STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on 08/09/22-08/11/22.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure it was free of hazards related to a broken glass exit door on A hall of a free standing special care facility. The findings are: Observations of Special Care Unit (SCU) A Hall on 08/09/22 at 9:00am revealed: -There was a metal door to the left of the hall and a metal framed door with a glass center to the right of the hall that entered the courtyard. -The glass center of the metal framed door was approximately six-foot-tall by two-foot-wide. -Approximately two feet from the top of the right of the glass were small cracks that correlated of originating from a point of impact and radiated in concentric circles. -The cracks became longer and more splintered towards the left and right sides of the glass and	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 079	Continued From page 1	D 079		

extended to the top of the glass and downwards.
-The bottom right side of the glass had a second impact site with long fractures extending up and down and towards the left side of the glass.
-There was a transparent film covering the inside of the glass.
-The glass flexed easily when pushed from the inside.

Observation of A hall on 08/09/22 at 4:38pm revealed:
-A resident paced up and down the hall.
-The resident stopped at the A hall exit door with the broken glass and stared at the door then turned and walked away.

Review of an Incident and Accident (I/A) report dated 03/17/22 revealed:
-A resident ran headfirst into a glass door and began punching the glass.
-The time was not documented.
-The I/A report was signed by the Administrator on 03/17/22.

Interview with a personal care aide (PCA) on 08/09/22 at 9:15am revealed:
-A resident ran into the A hall glass exit door, hitting the glass with his head and breaking the glass about six months ago.
-She could not remember the resident.
-She did not know the status of the door repair or who applied the transparent film.

Interview with the Administrator on 08/09/22 at 10:30am revealed:
-She thought a resident head butted the glass to A hall's exit door about two months ago.
-The current maintenance director placed the transparent film on the glass at that time to help stabilize the broken glass until it could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 079	Continued From page 2	D 079		

replaced.
-She needed to speak to the maintenance director regarding the status of replacing the glass.
-She had never witnessed any residents pushing at or attempting to exit the A hall exit door with the broken glass.

Interview with the maintenance director on 08/09/22 at 4:33pm revealed:
-A resident ran into and kicked the glass in A hall's exit door sometime before April 2022.
-Around that time, he placed the transparent film on the broken glass of A halls exit door until the glass could be replaced.
-He thought the previous maintenance director called a glass replacement company around April 2022 regarding the broken glass.
-He thought a representative from the glass company looked at the door sometime after April 2022 regarding replacing the glass, but the representative had not returned to the facility.
-He had not contacted anyone regarding replacing the broken glass in A hall's exit door until prompted by the Administrator today, 08/19/22, because he had not thought about it.

Interview with a PCA on 08/11/22 at 8:38am revealed the resident who broke the glass exit door on A hall approached the door on A hall and pushed and pulled on the door about twice a shift over the past three shifts she worked.

Telephone interview with the secretary for the facility's contracted glass company on 08/11/22 at 2:25pm revealed:
-The facility contacted them on 08/10/22 regarding replacing a broken glass door.
-She researched from March 2022 to present and there was no documentation that indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 079	Continued From page 3 facility had contacted them regarding repairing or replacing a broken glass exit door on A hall until 08/10/22. Request on 08/09/22 for documentation of attempts to repair the broken glass door was not provided by survey exit on 08/11/22. _____ The facility failed to ensure residents with dementia were protected from hazards regarding a shattered glass exit door on A hall which occurred on 03/17/22. The door exited into the courtyard and the glass flexed easily with light pressure and it was known by staff a resident approached the door pushing and pulling on the door at times; there had been no contact by the facility in an attempt to replace the glass until 08/10/22. This failure was detrimental to the health, safety, and welfare of the resident's and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 113	Continued From page 4 F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 4 of 6 fixtures sampled that were readily accessible and used by residents with water temperatures ranging from 80.1 degrees F to 86.9 degrees F. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 85 beds for a Special Care Unit (SCU). Review of the facility's census reports provided on 08/09/22 revealed: -The facility's in-house census was 54 residents. -There were 28 residents residing in the A-hall side of the facility. -There were 26 residents residing in the B- hall of the facility. Observation of the bathroom in shared resident room #8 on the B-hall on 08/12/22 at 9:13am revealed the water temperature at the bathroom sink was 86.9 degrees Fahrenheit (F). Observation of a residents' room #46 on the A hall on 08/09/22 at 10:00am revealed water temperature of the sink was 80.1 degrees Fahrenheit.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 113	Continued From page 5 Observation of a residents' room #32 on the A hall on 08/09/22 at 9:30am revealed water temperature of the sink was 94.6 degrees Fahrenheit. Observation of a residents' room #39 on the A hall on 8/09/22 at 9:40am revealed water temperature of the sink was 97.7 degrees Fahrenheit. Interview with the Maintenance Director on 08/11/22 at 8:04am revealed: -The circulation pump moves hot water down from the hot water heater and keeps it moving. -Some areas in the facility have hot water because there were two circulation pumps connected to the hot water heater and only one stopped working. -The circulation pump stopped working on Tuesday, 08/02/22. -He attempted to purchase the circulation pump at two different local stores, but they did not have it (not sure of date). -He called a plumbing company on Monday, 08/08/22 to order the circulation pump. -When the circulation pump first stopped working the temperatures were around 110 degrees F but recently, they had dropped. -He had checked the water temperature by looking at the gauge on the water heater. -He had not checked water temperatures in the residents' shared bathroom. Interview with the Administrator on 08/09/22 at 12:14pm revealed: -The circulation pump was not working. -The Maintenance Director called a plumbing company to replace the circulation pump. -The circulation pump stopped working last week (not sure of the date).	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 113	Continued From page 6 -The Maintenance Director went to a local store to purchase the part but was not able to find it (not sure of date).	D 113		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to complete an	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 254	Continued From page 7	D 254		

assessment within 30 days of admission for 1 of 6 sampled residents (#6) related to a functional assessment to determine the level of assistance required when admitted to a free-standing Special Care Unit (SCU).

The findings are:

Review of Resident #6's current FL-2 dated 03/01/22 revealed:
-Diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), chronic back pain, hypertension, gastroesophageal reflux disease (GERD), and tremors.
-The recommended level of care was a SCU.
-The resident was intermittently disoriented and ambulatory.
-There was no documentation under the section for personal care assistance.

Review of Resident #6's resident record revealed there was no care plan.

Review of Resident #6's activities of daily living (ADL) log revealed:
-The resident was totally dependent upon staff for nail care, shampoo/hair care, skin care, bathing her upper body, and toileting.
-The resident required limited staff assistance with bathing her lower body and dressing.
-The resident required staff supervision with eating and oral care.
-Mobility was documented as totally dependent upon staff for clearing pathways and minimizing clutter.
-There was not documentation regarding ambulation.

Observation of Resident #6 on 08/10/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 254	Continued From page 8 9:19am revealed she ambulated independently and steady from A hall to the common room. Interview with Resident #6's family member on 08/09/22 at 2:56pm revealed the resident required staff assistance with bathing and dressing. Interview with the Special Care Coordinator (SCC) on 08/10/22 at 12:00pm revealed: -It was her responsibility to complete resident care plans within 30 days of admission to the facility. -It was her responsibility to ensure the resident's Primary Care Provider (PCP) signed the care plan. -She completed Resident #6's care plan sometime in April 2022. -Resident #6's care plan was not in the resident's record because she personally delivered the resident's care plan she completed in April 2022 to the resident's PCP today (08/10/22) to sign. -She did not answer when asked why the care plan was not signed prior to today. -She did not have a copy of the resident's unsigned care plan to provide. -Staff knew what services to provide to residents because she discussed the resident's needs with staff. -If she was not present when new staff started working, the medication aide (MA) working would tell the new staff what assistance the resident needed. Interview with a MA on 08/10/22 at 3:10pm revealed: -Resident #6 required staff assistance with bathing. -Resident #6 was independent with ambulation, transfers, dressing, and grooming.	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 254	Continued From page 9 -Staff knew what care residents required from staff based on working with the residents and the staffs work experience. -Newly hired staff shadowed for three days with another staff before working independently. -The staff training would tell the new staff what care and staff assistance the residents needed. Interview with a personal care aide (PCA) on 08/11/22 at 8:36am revealed: -She never looked at a care plan to determine the level of care a resident required. -She knew the staff assistance and care residents required from shadowing with other staff when she was hired. -She asked the residents what assistance they needed. Interview with the Administrator on 08/11/22 at 10:57am revealed: -She observed the SCC give Resident #6's care plan to the family member today (08/11/22) to ask the resident's PCP to sign. -Care plans were to be completed by the SCC within 30 days of the resident's admission to the facility. -Staff could refer to the resident's electronic activities of daily living (ADL) log to determine the level of care needed if a care plan was not available. -She depended upon the SCC to ensure care plans were completed within 30 days and signed by the PCP.	D 254		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 10 (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care according to the resident's care plan for 1 of 5 sampled residents (#2) related to toileting, dressing, and bathing. The findings are: Review of Resident #2's current FL-2 dated 05/03/22 revealed: -Diagnoses included severe intellectual disabilities, mental disorder, aphasia, and hypertension. -The resident was constantly disoriented, wandered, and was verbally abuAsive. -The resident was semi-ambulatory with the assistance of a device. -The resident was incontinent of bladder and bowel. Review of Resident #2's care plan dated 03/01/22 revealed: -The resident wandered, had disruptive behavior, was always disoriented and had significant memory loss requiring direction. -The resident was totally dependent upon staff for toileting, bathing, dressing, and grooming/personal hygiene.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 11 a. Observation of Resident #2 on 08/09/22 at 9:30am revealed: -The resident was sitting in a wheelchair located at A halls' nurses' desk. -The resident's hair was greasy and unkempt, and he was drooling. -The resident had contractures to both hands, the right hand was fully clinched. -The resident's fingernails on both hands grew past his fingertips, were tinged yellow like nicotine stains, and the nails on his left hand were soiled with dark debris underneath. -The resident wore a white t-shirt stained with dark yellow drip patterns, grayish black sweatpants, and teal colored non-skid socks. Second observation of Resident #2 on 08/09/22 at 4:06pm reveled: -The resident was sitting in a wheelchair located at A halls nurses' desk. -The resident wore a white stained t-shirt, grayish black sweatpants, and teal colored non-skid socks. -The resident was drooling, his hair was greasy and unkempt, and his fingernails were tinged yellow. Observation of Resident #2 on 08/10/22 at 6:20am revealed: -The resident was in a wheelchair located on A hall wearing a white t-shirt with dark yellow and brown drip pattern stains, grayish black sweatpants, and teal colored non-skid socks. -The resident's hair was greasy, unkempt, and had flakes of white dander in the back of his hair. -The residents fingernails extended past his fingertips and were tinged yellow with brown colored debris under the nails and between his fingers.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 12 Interviews with a personal care aide (PCA) on 08/10/22 at 6:20am and 7:00am revealed: -She worked 7:00pm to 7:00am. -It was the responsibility of the PCAs during the 7:00pm to 7:00am shift to perform incontinent care every two hours to the residents. -She performed incontinent care to Resident #2 then assisted him to bed last night (08/09/22). -She did not know the time. -She did not know why she did not change Resident #2 into his pajamas last night (08/09/22). -She and the second PCA performed incontinent care to Resident #2 at 4:00am this morning, 08/10/22. -Incontinent care was not documented when performed. Interviews with the second PCA on 08/10/22 at 5:55am and 6:30am revealed: -She was assigned to work 9:00pm to 7:00am on 08/09/22. -It was her responsibility as a PCA to perform incontinent care to the residents. -Resident #2 drank too much water causing him to wet his incontinent briefs too much. -She double briefed Resident #2 so she wouldn't have to change the resident as often. -If Resident #2's first incontinent brief was wet she would tear the first brief off and pull up the dry brief without having to undress the resident. -She would only perform incontinent checks and wipe the residents with disposable wipes. -She did not perform incontinent care to Resident #2 when she arrived at work last night (08/09/22) at 9:00pm until now. -PCAs were not assigned to provide personal care to specific residents. -All PCAs were to assist all residents with	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13	D 269		

personal care.
-It was her responsibility as a PCA to bathe and assist with or change a resident's clothing.
-Resident #2 was sleeping when she arrived for work at 9:00pm on 08/09/22 and she did not want to wake him.

Observation of Resident #2 on 08/10/22 at 6:40am revealed:
-The PCA pushed the resident in the wheelchair to his bedside leaving the wheelchair unlocked.
-She grabbed the resident by his right arm pulling on him with force as she prompted him to stand.
-The resident stood unsteadily, leaned forward over the bed and propped himself up with his hands on the mattress; the resident's body trembled.
-The PCA removed the resident's shirt and placed a clean long-sleeve brown shirt partially on the resident.
-Resident #2 began falling backward towards the wheelchair.
-The PCA placed her hand behind the resident's back as she grabbed him to prevent from falling backwards.
-The PCA pulled down the resident's pants with him standing and leaning over the bed.
-The resident's brief was tinged yellow, congealed, and sagging between his upper thighs saturated in urine.
-The PCA tore the brief from the resident and dropped it on the floor beside the resident's wheelchair.
-Urine splashed from the brief.
-The PCA wiped Resident #2's buttocks and behind his posterior perineum with a disposable wipe.
-The resident's skin was intact without redness.
-The PCA prompted Resident #2 to sit in the wheelchair as she assisted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

-There was no barrier between the resident's skin and the wheelchair when he sat down.
-The PCA removed the resident's pants from his legs, dropping them on top of the urine saturated incontinent brief.
-The PCA pushed Resident #2 closer to the bed and adjusted his shirt.
-The PCA placed a bib around Resident #2's neck and tied it into a knot.
-Without cleaning the resident's groin or front pelvic region, the PCA applied two clean incontinent briefs pulling them up to the resident's knees as he sat in the wheelchair.
-The PCA put the resident's pants on and pulled them up to his knees just below the two incontinent briefs.
-The PCA wiped the resident's hands and fingers with a disposable wipe.
-The PCA instructed the resident to stand as she pulled the resident up by his right arm and counted to three.
-The resident was shaking and unsteady, leaned over the bed, and propped himself up with his hands.
-The PCA pulled up both incontinent briefs and then his pants by the belt loops.
-The PCA jerked the resident's pants up which pushed him forward while he was leaning over the bed propped up with his hands.
-The PCA fastened the resident's pants then instructed him to sit in the wheelchair.
-The resident sat back in the wheelchair in an uncontrolled manner.
-The PCA removed the soiled clothing from Resident #2 and dressed him in clean clothing without bathing or washing his hair.

