PRINTED: 09/26/2022

S I WE DINE	<u>1 of Health Service R</u> INT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		*	i Oitii	APPRO'
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G:	(X3) DAT COM	E SURVEY PLETED
**····		HAL099018	B. WING _	Ā.		R
NAME OF	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY	. STATE, ZIP CODE	09/	08/2022
PATRIO	LIVING OF YADKINV	ULLE 409 HAR	RISON AVE	NUE		
	·	YADKIN'	VILLE, NC 2	27055		
(X4) ID PREFIX TAG	I SEMON DEPICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A	인보스테 다 하는	(X5) COMPLE DATE
{D 000}	Initial Comments		(D.000)	DEFICIENCY)		
	The Adult Care Lice follow-up survey on	nsure Section conducted a 09/07/22 through 09/08/22. 1(d) Other Requirements	{D 000}	The following is the Plan Correction for Patriot Liv Yadkinville regarding the Statement of Deficiencie	ing of e s for the	Addition to the state of the st
	10A NCAC 13F .031 (d) The hot water sy provide an adequate kitchen, bathrooms, closets and soil utility temperature at all fix be maintained at a m (38 degrees C) and s	1 Other Requirements 1 other R	(D 113)	Follow up Survey comple 9/8/22. This Plan of Corr not to be construed as a admission of or agreeme findings and conclusions Statement of Deficiencies related sanction or fine. It is submitted as confirmation on going efforts to comply statutory and regulatory requirements. In this doctors	eted ection is n ent with the in the s, or any Rather, it ion of our	
T R fo	merviews, the facility emperatures for 1 fix esident was maintain fahrenheit (F) and 11 The findings are:  Review of the facility's or 09/01/22 through 0/ere water temperatures water available for residence available for the best 16 degrees F each data bservation of the batt 19/07/22 at 10:16am residence available for the batt 19/07/22 at 10:16am residence a	record reviews and failed to ensure hot water ture (sink) used by a ned between 100 degrees 6 degrees F.  Water Temperature Report 19/07/22 revealed there re checks conducted on and 09/06/22 on 6 faucets in and 5 residents' rooms that dent use and the tween 100 degree F and ay.		have outlined specific act response to identified issinave not provided a detail response to each allegatifinding, nor have we identified in mitigating factors. We remove the delivery health care services and continue to make change improvements to satisfy the objective.	tions in ues. We iled on or tified nain of quality will sand	

Reviewed and Acknowledged

Keisha Banks

10/20/22

Division	of Health Service R				FORM	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		SURVEY
		HAL099018	B. WING			R 08/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	l Osit	00/2022
PATRIO	LIVING OF YADKIN	VILLE 409 HARF	RISON AVE	NUE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ILLE, NC 2			
PRÉFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DRE	(X5) COMPLETE DATE
{D 113}	Continued From pa	age 1	{D 113}			
	faucet when the ho -The water temper sink.	t water was turned on. ature was 130 degrees F at the		D113	•	
	O9/07/22 at 10:19ar -The hot water at the She turned the fauthe left to let the war adjusted the temperature the middleShe had never been interview with the mat 10:17am revealeHe was provided a water temperatures Room #21 was not she had not checked the sink in Room #2 list to be checkedHe knew there was had not thought to coft the sink daily white temperatures at othe linterview with the M 09/07/22 at 10:31pn-All hallway bathroom bathrooms, and all pshould have had a very list of the sink daily white the did not know who the checked in Room mixing valve to the state temperature.	ne sink got very hot. Indeed on the sink all the way to exter get hot and then she reture by moving the faucet to en burned by the hot water. Inaintenance staff on 09/07/22 It is of fixtures where the needed to be checked and listed on the list. If the water temperature at the because it was not on the sea sink in Room #21, but he check the water temperature le checking water er faucets in the facility. In aintenance Director on In revealed: Instantante properature was water temperature check. In the water temperature was water temperature check. In the water temperature was in #21, but staff would install a sink in Room #21 to regulate		Maintenance technician install mixing valve to sink in Room # 9/7/2022 to regulate temperation 9/8/2022 recheck was completed Room #21 and said room was in regulation range.  Temperature checks on all sink accessible to residents will be performed no less than weekly Maintenance Technician and/or Designee. Out-of-range temperature will be reported immediately to Administrator and/or Designee adjust within range. Administrator and/or Designee to review wat temperature logs weekly for compliance. Completion date 9.	21 on ture. On ted on n ss by or ratures o the to ator er	
t	temperature in Roon There was a sign po	heck of the hot water n #21 on 09/08/22 revealed: psted on the bathroom sink				

