411 If continuation sheet 96 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL042005	B. WING		R-C 06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CAROLIN	A REST HOME	1361 CAR	OLINA REST H	OME ROAD	
		ROANOKE	RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	96	D 367		
	Refer to interview wit (DO) on 06/23/22 at	h the Director of Operations 10:31am.			
	Refer to interview wit 06/23/22 at 2:00pm.	h the Administrator on			
		h a pharmacist from the harmacy on 06/22/22 at			
	Refer to interview wit (PCP) on 06/23/22 at	h the primary care provider 10:46am.			
		t #5's previous physician 2 revealed an order for ily.			
		5's current FL-2 02/26/22 ot an order for omeprazole			
	medication administrative revealed: -There was an entry for the omeprazole 20 madministered daily from	for omeprazole 20mg daily. ng was documented as nm 04/01/22 - 04/16/22,			
		and 04/26/22 - 04/30/22.			
	-The omeprazole 20n	5's May 2022 eMAR for omeprazole 20mg daily. ng was documented as om 05/01/22 - 05/31/22.			
	-The omeprazole 20n	5's June 2022 eMAR for omeprazole 20mg daily. ng was documented as nm 06/01/22 - 06/21/22.			

Division of Health Service Regulation

STATE FORM R61411 If continuation sheet 97 of 130

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		OLINA REST H			
			RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	Έ
D 367	Continued From page	97	D 367			
	resident's previous phethe current FL-2 medialite was the RCC's resupdated FL-2 to the periodication aides would a resident's new most faxed to the pharm know there were charmed that the eMAR was in medications because responsibility to update orders.	revealed: y the eMAR matched the ysician orders instead of cation orders. ponsibility to fax a resident's				
	revealed: -She did not send upon pharmacy, only physic months, because she orders needed to be sordersShe was responsible to new orders for any-Residents needed to as ordered because the	dated FL-2s to the cians orders every six did not think updated FL-2 sent to the pharmacy as new to compare current orders changes. be administered accurately				
	(PCP) on 06/23/22 at -He expected medica: accurately as ordered 02/26/22He expected updated faxed to the pharmace ensure accurate eMA	tions to be administered				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 98 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		'	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		I	R-C 6/ 24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CAPOLIN	A REST HOME	1361 CA	ROLINA REST HO	OME ROAD		
CAROLIN	A REST HOME	ROANOI	KE RAPIDS, NC 2	7870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 98	D 367			
	and increased risk of	as drug interactions, t for a diagnosis the cribed for, potential s, electrolyte abnormalities, falls. h the medication aide (MA)				
	Refer to interview with the RCC on 06/22/22 at 11:58am.					
	Refer to interview wit (DO) on 06/23/22 at	h the Director of Operations 10:31am.				
	Refer to interview wit 06/23/22 at 2:00pm.	h the Administrator on				
		h a pharmacist from the harmacy on 06/22/22 at				
	Refer to interview wit (PCP) on 06/23/22 at	h the primary care provider : 10:46am.				
	06/22/22 at 12:16pm -New medication ord pharmacy by the MA possibleThe pharmacy enter resident's eMARWhen the medicatio was the MAs respons	ers were to be faxed to the s or the RCC as soon as ed the orders onto the ensarrived at the facility, it sible to compare the original the medication on hand for roved the order and dication.				

Division of Health Service Regulation

medication on hand to the resident's task list and

STATE FORM 6899 R61411 If continuation sheet 99 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R-C) 1/2022
	ROVIDER OR SUPPLIER A REST HOME	STREET ADI	DRESS, CITY, STA	OME ROAD	1 00/24	12022
			RAPIDS, NC		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	99	D 367			
	medication, then docu accurately on the MA -She would perform n monthly and documen where they were. -Medication cart audit original order to the m resident's eMAR for a	nedication cart audits once nted them but was not sure is included comparing an nedications on hand and the accuracy.				
	revealed: -She or an MA were remedication orders to a possible after receiving. -The pharmacy would the resident's eMAR aresponsible to review accuracy before appreached. When medications a medication order, it was compare the original shand and the eMAR for the email of the medication order, it was compared the original shand and the eMAR for the email of the management of the management of the management of the management of the email of t	I enter the new order into and she or an MA were the order on the eMAR for oving the order for use. rrived for the new as the MA's responsibility to order with the medication on or accuracy. It is in place to have a second uracy of the orders after her the order. It is administer medication see the order then estration of the medication AR. It is perform medication cart the but they were only expired medications and that				
	Interview with the Dire	ector of Operations (DO) on				

Division of Health Service Regulation

06/23/22 at 10:31am revealed:

STATE FORM 6899 R61411 If continuation sheet 100 of 130

DIVISION	n nealth Service Negu	ilalion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
						-C
		HAL042005	B. WING		l l	_
		HAL042005	B: Wilto		06/	24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		1361 CAF	OLINA REST H	OME ROAD		
CAROLIN	A REST HOME		E RAPIDS, NC			
	CLIMMADY CT		<u> </u>	1	CORRECTION	0.450
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION)		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		DATE
				DEFICIENCY	')	
D 367	Continued From page	100	D 367			
D 301	Continued From page	9 100	D 307			
	-She expected MAs to	o compare medications to				
	the eMAR prior to adr	ministration for resident				
	safety.					
	-If orders were not fax	xed to the pharmacy, the				
		entered onto the eMAR, and				
	MAs would not know	how to administer				
	medications accurate	ely.				
		not administered as ordered				
	it could cause a declin	ne in the resident's health				
	status.					
	Interview with the Adr	ministrator on 06/23/22 at				
	2:00pm revealed:					
	•	nt medication orders to be				
	reflected accurately o					
		ition administration to be				
	•	ely for proper evaluation and				
	assessment.	by for proper evaluation and				
	assessificiti.					
	Interview with a pharr	macist from the facility's				
		on 06/22/22 at 2:45pm				
	revealed:	511 55/22/22 at 2. 10pm				
		le to administer medications				
	accurately as ordered					
	•	to compare the medications				
	being administered to					
	accuracy prior to adm					
	- ·					
		re not administered as rimental to the safety of the				
		,				
		ere could be drug to drug				
	interactions and not re					
	-	noses the medication was				
	prescribed for.					
	Intonious with the fact	ility's contracted primary				
		ility's contracted primary				
		on 06/23/22 at 10:46am				
	revealed:					
		s at the facility to administer				
	medications to reside	ents accurately and safely.				