Second interview with the PCA on 08/10/22 at 6:55pm revealed:
-She did not know when residents were to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 15	D 269		

bathed.
-She only wiped the residents with disposable wipes.
-It was the responsibility of the other PCA to bath the residents.
-She did not perform nail care for the residents.

Review of Resident #2's assigned shower sheet on 08/10/22 revealed:
-The resident's assigned bath days were Monday, Wednesday, and Friday during first shift.
-There was documentation the resident was bathed from 08/01/22 to 08/08/22 and 08/10/22.

Interview with the Special Care Coordinator (SCC) on 08/10/22 at 12:30pm revealed:
-Incontinent care was to be performed every two hours or when soiled.
-Residents were assigned specific shower/bath days.
-Resident's did not have to wait for their assigned shower/baths day to be washed if they were soiled.
-Residents were to be bathed, their hair washed, nails cut/trimmed (if they were not a diabetic), and nails cleaned by the PCAs during their assigned shift's shower/baths.
-The PCAs were expected to change resident clothing as needed per soilage, assist them in pajamas before bed, and day clothes in the mornings.
-It was the responsibility of staff on the 7:00am to 7:00pm shift to dress residents in their day clothes.
-It was the responsibility of staff on the 7:00pm to 7:00am shift to dress residents in their pajamas.

Interview with the Administrator on 08/11/22 at 10:57am revealed:
-Residents were to be bathed three times weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 16 or sooner if soiled. -It was the PCAs responsibility to wash a resident's hair and perform nail care weekly or sooner if needed. -PCAs could cut or trim a non-diabetic resident's nails if needed. -Staff were not to double brief residents because it would increase the risk of urinary tract infections and skin breakdown. -Double briefing residents were not sanitary. -Incontinent care was to be performed every two hours or when soiled. Attempted interview with the MA who staffed 07/25/22 from 7:00pm to 7:00am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with the SCC on 08/10/22 at 12:30pm. Refer to interview with the Regional nurse on 08/10/22 at 12:45pm. _____ Interview with the Special Care Coordinator (SCC) on 08/10/22 at 12:30pm revealed: -Staff knew what care to perform for residents based on repetition in working with the residents. -Staff were trained on personal care when they were hired, then they shadowed for three days before taking a floor assignment independently. -It was the responsibility of the medication aide (MA) on both shifts to ensure the PCAs were providing personal care to the residents. -It was her responsibility as the SCC to make rounds to ensure the residents were receiving personal care as expected.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 17 -She had not rounded on A hall today, 08/10/22. Interview with the Regional nurse on 08/10/22 at 12:45am revealed: -She expected staff to care for the residents and ensure they were clean. -She expected staff to treat all residents with respect and dignity. The facility failed to ensure assistance with personal care was provided for Resident #2 who was wheelchair dependent and totally dependent upon staff for incontinent care, bathing, and dressing. The resident's brief was congealed, sagging, and saturated with urine; he slept in soiled clothing, hair was greasy, and nails were soiled, and he was unbathed. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a TYPE B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 18	D 270		

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided for 3 of 6 sampled residents (#1, #3, #7) for a resident who eloped a free-standing Special Care Unit (#1); had falls with injuries, and a physical altercation (#7); and unwitnessed falls from the bed (#3).

The findings are:

Review of the facility's license dated 01/01/22 revealed the facility was licensed as a Special Care Unit with a capacity of 85.

Review of the facility's census dated 08/09/22 revealed a census of 54.

1. Review of Resident #7's current FL-2 dated 03/30/22 revealed:
-Diagnoses included dementia and altered mental status.
-The residents recommended level of care was documented as domiciliary.
-The resident was ambulatory and constantly disoriented.

Review of Resident #7's previous FL-2 dated 03/08/22 revealed:
-Diagnoses included dementia.
-The resident was ambulatory, constantly disoriented, wandered, and was injurious to property.
-The resident's recommended level of care was documented as SCU.

Review of Resident #7's Resident Register revealed an admission date of 02/23/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19 Review of Resident #7's care plan dated 03/01/22 revealed: -The resident was always disoriented with significant memory loss requiring direction. -The resident required a lot of redirection and staff assistance with activities of daily living (ADL). -The resident enjoyed sitting and laying on the floor. -The resident was dependent on staff for activities of daily living (ADLs). -The resident required limited staff assistance with ambulation and transfers. Review of Resident #7's facility's electronic charting notes from 03/01/22 to 08/09/22 revealed: -On 03/02/22 at 6:21pm, there was documentation the resident was eating off the floor and laying in other beds. -On 04/01/22 at 6:43pm, there was documentation the resident was crawling on the floor, trying to eat things from the floor, flooded the room taking a shower, and required redirection multiple times. -On 04/08/22 at 6:09pm, there was documentation the resident kept trying to get out the door. -On 04/11/22 at 6:22pm, there was documentation the resident walked constantly up and down the hall, sat on the floor, laid in the floor, and slept on the floor, and was more confused. Observation of A Hall on 08/09/22 at 8:25am revealed: -There was a keypad to the right on the outside of the double doors. -The double doors to A hall were not secured,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20	D 270		

opening and closing freely.
-There were six residents congregated on the inside of A hall's double doors in the unit.
-There was no staff present on A Hall or at the nurse's desk.
-In the common television room of A Hall was a personal care aide (PCA) sitting in a chair, looking at her cell phone, with the television on.

Interview with the personal care aide (PCA) on 08/09/22 at 8:30am revealed:
-She did not know how many residents were on A Hall.
-There were three PCAs and one medication aide (MA) staffing A hall.
-She did not know where the other PCAs or the MA were.

Observation of A hall on 08/09/22 from 4:08pm to 4:13pm revealed:
-At 4:08pm, there were 9 residents congregated in the hall.
-There were no staff visible on the hall.
-There were 3 staff in the shower room with 1 resident.
-At 4:09pm, a staff walked out of the shower room and off the unit.
-There were 12 residents in the hall.
-There were no staff in the hall.
-At 4:13pm, there was 1 staff who walked out of a room carrying a laundry basket and walked off the unit.
-From 4:08pm to 4:13pm there were between 9 to 12 residents on A hall behind unlocked double doors who were not supervised by staff.

Interview with a second PCA assigned to A hall on 08/09/22 at 4:14pm revealed:
-It took 3 staff to assist with personal care and showering for 1 resident who was incontinent of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21	D 270		

stool.
-One of the staff walked off A hall to assist on B hall leaving the remaining 2 staff to perform personal care to the resident in the shower.
-There was no staff supervising the residents during the care provided to the resident.

a. Review of Resident #7's Incident/Accident (IA) report dated 03/17/22 revealed:
-The type of incident was documented as a physical assault/altercation in the hallway.
-The incident was not documented as witnessed or unwitnessed.
-Resident #7 ran into the hallway and began punching another resident in the head.
-Resident #7 ran headfirst into a glass door.
-Resident #7 began punching the glass door.
-The resident was transported to the hospital by emergency medical services (EMS) for a medical exam.
-The recommended steps to prevent recurrence was to follow up with his Primary Care Provider and mental health to monitor for medication changes.

Review of Resident #7's electronic charting notes for March 2022 revealed:
-There was no documentation regarding the 03/17/22 incident.
-There was no documentation of supervision interventions to include increased supervision.

Interview with a medication aide (MA) on 08/11/22 at 10:18am revealed:
-On 03/17/22, Resident #7 was hiding in a closet and she tried coaxing him out when the resident quickly ran from her.
-Resident #7 ran from the room down A hall and began punching another resident.
-She called Resident #7's name and he ran

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22	D 270		

headfirst into the glass exit door on A hall, three times.
-Another MA came on the hall and Resident #7 turned and ran into another resident's room.
-The other MA got Resident #7 out of the room and they walked up and down the hall.
-Resident #7 was transferred to the hospital for medical care.

Interview with the Administrator on 08/09/22 at 10:30am revealed:
-She was working about two months ago when Resident #7 ripped blinds from his window, ran out of his room, and she thought he head butted the glass door on A hall.
-A MA called the residents name and he calmed down.
-There were no supervision interventions put in place that she could remember because the resident calmed down when the MA called his name.

Observation of Special Care Unit (SCU) A Hall on 08/09/22 at 9:00am revealed:
-There was a metal door to the left of the hall and a metal framed door with a glass center to the right of the hall that entered the courtyard.
-The glass center of the metal framed door was approximately six-foot-tall by two-foot-wide.
-Approximately two feet from the top of the right of the glass were small cracks that correlated of originating from a point of impact and radiated in concentric circles.
-The cracks became longer and more splintered towards the left and right sides of the glass and extended to the top of the glass and downwards.
-The bottom right side of the glass had a second impact site with long fractures extending up and down and towards the left side of the glass.
-There was a transparent film covering the inside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 23	D 270		

of the glass.
-The glass flexed easily when pushed from the inside.

Observation of Resident #7 on 08/09/22 at 4:38pm revealed:
-The resident paced up and down the hall.
-The resident stopped at the A hall exit door with the broken glass and stared at the door then turned and walked away.

Review of Resident #7's psychiatric Nurse practitioner's visit note dated 04/28/22 revealed:
-The resident was seen for routine follow up.
-Diagnosis included dementia with behavioral disturbances.
-The resident was wandering the halls, was cognitively impaired, and oriented to self only.
-Staff reported the resident was playing in feces and crawling on the floor.
-On 04/01/22, the resident was found crawling on the floor, trying to eat things from the floor, and flooded the room with the shower.
-On 04/08/22, the resident was exit seeking.
-On 04/11/22, the resident was wandering and sitting, laying, and sleeping on the floor, and had increased confusion.
-Medication changes were made.
-Staff were to monitor for gait disturbances, risk for falls, and other safety risks.

Review of Resident #7's psychiatric Nurse Practitioners visit note dated 05/31/22 revealed:
-The resident was seen for a routine follow up.
-The resident was cognitively impaired and oriented to self only.
-Staff were to monitor for risk of falls and other safety risks.
-The resident's care plan was reviewed with clinical staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24 Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. b. Review of Resident #7's Incident/Accident (IA) report dated 06/11/22 at 4:00pm revealed: -The resident was memory and decision making impaired. -The resident sustained a witnessed fall while in the hallway without injuries. -The resident was transferred to the hospital for a medical evaluation. -The recommended steps to prevent recurrence was to follow up with the resident's medical provider. -There was no documentation of supervision interventions to include increased supervision. -The IA report was completed and signed by the Special Care Coordinator (SCC) on 06/14/22. -The IA report was signed by the Administrator on 06/15/22. Review of Resident #7's facility progress notes from 06/11/22 to 08/11/22 revealed: -There was no documentation regarding the 06/11/22 incident. -There was no documentation regarding supervision interventions. Review of Resident #7's local hospital discharge instructions dated 06/11/22 revealed: -The resident was diagnosed with a fall, right sided rib pain, and a neck fracture (cervical 7) of indeterminate age. -The resident was to follow with his Primary Care Provider (PCP) within 3 to 5 days. Interview with a medication aide (MA) on 08/11/22 at 10:18am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25	D 270		

-She was in the dining room when a personal care aide (PCA) told her Resident #7 ran into a wall then laid on the floor on A hall.
-She went to A hall to check on Resident #7.
-When she arrived, Resident #7 was laying on the floor between the nurse's station and the medication room in front of A halls double doors.
-Resident #7 was sent to the hospital.

Review of Resident #7's psychiatric Nurse Practitioners visit note dated 06/30/22 revealed:
-The resident was wandering the halls, was cognitively impaired, and oriented to self only.
-Diagnosis included dementia with behavioral disturbance.
-On 06/11/22, Resident #7 fell and sustained a neck fracture.
-Staff were to monitor for risk of falls and other safety risks.
-The resident's care plan was reviewed with clinical staff.

Interview with Resident #7's family member on 08/11/22 at 3:00pm revealed:
-She provided a private sitter for Resident #7 (sometime in April 2022) who sat with the resident 2 days a week because the resident's behavior and quality of life was better.
-The sitter distracted the resident by talking with him and playing music.

Interview with a PCA on 08/10/22 at 4:45pm revealed:
-Resident #7 bumped into things when he ran and had been doing so since he was admitted to the facility.
-Resident #7 had an unsteady gait.
-She redirected Resident #7 when he walked off A hall during her shifts.
-About 2 months ago, Resident #7's family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 26	D 270		

member provided a private sitter for the resident.
-Resident #7's sitter came once a week and stayed for a couple of hours each time.
-Resident #7 was calmer when the sitter visited because it occupied his time

Interview with the Administrator on 08/11/22 at 10:57am revealed:
-Resident #7's family member provided a private sitter for him at the facility because they felt it would help with his behaviors.
-Resident #7 had been calmer since the family member provided a private sitter.
-Resident #7 paced and walked the halls when the private sitter was not at the facility.