AND PLA	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		SURVEY PLETED
		HAL099018	B. WING			R
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY	STATE, ZIP CODE	09/	08/2022
PATRIO'	T LIVING OF YADKINV		RISON AVE			
		YADKINV	ILLE, NC 2			
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIODE	(X5) COMPLETE DATE
.{D 113}	Continued From pa	ge 2	{D 113}		<del></del>	
	temperatures.	Water temperature was 108				
	1:41pm revealed: -Maintenance staff v temperatures at all f -Maintenance staff i water temperatures -She did not know ti #21 had not been ch 130 degrees F.	ad not reported any high hot to her. e water temperature in Room ecked daily and that it was		D273		
	This Rule is not met Based on observation reviews, the facility fareferral and follow up needs for 2 of 5 sample attention of the property who did not have a different and follow who did not have a different to the property who did not have a different to the property and the p	2 Health Care assure referral and follow-up nd acute health care needs	i i i i i i i i i i i i i i i i i i i	Facility shall ensure referrals an follow-ups meet routine and act health care needs of the resider utilizing implemented "order log Order logs will track orders from to completion to see that all order completed. Resident Care Coordend/or Designee will review Quitand the order log daily to ensure completion of all orders and track refusals. In service training with medication aides relative to completion, recording and reported services.	ute nts gs". n start ders are dinator ck Mar e ck order all	
L	3//19/22 revealed dia	#1's current FL2 dated gnoses included pelow knee amputation	C t r D	completed. The Resident Care Coordinator and/or Designee with he review of order logs and Quite ports to the Administrator and Designee weekly. Completion dangle 1/2/2022	ck Mar I/or	n na

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 409 HARRISON AVENUE PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY** (D 273) Continued From page 3 {D 273} Review of Resident #1's physician's order revealed there was an order to treat and evaluate by home health skilled nursing. Review of Resident #1's progress note dated 07/08/22 revealed: -Resident #1 was evaluated by a home health -There were instructions for wound care written by the home health nurse. -Both sites on the right BKA were cleaned with normal saline, xeroform was applied and wrapped -The left BKA was cleaned with betadine, covered with a dry dressing, and wrapped with gauze. Observation of Resident #1's in the hallway on 09/07/22 at 9:23am revealed: -Resident #1 was sitting on the floor. -There was a wound on his left leg that was uncovered. -Two staff assisted Resident #1 back into his wheelchair. Observation of Resident #1 on 09/07/22 at 1:48pm revealed a medication aide (MA) was placing a new bandage over the left leg wound. Interview with a MA on 09/08/22 at 3:30pm revealed: -She was not sure what Resident #1's wound care order was. -She was not sure how often the home health nurse came to the facility for Resident #1's wound -If Resident #1's dressing came off, she would check the eMAR system for the order and call the Resident Care Coordinator (RCC) for guidance. -Resident #1's dressing frequently came off, but she was not sure how the dressing came off.