Division of Health Service Regulation

-He expected orders to be reflected accurately on

STATE FORM 6899 R61411 If continuation sheet 101 of 130

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R-C	<u> </u>
		HAL042005	B. WING			/2022
					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	•		
CAROLINA	A REST HOME		ROLINA REST H			
		ROANO	KE RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
				DEFICIENCY)		
D 367	Continued From page	101	D 367			
D 307	Continued From page	: 101	D 307			
	resident eMARs.					
	-He expected to be notified when errors or					
	adverse side effects f	rom medications occurred.				
D 438		Health Care Personnel	D 438			
	Registry					
	404 NCAC 42E 420	Licelth Care Developed				
	10A NCAC 13F .1205 Health Care Personnel					
	Registry The facility shall come	ply with G.S. 131E-256 and				
		NCAC 130 .0101 and				
	.0102.	(140/10 100 1010 t dild				
	This Rule is not met	as evidenced by:				
	TYPE A2 VIOLATION	I				
		ews and interviews, the				
		allegations of physical				
		misappropriation of funds by the North Carolina Health				
		stry (HCPR) within 24 hours				
	for 2 of 2 sampled res					
	ioi 2 oi 2 oampiou ioi	siderite (#0, #0).				
	The findings are:					
		t #3's current FL-2 dated				
	02/05/22 revealed:					
	-Diagnosis included r					
		with loss of consciousness,				
		right side as a late effect of				
	cerebral vascular acc					
	accident sequela and	expressive apnasia. nentation of orientation				
	status.	ionadon of one ilation				
	ctatuo.					
	Review of Resident #	3's current care plan dated				

Division of Health Service Regulation

09/03/21 revealed:

-There was no documentation of physical or

STATE FORM 6899 R61411 If continuation sheet 102 of 130

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-	_
		HAL042005	B. WING		1	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAROLIN	A REST HOME		OLINA REST H			
ROANOKE			RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 102	D 438			
	verbal aggressionThere was no documbehaviorHe was oriented and through gesturesHe required an assis-He required glasses Interview with the Director of the control	nentation of disruptive I was able to communicate Itive device for ambulation. for limited vision. ector of Operations (DO) on evealed there were no sion or behaviors. 3's progress note dated evealed he had a lighter and hen she took it away from				
	05/29/22 at 6:10pm re	3's progress note dated evealed he swung at a staff ed to take cigarettes away				
	05/30/22 at 6:20pm re -The progress note w -Resident #3 was ent back porch and tried is she moved his wheele overResident #3 hit the S					
	revealed: -She witnessed Resid Staff A tried to make h building.	ent on 06/21/22 at 8:48am dent #3 outside smoking and nim go back inside the				

Division of Health Service Regulation

Resident #3 three times in the face, breaking his

STATE FORM 6899 R61411 If continuation sheet 103 of 130

Division of	<u>of Health Service Regu</u>	ılation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		
			B. WING		R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			ROLINA REST H		
CAROLINA	A REST HOME		KE RAPIDS, NC		
			TE RAFIDS, NC 2		
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	
IAO		,	l lAG	DEFICIENCY)	
			+		
D 438	Continued From page	e 103	D 438		
	alaccae				
	glasses.				
	Interview with a seco	nd resident on 06/21/22 at			
	2:48pm revealed:	nd resident on 00/2 1/22 at			
		A hit Resident #3 about two			
		ntered the dining room from			
	the smoking area out				
		#3 in the head three times			
	_	vith a bruised face and a			
	black eye.				
		any other staff members			
	witnessed the inciden				
	residents had witness				
	-She did not report th				
	because Staff A shou	lld have reported the incident			
	to management.				
		porting the incident would			
	have been beneficial.				
	-She was concerned	about saying too much			
		ainst Resident #3 because if			
	_	e, she would be concerned			
		nst herself or other residents			
	_	d make life difficult for them.			
		a mano mo amount or them.			
	Interview with a third	resident on 06/21/22 at			
	3:20pm revealed:				
		Resident #3 three times in			
		ne into the dining room from			
	smoking.	he into the diffing room from			
		ck and blue bruises on his			
	face after the incident				
		ւ. Activities Director (AD) say			
		, , ,			
	that it should not have	e gone that far.			
	Interview with Reside	ent #3 on 06/21/22 at 9:30am			
	revealed:	711 / 10 011 00/2 1/22 at 0.00am			
	-He hit Staff A about 2	2 weeks prior			
ļ		n the right shoulder but did			
		i tile light shoulder but did			

not hit him in the face.

-There was no other staff in the smoking area to

STATE FORM 6899 R61411 If continuation sheet 104 of 130

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILBING		
		HAL042005	B. WING		R-C 06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	
			ROLINA REST H	,	
CAROLIN	A REST HOME		KE RAPIDS, NC		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORT OR E	SO IDENTIFY THO IN CHARACTER	TAG	DEFICIENCY)	WATE
D 438	Continued From page	e 104	D 438		
	witness the staff hittin	a him			
	-He did not report the				
	Observation of Reside	ent #3 on 06/21/22 at			
	9:30am revealed ther	e were no bruises on his			
	face or right shoulder	and he was not wearing			
	glasses.				
	Interview with the Activities Director (AD) on				
	06/22/22 at 11:12am				
		staff that Resident #3 had			
	been physically aggre witnessed any aggres				
		to locate Resident #3's			
	missing eyeglasses w				
		reglasses were broken			
		n a Staff A and Resident #3.			
	-She did not know wh occurred.	en the altercation had			
	-She reported what th	e resident had told her to			
		tions (DO) immediately but			
	she could not rememb	per the date and the report			
	was not documented.				
		onal care aide (PCA) on			
	06/21/22 at 2:22pm re				
	•	d Staff A in the stomach.			
		nber the date of the incident			
	•	urred more than 2 weeks edirected Resident #3 back			
	inside to stop him from				
		portion of the facility when			
	she heard Resident #	•			
	derogatory name and				
		Resident #3 inside the			
	building when she arr				
		3 trying to get Staff A away			

from him.