Interview with another MA on 08/11/22 at 3:10pm revealed:
-During July 2022, Resident #7's family hired someone to sit with the resident a few hours a day.
-Resident #7 never had increased monitoring or supervision by staff.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

c. Review of Resident #7's Incident/Accident (IA) report dated 08/07/22 at 11:45am revealed:
-The resident had memory and decision-making impairment.
-It was observed, the resident ran into the door on the hallway and laid on the floor.
-The resident had a cut above his left eye.
-The resident was transported to the hospital by emergency medical services (EMS) for a medical evaluation.
-The recommended steps to prevent recurrence was to follow up with the resident's Primary Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27	D 270		

Provider (PCP).

Review of Resident #7's facility's electronic charting notes for August 2022 revealed:
-There was no documentation of the 08/07/22 incident.
-There was no documentation of supervision interventions.

Interview with the Administrator on 08/11/22 at 10:57am revealed she did not remember Resident #7's IA that occurred on 08/07/22.

Attempted interview with the PCA who was documented as witnessed Resident #7's incident on 08/07/22 was unsuccessful.

Review of Resident #7's local hospital emergency department discharge instructions dated 08/07/22 revealed:
-The resident was treated for a fall.
-The residents radiology reports of his head and neck did not reveal acute findings.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

d. Review of Resident #7's Incident/Accident (IA) report dated 08/08/22 at 11:30am revealed:
-The resident had memory and decision-making impairment.
-The resident tried to touch another resident's plate in the dining room.
-The other resident pushed Resident #7 causing Resident #7 to fall.
-Resident #7 sustained a laceration to the back of his head.
-The resident was transported by emergency medical services (EMS) to the hospital for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 28	D 270		

medical evaluation.
-The recommended steps to take to prevent recurrence was to notify the resident's Primary Care Provider (PCP).
-There was no documentation that indicated the incident was witnessed or unwitnessed.
-There was no documentation of supervision interventions to include increased supervision.

Review of Resident #7's facility's electronic charting notes for August 2022 revealed:
-On 08/08/22 at 4:20pm there was documentation the resident was transferred to the hospital for a fall; specifics were not documented.
-There were no supervision interventions documented for the month of August 2022.

Review of Resident #7's local hospital emergency department discharge instructions dated 08/08/22 revealed:
-The resident was diagnosed with a closed head injury and scalp laceration.
-The resident was to follow-up with his PCP in 10 to 14 days for staple removal.

Interview with a medication aide (MA) on 08/11/22 at 3:10pm revealed:
-A few days ago, Resident #7 was seated in the back of the dining room, he stood, walked to the front of the dining room, and placed his hand in another resident's plate.
-She heard a noise, turned, and saw Resident #7 on the dining room floor.
-Resident #7 required supervision while eating because he wandered and touched others, or their things, while in the dining room if staff did feed him.
-Staff were not supervising Resident #7 in the dining room because they were assisting with serving other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 29 -Resident #7 required increased supervision because he wandered and touched other residents. -Other residents were bothered by Resident #7 touching them. -Other residents would scream at Resident #7 when they saw him walking towards them. -She told the Special Care Coordinator (SCC) and the Administrator several times in the past, last being one week ago, that -Resident #7 bothered other resident's by touching them. -Resident #7 opened the exit doors on A hall at times. -He would either turn around or stare at the door when the alarm sounded. -Sometimes, Resident #7 walked off A hall into the main hallway. Interview with a resident on 08/11/22 at 8:30am revealed: -Resident #7 placed his hands in his food when in the dining room last week. -He told Resident #7 to not place his hands in his food. -He pushed Resident #7 and hit him when he placed his hands in his food. Interview with the Administrator on 08/11/22 at 10:57am revealed: -On 08/08/22, she was in her office and heard a loud noise. -She walked in the dining room and Resident #7 had been in an altercation with another resident. -The other resident told her Resident #7 tried to touch his food so he pushed the resident. -She did not know Resident #7 touched other residents. -She did not know other residents screamed when Resident #7 touched them.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 30 -She did not remember Resident #7's IA that occurred on 08/07/22. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. _____ Interview with the Administrator on 08/11/22 at 10:57am revealed: -The SCC told her in the past increased supervision had been initiated for Resident #7. -She did not specify regarding increased supervision. -She did not check with staff to make sure they had provided increased supervision for Resident #7; there was no reason why. Telephone interview with Resident #7's hospice nurse on 08/11/22 at 2:30pm revealed: -The resident was admitted to hospice in 05/2022 with a diagnosis of senile brain degeneration. -The resident was incoherent and wandered in and out other resident rooms. -The resident wandered in the dining room and drank other resident's beverages. -The resident was unpredictable. Interview with Resident #7's family member on 08/11/22 at 3:00pm revealed: -The resident was dependent upon staff for all ADLs. -Resident #7 wandered in the hallway or in other resident's rooms. -She knew the resident had multiple falls because she reviewed the resident's electronic documentation from the hospital. -Resident #7 had 2 falls in March 2022, 1 fall in June 2022, and 1 fall in July 2022. -She expected staff to supervise the resident more frequently than every 2 hours to keep him	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 31 safe. Telephone interview with Resident #7's psychiatric Nurse Practitioner on 08/11/22 at 3:30pm revealed: -The resident wandered back and forth on A hall. -It was never known when the resident would lash out at anyone. -The resident had unpredictable behaviors and needed a controlled environment to keep him and others safe. -Resident #7 required every 1-hour staff supervision. -Staff did not need an order to implement supervision interventions. -Resident #7 was at risk for external skull injuries, fractures, and brain trauma from sustaining head injuries. Interview with a PCA on 08/10/22 at 4:45pm revealed: -She redirected Resident #7 when he walked off A hall during her shifts. -Resident #7 did not have increased supervision. -Resident #7 was calmer when the sitter visited because it occupied his time Interview with a medication aide (MA) on 08/11/22 at 3:10pm revealed: -Resident #7 opened the exit doors on A hall at times. -He would either turn around or stare at the door when the alarm sounded. -Sometimes, Resident #7 walked off A hall into the main hallway. -Resident #7 was totally dependent upon staff for dressing, bathing, feeding, and toileting. -Resident #7 was independent with ambulation. -Resident #7 never had increased monitoring or supervision.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 32 2. Review of Resident #1's current FL-2 dated 08/24/21 revealed: -The recommended level of care was a Special Care Unit (SCU). -Diagnoses included dementia, schizophrenia, hypertension, and diabetes mellitus. -The resident was constantly disoriented, wandered, verbally abusive, and injurious to others and property. Review of Resident #1's Resident Register revealed an admission date of 05/28/20. Review of Resident #1's current care plan dated 03/01/22 revealed: -The resident was verbally and physically abusive, wandered, resisted care, and had disruptive behavior/was socially inappropriate. -The resident was injurious to others and had a history of mental illness. -The resident had visual and auditory hallucinations telling him to hurt others. -He pushed or self-propelled a wheelchair with his feet. -The resident was always disoriented and had significant memory loss requiring direction. -There was no documentation of supervision related to behaviors or wandering. -The resident required staff supervision with ambulation and transfers. Review of Resident #1's preadmission screening assessment dated 07/15/21 revealed: -The resident was dangerous to self or others. -The resident had attempted to leave the home or facility and was unable to return without help. -The resident had significant behavior problems that disrupted other people in the facility. -The preadmission screening assessment was	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 33	D 270		

signed by the former Administrator.

Review of the facility's Elopement/ Missing Resident policy revealed:
-Staff should follow redirection techniques if a wandering resident gains access to any exit areas.
-In house transportation staff will be notified of potential elopers possibly seeking rides and advised to be observant for wandering confused residents.
-Staff will find pertinent documentation in the resident record that alerts which residents are at risk.
-Staff will make routine safety checks.
-Appropriate staff will monitor resident whereabouts including the monitoring of responses/reactions to events/activity in surroundings at time of wandering and report unusual behaviors to supervisor immediately.
-Staff education regarding responsibility to identify, report, and intervene related to wandering/elopement risk such as but not limited to: Anticipate resident needs based upon wandering triggers and patterns, acknowledge resident's behavior as an attempt to communicate needs and encourage verbalization, identify etiology and recognize feelings, etc.

Review of Resident #1's electronic charting notes from 06/26/22 to 08/09/22 revealed there was no documentation of supervision interventions.

Review of Resident #1's psychiatric nurse practitioner's (NP) visit note dated 06/15/22 revealed:
-The resident was seen for a routine visit.
-Staff reported the resident was kicking at doors, hitting at staff, and had increased agitated behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 34	D 270		

-The resident was oriented to self, place, and situation and was calm.
-Staff were to monitor for safety risks, current mood, and behavioral symptoms.
-The residents care plan was reviewed with clinical staff.

Observation of the facility's front exit door on 08/09/22 at 8:36am revealed:
-The door was locked.
-There was an audible alarm that sounded when the door was pushed.
-There was a red light that displayed on the alarm device located to the top left of the door frame.
-The alarm stopped sounding after approximately 15 seconds.
-The light on the alarm device located to the top left of the door turned green.
-The door opened freely after the light turned green, and a second alarm sounded.

Interview with Resident #1 on 08/11/22 at 8:30am revealed:
-He sometimes left the facility unsupervised.
-Staff told him he was not allowed to go out the facility alone.
-The facility's front entrance alarm displayed a green light at times, which meant the alarm was not armed.

Observation of B hall on 08/09/22 at 11:26am revealed Resident #1 was not on B hall.

Interview with the MA assigned to B hall on 08/09/22 at 11:26am revealed she did not know where Resident #1 was.

Interview with a PCA assigned to B hall on 08/09/22 at 11:27am revealed she did not know where Resident #1 was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35 Observation of the facility on 08/09/22 at 11:28am revealed: -Resident #1 was sitting on his rollator looking out the front exit door on the main hall. -There was an office located to the left with two staff in the office. Interview with Resident #1 on 08/09/22 at 11:28am revealed he was trying to get to the store. Observation of B hall on 08/10/22 from 7:34am to 7:38am revealed: -At 7:34am, a housekeeper entered the double doors leaving both doors open against each hall side. -There were two residents standing on the inside of B hall doors. -One resident walked out the double doors into the main hallway. -A second resident attempted to exit B hall. -The medication and (MA) stopped her medication pass and directed both residents to return to and stay on B hall. -At 7:38am, the MA told the housekeeper to close the double doors as she exited B hall. a. Review of Resident #1's Incident/Accident (IA) report dated 06/26/22 at 12:00 (am/pm not documented) revealed: -The resident was on the front porch with staff. -The resident told staff he was not going back to the facility and refused to return. -Law enforcement was called. -The resident was redirected with a soda prior to law enforcement arriving. -Emergency Medical Services (EMS) was called and transported the resident to the hospital. -The recommended steps to prevent recurrence	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

was to notify the resident's Primary Care Provider (PCP) and mental health provider.
-There were no supervision interventions documented.
-The report was completed and signed by the Special Care Coordinator (SCC) on 06/27/22.
-The report was signed by the Administrator on 06/28/22.

Review of Resident #1's local hospital emergency department discharge instructions dated 06/26/22 revealed:
-The resident was treated for an encounter for medical screening examination.
-There were instructions provided regarding living with anxiety.
-The resident was to follow up with his PCP within 3 to 5 days.

Review of Resident #1's Primary Care Provider's (PCP) visit note dated 06/28/22 revealed:
-Diagnosis included unspecified dementia with behavioral disturbance.
-The resident was oriented to person and place and mood was normal.
-On 06/26/22, the resident was outside the facility and refused to return.
-The resident was transferred to the emergency department for evaluation.
-The resident was to follow-up with his mental health provider.

Review of Resident #1's psychiatric Nurse Practitioner's visit note dated 07/14/22 revealed:
-The resident was seen for a routine visit.
-On 06/26/22, the resident was transferred to the emergency department for an evaluation after rolling down the hill into the street.
-The resident was oriented to self, place, and situation and was cooperative and calm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 37 -Staff were to monitor the resident for safety risks, mood, and behavioral symptoms. -The resident's care plan was reviewed with clinical staff. Interview with a personal care aide (PCA) documented as an observer on Resident #1's 06/26/22 I/A report on 08/09/22 at 4:45pm revealed: -Sometime in June 2022, (she could not remember the date) Resident #1 kicked the front facility exit door open. -She looked out and saw Resident #1 was in a wheelchair and he self-propelled to the bottom of the hill by the Assisted Living facility unsupervised. -She chased after him and brought him back inside the facility. Interview with a medication aide (MA) on 08/10/22 at 7:28am revealed: -One day she heard the front door alarm sound and a PCA told her Resident #1 kicked the front facility door open. -She saw Resident #1 going down the hill from the facility. -She ran after Resident #1 and convinced him to return to the facility. Interview with Resident #1 on 08/11/22 at 8:30am revealed: -He got out the front door and pushed himself down the hill from the facility while sitting on his rollator trying to go to the store. -He did not remember when. -Staff stopped him before he could make his way to the store. b. Interview with a medication aide (MA) on 08/09/22 at 11:00am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

-The first time Resident #1 eloped from the facility was on a Saturday, sometime after 07/04/22.
-She told the Special Care Coordinator (SCC) and Administrator at that time in July 2022 that Resident #1 eloped from the facility.
-She did not receive direction from the SCC or Administrator regarding initiating supervision interventions for Resident #1 at that time.