Divis	on of Health Service R	egulation			FORM	D: 09/26/2022 MAPPROVED
STATE	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG:	(X3) DATE COM	E SURVEY PLETED
		HAL099018	B. WING		•	R 08/2022
NAME	OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CIT	Y, STATE, ZIP CODE		
PATRI	OT LIVING OF YADKINV	ILLE 409 HAR	RISON AVI VILLE, NC	ENUE		
(X4) II	SUMMARY STA	TEMENT OF DEGICIENOSES	1	······································		
PRÉFI TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD DE	(X5) COMPLETE DATE
{D 27	o i i i i i i i i i i i i i i i i i i i		{D 273}			
	-She had never see completely uncover	n Resident #1's wounds ed.				
	3:45pm revealed:  -The home health non 09/08/22 becaus non-compliant with a following a dressing -She thought the hor facility either every conductive do dressing changes -Resident #1 constates -Resident #1 tried to the dressing slide do -There were times was left uncovered for Sometimes a MA was	wound care immediately change, me health nurse came to the other day or twice a week to s. mes refused wound care. Intly pulled off his dressing, walk sometimes which made own. The Resident #1's dressing or a period of 3 or 4 hours. Duld do a dressing change alid remove the new dressing of the new dressin				
	-The bandages on his	ent #1 on 09/08/22 at 5:19pm				
	i wounds came on eas	Was changing his wound				
	-She or another nurse agency came to the fa Resident #1 twice a w -The initial wound can to clean the right BKA with normal saline, xe dressing.	ome health agency on evealed:  from the home health acility to do would care for				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING\_ HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) {D 273} Continued From page 5 {D 273} was to rinse with normal saline, xeroform, and wrap all wounds on both legs with kerlix gauze wrap. -When she came to the facility for wound care. Resident #1's wound care dressing was sometimes not in place. -Facility staff knew how to change Resident #1's dressing. -Facility staff was able to ask for more wound care supplies from the home health agency if needed. -Resident #1 would sometimes pull off his dressing. -Resident #1 was non-compliant with wound care. -Resident #1 walked on his legs even though he was not supposed to, which could dislodge the dressing and possibly open the wound. -Resident #1 liked to walk around sometimes even if his wound was uncovered. -The wounds had not improved recently. Interview with the RCC on 09/08/22 at 5:00pm revealed: -The home health nurse came out to the facility about every 3 days to change Resident #1's dressings. -Resident #1's dressings were supposed to stay on for about 3 days. -If the dressing was soiled, MAs were expected to put a new dressing in place if Resident #1 would allow them. -Resident #1 constantly pulled off his dressing. -The home health care agency had dropped Resident #1 from wound care on 09/08/22. Interview with the Administrator on 09/08/22 at 6:26pm revealed: -She was not aware there was a 4 hour time period on 09/07/22 where Resident #1's dressing on his left leg was not in place.