-She did not see Staff A strike Resident #3 at any

STATE FORM 6899 R61411 If continuation sheet 105 of 130

Division of	of Health Service Regu	lation			FORM	APPROVED
STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL042005	B. WING		R-C 06/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
CAROLINA REST HOME			ROLINA REST H KE RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	÷ 105	D 438			
		what happened outside in				
	revealed: -Resident #3 had a ni orderedHe kicked her in her he could not smoke washe tried to roll him i by her wrist and would have a second staff members and the second staff members are the second staff members and the second staff members are ported the incition of the second staff members are ported the incition of the second staff members are ported the incition of the second staff members are ported the incition of the second staff members are ported to the second staff members are provided in the second staff mem	nside and he grabbed her d not let go. er intervened to get of her wrist. dent to the Director of lent Care Coordinator but				
	(RCC) on 06/22/22 at -Staff A reported to he the stomach and grab -Staff A reported a serincidentNo allegation of Staff been made to her unt -She and the Director responsible for invest abuse and notification Division of Social Serfamily and the Health	er that Resident #3 hit her in abed her arm. cond staff responded to the FA hitting Resident #3 had il 06/21/22. of Operations (DO) were igating any allegations of as would be made to the vices (DSS), the resident's Care Personal Registry stigation was completed was found to be true.				

complete.

nothing to report.

regarding the allegation she became aware of on 06/21/22 because the investigation was not

-If there was not enough evidence, there was

STATE FORM 6899 R61411 If continuation sheet 106 of 130

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					_	_
			B. WING		R-(
		HAL042005			Ub/∠	4/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAF	OLINA REST H	OME ROAD		
CAROLIN	A REST HOME		E RAPIDS, NC			
	CLIMMA DV CT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
5.400			7 120			
D 438	Continued From page	∍ 106	D 438			
	She was not aware r	notification to the HCPR was				
		urs of becoming aware of				
	any abuse allegation.	_				
		of the 24-Hour Report or the				
		notify the Health Care				
	Personnel Registry.	Houry the Floatal Care				
		conducting investigations				
		CC in August or September				
	2021.	JO III August of Coptomists				
	2021.					
	Interview with the Dire	ector of Operations (DO) on				
	06/22/22 at 4:20pm re					
	-She and the RCC we					
		gation when an abuse				
	allegation was reported					
		of any report of Staff A hitting				
	Resident #3 prior to 0					
	•	Health Care Personal				
	_	ional Director (RD) only if				
	there was enough evi					
		rough the investigation				
	process.	rough and announg and				
	· .	report made to the HCPR for				
	the allegation of abus					
		ecause the investigation				
		d she did not know if it there				
	was anything to repor					
		the previous manager how to				
	1	s and who to report to but				
		ct any investigation of abuse				
		g the role and had not				
		O or the Administrator for				
	guidance.					
	Interview with the Re	gional Director (RD) on				
	06/22/22 at 5:33pm re	- , , ,				
		O were responsible for				
		ions of allegations of abuse				
		ılth Care Personnel Registry.				
		O were not aware HCPR had				

STATE FORM 6899 R61411 If continuation sheet 107 of 130

Division of	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						0
		1141 040005	B. WING		R-	
		HAL042005			06/2	24/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		1361 CA	ROLINA REST H	OME ROAD		
CAROLIN	A REST HOME		KE RAPIDS, NC			
0/10/15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 438	Continued From page	e 107	D 438			
	to be notified within 2	4 hours of learning of an				
	allegation of abuse w					
	•	nplete, substantiated or				
	unsubstantiated.	inproto, oubotaritatou or				
		them to complete the HCPR				
		ning of the allegation on				
	06/21/22.	5 5				
		ministrator on 06/23/22 at				
	1:59pm revealed:	f an allegation of abuse until				
	06/21/22.	-				
	-He was not aware th					
	_	should be reported to the				
	HCPR within 24-hour					
	-	gations of abuse to be				
	reported within 24-ho	urs.				
	Review of a fax trans	•				
	•	evealed a 24-Hour Initial				
	•	6:52pm to notify the Health				
	_	try of a resident abuse				
	Operations.	and signed by the Director of				
	Орегацопъ.					
	Telephone interview v	with the Health Care				
	Personal Registry on					
		ed a report for an allegation				
		06/22/22 at 6:58pm for Staff				
	Α.	•				
		t #6's current FL-2 dated				
	03/25/22 revealed:					
	_	advanced dementia with				
		petes, hypothyroidism, sick				
	sinus syndrome.	diagricutod				
	-She was constantly	uisorientea.				
	Review of Resident #	6's Resident Register				
	revealed she was adr					
	TO VOCATOR SITE Was aut	Thicoa to the facility	1			1

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 108 of 130

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	-
	10115211 011 001 1 21211		OLINA REST H		
CAROLIN	A REST HOME		ERAPIDS, NC		
			KAPIDS, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 108	D 438		
	04/04/22.				
	Review of Resident #	Cla record revealed.			
		gned by Resident #6's			
		(PCP) on 05/25/22 which			
		nt had dementia and was			
		fic important events and was			
		and occurrences at her office			
	visit on 05/02/22.				
	-Resident #6 was not	capable of managing or			
		ment of benefits in her own			
	best interest and that				
		o manage her funds in the			
	future.				
	Telephone interview v	vith Resident #6's family			
	member on 06/22/22				
	-The bank sent a lette	er stating Resident #6's			
	account had been clo	sed.			
	-Resident #6 had aro	und \$160,000 in her bank			
	account when it was				
		Resident #6's money was			
		nk account because she			
		aking decisions on her own			
	and he did not approved from her according to the contract of				
	Temoved from the act	Sourt.			
		on 06/22/22 at 3:16pm			
	revealed: -After Resident #6 wa	as admitted to the facility she			
		dent #6 to the bank and			
	closed her bank acco				
		itive gave them a cashier's			
		cover 2 years' worth of room			
	and board for Reside				
	-The money that was	left over after receiving the			
		placed into Resident #6's			
	facility account.				