Interview with the same MA on 08/11/22 at 10:18am revealed:
-The first time Resident #1 eloped was a Saturday around 2:00pm, sometime after 07/04/22, Resident #1 was sitting by the facility's front door in the foyer.
-She was in an office located just outside of B hall on the main hall when she heard a loud noise then the front door alarm sound.
-Resident #1 was leaving the facility.
-By the time she approached Resident #1, he was sitting in a wheelchair on the grass across a busy street in front of the facility on the other side of the road between two providers offices.
-Resident #1 stood up from the wheelchair and started pushing it towards the gas station as she approached him.
-Resident #1 told her he was going to the store for a soda.
-Resident #1 was coaxed back to the facility by a PCA who offered him a beverage if he returned.
-She called the SCC as she was chasing after Resident #1 to report the resident had eloped from the facility.
-The SCC told her to send Resident #1 to the hospital for an evaluation.

c. Interview with a medication aide (MA) on 08/09/22 at 11:00am revealed:
-The end of July 2022 or the first of August 2022, she was walking on the main hall from B hall to A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

hall when she heard the front facility door alarm sound.
-She responded and found Resident #1 sitting in the breezeway of the facility.
-The resident told her he wanted to sit on the front porch.
-The resident returned inside the facility with her.
-She did not know Resident #1 had gotten off B hall until she saw him sitting in the breezeway.
-She told the Special Care Coordinator (SCC) and Administrator at that time that Resident #1 had gotten out of the facility.
-She did not receive direction from the SCC or Administrator regarding initiating supervision interventions for Resident #1 at that time.

Review of Resident #1's facility's electronic charting notes for July 2022 - August 2022 revealed:
-There was no documentation the resident was found sitting in the breezeway of the facility.
-There was no documentation of supervision interventions.

_____

Interview with a personal care aide (PCA) documented as an observer on Resident #1's 06/26/22 IA report on 08/09/22 at 4:45pm revealed:
-Resident #1 would sit and watch the front door for an opportunity to exit.
-When Resident #1 saw the light turn green, he knew the door was unlocked and could get out of the facility.

Interview with the first medication aide (MA) on 08/09/22 at 11:00am revealed:
-There was not always staff in the main hall of the facility leading to A and B halls to supervise the residents.
-There were no residents on increased

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

supervision on B hall including Resident #1.
-It was standard of care to supervise the residents every 2 hours.
-The front exit door of the facility would automatically open when kicked.
-She had observed Resident #1 and another resident kick the B hall doors open to exit the unit in the past.
-She told the SCC and the Administrator Resident #1 and another resident were kicking B hall double doors open.
-Resident #1 would get out of B hall every day and any chance he could.
-There was no way to know when Resident #1 got out of B hall.
-Sometimes Resident #1 wanted to go to the store.

Interview with the Special Care Coordinator (SCC) on 08/09/22 at 3:15pm revealed:
-She did not remember anything about Resident #1 leaving or attempting to leave the facility.
-She did not remember staff calling to tell her Resident #1 had left the facility.
-Her cell phone call log did not go past 08/02/22 to verify any phone calls received from staff telling her Resident #1 had left the facility.

Interview with the first MA on 08/11/22 at 10:18am revealed:
-Resident #1 sat by the inside front door of the facility on the days he got out of the facility.
-Resident #1 wanted to go to the store for lottery tickets.
-Resident #1 kicked the double doors to B hall open to leave and return to the unit.
-Resident #1 had a good memory and was not forgetful.
-Resident #1 was independent with all ADLs.
-Resident #1 did not have supervision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

interventions initiated.
-She had never received directive from the SCC or the ED to increase supervision or provide other supervision interventions for Resident #1.

Interview with the second MA on 08/10/22 at 7:28am revealed:
-Resident #1 sat at the inside of B hall double doors waiting for the doors to open.
-Resident #1 would exit the B hall double doors when staff entered or exited the hall.
-She never stopped Resident #1 from exiting B hall because he would fight with staff if they tried stopping him.
-Resident #1 exiting the facility depended on how determined he was to go to the store up the road from the facility.
-Resident #1 had never made it to the store.

Interview with the Administrator on 08/09/22 at 9:15am and 10:30am revealed:
-The B Hall double doors had a keypad magnet lock.
-Staff had to hold the B Hall doors closed to ensure the lock caught before they walked away from the doors.
-It did not matter if the A or B Hall double doors did not lock because the entire facility was a locked unit.
-Staff were expected to escort residents back to B hall when they saw the resident walk out of that unit, but it was not necessary because the entire facility was a locked unit.
-The facility's exit doors would sound an alarm when pushed or opened.
-The facility exit door alarms must be disarmed by staff once sounding.
-Resident #1 sat often at the inside of the front exit door wanting to go outside.
-She never knew of, or had been told, Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

#1 went outside the facility unsupervised.
-It was easy for staff to see their assigned halls' exit doors on both A and B halls because there were exit doors at each end of the halls.
-There was no specific staff assigned to check the exit doors when the alarm sounded.
-Once the alarm sounded, staff were to check to see if any of the residents were outside.
-If so, staff were to direct the residents back inside the facility.
-If residents exited the facility, the PCA was to notify the MA, the MA notify the SCC, and the SCC notify the Administrator immediately.
-Both she and the SCC were available by phone 24 hours a day 7 days a week.
-The SCC was to document on an Incident and Accident (IA) report the resident exited the facility.
-Care staff were responsible for supervising residents every 30 minutes to 1 hour if a resident exited the facility or was agitated for as long as the resident was agitated or exit seeking.
-A Hall's double doors to and from the unit had not locked since October 2021 because of an electrical problem with the keypad.
-At one time (she could not remember when) residents with increased behavior who required more supervision were placed on B hall because the doors to that unit locked.
-Last week, she moved a resident from A hall to B hall because the resident kept going to the front exit door pushing it to unlock.
-The resident who was moved to B hall knew the door would unlock if it were pushed and held.

Interview with a third MA on 08/11/22 at 3:10pm revealed:
-It was normal for residents to try to exit B hall when she was performing a medication pass.
-She would not know if residents left B hall when performing the medication pass because she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

occupied administering other residents their medications.
-If a resident exited B hall during a medication pass, she sometimes may not know and could not supervise the resident if she did not know where the resident was located.

Second interview with the Administrator on 08/09/22 at 12:00pm revealed:
-Resident #1 had not been on increased supervision since she began working at the facility in October 2021.
-There were no residents on B hall currently on increased supervision.

Telephone interview with Resident #1's psychiatric nurse practitioner on 08/11/22 at 3:30pm revealed:
-Resident #1 required every 15-minute staff supervision when exit seeking and/or elopement occurred.
-He expected Resident #1 to remain on the locked B hall or staff to escort out when the resident left the unit.
-He expected staff to always have their eyes on Resident #1 when he was not on B hall because of his risk of his history of exit seeking and risk for elopement.
-It was a danger to the resident for the facility to allow him to leave B hall unsupervised.
-The facility placed Resident #1 at risk for being struck by a vehicle when he eloped the facility because he was not supervised.
-He did not know if Resident #1 could find his way back to the facility if he wandered away too far from the facility when he eloped.
-Every 2-hour supervision rounds were not safe for Resident #1 because of his history of exit seeking and elopement.
-Resident #1 could travel a long distance in 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

hours should he elope, and staff not realize until performing the standard every 2-hour supervision rounds.
-Staff did not need an order to increase supervision.

3. Review of the facility's Fall Policy revealed:
-Should a resident experience a fall, staff would provide or arrange for necessary emergency care, and would follow up with necessary service plan updates.
-Should the resident had trauma resulting in deformity, exhibited any change in level of consciousness, received obvious head or significant trauma, the Administrator or caregivers would summon emergency medical services (call 911).
-When a resident falls, caregivers were instructed to summon immediate assistance from the Administrator or another caregiver.
-Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment.
-The physician was contacted for further instructions if the head was not involved in the fall and the resident is able to move all extremities.
-The Administrator or designee instructed caregivers to provide appropriate care and frequent resident checks.
-Any change in status was reported to the Administrator.
-An incident report was completed.

Review of Resident #3's FL-2 dated 07/22/22 revealed:
-Diagnoses included vision loss of left eye, glaucoma, type 2 diabetes mellitus, and Alzheimer's disease.
-She was intermittently disoriented.
-She had limited vision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45 -She needed assistance with bathing, feeding, and dressing. Review of an Incident Report signed 04/04/22 revealed: -Resident #3 had an unwitnessed fall on 04/02/22. -There was nothing indicated in the injury section. -The resident was dizzy and lost her balance. -The resident was sent to the emergency room (ER) on 04/02/22 at 9:50pm.. -The primary care provider was notified (PCP). -The family was notified. -There was a recommendation to follow-up with the PCP to prevent recurrence. -The Incident Report was signed by the Special Care Coordinator (SCC) and the Administrator. Review of an Incident Report signed 04/20/22 revealed: -Resident #3 had a witnessed fall on 04/18/22. -There was no apparent injury. -The resident was walking out of the dining area and fell. -The resident was sent to the ER on 04/18/22. -The PCP was notified. -The family was notified. -There was a recommendation to follow-up with the PCP and occupational/physical therapy (OT/PT) to prevent recurrence. -The Incident Report was signed by the SCC and the Administrator. Review of an Incident Report signed 04/30/22 revealed: -Resident #3 had an unwitnessed fall on 04/28/22. -There was no apparent injury -The resident was sent to the ER on 04/28/22. -The PCP was notified.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

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

-The family was notified.
-There was a recommendation to follow-up with the PCP and Orthopaedic to prevent recurrence.
-The Incident Report was signed by the SCC and the Administrator.

Review of an Incident Report signed 08/06/22:
-Resident #3 had an unwitnessed fall on 08/06/22.
-The resident stated her head was hurting and she hit her head.
-No apparent injury was checked in the injury section.
-The resident was sent to the ER on 08/06/22 at 8:05am.
-The PCP was notified.
-The family was notified.
-There was recommendation to follow-up with the PCP and Hospice referral will be submitted on 08/09/2..
-The Incident Report was signed by the SCC.

Review of Resident #3's hospital discharge summary dated 08/06/22 revealed:
-There were no concerning injuries.
-Resident #3 was given written patient education materials on falls prevention.
-Resident #3 was instructed to follow-up with her PCP regarding the ER visit and recent fall.

Review of Resident #3's PCP follow-up visit report dated 08/09/22 revealed:
-Resident #3 was seen by the PCP on 08/09/22 for a follow-up visit to the resident's recent ER visit on 08/06/22 as a result of a fall.
-Problem List included repeated falls.
-Treatment plan included resident required 24/7 supervision and hospice evaluation.

Observation of Resident #3's room on 08/10/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 47 6:05am revealed: -A personal care aide (PCA) entered Resident #3's room on the A hall. -Resident #3 was lying on the floor on her back perpendicular to the bed with her feet pointing towards the bed. -The resident was alert. -The PCA called out (without leaving the room) for another PCA to come to the room to assist. -The two PCAs picked Resident #3 up off the floor and placed her back in the bed. -One of the PCAs commented to the other PCA that she needed to notify the medication aide (MA). -The medication aide (MA) was in the facility but was not on the hall. -The PCAs proceeded down the hall providing morning care to other residents. Observation of Resident #3 on 08/10/22 at 6:25am revealed the resident was dressed and sitting in a chair in her room. Interview with Resident #3 on 08/10/22 at 6:26am revealed: -Her head was hurting. -She might have hurt her arm. -She was shivering because she was cold. Observation on 08/10/22 at 6:26am revealed Resident #3 was shivering. Observation on 08/10/22 at 6:40am revealed: -One of the PCA's went into Resident #3's room and asked if she was alright. -The resident commented she was okay. Interview with the PCA on 08/10/22 at 7:05am revealed: -Resident #3 had been experiencing more falls	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 48	D 270		

now that she was completely blind.
-She had been used to getting up on her own and getting dressed.
-She forgot that she could no longer get up on her own and dressed and was supposed to call for assistance.
-The MA was to be notified when a fall occurred to evaluate for injuries and whether the resident should be sent to the ER.
-If a fall was unwitnessed the resident was not to be moved until the MA assessed the resident.

Interview with the second PCA on 08/10/22 at 7:01 revealed:
-She had worked at the facility about three weeks.
-The MA was to be notified when a fall occurred to assess for injuries.
-She thought the other PCA notified the MA.

Interview with the MA on 08/10/22 at 6:51am revealed:
-She was not notified or aware of Resident #3's fall at the time it occurred.
-She worked on the A and B halls on the third shift from 7:00pm to 7:00am.
-She was on the B hall when the fall occurred.
-The process was for the PCA to call the MA when a fall occurred for the resident to be assessed for injuries, to immediately call EMS for the resident to be sent to the ER if injured or unwitnessed, to notify the PCP, to notify the family, and compete an incident/accident report.

Telephone interview with Resident #3's family member on 08/11/22 at 10:00am revealed:
-She was not aware of the recent fall that occurred on 08/10/22.
-Resident #3 required more supervision than the facility could provide due to limited vision and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 49	D 270		

history of multiple falls.
-She was meeting with management this weekend to discuss hospice placement for Resident #3.
-Hospice would provide more caregiver-to resident contact because hospice usually came into the facility 3 times a week to provide resident care.

Interview with the SCC on 08/11/22 at 8:40am revealed:
-She was not notified or aware of Resident #3's fall that occurred on 08/10/22.
-She was aware Resident #3 had a history of falls.
-She was aware that Resident #3 was blind.
-Her expectation was for increased supervision after a fall with hourly observations for 24 hours.
-There was a form to document 24-hour observations.
-The MA or the SCC would notify the PCP.