Division	of Health Service F	Regulation			FORM	1 APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:		E SURVEY PLETED
		HAL099018	B. WING			R 08/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY,	STATE, ZIP CODE	·*	
PATRIO*	T LIVING OF YADKIN		RISON AVEI ILLE, NC 2			
(X4) ID PREFIX TAG	1 (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
{D 273}	Continued From pa	age 6	{D 273}			
	-She expected stat Resident #1's would uncovered.	ff to put a new dressing over nd if they saw that it was				
	Attempted telephor primary care provid unsuccessful.	ne Interview with Resident #1's ler on 09/08/22 at 7:33am was	Marin - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -			
	08/22/22 revealed: -Diagnoses include with psychotic featu disorder, and chron -There was an orde	ent #2's current FL2 dated d bipolar disorder, depressed ures, borderline personality lic back pain. er for Levemir U-100 insulin (a lower blood sugar) 25 units		•		
	administration recording through 08/31/22 re -There was an entry 25 units twice daily: at 6:00am and 6:00 -There was docume Levemir 5 of 17 opp and 08/31/22, on 08 6:00am, 08/29/22 at 6	of for Levemir 100u/mL inject scheduled for administration pm. Intation Resident #2 refused ortunities, between 08/23/22 at 6:00pm, 08/30/22 at 6:00pm, 08/30/20 at 6:			To the state of th	
1 - X & B - LL &	through 09/07/22 rev There was an entry 25 units twice daily s at 6:00am and 6:00p There was document evemir 6 of 13 opposed and 09/07/22, on 09/	for Levemir 100u/mL inject cheduled for administration				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) {D 273} Continued From page 7 (D 273) 09/06/22 at 8:00am, and on 09/07/22 at 8:00am. -Resident #2's fingerstick blood sugars (FSBS) ranged from 102 to 222. Review of Resident #2's record revealed there was no documentation Resident #2's primary care provider (PCP) was contacted regarding refusal of medication. Observation of medication available for Resident #2 on 09/08/22 at 2:30pm revealed there was one opened pen and 3 unopened pens of levemir insulin on the medication cart. Interview with a pharmacist from the facility's contracted pharmacy on 09/08/22 at 10:17am revealed: -Resident #2 had an order for Levemir 25 units twice daily. -Levemir was dispensed to the facility on 08/22/22 in a quantity of 15 mL (5 pens). Interview with Resident #2 on 09/08/22 at 5:22 revealed: -She was diabetic and was administered insulin. -She refused her insulin in the morning when her FSBS was below 150 because her FSBS had gotten too low once before and she did not like the way it made her feel. -She may have refused insulin at other times if her FSBS was low. Interview with a medication aide (MA) on 09/08/22 at 2:32pm revealed: -Resident #2 was diabetic and was administered -If Resident #2 did not eat supper and her FSBS was low, she refused Levemir. -Resident #2 did not eat breakfast a lot and refused Levemir when she did not eat breakfast.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY	
			A. BUILDING		COV	COMPLETED	
		HAL099018	B. WING			R	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY	STATE, ZIP CODE		/08/2022	
PATRIOT	LIVING OF YADKIN	409 HAE	RISON AVEN	STATE, ZIP CODE			
		YADKIN'	VILLE, NC 27	IVE '055			
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID ID				
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS PERSONNELLA	ALCHOUR DE	(X5) COMPLETE	
				CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	DATE	
{D 273}	Continued From pa	age 8	(D 273)			<del> </del>	
l	-After a resident ref	fused medication 3 times, the	( =)				
•	MAs were to let the	Resident Care Coordinator					
1	(べいい)Know, and th	18 RCC Would contact the					
	residents primary c	are provider (DCD)	1				
	-one did not know i	f Resident #2's DCD had have					
Cont	contacted about her	r refusing Levemir.					
	Intonione with a sea	t	]				
	09/08/22 at 3:09pm	/personal care aide (PCA) on					
[	-If a resident refuse	revealed: d medication, the MA tried at					
leas	least 3 times to adm	o medication, the MA tried at initial	.			}	
١.	-bometimes the MA	Would get a different MA to					
[ 1	arrembr to saministe	€F the medication					
١.	-After 3 attempts to :	administer medication, the					
1 1	MA Marked the med	Cations as "refused"					
	imes the DOO	medication 3 consecutive					
	notified the resident's	ld be notified and the RCC				•	
	She did not know if	s PCP. Resident #2's PCP was					
r	notified of her insulin	refusals					
			1		ļ		
	nterview with the RC	C on 09/08/22 at 3:26pm			i		
[ 11	evealed:	i			Ī		
	18/22/22) and first on	w to the facility (admitted on			į		
-	The MAs were sunn	aw her PCP on 09/06/22. osed to notify her after a	[				
1 10	soluciil refused men	lication for 3 consociation					
- 4	ays and sile would r	10111V the resident's DCD	[				
, -,	THE WAS HED BOT LET	corted to her that Resident					
117	z jejusea Levemir.						
-r	nad the MAs notified	her Resident #2 refused	1		1		
n.	evernir, she would h	ave sent an electronic					
111	ouncation to Resider	nt#2's PCP and left a			ļ	İ	
vi	sited the facility.	er to review when she	1			[	
-8	he was responsible	for reviewing eMARs				ł	
m	onthly, but she had	not had an opportunity to	Ī		,		
1.23	CAIGM LAGSIDEUS #5.8	eMARs yet because she				Ì	
Wa	as a new resident.	Jer sepade Sile					
1					· ·		

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {D 273} Continued From page 9 {D 273} Interview with Resident #2's PCP's supervisor physician on 09/08/22 at 11:04am revealed: -He was not aware of Resident #2 refusing Levemir. -His assistant saw Resident #2 on today (09/08/22) and was not notified of Resident#2 refusing Levemir. -He would have to check with the nurse practitioner, Resident #2's PCP, and check messages to see if the facility contacted the PCP regarding Resident #2 refusing Levemir. Interview with the Administrator on 09/08/22 at 4:56pm revealed: -After a resident refused medication for 3 days in a row, the MAs should have informed the RCC and the RCC should have notified the resident's PCP. -The MAs should have made contact with the resident's PCP if the RCC was not available. D310 -She knew Resident #2 refused Levemir, but she did not know Resident #2 had refused Levemir as many times as she had. Facility to have dietary staff re-trained -She did not know staff had not followed up with on modified diets and texture Resident #2's PCP regarding her refusing consistencies by facilities food service Levemir. vendor. In-service training will be D 310 10A NCAC 13F .0904(e)(4) Nutrition and Food D 310 completed twice a year with all dietary Service staff and online training will be provided throughout the year. Resident 10A NCAC 13F .0904 Nutrition and Food Service Care Coordinator/and or Designee to (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional review special diet report and monitor supplements and thickened liquids, shall be order log to ensure all diet orders are served as ordered by the resident's physician. being followed. Administrator and/or Designee to review diet orders and view the presentation for at least one meal

weekly. Completion date 11/02/2022.