Division of Health Service Regulation

Telephone interview with Resident #6's primary

STATE FORM 6899 R61411 If continuation sheet 109 of 130

DIVISION	n Health Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1 _	_
			D WING		R-	
		HAL042005	B. WING		06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
			OLINA REST H			
CAROLINA	A REST HOME					
		RUANUKE	RAPIDS, NC	2/8/0		T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
			+			
D 438	Continued From page	e 109	D 438			
	care provider (PCP) of	on 06/23/22 at 10:46am				
	revealed:					
		story of dementia and				
	cognitive issues.	otory or domentia and				
	•	k in May 2022 stating that				
		pable of handling her own				
	finances.	pable of flatiding flet own				
		ns that were being made for				
		e made by a Health Care				
		acility because the facility				
	•	•				
		making financial decisions				
	for Resident #6.					
	Tolonhono intonvious v	vith a second family member				
		23/22 at 11:26am revealed:				
	financial decisions.	ompetent to make her own				
	-She was contacted b	y the facility and knew they				
	had closed Resident	#6's bank account and she				
	thought they put Resi	dent #6's money into a trust				
	until guardianship cou	uld be established for the				
	resident.					
	-She knew that Resid	ent #6's room and board at				
	the facility was \$4300	.00 per month but she did				
	not know that the faci	lity had taken money out of				
		t to pre-pay for 23 months of				
	room and board.	1 1 7				
		nformed by the facility that				
		pre-pay that far in advance.				
		e aware by the facility that				
	they wanted Resident					
		poard she would not have				
	consented to it.	Table of the state				
	- 55564 to It.					
	Telephone interview v	vith Staff D on 06/24/22 at				
	9:20am revealed:					
		aff E, and Resident #6 went				
	to the resident's bank					
	resident's money from					
			1	1		1

Division of Health Service Regulation

-The bank issued a cashier's check for

STATE FORM 6899 R61411 If continuation sheet 110 of 130

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED
		HAL042005	B. WING		R-C 06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CAROLIN	A DEST HOME	1361 CARC	DLINA REST H	OME ROAD	
CAROLIN	A REST HOME	ROANOKE	RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 110	D 438		
D 438	\$98,900.00 for Reside 23 months. -The \$98,900.00 was operational account. -The remainder of Replaced into Resident in the remainder of Replaced into Resident in the remainder of Replaced into Resident in the second into the second into the remainder of the remainder of Replaced into the remainder of Resident in the facility's because the facility of the room and board. -The Regional Director of Resident #6's reposited into Resident in the Resident in the Resident in the Regional Director of Resident in the R	ent #6's room and board for placed into the facility's sident #6's money was #6's facility account. with the Administrator on revealed: 0 of Resident #6's money e facility's operational lance of \$64,556.62 that was Resident #6's facility no record of the \$64,556.62 Resident #6's facility or, staff D, and Staff E had acility accounts. 's money should have been operational account perational account should	D 438		
		erview with Staff D on evealed the allegation of the			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 111 of 130

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
			7. BOILBING			₹-C
		HAL042005	B. WING			124/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
0450111	A DECT HOME	1361 CAF	ROLINA REST HOI	ME ROAD		
CAROLIN	A REST HOME	ROANOK	E RAPIDS, NC 27	870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 111	D 438			
		tesident #6's funds had been R by the Regional Director on				
	06/24/22 at 2:40pm reallegations of misapp	with the Regional Director on evealed a report about the ropriation of Resident #6's he HCPR on 06/24/22 at				
	the facility revealed a faxed to HCPR regist	mission report provided by 24-hour initial report was ry regarding Staff D's lesident #6's finances on				
	Director on 06/24/22					
		ns, interviews, and record nined Resident #6 was not				
	Refer to Tag D 338 1 Resident Rights	0A NCAC 13F .0909				
	abuse by a staff (Staff personal funds (Staff 2 sampled resident (# A was alleged to have and face after Reside and Staff D and Staff resident's personal furoperating account an for \$64,556.62 of the	eport allegations of physical ff A) and misappropriation of D and Staff E) involving 2 of #3, #6) within 24 hours. Staff e hit Resident #3 in the head ent #3 hit her in the stomach E deposited \$98,900 of a ends into the facility's d were not able to account resident's money which was a resident's facility account.				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 112 of 130