Review of Resident #3's records from 04/01/22 to 08/11/22 revealed:
-There was a 24-hour observation sheet dated 08/11/22 from 12:00am to 11:00pm.
-There was documentation at 7:00am the resident was lying down.
-There was documentation at 8:00am the resident was lying down.
-There was documentation at 9:00am the resident was lying down and talking.
-There was documentation at 10:00am the resident was sitting and talking.
-There was documentation at 11:00am the resident was sitting and talking.
-There was no other documentation on the 24-hour sheet dated 08/11/22.
-There was no 24-hour observation sheets for falls that occurred on 04/02/22, 04/18/22,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 50 04/28/22 and 08/06/22. Interview with the Administrator on 08/11/22 at 10:30am revealed: -She was not notified or aware of Resident #3's fall that occurred on 08/10/22. -She expected Resident #3 to be on 24-hour falls precautions which included frequent monitoring when she fell. -When a resident falls the PCA was to notify the MA who evaluates the resident for injury, and the MA was to notify the SCC. -The MA or the SCC would notify the PCP. -The resident was to be sent out to the ER if an unwitnessed fall or injury. Interview with Resident #3's PCP on 08/22/22 at 1:00pm was unsuccessful. Refer to interview with the Administrator on 08/09/22 at 10:30am. Refer to interview with the Regional nurse on 08/10/22 at 4:00pm Refer to interview with a MA on 08/11/22 at 10:18am. Refer to interview with the Administrator on 08/11/22 at 10:57am. Refer to interview with a MA on 08/11/22 at 3:10pm. _____ Interview with the Administrator on 08/09/22 at 10:30am revealed: -Both she and the SCC were available by phone 24 hours a day 7 days a week. -Care staff were responsible for supervising residents every 30 minutes to 1 hour if a resident	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 51	D 270		

exited the facility or was agitated.

Interview with the Regional nurse on 08/10/22 at 4:00pm revealed:
-There should always be staff on the floor to supervise and monitor the residents.
-The facility should have alternate staff to supervisor and monitor residents when regular assigned staff was taking breaks or at lunch.
-The standard of care regarding resident supervision was staff should always be in a room or area with residents.
-Residents were in the SCU for a reason; they could not understand their safety needs.
-Staff could determine when a resident required increased supervision to keep the residents safe.

Interview with a MA on 08/11/22 at 10:18am revealed:
-She did not know what the supervision policy was.
-She had never seen the supervision policy.
-The facility never provided her education regarding the supervision policy.

Interview with the Administrator on 08/11/22 at 10:57am revealed:
-She, the SCC, the maintenance director, and the dietary manager were able to observe and supervise the residents when they walked the halls of the facility from 6:00am to 7:00pm.
-She was on the hall at random times throughout the day.
-The SCC rounded every morning and in the afternoons.
-The maintenance director would let her know if he felt a resident needed "attention" when he was on the hall.
-The maintenance director was able to determine when a resident needed "attention" based on his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 52	D 270		

experience in the facility.
-She expected care staff to be on the halls daily to check the residents for safety.
-Staff were assigned to halls but not specific residents on their assigned halls.
-Staff needed to know where the residents were in order to supervise them because they physically had to see the resident.
-A resident who needed increase supervision would be supervised every 1 hour.
-Other supervision interventions were to provide redirection, remove from the situation, and provide stimulation to help the resident relax.
-She did not know if supervision interventions were documented by staff.
-When a resident needed increased supervision, she told the SCC, the SCC told the MA, and the PCA performed the increased supervision.
-It was the responsibility of the SCC to ensure increased supervision was put in place for residents by following up with the MAs.
-It was the responsibility of the MAs to ensure the PCAs were implementing increased supervision for the residents.
-Staff could decide independently when to provide increased supervision for residents.

Interview with a MA on 08/11/22 at 3:10pm revealed:
-Supervision rounds were made every 2 hours by staff.
-She knew a resident required increased supervision if a resident could not be redirected verbally.
-The facility did not provide training regarding supervising residents.

_____
The facility failed to provide supervision for Resident #7 who had a documented history of constant disorientation and injury to property

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 53 upon admission, who ran into a hallway and blinds ripped from a window, punched a resident, then ran head first into a glass door hitting his head into the glass on the door on 03/17/22, had an unwitnessed fall on 06/11/22 and diagnosed at the hospital with a neck fracture of undetermined age, ran into a door and fell on 08/07/22, and wandered in the dining room on 08/08/22 where he tried to place his hands in a residents plate and was hit and fell on the floor requiring emergent care where he was diagnosed with a closed head injury and scalp laceration requiring staples placing the resident at risk for skull injuries, fractures, and brain trauma from sustaining head injuries. Resident #1, who had a know history of wandering and ability to leave the Special Care Unit, was able to elope from the facility on at least three occasions in one month, on one occasion found across a busy street. The facility's failure resulted in physical harm and neglect to the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2022	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 271	Continued From page 54 facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to respond to a fall in accordance with the facility's policy and procedures for 1 of 5 residents (#3) who had a fall and required first aid. The findings are: Review of the facility's Fall Policy revealed: -When a resident falls, caregivers were instructed to summon immediate assistance from the Administrator or another caregiver. -Caregivers do not move the resident, except to protect against further injury, as in the case of a dangerous environment. -The physician was contacted for further instructions if the head was not involved in the fall and the resident is able to move all extremities. -The Administrator or designee instructed caregivers to provide appropriate care and frequent resident checks. -Any change in status was reported to the Administrator. -An incident report was completed. Review of Resident #3's current FL-2 dated 07/22/22 revealed: -Diagnoses included vision loss of left eye, glaucoma, type 2 diabetes mellitus, and Alzheimer's disease.	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 271	Continued From page 55	D 271		

-She was intermittently disoriented.
-She had limited sight.
-She needed assistance with bathing, feeding, and dressing

Review of Resident #3's Resident Register revealed an admission date of 10/12/21.

Observation of Resident #3's room on 08/10/22 at 6:05am revealed:
-A personal care aide (PCA) entered Resident #3's room on the A hall.
-Resident #3 was lying on the floor on her back perpendicular to the bed with her feet pointing towards the bed.
-The resident was alert.
-The PCA called out (without leaving the room) for another PCA to come to the room to assist with the resident.
-The two PCA's picked Resident #3 up off the floor and placed her back in the bed.
-One of the PCA's commented to the other PCA that she needed to notify the medication aide (MA) to wrap the resident's left arm because it was bleeding.
-The MA was in the facility but was not on the hall.
-The PCAs proceeded down the hall providing morning care to other residents.

Interview with Resident #3 on 08/10/22 at 6:26 am revealed:
-Her left eye and left side of her head was hurting.
-She might have hurt her arm.
-She was shivering because she was cold.

Another interview with Resident #3 on 10/08/22 at 6:45am revealed she was okay but thought she might have hurt her arm (pointed to left arm).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 271	Continued From page 56 Observation on 08/10/22 at 6:51am revealed the MA was on the hall. Interview with the MA on 08/10/22 at 6:51am revealed: -She was not notified or aware of Resident #3's fall at the time it occurred. -She worked on the A and B halls on the third shift from 7:00pm to 7:00am. -She was on the B hall when the fall occurred. -The process was for the PCA to call the MA when a fall occurred for the resident to be assessed for injuries, to immediately call EMS for the resident to be sent to the emergency room (ER) if injured or unwitnessed, notify the family, and compete an incident/accident report. -The Special Care Coordinator (SCC) usually notified the primary care provider (PCP) and signed the incident/accident report. Interview with the PCA on 08/10/22 at 7:08am revealed: -The MA was to be notified when a fall occurred to evaluate the resident for injuries and whether the resident should be sent to the ER.. -If a fall was unwitnessed the resident was not to be moved until the MA assessed the resident. -The MA or the SCC would notify the PCP. Interview with the second PCA on 08/10/22 at 7:01 revealed: -She had worked at the facility about three weeks. -The resident was to be placed back in bed when a resident fell out of the bed. -The MA was to be immediately notified to assess the resident for injuries. -She thought the other PCA notified the MA. -The MA or the SCC would notify the PCP.	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 271	Continued From page 57 Interview with the SCC on 08/11/22 at 8:40am revealed: -She was not notified or aware of Resident #3's fall that occurred on 08/10/22. -She was aware Resident #3 had a history of falls. -She was aware Resident #3 had significant vision loss. -The PCA should immediately notify the MA when a fall occurred for the resident to be assessed for injuries. -The MA had a phone and the PCAs had access to a phone at the nurses' station and there was an intercom. -If the MA was not available, the PCA could have notified her. -Her expectation was for the process to be followed for the safety of the resident. -When there was an unwitnessed fall, the resident was to be sent immediately to the emergency room (ER) for further evaluation and management. -She was not sure why the process was not followed. -She usually notified the PCP. -She did not notify the PCP because she was not aware of Resident #3's fall on 08/10/22. -She did not complete an accident/report at the time because she was not aware of Resident #3's fall. Interview with the Administrator on 08/11/22 at 10:30am revealed: -She was not notified or aware of Resident #3's fall that occurred on 08/10/22. -The process was to notify the MA, notify the SCC, send the resident to the emergency room if an unwitnessed fall or injury, notify the PCP, notify the family, and complete an accident and	D 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 271	Continued From page 58 incident report. -She did not know if the PCP was notified. -The SCC usually notified the PCP. -She expected the process to be followed to ensure the safety of the resident. Interview with Resident #3's PCP on 08/11/22 at 1:00pm was unsuccessful.	D 271		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide 14 hours of a variety of planned group activities per week for active involvement of residents in the free-standing Special Care Unit. The findings are: Review of the facility's August 2022 activity calendar revealed: -There were activities listed for the assisted living (AL) and Special Care Unit (SCU). -On 08/09/22 music was scheduled for the SCU	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 59	D 315		

at 10:00am.
-on 08/09/22 indoor bowling was scheduled for the SCU at 1:00pm.

Observation of the free-standing SCU on 08/09/22 at 10:30am revealed:
-There were residents standing in A hall.
-There were some residents gathered at the nurse's station and some ambulating in the hallway.
-There was no music playing.

Review of the facility's activity calendar for 08/10/22 revealed:
-There were activities listed for the AL and SCU.
-An activity called "Sit and Fit" was scheduled for 10:00am/11:00am.

Observation of the free-standing SCU on 08/10/22 at 10:30am revealed there was no "Sit and Fit" activity for the residents.

Interview with a resident on 08/11/22 at 8:30am revealed:
-There was never anything to do in the facility.
-Sometimes it would be nice to go outside for some fresh air and look at the birds and watch the leaves fall from the trees.

Interview with a personal care aide (PCA) for A hall on 08/09/22 at 2:54pm revealed:
-The facility did not have an activity coordinator (AC).
-She did not know how long the facility had been without an AC.
-Residents were not offered activities today (08/09/22).
-Sometimes the PCAs offered bingo to the residents.
-She did not remember the last time residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 60 were offered activities. Interview with a second PCA on 08/09/22 at 2:56pm revealed: -The facility no longer had an AC. -She did not remember how long the facility had been without an AC, but there were no activites provided since she left. -Personal care staff were responsible to offer activities to the residents until the facility replaced the AC. -Residents were not offered activities today because she did not have time. Interview with a medication aide (MA) on 08/10/22 at 11:00am revealed: -The AC left about a week ago. -There had not been any activities for the residents since that time. Interview with the Special Care Coordinator (SCC) on 08/11/22 at 8:40 am revealed: -The facility had not had an AC for about a week. -There was a calendar of daily activities posted for the month of August. -She had pulled staff off the "floor" to do activities with residents until a new AC was hired. -She could not recall if activities were done on Monday and Tuesday of this week. -The residents from both halls were gathered to watch a popular game show on TV (which was on the activities schedule) in the dining area during snack time on Wednesday of this week. Interview with the Administrator on 08/11/22 at 10:30am revealed: -The facility did not have an AC currently. -Staff was pulled off the "floor" to provide activities for the residents since the AC left about a week ago while maintaining compliance	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 315	Continued From page 61 regarding staff/resident ratio.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure resident's rights were protected for 3 of 7 sampled residents (#2, #6, #10) who sustained bruising to both forearms during personal care services (#6), skin tears to forearms after being grabbed by staff (#10) and clean linen placed on a urine saturated mattress (#2). The findings are: Review of the facility's resident rights policy revealed staff respects each resident's personal rights, which include, but are not limited to, the right to be free from corporal or unusual punishment, humiliation, intimidation, mental abuse, or other actions of a punitive nature, such as withholding of monetary allowances or interfering with activities of daily living. 1. Review of Resident #6's current FL-2 dated 03/01/22 revealed: -Diagnoses included Alzheimer's dementia, tremors, and hypertension. -Special Care Unit was the recommended level of care.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 62	D 338		

-The resident was intermittently disoriented and ambulatory.
-The resident's skin was documented as normal.

Review of Resident #6's Resident Register revealed an admission date of 03/18/22.

Review of Resident #6's resident record revealed there was no documentation of a care plan.

Review of Resident #6's physician's orders from 03/01/22 to 08/11/22 revealed there were no orders for anticoagulants or aspirin (both known to cause skin to be easily bruised).

Requests on 08/09/22 and 08/11/22 for Resident #6's skin assessment sheets from 07/01/22 to 08/11/22 were not provided by survey exit on 08/11/22.

Review of the facility's Investigation report for Staff D dated 08/01/22 reviewed:
-There was an allegation of resident abuse that occurred on 07/25/22 in the resident's room.
-The time was not documented.
-There was documentation there were multiple accused employees in the same incident with direction to complete a separate incident report for each accused.
-Resident #6 reported two staff hurt her while trying to get her to take a shower.
-There was bruising to both Resident #6's arms.
-There was documentation Resident #6 was on Aspirin daily and her skin bruised easily.
-It was concluded no harm to Resident #6 was intentionally done by Staff D.
-Resident #6's roommate stated she grabbed the resident's arm and demonstrated to the same location of the resident's bruising.
-The facility would provide additional training on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 63	D 338		

dementia and bathing without a battle.
-The investigation was performed by the Administrator.