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R B. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 310 Continued From page 10 D 310 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record observations, record reviews, and interviews, the facility failed to ensure a therapeutic diet was served for 1 of 1 sampled resident (#4) with an order for a no concentrated sweets (NCS), pureed diet with no bread. The findings are: Review of Resident #2's current FL2 dated 05/24/22 revealed: -Diagnoses included vascular dementia, cerebral infarction, essential hypertension, below the knee amputation, and diabetes mellitus. -There was an order for a no concentrated sweets (NCS)/puree diet with no bread and thin liquids. Review of Resident #2's diet order dated 05/24/22 revealed an order for a NCS/puree diet with thin liquids. Review of Resident #2's diet order dated 07/19/22 revealed an order for a NCS/puree diet with no bread. Review of the facility's therapeutic diet list on 09/07/22 posted in the kitchen revealed Resident #4 was to be served a NCS, puree diet with no bread. Review of the facility's therapeutic menu for a NCS diet for the lunch meal on 09/07/22 revealed Resident #4 should have been served hamburger steak, roasted potatoes, broccoli florets, dinner roll, reduced calorie dessert, reduced calorie

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ COMPLETED R HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 310 Continued From page 11 D 310 beverage, and water. Review of the facility's therapeutic menu for a puree diet for the lunch meal on 09/07/22 revealed Resident #4 should have been served pureed ground hamburger steak, pureed roasted potatoes, pureed broccoli florets, pureed dinner roll, pureed cake, beverage, and water. Observation of Resident #4's lunch meal service on 09/07/22 at 12:11pm revealed: -Resident #4 began coughing during his meal. -Resident #4 had been served a bowl of a white pureed food item, a bowl of a thick, chunky green food item, and a bowl of a thick brown meat like food item, and ice cream. -Resident #4 was eating the green food item and the meat-like food item with a fork. -After Resident #4 began coughing, a personal care aide (PCA) went over to him, patted him on the back, told him to spit the food out onto a plate, and told him to slow down. Interview with the PCA on 09/07/22 at 12:19pm revealed: -Resident #4 put so much food in his mouth and tried to swallow it all at once. -Resident #4 got choked pretty much every day. -Sometimes the consistency of Resident #4's food was very thin and sometimes it was much thicker. -She though Resident #4 choked on his food because he ate too fast. -Resident #4 choked mostly when he ate meats; meats looked like they were mashed rather than pureed. Interview with the Resident Care Coordinator on 09/07/22 at 12:13pm revealed: -Resident #4 was supposed to be served a

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D 310	Continued From pa	ge 12	D 310	1000	• /		
		90 12	10310				
	pureed dietThe lunch meal the did not look pureed.	the was served on 09/07/22					
	Interview with a med 09/08/22 at 3:04pm	dication aide (MA) on					
	-Resident #4 had ph meal.	ysician's orders for a pureed					
	observed Resident #	dining hall when needed and 44 choked when served a					
	100g,	e he rushed while eating his					
	-rureed meals shou pudding.	ld have looked like rice or					
	Interview with a PCA revealed:	on 09/07/22 at 5:36pm					
	lwice a day.	d with his meals at least					
1	too quickiy.	ked because he ate his food					
	-one inought Reside consistency for a pur	nt #4 received the correct ee diet.					
	b:40pm revealed:	n the RCC on 09/07/22 at					
	The dietary manage preparing puree mea served as ordered.	r (DM) was responsible for Is and ensuring they were					
-	She thought the DM	worked with a dietician					
	The PCP changed R	esident #4's diet order to					
y d	vhen, because Resid liet.	ent #4 refused a pureed					
į d	liet as he coughed ar	ot tolerate a mechanical soft and choked with his meals.,					
S	o the PCP changed I	his diet back to puree.			İ		
-;	ouine of Kesident #4	's lunch food items looked	.				
	nore mechanical soft th Service Regulation	man they did pureed.	1				