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				R-C
	HAL042005	B. WING		06/24/2022
OVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
	1361 CAR	OLINA REST H	OME ROAD	
REST HOME				
SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
Continued From page	e 112	D 438		
The facility's failure to physical abuse to the hours resulted in subsphysical harm could ore port an allegation to resulted in Staff D and in the facility and have accounts which result exploitation. The facil substantial risk for coharm, exploitation and Violation. The facility provided a accordance with G.S. this violation.	o report an allegation of HCPR by Staff A within 24 stantial risk that serious occur. The facility's failure to HCPR within 24 hours d Staff E continuing to work e access to resident's facility ted in a substantial risk for ity's failure resulted in ntinued abuse, physical d constitutes a Type A2 a plan of protection in 131D-34 on 06/23/22 for			
G.S. 131D-21 Declar Every resident shall had 2. To receive care an adequate, appropriate relevant federal and stregulations. This Rule is not met Based on observation reviews, the facility fareceived care and set appropriate and in confederal and state laws related to Other Staff	ration of Residents' Rights have the following rights: ad services which are a, and in compliance with state laws and rules and as evidenced by: as, interviews, and record illed to ensure residents rvices which were adequate, mpliance with relevant s and rules and regulations Qualifications, Health Care,	D912		
	OVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page The facility's failure to physical abuse to the hours resulted in subsphysical harm could ore port an allegation to resulted in Staff D and in the facility and have accounts which result exploitation. The facil substantial risk for co harm, exploitation and Violation. The facility provided a accordance with G.S. this violation. THE CORRECTIVE II VIOLATION SHALL N G.S. 131D-21 Declar Every resident shall he 2. To receive care and adequate, appropriate relevant federal and strengulations. This Rule is not met Based on observation reviews, the facility fare reported and state laws related to Other Staff	TOURIER OR SUPPLIER THAL 1361 CARR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 112 The facility's failure to report an allegation of physical abuse to the HCPR by Staff A within 24 hours resulted in substantial risk that serious physical harm could occur. The facility's failure to report an allegation to HCPR within 24 hours resulted in Staff D and Staff E continuing to work in the facility and have access to resident's facility accounts which resulted in a substantial risk for exploitation. The facility's failure resulted in substantial risk for exploitation. The facility's failure accounts which resulted in a substantial risk for exploitation and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/23/22 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 24, 2022. G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. 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 Other Staff Qualifications, Health Care, and ACH Medication Aides: Training and	OVIDER OR SUPPLIER REST HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 112 The facility's failure to report an allegation of physical abuse to the HCPR by Staff A within 24 hours resulted in substantial risk that serious physical harm could occur. The facility's failure to report an allegation to HCPR within 24 hours resulted in Staff D and Staff E continuing to work in the facility and have access to resident's facility accounts which resulted in a substantial risk for exploitation. The facility's failure resulted in substantial risk for continued abuse, physical harm, exploitation and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/23/22 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 24, 2022. G.S. 131D-21(2) Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with 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 Other Staff Qualifications, Health Care, and ACH Medication Aides: Training and	MALO42005 MALO42005

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 113 of 130

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING		R-C	
		HAL042005	B. WING		06/24/2022	
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	•		
CAROLIN	A REST HOME		DLINA REST H ERAPIDS, NC			
()(1) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
D912	Continued From page	2 113	D912			
	The findings are:					
	facility failed to ensure A, B, C) had no substitute North Carolina He Registry (HCPR) prio 10A NCAC 13F .0407 Qualifications (Type E 2. Based on record refacility failed to ensure A, Staff B) had a crim completed upon hire. NCAC 13F .0407(a)(7 (Type B Violation)]. 3. Based on observative reviews, the facility facare provider (PCP) from the complete injury that displayed from the complete injury the complete injury the complete injury the co	r to hire. [Refer to Tag 0137 r(a)(5) Other Staff 3 Violation)]. eviews and interviews the e 2 of 5 sampled staff (Staff inal background check [Refer to Tag 0139 10A r) Other Staff Qualifications ions, interviews, and record iled to notify the primary or 2 of 5 sampled residents esident with traumatic brain requent aggressive r a resident with multiple				
	to or less than 80 as I	ars (FSBS) that were equal per ordered parameters 73 10A NCAC 13F .0902(b) Violation)].				
	reviews the facility fai staff (Staff B) who add completed the medica the 5, 10, or 15 hour a course and the clinical competency evaluation medications. [Refer to	on before administering o Tag 0935 G.S. Medication Aides; Training				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 114 of 130

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			A. BUILDING: _			
		HAL042005	B. WING		R-0 06/2	C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
CAROLIN	A REST HOME	1361 CARC	LINA REST H	OME ROAD		
- CAROLINA	A REOT HOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D914	Continued From page	: 114	D914			
D914	G.S. 131D-21(4) Decl	aration of Residents' Rights	D914			
	Every resident shall h	ation of Residents' Rights ave the following rights: al and physical abuse, ion.				
	reviews, the facility fa were free from menta neglect, and exploitat	is, interviews, and record iled to ensure residents				
	The findings are:					
	facility failed to ensure maintained as related resident funds (#6) ar	to misappropriation of nd abuse and neglect of a o Tag 0338 10A NCAC 13F				
	facility failed to report abuse by Staff A and Staff D and Staff E to Care Personnel Regis for 2 of 2 sampled res Tag 0438 10A NCAC Personnel Registry (T 3. Based on observat	ions, interviews and record				
		rator failed to ensure the				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 115 of 130

	<u>of Health Service Regu</u>				T
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CAROLIN	A REST HOME	1361 CAF	ROLINA REST H	OME ROAD	
CAROLIN	A REST HOWE	ROANOK	E RAPIDS, NC	27870	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D914	Continued From page	: 115	D914		
	to receive care and se abuse and exploitatio substantial compliant governing adult care I G.S. 131D-25 Implem Violation)].	ntained each residents' right ervices and remain free from n and to maintain e with the rules and statutes nomes. [Refer to Tag 0980 tentation (Type A1			
D935	G.S.§ 131D-4.5B(b) A Training and Compete		D935		
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requireme	ining and Competency			
	home is prohibited from any unsupervised me that individual has presented in an adult care home of the following: (1) A five-hour training Department that incluin all of the following: a. The key principles administration.	g the previous 24 months in r successfully completed all g program developed by the des training and instruction			

exists.

Prevention guidelines on infection control and, if

(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program

applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding

STATE FORM 6899 R61411 If continuation sheet 116 of 130

Division of Health Service Regulation

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL042005	B. WING		R-C 06/24/2022
	ROVIDER OR SUPPLIER A REST HOME	1361 CAR	DRESS, CITY, STA OLINA REST H E RAPIDS, NC	OME ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D935	training and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monitor bleeding occurs or the exists. b. An examination deby the Division of Heat accordance with substitute and the staff (Staff B) who adcompleted the medicate the 5, 10, or 15 hour course and the clinicate competency evaluation medications. The findings are: Review of Staff B's, in personnel record reversities was hired on the exist of the staff (Staff B) was hired on the exist of the staff B was hired on the exist of the staff B was hired on the exist of the staff B was no document written MA exam on the exam on the exam on document a medication clinical staff B was no document of the exam on document of the exam	partment that includes in in all of the following: of medication as of Disease Control and is on infection control and, if the protection in the potential for bleeding and administered alth Service Regulation in section (c) of this section. The protection is section as evidenced by: The protection is section as evidenced by: The protection is section as evidenced by: The protection is section and is section. The protection is section and is section. The protection is section and is section. The protection is section and is section. The protection is section and is section and is section and is section and is section. The protection is section and is section and is section and is section. The protection is section and is section. The protection is section and is section and is section and is section.	D935		