Review of Resident #6's Primary Care Provider's (PCP) visit note dated 07/26/22 revealed:
-The resident was 5 foot 3 inches tall and weighed 87 pounds.
-The resident's chief complaint was bilateral trauma/injury.
-The resident arrived with her family member and had bilateral arm bruising from " ...an awful attack at her nursing home".
-The resident reported she was grabbed by her arms and drug into the hallway after refusing a shower by two staff on the night of 07/25/22 because she did not want them to undress her.
-The resident was slightly confused due to dementia and was anxious.
-The resident had difficulty recalling details of the event.
-The resident expressed fear and anxiety related to returning to the facility.
-Inspection of the resident's skin revealed bruising over both the resident's both lower arms.
-There were isolated large bruises on both lower arms spanning 10 to 15 centimeters in length.
-It was recommended the resident's family member file a police report.

Telephone interview with Resident #6's PCP's Physician Assistant on 08/10/22 at 11:45am revealed:
-He treated Resident #6 on 07/26/22 for an alleged assault by staff.
-Resident #6 reported staff grabbed and drug her on the ground and beat her.
-Resident #6 had bruising that was possible to be from hand grips to her lower arms.
-Resident #6's lower arm bruising was consistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 64	D 338		

to the size of hands or palms.
-Resident #6 did not have bruising to other parts of her body that would suggest she was beat.
-Resident #6 was not prescribed medications that would cause her to bruise easily.

Review on 08/09/22 at 3:00pm of photos of Resident #6 dated 07/26/22 at 11:04am revealed:
-The resident was sitting in a chair with her arms at her side and hands folded in her lap.
-There was a purplish red colored circular bruise to the resident's right upper forearm just below the elbow located on the outer part of the arm.
-There was a purplish red colored bruise from the right mid forearm to the lower forearm.
-There were scattered purplish colored bruises just above the resident's right wrist.
-There was a purplish red colored bruise between the right first and second fingers on her right hand.
-There was a purplish red colored bruise to the left mid forearm.
-There was a purplish red colored bruise to the left wrist extending to the top of the left hand.
-The underside of the resident's right and left forearms was not pictured.

Interview with the Administrator on 08/09/22 at 12:00pm revealed:
-It was reported Resident #6 was assaulted by staff A and D.
-Resident #6 had bruises to both arms upon her observations.
-The Special Care Coordinator (SCC) told her Resident #6 took Aspirin which would cause the resident to easily bruise.
-Resident #6 told her staff grabbed her and pulled her on the floor.
-Resident #6's roommate told her she grabbed the resident's arms to prevent the resident from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 65	D 338		

scratching her.
-She determined Staff A and D did not cause bruising to Resident #6's arms because the resident's roommate told her she was the one who grabbed the resident's arms.
-The combination of Resident #6 taking Aspirin and the resident's roommate grabbing her arms would have caused the bruising.

Interview with Resident #6's roommate on 08/10/22 at 9:25am revealed:
-She was moved to another room about one week ago, but she did not know why.
-Resident #6 told her staff grabbed her arms.
-She had never grabbed or hurt Resident #6.

Interview with Resident #6's family member on 08/09/22 at 2:56pm revealed:
-She normally visited Resident #6 every other day if not more.
-She visited with Resident #6 until about 4:30pm on 07/25/22.
-Resident #6 told her at that time she did not want staff bathing her; she did not say why.
-She told Resident #6 she or other family members would bathe her during their visits.
-She returned the morning of 07/26/22 to see Resident #6 standing at the double doors of A hall with a lost and terrified look which was not normal.
-Resident #6 had bruising to both lower arms when she returned the morning of 07/26/22.
-Resident #6 did not have bruises to her arms when she last saw the resident the afternoon of 07/25/22.
-On 07/26/22, Resident #6 told her two female staff beat her when she refused to take a bath the night of 07/25/22.
-She and the resident were outside when the resident identified one of the staff as assaulting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 66	D 338		

her; the resident had a feared look.
-Staff A told her she was asked to assist with bathing an uncooperative resident.
-Staff A told her when she saw Resident #6 was uncooperative, she left the room and reported the refusal to a medication aide (MA).

Interview with a personal care aide (PCA) on 08/09/22 at 4:13pm revealed:
-She arrived for work one morning and saw bruising to both of Resident #6's lower arms.
-She reported the bruising to a MA; the MA reported it to the Special Care Coordinator (SCC).
-She did not know how the bruising occurred.

Interview with Staff D on 08/10/22 at 6:10am revealed:
-She and Staff A went in Resident #6's room during third shift to assist her with a shower towards the end of July 2022.
-She saw bruising to both of Resident #6's lower arms when the resident began undressing.
-She was assisting Resident #6 to unbutton her shirt when the resident began screaming.
-Resident #6 then jumped over the bed towards the window in her room.
-Resident #6 said she did not want a bath because her stomach hurt.
-She and Staff A walked out of the room leaving the resident alone.
-She called the SCC two to three times to tell her the resident refused her bath and was screaming, but she was unable to contact the SCC.

Review of Staff D's statement dated 07/25/22 revealed:
-She and Staff A went in Resident #6's room on a Monday night to assist with a bath.
-She assisted Resident #6 with unbuttoning a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 67	D 338		

button.
-Resident #6 disrobed to her undergarments and began screaming.
-Resident #6 climbed under the bed.
-She and Staff A exited the room.
-Staff did not touch Resident #6.

Interview with Staff A on 08/10/22 at 6:30pm revealed:
-She had been working at the facility for three weeks.
-The Staff D asked her to assist with bathing a resident during her 7:00pm to 7:00am shift shortly after she started working at the facility.
-She had never had to bathe or assist with bathing a resident.
-She and Staff D both had a hand on each of Resident #6's lower arms and their other hand behind the resident's back.
-They assisted Resident #6 with removing her shirt.
-Resident #6 began screaming when they started removing her pants.
-Resident #6 walked around her bed to the opposite side.
-She and Staff D exited the room leaving Resident #6 in her room.
-She reported what happened to the MA.
-Resident #6 remained in her room.
-She did not remember seeing bruising to Resident #6's arms.
-Resident #6 was older in age and that made her skin bruise easily.

Review of Staff A's statement dated 07/25/22 revealed:
-She was asked to assist with giving Resident #6 a bath.
-She assisted Resident #6 with removing her clothing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 68 -Resident #6 began screaming they were hurting her. -She walked out of Resident #6's room. -She did not know showering could be refused. Interview with Resident #6 on 08/10/22 at 9:19am revealed: -Two staff placed their hands on her arms during the night or close to nighttime and were jerking her because she would not do what they wanted her to do, so she could not report what day this occurred. -She could not remember what it was they wanted her to do. -She did not want to talk about it because no one had tried to hurt her since. -Her roommate had never grabbed or hurt her. Interview with the SCC on 08/10/22 at 12:00pm revealed: -On the morning of 07/26/22, the MA and a PCA told her Resident #6 reported staff grabbed her. -She did not remember the extent of the conversation. -She called and reported it to the Administrator. -Staff A and Staff D were suspended pending an investigation. -She, the Administrator, and a MA performed a skin assessment on Resident #6. -Resident #6 had bruising to her right and left lower arms only. -Resident #6's roommate told she and the Administrator that staff went in the room to give the resident a shower when the resident became upset and tried to get behind her bed. -Resident #6's roommate told them she grabbed the resident's arm when the resident went towards her. -Resident #6 and her roommate were separated about one week ago.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 69 Interview with a MA on 08/11/22 at 10:18am revealed: -Resident #6 required assistance with bathing. -Resident #6 was independent with dressing, ambulation, and transfers. -Resident #6 refused bathing at times. -The morning of 07/26/22, Resident #6 reported she was assaulted the night of 07/25/22. -She escorted Resident #6 to the SCC's office. -In the office were Staff D and a dietary aide. -Resident #6 verbally identified to her that Staff D was one of the staff who assaulted her. -She had observed on occasion Staff D being loud with the residents telling them they were going to do what she said to do. Interview with the Administrator on 08/10/22 at 10:57am revealed: -Resident's had the right to refuse care. -Staff were not to be forceful with residents who resisted care. -A different staff was to attempt to redirect the resident to have the care performed. -If the resident still resisted, the staff was to tell the SCC and document in the resident's care notes. 2. Review of Resident #10's current FL-2 dated 09/22/21 revealed: -Diagnoses included Alzheimer's disease, hypertension, anxiety, and depression. -The resident was ambulatory and wandered. -There was no documentation regarding disorientation. -The resident was sight and hearing impaired. -The resident's skin was documented as normal. Review of Resident #10's care plan dated 10/19/21 revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 70 -The resident required limited staff assistance with bathing and grooming. -The resident required staff supervision with ambulation and toileting. -The resident was independent with dressing and transferring. -The resident's skin was documented as normal. Observations of Resident #10 on 08/11/22 at 1:13pm revealed: -There were six circular faded pale-yellow colored bruises fingertip size on the outside of the resident's right forearm. -There was one circular fingertip size faded pale-yellow to light tan colored bruise on the inside of the residents right lower forearm. -There was bright pink colored intact skin approximately 1/4th inch long on the inside of the residents right lower forearm. -There were no bruising or injuries to the resident's left forearm. Interview with a medication aide (MA) on 08/11/22 at 10:18am revealed: -On 07/29/22, a personal care aide (PCA) reported to her Resident #10 sustained skin tears to her lower forearms after Staff E grabbed and pulled at the resident's forearms. -She then examined Resident #10's arms and there were skin tears approximately three inches long across the inside of her mid forearms. -Resident #10's skin was peeled up the inside right and left forearms towards her elbows. -Resident #10 complained of pain to the areas when touched for about two weeks. -The Administrator was on leave during that time frame. -She told the Special Care Coordinator (SCC) of the allegations of Resident #10 on the same date as reported to her.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 71 -A few days later, she observed Resident #10's family member question the SCC about the resident's forearms. -She observed the SCC tell the family member Resident #10's skin was fragile because the resident was on blood thinners. -That same day, she reminded the SCC of her report on 07/29/22 regarding the allegations of Staff E causing the skin tears to Resident #10's forearms. -The SCC told her she had too much to do that prevented her from following up with Resident #10. -She told the Administrator of the allegations of Resident #10 being assaulted by Staff E when the Administrator returned from leave. -The Administrator assured her she would follow up with Resident #10. -Staff E also shoved food in another resident's face after the allegations of injuries to Resident #10's forearms were reported to the SCC. Interview with a second MA on 08/11/22 at 1:15pm revealed: -The fingertip sized bruises to Resident #10's right forearm was not normal for her. -She did not know how long the bruises had been present on Resident #10's right forearm. Interview with the Administrator on 08/11/22 at 10:57am revealed: -The MA told her on 08/04/22 a PCA reported to her Resident #10 sustained skin tears to both forearms after Staff E grabbed and pulled at the resident's arms. -She questioned the SCC and the SCC told her Resident #10's skin tears did not look like they were obtained from being grabbed. -Resident #10 was not a resident who resisted care that she knew of.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 72	D 338		

-Staff E was terminated on 08/02/22 for shoving food in another resident's face.
-She would have suspended Staff E on 07/29/22 pending an investigation if the SCC had notified her on 07/29/22 when she was told of the allegation.
-She was on leave from 07/18/22 to 07/26/22 and 07/29/22 to 08/01/22.
-She worked a few hours on 07/27/22 and 07/28/22.
-She was available for the facility 24 hours a day seven days a week even when she was on leave.
-The SCC was responsible for the operations of the facility when she was not in the facility.
-PCAs were to report allegations of resident abuse to the MA on duty, the MA was to report to the SCC, and the SCC notify the Administrator immediately.
-The SCC was to inform the MA to document a statement of the allegation.
-The alleged staff was to be suspended immediately (at that moment) from employment pending an investigation.

Interview with the SCC on 08/11/22 at 12:25pm revealed:
-It was policy for the SCC to immediately report to the Administrator any allegations of staff to resident abuse.
-Her main duty as SCC was to make sure staff were performing their roles as expected and resident care.
-A few weeks ago, a MA told her a PCA reported to her Resident #10 sustained skin tears to both forearms when Staff E was being "verbally bad and rough" with the resident.
-She told the MA to talk to Staff E about the allegation because she thought the MA meant Staff E was being loud with the resident.
-The MA did not tell her Staff E placed her hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 73	D 338		

on Resident #10.
-She did not report to the Administrator or investigate the allegation because she did not receive any other allegations of Staff E being rough with residents and she was busy with other duties.
-She did not examine Resident #10 to see if she had any injuries.
-It was difficult to perform her role as a SCC in addition to other duties assigned to her such as assisting in the Assisted Living facility.

Attempted telephone interview with Resident #10's Primary Care Provider (PCP) on 08/11/22 at 1:00pm was unsuccessful.

Attempted telephone interview with Resident #10's family member on 08/11/22 at 1:30pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable.

3. Review of Resident #2's current FL-2 dated 05/03/22 revealed:
-Diagnoses included severe intellectual disabilities, mental disorder, aphasia, and hypertension.
-The resident was constantly disoriented, wandered, and was verbally abusive.
-The resident was semi-ambulatory with the assistance of a device.
-The resident was incontinent of bladder and bowel.

Review of Resident #2's care plan dated 03/01/22 revealed:
-The resident wandered, had disruptive behavior, was always disoriented and had significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 74	D 338		

memory loss requiring direction.
-The resident was totally dependent upon staff for toileting, bathing, dressing, and grooming/personal hygiene.