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED . IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_ B. WING HAL099018 09/08/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 310 D 310 Continued From page 13 Interview with Resident #4 on 09/08/22 at 8:42am revealed: -He was on a pureed diet because it was hard for him to chew his food. -He got choked sometimes when he ate his food. -When he got choked on his food, staff patted him on the back until he stopped coughing and gave him a drink of water. -He thought all food items were pureed for his meals. Interview with Resident #4's PCP's supervising physician on 09/08/22 at 11:04am revealed: -Resident #4 was seen by the nurse practitioner. -If Resident #4 had an order for a pureed diet and was not served according to the order, he would be at risk for aspiration or a mechanical blockage. Interview with the DM on 09/08/22 at 11:41pm revealed: -Resident #4 was served hamburger helper, peas, mashed potatoes, and ice cream for the lunch meal on 09/07/22. -Resident #4 was not allowed to have bread according to his diet order. -He pureed all of Resident #4's food using a food blender and water. -He pureed the food at the kitchen shared with the sister facility and there was not a blender available in the kitchen in the facility. -He realized the pureed hamburger helper was thick when he got to the facility; he thought the pureed noodles absorbed the moisture. -He was not sure why other food items were thick or chunky. Interview with the facility's contracted speech therapist on 09/08/22 at 1:05pm revealed: -She did not currently have Resident #4 has a

Division of Health Service Regulation

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			IAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
D 310	Continued From page	ge 14	D 310		-,	<u> </u>
	patient, but she was at the facility.	working with other residents				
	-She observed the r	prepared texture modified				
	Trous, including the	puree meals, and they were				-
	Properties compactive				•	
3	VII VVIVIIAA 0110 1116	hotos of lunch meal prepared photo of the (pureed)			,	
	nginonidel Velber, #	ie hamhurger halman				
	pureed and resemble	ed more of a ground texture.				
	Interview with the Ad	ministrator on 09/07/22 at				
	o topin evesien				- Angeles - L	
	- i ne DIVI was respon	sible for preparing meals				
, ,	HOU WICK DIDERS.	ts were served according to				
-	She did not know for	od items served to Resident			Į	
1.7	La Maia Hot selveu M	rith a pureed consistency. pureed consistency should				
1 1	ior pe too fillii Ot f00 .	TDICK				
~	A corporate consulta	nt trained the DM on				
-	The DM manager are	iding texture modified diets;	}	•	1	
1 14	Pydrumy inerabeutic	diets including texture	- ]		į	
1 11	ivallied diets.					
р	ureed as ordered.	ent #4 to be served his meal				
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170	he facility failed to en	sure a therapeutic diet was	1		į	
~~	a voa de videieu iu s	resident (Resident #4) pureed food and was			ļ	
450	a ved lood items that	Were not at a nuroed				
, 00	a respectively leadiffuld it	The resident coughing				
u.	uma medi setvice wr	IICh Cosid requit in the				
1 """	- Traini, Salety and v	s failure was detrimental to velfare of Resident #4			į	
wh	ich constitutes a Typ	e B Violation.				
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1 444	e facility provided a poordance with G.S. 1	olan of protection in 31D-34 on 09/07/22 for				
thic	violation.	VT OII US/U/122 TOF	i		ſ	

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		N DATE FOR THIS TYPE B L NOT EXCEED OCTOBER				
D 338	10A NCAC 13F .09	909 Resident Rights	D 338			
	An adult care home all residents guara Declaration of Res	909 Resident Rights e shall assure that the rights of nteed under G.S. 131D-21, idents' Rights, are maintained sed without hindrance.		D338 The facility shall assure that the of all residents which are guarunder the "Declaration of Resi Rights" are maintained and ex	anteed dent's	
	This Rule is not m TYPE B VIOLATIO	net as evidenced by: ON		without hindrance. The facility a doorbell on each side of the	front	
	failed to ensure res related to providing residents to go out	tions and interviews, the facility sident rights were maintained g unrestricted access for all tside of the facility when they residents to smoke when they		door, with distinct sounds, wh indicate to staff whether a reswants in or out. This will allow residents the freedom to comout as they desire. Staff was truthe importance of responding	ident the e in and rained in	
	The findings are:			residents' requests on 10/14/2 Resident Care Coordinator and	2022. The	
		lity's census report updated on a census of 44 residents.		Designee will ensure residents to exercise their rights as requ	are able	
	9:15am and 5:15p	e facility on 09/07/22 between om revealed:		Completion date 10/14/2022		
	the left hall of the t	aned glass doors at the end of facility. ors was a sign that read: "Patio				
	closed due to repa				:	
	the door will be op	pen for you to go out and 0:00am, 11:30am-12:00pm,				
		4:30pm, 5:00pm, 7:30pm 0pm-10pm. Any other time you				