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 117 of 130

Division o	of Health Service Regul	lation			FURIVI API	ROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		HAL042005	B. WING		R-C 06/24/2 0)22
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		1361 CAI	ROLINA REST H	OME ROAD		
CAROLINA	CAROLINA REST HOME ROAN			27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CO	(X5) DMPLETE DATE
D935	Continued From page	: 117	D935			
	8:17am to 9:07am rev	ons on 06/21/22 at from vealed Staff B was g medications to residents				
	medication administrative revealed: -There was an entry for mood stabilization -Staff B documented a Buspirone on 06/21/2 -There was an entry for finger stick blood sugate 80, give every 10 m than or equal to 100, indicated. (Used to include.) -Staff B documented a glucose tablets on 06, even though the medicated due to the ordere resulted in a medicatire.	or Buspirone 10mg (used) every 12 hours. administration of the 2 at 8:00am. or glucose tablets, take 2 for ar (FSBS) less than or equal ninutes until FSBS is great twice daily or more often as crease FSBS that are too administration of the //21/22 for a FSBS of 480 ication should have been ed parameters which on error. or Duloxetine 60mg (used or to treat nerve pain) twice				
	Duloxetine on 06/21/2 -There was an entry for to treat anxiety) each -Staff B documented a Hydroxyzine on 06/21	22 at 8:00am. or Hydroxyzine 25mg (used morning. administration of the /22 at 8:00am. or Lactulose 10gram/15mL				

morning.

-Staff B documented administration of the Lactulose on 06/21/22 at 8:00am.

an anticonvulsant) twice daily.

-There was an entry for Keppra 500mg (used as

-Staff B documented administration of the Keppra

STATE FORM 6899 R61411 If continuation sheet 118 of 130

	Bivioloti di Fidaliti del vide i tega	idion		
I	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
l		HAL042005	B. WING	R-C 06/24/2022
I	NAME OF DROVIDER OR SLIPPLIER	STREET AND	DESS CITY STATE 7ID CODE	

STREET ADDRESS, CITY, STATE, ZIP CODE

1361 CAROLINA REST HOME ROAD

CAROLIN	A REST HOME	ROLINA REST HO	ME ROAD	
	ROANO	KE RAPIDS, NC 2	7870	
(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
D935	Continued From page 118	D935		
D935	on 06/21/22 at 8:00am. -There was an entry for a Lidocaine 5% patch (used to treat pain) to be applied every morning. -Staff B documented administration of the Lidocaine 5% patch on 06/21/22 at 8:00am. -There was an entry for Metformin 1,000mg (used to regulate blood sugars) twice daily. -Staff B documented administration of the Metformin on 06/21/22 at 8:00am. -There was an entry for Mupirocin 2% ointment (used to treat infections) daily. -Staff B documented administration of the Mupirocin 2% on 06/21/22 at 8:00am. -There was an entry for Novolog (short-acting insulin used to lower blood sugars) 40 units twice daily with meals at 8:00am and 5:00pm. -Staff B documented administration of the Novolog to the resident on 06/21/22 at 8:00am. -There was an entry for Pantoprazole 40mg (used to prevent and treat acid reflux) daily. -Staff B documented administration of the Pantoprazole 40mg on 06/21/22 at 8:00am. -There was an entry for Actos 15mg (used to regulate blood sugars) daily. -Staff B documented administration of the Actos on 06/21/22 at 8:00am. -There was an entry for stool softener 100mg daily. -Staff B documented the administration of the stool softener on 06/21/22 at 8:00am. -There was an entry for Trelegy Ellipta inhaler, one puff every day for COPD. -Staff B documented the administration of the Trelegy Ellipta inhaler on 06/21/22 at 8:00am. Review of a second resident's June 2022 eMAR revealed: -There was an entry for Xanax (controlled medication to reduce anxiety) 0.5mg twice daily. -Staff B documented administration of the Xanax	D935		
Division of He	alth Service Regulation	,		1

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 119 of 130 R61411

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL042005	B. WING	R-C 06/24/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

CAROLINA REST HOME

1361 CAROLINA REST HOME ROAD

D935 Continue	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	ed From page 119	D935		
-There we (used to -Staff B Amiodar -There we lower blue-Staff B Norvasce -There we blood th -Staff B Aspirin of -There we to treat in -Staff B Gabape -There we treat chespasms -Staff B on 06/2 -There we (used to dailyStaff B Levothy -There we treat high -Staff B Lisinopri -There we (used to dailyStaff B Nystatin -There we supplem	1/22 at 8:00am. vas an order for Amiodarone 200mg regulate heart rhythms) once daily. documented administration of the rone on 06/21/22 at 8:00am. vas an entry for Norvasc 5mg (used to rood pressure) once daily. documented administration of the ron 06/21/22 at 8:00am. vas an entry for Aspirin 325mg (used as a inner or to treat pain) once daily. documented the administration of the ron 06/21/22 at 8:00am. vas an entry for Gabapentin 100mg (used nerve pain) three times daily. documented the administration of the ntin on 06/21/22 at 8:00am. vas an entry for Indur 30mg (used to rest pain, heart failure, or esophageal	D935		

STATE FORM 6899 R61411 If continuation sheet 120 of 130

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLI	EIED
		HAL042005	B. WING		R- 06/2	C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOKE	RAPIDS, NC	27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D935	Continued From page	e 120	D935			
	prevent and treat acid -Staff B documented Prilosec 20mg on 06/ -There was an entry f treat overactive bladd -Staff B documented Oxybutynin on 06/21/ -There was an entry f to treat asthma or CC -Staff B documented Symbicort inhaler on -There was an entry f supplement) daily.	administration of the 21/22 at 8:00am. or Oxybutynin 5mg (used to ler) twice daily. the administration of the 22 at 8:00am. or Symbicort inhaler (used DPD) twice daily. administration of the 06/21/22 at 8:00am. or Vitamin D3 (dietary				
	Interview with Staff B on 06/24/22 at 3:27pm revealed: -The lead MA had spent three days with her upon hire supervising her medication passes and training her. -When she worked on 06/21/22, it was her fourth day and she passed medications to all residents. -The lead MA had intermittently checked on her to ensure she was doing okay, but she did not supervise her medication passes that day.					
	revealed: -Staff B passed medic 06/21/22 while she w -She did not realized further documentation supervise her adminis residents because sh training status.	that Staff B required any n of training and did not				

Division of Health Service Regulation

supervise Staff B.