Observation of Resident #2's room on 08/10/22 at 6:35am revealed:
-Resident #2 was in a wheelchair, had bilateral hand contractures, jerking movements, and was non-verbal.
-Resident #2's mattress was wet with urine from side to side of the mattress.
-There were multiple brown circular stains from the head of the mattress to below the middle.
-Staff A removed soiled linen from Resident #2's twin size bed.
-Staff A placed a clean, dry incontinent pad on Resident #2's brown stained mattress.
-Staff A placed a fitted sheet on the mattress over the incontinent pad.
-Staff A placed a flat sheet on top of the fitted sheet, then a bedspread.
-Staff A exited the room with Resident #2's linen.

Interviews with Staff A on 08/10/22 at 6:30am and 6:55pm revealed:
-It was her responsibility as a PCA to change resident bed linens.
-She placed a dry incontinent pad on Resident #2's mattress to keep from wetting the sheets with urine when she made the bed.
-She was trained by other PCAs when hired to place incontinent pads on wet mattress before making the bed to prevent the sheets from being wet with urine.
-No one told her to notify management when a mattress was wet with urine.

Interview with the Special Care Coordinator (SCC) on 08/10/22 at 12:30pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 75 -Staff knew what care to perform for residents based on repetition in working with the residents. -Staff were trained on personal care when they were hired, then they shadowed for three days before taking a floor assignment independently. -It was the responsibility of the medication aide (MA) on both shifts to ensure the PCAs were providing personal care to the residents. -It was her responsibility as the SCC to make rounds to ensure the residents were receiving personal care as expected. -She had not rounded on A hall today, 08/10/22. Interview with the Regional nurse on 08/10/22 at 12:45am revealed: -She expected staff to care for the residents and ensure they were clean. -She expected staff to treat all residents with respect and dignity. -It was unacceptable for Staff A to place clean linen on a resident's soiled bed. Attempted interview with the MA who staffed on 07/25/22 from 7:00pm to 7:00am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. _____ The facility failed to ensure resident rights were protected related to bruising to Resident #6's forearms after refusing personal care. On 7/25/22, when visited by the resident's family member, the resident did not have bruising; however, on the morning of 7/26/22, the resident displayed a lot of fear, and there were large bruises on both lower arms spanning 10-15 centimeters in length. The Primary Care Provider found the bruises to be consistent to the size of	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 76 hands and the resident exhibited fear to him and did not want to return to the facility because she was afraid. Resident #10 sustained skin tears three inches long to the inside of her forearms and the skin had peeled up towards her elbows after Staff E grabbed and pulled the resident. This incident was reported to the Special Care Coordinator and she did not examine Resident #10 for injuries nor report the abuse allegations to the Administrator therefore no additional follow up was provided by management to ensure the residents were safe from Staff E while she continued to work in the facility. This failure resulted in serious physical abuse and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 08/11/22. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2022.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 77	D 358		

medications as ordered for 3 of 6 residents (#6, #8, #9) observed during the medication pass including errors with a medication for chronic obstructive pulmonary disease (#6), a nasal spray to treat allergies (#8), and a medication used to treat low thyroid (#9).

The findings are:

The medication error rate was 9% as evidenced by the observation of 3 errors out of 33 opportunities during the 9:00am medication pass on 08/09/22 and 8:00am medication pass on 08/10/22.

Review of the facility's undated Medication Administration Policy revealed:
-The reason for the policy was to ensure medications were administered accurately.
-Medications ordered to be administered before meals were to be administered one-half to one hour prior to the meal as ordered.

1. Review of Resident #6's current FL-2 dated 03/01/22 revealed:
-Diagnoses included Alzheimer's dementia and chronic obstructive pulmonary disease (COPD).
-The resident was intermittently confused.
-There was an order for Spiriva inhale 2 puffs daily (used to treat bronchospasm's caused by COPD and reduce flare ups of serious symptoms).

Review of Resident #6's physician order sheet dated 04/09/22 revealed there was an order for Spiriva 2.5mcg per inhalation inhale 2 puffs by mouth once daily.

Review of Resident #6's physician order dated 07/15/22 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 78	D 358		

-Diagnoses included COPD and chronic bronchitis.
-There was an order for Spiriva 2.5mcg daily.

Review of Resident #6's Primary Care Provider (PCP) visit note dated 07/26/22 revealed:
-The problems reviewed were COPD.
-There was an order for Spiriva 2.5mcg/actuation inhale 2 puffs by mouth daily.
-The PCP visit note was electronically signed by the provider on 07/29/22 at 11:44am.

Observation of the 9:00am A hall medication pass on 08/09/22 revealed:
-Resident #6 was standing on A hall by the nurse's desk.
-The medication aide (MA) electronically scanned Resident #6's medications.
-A check mark appeared on the medication name in the electronic medication administration record (eMAR) after scanning.
-The MA approached Resident #6, shook the resident's Spiriva, gave the Spiriva to Resident #6 to self-administer, and instructed the resident to take a deep breath and hold.
-The resident pressed the actuation device, inhaled once, the MA took and capped the Spiriva, and returned the Spiriva to the medication cart documenting the medication was administered.
-The MA did not administer or prompt Resident #6 to administer a second dose of Spiriva.

Review of Resident #6's August 2022 eMAR revealed:
-There was an entry for Spiriva 2.5mcg/inhalation inhale 2 puffs once daily to be administered at 10:00am.
-There was documentation Spiriva 2 puffs was administered to the resident on 08/09/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 79 10:00am. Interview with the MA on 08/09/22 at 12:24pm revealed: -She gave Resident #6 the Spiriva. -She instructed Resident #6 to inhale a deep breath and hold. -Resident #6 was not administered nor did the resident self-administer the second dose of Spiriva because normally she refused. -She normally would only administer one dose of Spiriva to Resident #6. Interview with Resident #6 on 08/10/22 at 9:19am revealed she did not remember how many doses of Spiriva she was normally administered. Refer to interview with the MA on 08/09/22 at 12:22pm. Refer to interview with the Administrator on 08/11/22 at 10:57am. 2. Review of Resident #8's current FL-2 dated 06/15/22 revealed: -Diagnoses included dementia with behavioral disturbances, hypertension, and diabetes. -The resident was intermittently confused. -There was an order for Flonase 50mcg 2 sprays in each nostril daily (used to treat allergies). Review of Resident #8's physician order sheet dated 07/19/22 revealed there was an order for Flonase 50mcg administer 2 sprays in each nostril daily. Review of Resident #8's Primary Care Provider (PCP) visit note dated 07/26/22 revealed there was documentation to refer to the medication administration record (MAR) for an accurate	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 80 medication list. Observation of the 9:00am A hall medication pass on 08/09/22 revealed: -Resident #8 was sitting in a wheelchair located on A hall by the nurses' desk. -The medication aide (MA) placed the Flonase tip in Resident #8's right nostril and administered 1 dose. -The MA placed the Flonase tip in Resident #8's left nostril and administered 1 dose. -The MA gave Resident #8 a tissue, the resident wiped her nose. -The MA returned the Flonase to the medication cart. -The MA did not administer a second dose of Flonase to Resident #8. Review of Resident #8's August 2022 eMAR revealed: -There was an entry for Flonase 50mcg administer 2 sprays in each nostril daily to be administered at 10:00am. -There was documentation Flonase was administered to the resident on 08/09/22 at 10:00am. Interview with the MA on 08/09/22 at 12:22pm revealed she did not remember how many doses of Flonase she administered to Resident #8. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to interview with the MA on 08/09/22 at 12:22pm. Refer to interview with the Administrator on 08/11/22 at 10:57am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 81 3. Review of Resident #9's current FL-2 dated 02/25/22 revealed: -Diagnoses included advanced dementia, hypertension, and diabetes. -The resident was constantly disoriented and wandered. Review of Resident #9's physician order sheet dated 06/20/22 revealed: -Diagnosis included hypothyroidism. -There was an order for Synthroid 25mcg daily at least 30 minutes before breakfast (used to treat hypothyroidism). Observation of the 9:00am A hall medication pass on 08/09/22 revealed: -The medication aide (MA) compared the medication instructions documented in the electronic medication administration record (eMAR) to Resident #9's medication administration label, including the Synthroid which was in a bubble pack, prior to popping the medication in the medication cup. -The MA clicked on the Synthroid in the eMAR and a check appeared. -Resident #9 was standing on A hall by the nurses' desk. -The MA administered the Synthroid to Resident #9 prompting her to swallow the medication. -Resident #9 swallowed the medications, including the Synthroid. -The MA returned to the medication cart and documented in the eMAR Synthroid was administered. -A warning box appeared on the eMAR screen with documentation it was to early or to late to administer the Synthroid. -The MA documented in the Synthroid warning box the medication was administered.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 82 Review of Resident #9's August 2022 eMAR revealed: -There was an entry for Synthroid 25mcg once daily at least 30 minutes before breakfast to be administered at 7:00am. -There was documentation Synthroid was administered on 08/09/22 at 7:00am. -Synthroid did not populate under the medication exceptions for the resident. Interview with the MA on 08/09/22 at 12:26pm revealed: -Breakfast was to be served to the residents at 7:30am. -She thought Resident #9 ate breakfast today around 8:00am, but she was not certain. -She was late arriving to work this morning, 08/09/22, and was not there to administer the 7:00am medication pass. Interview with the Administrator on 08/09/22 at 9:19am revealed: -The MA did not arrive for work until 8:27am this morning, 08/09/22. -The Special Care Coordinator (SCC) was to administer the 7:00am medication pass this morning, 08/09/22. -She did not know if the SCC administered the 7:00am medication pass this morning, 08/09/22. Interview with the facility's cook on 08/09/22 at 12:30pm revealed breakfast was served to residents on A hall today, 08/09/22, at 7:00am. Interview with the SCC on 08/09/22 at 12:32pm revealed she did not administer the 7:00am medication pass this morning, 08/09/22, because she had to prepare for the facility's physician visit scheduled for today.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 83 Refer to interview with the MA on 08/09/22 at 12:22pm. Refer to interview with the Administrator on 08/11/22 at 10:57am. _____ Interview with the MA on 08/09/22 at 12:22pm revealed she was trained to compare the electronic MAR administration instructions to the medication label prior to administering medications to ensure administered accurately per orders. Interview with the Administrator on 08/11/22 at 10:57am revealed: -The MAs were trained to administer medications per physician orders. -The MAs were expected to scan the medications and compare the eMAR to the medications before administering to ensure the medications were administered accurately per orders.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the 9:00am medication pass observed on 08/09/22	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 371	Continued From page 84	D 371		

for 1 of 1 medication aide observed who failed to perform hand hygiene before preparing and after administering nasal and oral medications to three residents.

The findings are:

Review of the facility's infection control policy dated 04/13/21 revealed hands must be washed between any tasks that have the possibility of transferring bacteria from resident to resident.

Observation of two medication carts on A hall on 08/09/22 revealed:
-One cart had an alcohol-based hand sanitizer placed at the back of the cart.
-The second cart did not have an alcohol-based hand sanitizer on the cart.

Observation of the A hall medication aide (MA) administering medications during the 9:00am medication pass on 08/09/22 revealed:
-At 9:00am, the MA prepared the resident's medications at the first medication cart.
-At 9:01am, the MA gave the resident medications to swallow and an oral inhalant to self-administer.
-The MA took the oral inhalant from the resident, capped the inhalant, and placed it in the medication box.
-The MA applied a glove to her right hand and administered one dose of a nasal inhalant in each of the resident's nostrils.
-The MA applied the cap to the nasal inhalant and removed her glove.
-The MA did not apply hand sanitizer after removing her glove.
-The MA touched the computer keypad on the medication cart, unlocked the cart with keys, and returned the medications back to the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 371	Continued From page 85	D 371		

cart.
-The MA then moved to the second medication cart and began preparing medications for the second resident.
-The MA did not wash her hands or use an alcohol-based sanitizer when she returned to the medication cart before she began preparing medications for the second resident.
-The MA unlocked the second medication cart with the keys, opened the drawer, touched the scanner and scanned each medication prior to popping medications from two bubble packs and dispensing a medication from a medication bottle into a pill cup.
-At 9:07am, the MA touched the water dispenser, poured water into a cup, and administered the medications to the second resident.
-The MA did not wash her hands or use an alcohol-based sanitizer when she returned to the medication cart before she began preparing medications for the third resident.
-The MA returned to the medication cart, touched the keypad and began preparing medications for the third resident.
-The MA touched the keypad located on the medication cart, opened the medication cart drawer, removed medications for the third resident, and prepared the medications into a pill cup.
-At 9:15am, the MA touched the water dispenser, poured water into a cup, administered the medications to the third resident, and the MA returned to the medication cart .
-The MA did not perform hand hygiene in between three residents during the 9:00am medication pass on 08/09/22.