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AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DAT COM	E SURVEY IPLETED
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D 338	Continued From pa	ge 16	D 338			
	the medication aide (PCA) are busy, the possible.  -There was a deck of glass doors and the missing throughoutThere were weeds the holes where son and the some of the 4 feet above the leveThere was a fence fence door had beer -There was also a si the inside of the doo facility and on the do -The scheduled on ti the medication room	that had grown up through ne of the boards were missing weeds had grown up at least el of the deck. around the deck and the removed.  moking schedule posted on at the entrance of the por of the medication room, he doors at the entrance and included third shift times as 100pm, 11:30pm-12:00am.				
	revealed: -The residents could certain timesThe residents could they wanted to in bet -Residents used to b back patio to smoke, repairs for about eight-staff were not alway outside to smoke at the door to go outside the door to go outside the counter of the lot of the servation of the lot or revealed:	s available to let residents he set times. s had to wait for staff to open				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 8. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 338 Continued From page 17 D 338 area waiting to be let outside by staff to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 9:30am). -At 1:15pm, there were 4 residents waiting in the lobby to go outside to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 2:30pm). -At 1:43pm, there were 9 residents in the lobby entrance of the foyer area waiting to be let outside to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 2:30pm). -At 1:45pm, residents were let out of the facility by staff. Interview with 2 residents on 09/08/22 at 1:15pm revealed: -The residents were waiting in the lobby area to be let out of the facility by staff. -The last smoke break for the residents was from 11:30am to 12:00pm, before lunch, and the next one was not until 2:30pm. -Residents usually waited in the lobby area for a long time until the staff opened the front door at the scheduled smoke times. -A resident stated he did not smoke, but he liked to sit outside; "I had more freedom living on the streets." Observation of the area outside the front of the facility on 09/08/22 between 1:45pm and 2:30pm revealed there were 12 residents outside of the facility and 2 of the residents were not smoking. Interview with a third resident on 09/08/22 at 1:46pm revealed: -"Thank you ma'am for helping us to get out to -She had been out for a smoke break at 11:30am on 09/08/22, but she had to come back in at

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1	12:00pm for lunch.		D 000			]	
	-Residents revally	had to wait 2 hours after lunch				Ì	
	to go outside to sm	oke, but the staff let them out					
ľ	early today.	one, but the staff let them out					
.	-The staff had to let	residents out to smoke					
	because the doors	to the facility were locked and	}				
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į <b>(</b>	2001 and smoke any	Time they wanted too					
*-	vergings the 2lde GO	Of Staved unlocked					
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"	wosed the deck; les	dents were fold the dock was	]		1		
18	joing to be repaired.	İ			-		
ı İ	nterview with a fourt	h resident on 09/08/22 at			į		
1 1	:04pm revealer:	1	1				
	He thought residents	should have been able to	İ		1		
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4.55	440 MACH ANIS IO 00	Oli to emoka when he			1		
W	anted to and come i	pack in when he wanted to.					
In	terview with a fifth re	esident on 09/08/22 at					
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-S	he loved being able	to go out on the side deck,					
	van ir was opetti ped	cause she could go outside					
1 461	ion and wallten to:				Ī		
-Si	he hated having to v	vait for certain times to go	-		J		
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-If	she just wanted to g	o outside to get some					
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PATRIOT	LIVING OF YADKINV	ILLE YADKINV	ILLE, NC 2	7055	
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D 338	-Smoke breaks we 11:30am, 2:30pm, and each smoke brown and each smoke brown and each smoke brown and each smoke brown and each smoke and each was deck where resider they wanted toStaff sometimes the being able to smoke a stold once to bed, she would reside they wanted to bed, she would resident good to be on the did not like was scheduleThe door to the sire residents could go they wanted toThe side door was months ago to repaired yetHe liked when the unlocked for reside was like having free-Now the residents when they wanted smoking, because facility were locked to let them outside	re at 6:30am, 9:30am, 4:30pm, 6:30pm, and 9:30pm reak lasted 30 minutes, ing to wait to go outside and c out when she wanted to. c once unlocked and led to a nts could go outside any time hreatened residents with not e. c by staff that if she did not go not get to go out to smoke.  Ith resident on 09/08/22 at utside. iting to go out to smoke on a de deck was once unlocked so outside to smoke any time s blocked off to residents a few air the deck and it had not been c door to the side deck was ents to go outside because it			
	2:10pm revealed: -He smoked, but h times to go outside smoke at the time.	eventh resident on 09/08/22 at the had to wait until smoking the even if he did not want to mad because he could not go			
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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 338 Continued From page 20 D 338 outside when he wanted to. -It made him feel like a kid. Interview with an eighth resident on 09/08/22 at 2:11pm revealed: -Today after lunch, residents were let out early for their smoke breaks. -Usually residents had to wait 2 hours after lunch to go outside to smoke. -She got a little edgy having to wait. -It was not fair having to wait because there were 1 or 2 people who were allowed outside any time they wanted to be outside. interview with a ninth resident on 09/08/22 at 2:12pm revealed: -Staff "hung cigarettes over their heads" by threatening to take away residents' smoke breaks. -There were not enough cans for cigarette butts outside so residents had to throw their butts on the ground. -Staff went outside to smoke any time they wanted to, and it made her feel like she was 2 years old having to wait until a certain time to go outside. Observation of the facility on 09/0/22 at 2:55pm -A resident asked a personal care aide (PCA), who was sitting at the staff desk, to be let out of the front door. -The PCA responded to the resident, "When I'm done with this, I will let you out." Interview with a medication aide (MA) on 09/08/22 at 2:54pm revealed: -Residents were going out on the deck at the side of the facility to smoke. -The deck was falling apart and was a hazard to