STATE FORM 6899 R61411 If continuation sheet 121 of 130

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					R-	C
		HAL042005	B. WING		1	4/2022
		HAL042003			00/2	4/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAR	OLINA REST H	OME ROAD		
CAROLINA	A REST HOME	ROANOKI	E RAPIDS, NC	27870		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
1710		,	1,7,6	DEFICIENCY)		
D935	Continued From page	 - 121	D935			
2000	Continued From page	, 121				
		sident Care Coordinator				
	(RCC) on 06/22/22 at	t 3:58pm revealed:				
	-Medication aides (Ma	A) train with the lead MA for				
	40 hours.					
	-New MAs were to sh	nadow the lead MA until they				
	were checked off on t	the medical clinical skills by				
	the facility nurse.					
	-Once the MA's clinic					
		able to pass medications				
	independently.					
		ad been a MA in the past at				
	another facility, the fa	-				
		10, or 15-hour medication				
	training.					
	-	ked newly hired MAs if they				
		ons before and if they had				
	-	plete their clinical skills				
	checklist.					
	-	ssed medications before the				
	-	o a 15-hour training with that				
	MA.					
		MA sometimes they would				
	-	oyer for verification of their				
		mes MAs said they left their				
		t without notice and then the				
		tact the former employer for				
		they did not realized they				
	needed to.	at the facility recorded				
	-She was unaware the					
		5, 10 or 15- hour medication				
	to be done upon hire.	loyment verification needed				
		n in place to audit employee				
	records.	If it place to addit employee				
	records.					
	Interview with the Dir	ector of Operations (DO) on				
	06/22/22 at 4:50pm re	. , ,				
		at MA verification or the 15				
	-Sile was ullawate th	at MA verilleation of the 13				

upon hire.

hour MA training needed to be done for all MAs

STATE FORM 6899 R61411 If continuation sheet 122 of 130

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
			_		l _	
			B. WING		R-	
		HAL042005	B. WING		06/2	4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		1361 CAF	ROLINA REST H	OME ROAD		
CAROLINA	A REST HOME		E RAPIDS, NC			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE	BATE
D935	Continued From page	e 122	D935			
	-When a MA was hire	nd by the facility, they				
		A on the medication cart for				
	1 to 1 1/2 weeks.	A of the medication cart for				
		d MA shadowed another				
		atch the newly hired MA pass				
	medications.	tter the newly filled WA pass				
		MA shadowed another MA				
	the facility nurse shou					
	medication clinical sk	•				
		passed medications prior to				
	their hire, they were to					
		on or their 5, 10, or 15-hour				
		nd their medication test.				
	-If the newly hired MA					
	<u> </u>	ld contact the facility nurse				
		do the medication training				
	and competency chec					
		a certificate for the 5, 10, or				
		raining or a MA employment				
	verification.					
	-Staff B should not be	e passing medications				
		ne was unaware that she was				
	doing so.					
		3 to shadow the lead MA				
		er medication training.				
		nedication errors if she had				
	not received medicati	ion training or deemed				
	competent by the RN	_				
	Interview with the Adr	ministrator on 06/23/22 at				
	2:00pm revealed:					
	-It was the Resident 0	Care Coordinator's (RCC)				
		sibility to ensure all required				
	training was complete	ed and kept on file in staff				
	records.					
	-It was the RCC's or I	DO's responsibility to ensure				
	the pharmacy and the	e nurse provided training to				

MAs as required.

-He expected MAs to be supervised and trained properly prior to passing medications to residents

STATE FORM 6899 R61411 If continuation sheet 123 of 130

Division of Health Service Regulation

` '	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL042005	B. WING		R-	
_				06/2	4/2022
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STAT LINA REST HO			
CAROLINA REST HOME		RAPIDS, NC 2			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
independentlyIt was important for MAs to medication administration trare capable of passing medicately. Interview with the facility's of care provider (PCP) on 06/2 revealed: -He expected the facility to to the MAs passing medicately. -Proper training was imperate resident safety and accurate administrationWithout proper training, MA how to accurately follow or or adverse reactions to medicate what to report to him as need. The facility failed to ensure sate as a medication aide (MA) at medications to residents with completed the medication accompetency evaluation beformedication aide training conskills checklist. The facility's detrimental to the health, sate the residents and constitute. The facility provided a plant accordance with G.S. 131D this violation. CORRECTION DATE FOR VIOLATION SHALL NOT Example.	raining to ensure they dications to residents contracted primary 23/22 at 10:46am provide proper training tion to residents. ative to ensure by in medication As would not know ders, what side effects dications to look for, or eded. Staff B who functioned and administered in thout supervision had aide training and fore administering sort on 15 hour turse and the clinical shall are as a Type B Violation. of protection in 0-34 on 06/22/22 for	D935			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 124 of 130

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
		· · · · · · · · · · · · · · · · · · ·	A. BUILDING:			
		HAL042005	B. WING		06/2	C 4/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAROLINA	A REST HOME		LINA REST H RAPIDS, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D980	Continued From page	2 124	D980			
D980	G.S. § 131D-25 Impl	ementation	D980			
	G.S. 131D-25 Implem	nentation				
	this Article shall rest vifacility. Each facility straining to staff to impresidents' rights included. This Rule is not met and TYPE A1 VIOLATION. Based on observation reviews, the Administ management, total oppolicies/procedures or	as evidenced by: ns, interviews and record rator failed to ensure the perations, and				
	to receive care and se abuse and exploitatio	ervices and remain free from n and to maintain se with the rules and statutes				
	The findings are:					
	06/23/22 at 10:31 rev	ector of Operations on ealed she performed the nistrator in Charge for the				
	06/22/22 at 5:33pm re -The previous DO wa current DO but she di -The DO was new to some rules.	s responsible for training the d not train her well. the role and wasn't aware of				
	10:52am revealed:	ministrator on 06/21/22 at y monthly but it had been				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 125 of 130