Interview with the MA on 08/09/22 at 12:26pm revealed:
-She was trained to use hand sanitizer in between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 371	Continued From page 86 each resident during the medication pass. -She was trained to wash her hands after administering medications to the third or fourth resident. -She did not sanitize her hands after administering medications to the residents because she moved medication carts and forgot to place the hand sanitizer on the second medication cart. -She failed to wash her hands during the medication pass because she forgot. Interview with the Administrator on 08/11/22 at 10:57am revealed: -Infection control training for the staff was provided yearly. -Newly hired MAs were to complete the North Carolina Statewide Program for Infection Control and Epidemiology online training prior to staffing. -MAs were expected to sanitize their hands with an alcohol-based hand sanitizer before and after each resident during the medication pass to decrease the risk of spreading infection between residents. -MAs were expected to wash their hands as much as possible and at least after every three to four residents to decrease the risk of spreading infection between residents.	D 371		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 87 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to report allegations of physical abuse by staff to the Health Care Personnel Registry within 24 hours of knowledge related to staff accused of causing skin tears to a resident's forearms during personal care (#10). The findings are: Review of the facility's resident rights policy revealed staff respects each resident's personal rights, which include, but are not limited to, the right to be free from corporal or unusual punishment, humiliation, intimidation, mental abuse, or other actions of a punitive nature, such as withholding of monetary allowances or interfering with activities of daily living. Review of the facility's resident abuse policy revealed: -Management was responsible to notify state licensing authorities reports of resident abuse or neglect. -Management was responsible to notify law enforcement of reports of resident abuse or neglect if necessary. -Management was responsible to notify state and local agencies responsible for protecting older adults or reports of resident abuse or neglect. Review of Resident #10's current FL-2 dated 09/22/21 revealed: -Diagnoses included Alzheimer's disease, hypertension, anxiety, and depression. -The resident was ambulatory and wandered. -There was no documentation regarding disorientation.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 88 -The resident was sight and hearing impaired. -The resident's skin was documented as normal. Review of Resident #10's care plan dated 10/19/21 revealed: -The resident required limited staff assistance with bathing and grooming. -The resident required staff supervision with ambulation and toileting. -The resident was independent with dressing and transferring. Interview with a medication aide (MA) on 08/11/22 at 10:18am revealed: -On 07/29/22, a personal care aide (PCA) reported to her Resident #10 sustained skin tears to her lower forearms after Staff E grabbed and pulled at the resident's forearms. -She then examined Resident #10's arms and there were skin tears approximately three inches long across the inside of her mid forearms. -Resident #10's skin was peeled up the inside right and left forearms towards her elbows. -Resident #10 complained of pain to the areas when touched for about two weeks. -The Administrator was on leave during that time frame. -She told the Special Care Coordinator (SCC) of the allegations of resident abuse by Staff E on the same date as reported to her. -A few days later, she observed the resident's family member question the SCC about the resident's forearms. -She observed the SCC tell the family member Resident #10's skin was fragile because the resident was on blood thinners. -That same day, she reminded the SCC of her report on 07/29/22 regarding the allegations of Staff E causing the skin tears to Resident #10's forearms.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 89	D 438		

-The SCC told her she had too much to do that prevented her from reviewing camera footage and investigating the allegations.
-She told the Administrator of the allegations of resident abuse by Staff E when the Administrator returned from leave.
-The Administrator assured her she would investigate the allegations.
-Staff E also shoved food in another resident's face after the allegations of injuries to Resident #10's forearms.

Observations of Resident #10 on 08/11/22 at 1:13pm revealed:
-There were six circular faded pale-yellow colored bruises fingertip size on the outside of the resident's right forearm.
-There was one circular fingertip size faded pale-yellow to light tan colored bruise on the inside of the residents right lower forearm.
-There was bright pink colored intact skin approximately 1/4th inch long on the inside of the residents right lower forearm.
-There were no bruising or injuries to the resident's left forearm.

Interview with a second MA on 08/11/22 at 1:15pm revealed:
-The fingertip sized bruises to Resident #10's right forearm were not normal for her.
-She did not know how long the bruises had been present on Resident #10's right forearm.

Interview with the SCC on 08/11/22 at 12:25pm revealed:
-It was policy for the SCC to immediately report to the Administrator any allegations of staff to resident abuse so the Administrator could investigate the allegation.
-Her main duty as SCC was to make sure staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 90	D 438		

were performing their roles as expected and resident care.
-A few weeks ago, a MA told her a PCA reported to her Resident #10 sustained skin tears to both forearms when Staff E was being "verbally bad and rough" with the resident.
-She told the MA to talk to Staff E about the allegation because she thought the MA meant Staff E was being loud with the resident.
-The MA did not tell her Staff E placed her hands on Resident #10.
-She did not report to the Administrator or investigate the allegation because she did not receive any other allegations of Staff E being rough with residents and she was busy with other duties.
-She did not examine Resident #10 to see if she had any injuries.
-It was difficult to perform her role as a SCC in addition to other duties assigned to her such as assisting in the Assisted Living facility.

Interview with the Administrator on 08/11/22 at 10:57am revealed:
-She was on leave from 07/18/22 to 07/26/22 and 07/29/22 to 08/01/22.
-She worked a few hours on 07/27/22 and 07/28/22.
-She was available for the facility 24 hours a day seven days a week even when she was on leave.
-The SCC was responsible for the operations of the facility when she was not in the facility.
-PCAs were to report allegations of resident abuse to the MA on duty, the MA was to report to the SCC, and the SCC notify the Administrator immediately.
-The SCC was to inform the MA to document a statement of the allegation.
-The alleged staff was to be suspended immediately (at that moment) from employment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 91	D 438		

pending an investigation.
-The MA told her on 08/04/22 a PCA reported to her Resident #10 sustained skin tears to both forearms after staff E grabbed and pulled at the resident's arms.
-She questioned the SCC and the SCC told her Resident #10's skin tears did not look like they were obtained from being grabbed.
-She did not report the allegation to HCPR because she terminated Staff E on 08/02/22 for shoving food in a resident's face on 07/30/22.
-She did not think she needed to report the allegation to HCPR because Staff E was no longer employed at the facility.
-She would have suspended Staff E on 07/29/22 pending an investigation if the SCC had notified her on 07/29/22 when she was told of the allegation.

Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable.

Attempted telephone interview with Resident #10's family member on 08/11/22 at 1:30pm was unsuccessful.

_____
The facility failed to report and investigate allegations of physical abuse by staff to the Health Care Personnel Registry (HCPR). Staff E was alleged to have grabbed and pulled at Resident #10's forearms on 07/29/22 causing skin tears approximately 3 inches long peeling the skin up towards the resident's elbow. The next day, the same staff allegedly shoved food in a resident's face and was terminated by the Administrator on 08/02/22 for that incident. The Administrator failed to report the 07/29/22 incident the HCPR. The facility's failure to report allegations of physical abuse to the HCPR placed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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 438	Continued From page 92 the residents in substantial risk of further serious abuse and physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. The CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2022.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the facility, which was licensed as a special care unit (SCU), for 6 of 9 shifts sampled on 07/25/22, 07/26/22 and 08/08/22. The findings are:	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 93 Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 85 memory care residents. Review of the facility's resident census report revealed the SCU census was 54 on 07/25/22 which required 54 aide hours on first and second shifts and 43.2 aide hours on 3rd shift. Review of staff timecards dated 07/25/22 revealed: -There was a total of 36.75 staff hours provided on second shift for a shortage of 17.25 hours. -There was a total of 31.75 staff hours provided on third shift for a shortage of 11.25 hours. Review of the facility's resident census report revealed the SCU census was 54 on 07/26/22 which required 54 aide hours on first and second shifts and 43.2 aide hours on 3rd shift. Review of staff timecards dated 07/26/22 revealed there was a total of 31.25 staff hours provided on third shift for a shortage of 11.75 hours. Review of the facility's resident census report revealed the SCU census was 55 on 08/08/22 which required 55 aide hours on first and second shifts and 44 aide hours on 3rd shift. Review of staff timecards dated 08/08/22 revealed: -There was a total of 41 staff hours provided on first shift for a shortage of 14 hours. -There was a total of 49.25 staff hours provided on second shift for a shortage of 5.75 hours. -There was a total of 41.5 staff hours provided on third shift for a shortage of 2.5 hours.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 94 Interview with a personal care aide (PCA) on 08/09/22 at 8:36am revealed: -She was scheduled to work in the sister facility today. -She had just arrived in the SCU facility because she was told to work there this morning. Interview with a medication aide (MA) on 08/10/22 at 3:14pm revealed: -Some days the facility did not have enough staff on duty. -The facility had enough employees; staff did not report to work which caused shifts to be short. -If staff worked their scheduled shifts the hours needed in the facility would be met. -She notified the Special Care Coordinator (SCC) when shifts were short. Interview Administrator was responsible for completing the schedule for staff. -She completed the schedule for staff when the ED was not available. -The normal schedule pattern for the facility was to have 2 medication aides and 4 to 5 personal care aides on duty for both shifts. -The supervisor was responsible to ensure assignment sheets were updated when staff did not report to work, and another staff came in to fill in a position. -She was not sure if the facility was short staffed on 07/25/22 because the assignment sheet was not completed. -It was possible the facility was short staffed on 07/25/22, 07/26/22 and 08/08/22. -The SIC was expected to call her when shifts were short. Interview with the Administrator on 08/11/22 at 8:28am revealed: -She and the SCC completed the schedule.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 95 -She scheduled staff according to the residents' census. -Staff were expected to call the SCC on the on-call phone when they were not planning to report to work. -She and the SCC attempted to find coverage when staff called out of work. -She had hired new staff, but it was difficult to keep new staff. _____ The facility failed to ensure the SCU was staffed to meet minimal staffing requirements for 6 of 9 shifts sampled resulting in being understaffed. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation._____ The facility provided a plan of protection in accordance with G.S. 131D-34 08/10/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022.	D 465		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 96 communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff not properly wearing personal protective equipment (PPE), a mask/ face covering while on duty in the facility. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in Assisted Living Facilities (ALF) updated 02/02/22 revealed: -Implement source control measures. Source Control refers to use of respirators or well-fitted facemasks or cloth masks to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. -Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 97	D 612		

-Health Care Personnel who are up to date with recommended COVID-19 vaccine doses should wear source control when they are in areas of the healthcare facility where they could encounter residents.

Review of the facility's COVID-19 Policy and Procedure for Infection Control dated 03/16/20 revealed:
-Use this policy with the recommendations of the CDC's Interim Infection Prevention and Control recommendations.
-Personnel should receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use and doff PPE in a manner to prevent self-contamination.

Review of the resident roster dated 08/09/22 revealed there were 54 residents residing in the facility.

Intermittent observations on 08/10/22 from 10:24am- 3:20pm revealed:
-There were 2 staff present in the hallway, 1 staff was not wearing a mask.
-A staff person came from the B- hall with her mask below her nose.
-Another staff person was coming from the A-hall walking toward the B- hall with her mask covering her chin. Her mouth and nose were not covered.
-At 3:10pm, staff was standing in the hallway without wearing a mask.
-Staff was at the nurses' station on B-hall not wearing a mask; staff saw surveyor and placed mask over her mouth, her nose was not covered.

Observations on 08/11/22 at 11:41am- 11:43am revealed:
-There was staff serving food to residents in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 98	D 612		

dining room, without wearing a mask.
-Another staff person prompted her to put on a mask, when they observed the surveyor making observations.

Interview with a medication aide (MA) on 08/10/22 at 3:25pm revealed:
-Staff did not wear mask in the facility.
-Staff were told on 08/09/22 they had to wear mask.

Interview with a personal care aide (PCA) on 08/10/22 at 3:27pm revealed:
-The facility provided mask.
-She knew she had to wear a mask.
-She did not know why she was not wearing a mask.

Interview with the Resident Care Coordinator (RCC) on 08/10/22 at 3:32pm revealed:
-Mask were provided at the front entrance.
-She expected staff to wear masks in the facility.
-Staff were trained and provided demonstrations on how to properly wear mask.
-When wearing a mask, staff were to ensure their mouth and nose were covered.
-It was important for staff to wear mask and have them on correctly to protect the residents and prevent the spread of COVID-19.

Telephone interview with the Local Health Department (LHD) on 08/11/22 at 10:21am revealed:
-Mask were worn to protect the staff and residents from spreading or contracting COVID-19.
-Mask were to cover the mouth and nose.
-She provided guidance to the facility on the correct use of wearing a mask (not sure of date).
-She provided guidance to the facility (not sure of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 99 date) because the sister facility was in outbreak status a few weeks ago. -She expected staff to wear mask, especially if they were less than 6 feet from a person. Interview with the Administrator on 08/11/22 at 8:12am revealed: -Staff had been trained on how to wear mask properly. -Staff should wear mask over their mouth and nose. -She always expected staff to wear mask in the facility. The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic as evidence by staff not wearing a mask/ face covering while on duty in the facility and not wearing a mask/ face covering properly. The facility's failure was detrimental to the health, safety and well-being of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 100 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 Housekeeping and Furnishings, Personal Care and Supervision, Health Care Personnel Registry, Special Care Unit Staffing and Infection Prevention and Control Program. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure it was free of hazards related to a broken glass exit door on A hall of a free standing special care facility. [Refer to Tag 0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide personal care according to the resident's care plan for 1 of 5 sampled residents (#2) related to toileting, dressing, and bathing. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on interviews the facility failed to report allegations of physical abuse to the Health Care Personnel Registry report within 24 hours of knowledge related to staff accused of causing	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 101 skin tears to a resident's forearms. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the facility, which was a special care unit (SCU), for 6 of 9 shifts sampled on 07/25/22, 07/26/22 and 08/08/22.[Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 5. Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff not properly wearing personal protective equipment (PPE), a mask/ face covering while on duty in the facility. [Refer to Tag 612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053030	A. BUILDING: _____ B. WING _____	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 102 reviews, the facility failed to ensure residents were free from mental and physical abuse. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure resident's rights were protected for 1 of 5 sampled resident (#6) who sustained bruising to both forearms during personal care services. [Refer to Tag 338, 10A NCAC 13F.0909 Resident Rights (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure supervision was provided for 3 of 6 sampled residents (#1, #3, #7) for a resident who eloped a free-standing Special Care Unit (#1); had falls, head injuries and a neck fracture, and a physical altercation (#7); and unwitnessed falls from the bed (#3). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914		