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE Co			E SURVEY PLETED	
		HAL042005	B. WING		l l	R-C 6/ 24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		· · · · · ·
CAPOLIN	A REST HOME	1361 CA	ROLINA REST HO	ME ROAD		
CAROLIN	A REST HOWE	ROANO	KE RAPIDS, NC 27	870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D980	Continued From page	e 125	D980			
	about six weeks since -The DO and the Res					
	06/23/22 at 1:59am re -The DO was the Adn the facility and was tr previous AICThe DO's management the course of 5 yrs as AIC but he was not an should be documented -He did not know the of the rules as he had	ninistrator in Charge (AIC) of ained by following the ent training occurred over a she assisted the previous ware management training ed. DO was not aware of many				
	reviews, the facility fare doors accessible to rewith a sounding device safety of 2 sampled redocumented as disord wandering behaviors 10A NCAC 13F .0305 (Standard Deficiency) 2. Based on interview facility failed to ensure A, B, C) had no substitute North Carolina Herman accessible to the substitute of the substitu	vs and record reviews, the e 3 of 5 sampled staff (Staff tantiated findings listed on				
	10A NCAC 13F .0407 Qualifications (Type E 3. Based on record re	7(a)(5) Other Staff				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 126 of 130

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL042005	B. WING R-C 06/24		R-C 6/24/2022	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	, ,	
CAROLIN	A REST HOME	1361 CA	ROLINA REST HOM	ME ROAD		
CAROLIN	A REST HOWE	ROANOP	(E RAPIDS, NC 27	870		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D980	Continued From page	2 126	D980			
	completed upon hire.	inal background check [Refer to Tag D139 10A 7) Other Staff Qualifications				
	reviews, the facility fa medication aides (B) finger stick blood sug but did not receive tra residents in accordan administering insuling	sampled who obtained ars and administered insulin aining on the care of diabetic ce with the rule prior to to residents. [Refer to Tag 5.0505 Training on Care of				
	facility failed to notify change or provide an	•				
	reviews, the facility facare provider (PCP) f (#1, #3) including a reinjury that displayed f behaviors (#3) and fo finger stick blood sug to or less than 80 as p	r a resident with multiple ars (FSBS) that were equal per ordered parameters 3 10A NCAC 13F .0902(b)				
	reviews, the facility fa implemented for 2 of #5) including errors in hose (#1) and a conti	ions, interviews, and record iled to ensure orders were 5 sampled residents (#1, a the use of compression nuous positive pressure tent (#5). [Refer to Tag 276 P(c) 3-4 Health Care				

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 127 of 130

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL042005	B. WING		R- 06/2	C 4/2022
	ROVIDER OR SUPPLIER A REST HOME	1361 CARC	RESS, CITY, STA DLINA REST H RAPIDS, NC	OME ROAD	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D980	reviews, the facility fadiet menus were avairesidents with therape order for a no added concentrated sweets 10A NCAC 13F .0904 Service (Standard Deservice (Standard Deservice (Standard Deservice (Standard Deservice) service (Standard Standard Stan	ions, interviews and record iled to ensure therapeutic lable for 2 of 2 sampled eutic diets (#1, #4) with an salt diet (#1, #4), and no diet (#1). [Refer to Tag D296 e.(c)(7) Nutrition and Food ficiency)]. Is and record reviews, the eresident rights were to misappropriation of and abuse and neglect of a to Tag D338 10A NCAC 13F is (Type A1 Violation)]. Interviews, and cility failed to administer end for 2 of 5 sampled auding errors in diabetic in relation to finger stick that arameters (#1), a blood of (used to treat seasonal flux medications (used to [Refer to Tag D358 10A Medication Administration	D980			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 128 of 130

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL042005	B. WING		06/24/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		1361 CAR	DLINA REST H	OME ROAD	
CAROLIN	A REST HOME	ROANOKE	RAPIDS, NC	27870	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D980	Continued From page	e 128	D980		
	12. Based on record of facility failed to report abuse by Staff A and Staff D and Staff E to Care Personnel Registor 2 of 2 sampled restag D438 10A NCAC Personal Registry (Ty 13. Based on observation record reviews the facts sampled staff (Staff B medications had combaining, including the medication aide training skills checklist, and cobefore administering	reviews and interviews, the allegations of physical misappropriation of funds by the North Carolina Health stry (HCPR) within 24 hours sidents (#3, #6). [Refer to 13F .1205 Health Care ype A2 Violation)].			
	procedures were implianted appropriate care and substantial complianted and Staff C working in residents without have completed, Staff A and contact with residents background check con Resident #3 who was failure of notification to frequent low finger stip parameters that were tablets as ordered, not Resident #3's and Refergarding abuse and reporting allegations of and a delay in investigallegations of exploits.	services maintained within the resulted in Staff A, Staff B, an direct contact with the ing a HCPR check d Staff B working in direct to without having a criminal mpleted, a delay in care for a frequently aggressive, to the provider who had tick blood sugars outside of left untreated with glucose to tensuring the rights of the sident #6's were protected exploitation, a delay in the provider who had the sident #6's were protected exploitation, a delay in the physical abuse by Staff A the staff D in the of serious neglect and			

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 129 of 130

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED			
					F	R-C		
		HAL042005	B. WING		06	/24/2022		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CAROLIN	A REST HOME		AROLINA REST HO KE RAPIDS, NC 2					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
	Continued From page violation. The facility provided accordance with G.S this violation. THE CORRECTION	·				DATE		

Division of Health Service Regulation

STATE FORM 6899 R61411 If continuation sheet 130 of 130