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	Division of Health Service Regulation  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
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D 338	the residents.  -The deck had bee for repairs.  -All the other doors could only be open the residents were asking schebecause after the owere asking every was taking the MA 15-minute medicat.  -The corporate offi quotes for repairs; completed yet.  -Residents went outsident was let outsident was let outside, the resident scheduled smoking residents outside.  -Residents completimes and not bein when they wanted residents had stately were in a priscould not smoke with the could not smoke with	in the facility were locked and ed with a code, and none of supposed to have the code. Edule was implemented deck was closed, the residents 5 minutes to go outside, and it is an hour to complete a ion pass. It is an an every two hours, sidents out to smoke between oking hours because when one it, all of them wanted to go out. It is moke and just wanted to go not had to wait until the grimes to go outside so would not try to push their way alined daily about the smoke to, ated to her that they felt like on and it was not fair that they when they wanted to.  I facility on 09/08/22 at 3:04pm a medication aide (MA) for a				
Division of I	Interview with a M	A/PCA on 09/08/22 at 3:09pm				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 409 HARRISON AVENUE PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 338 Continued From page 22 D 338 revealed: -Residents were caught smoking in the facility and were put on restrictions. -Staff held the residents' cigarettes so staff could make sure they were smoking outside instead of in the facility. -Residents were let out of the facility to smoke every 2 hours for 30 minutes each time. -She let them outside between the scheduled times if she had time to. -Residents asked to go outside all day every day. -The scheduled smoking times were put in place because staff were not able to get anything done except for letting residents outside and letting them back inside. -Some residents complained to her, but she reminded them of the scheduled times. -There used to be a deck where residents could go outside when they wanted to and the door to the deck stayed unlocked. -The deck had been closed before she began working at the facility in May 2022. -The facility was currently getting quotes to get the deck fixed. Interview with a PCA on 09/08/22 at 3:20pm revealed: -On day shift, there were certain times residents could go outside. -Residents were let out 30 minutes before meals and then they had to wait 1 to 2 hours after meals for the next smoke break. -Residents were constantly hounding staff to let them outside. -Residents asked her to go outside to smoke prior to the scheduled time and she told them she could not; she could only let them outside during the scheduled times. -The scheduled times were to ensure that residents were administered their medications

Division of Health Service Regulation

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL099018 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 338 Continued From page 23 D 338 before they went outside. Interview with the RCC on 09/08/22 at 3:26pm revealed: -Residents were on a smoking schedule. Smoking was a privilege and not a necessity. -MAs and PCAs were not able to get anything done because residents kept asking them to go outside to smoke. -Residents got really mad because they wanted to go outside when they want to. -Residents used to go out on the deck on the side of the facility to smoke, but the deck had been closed off since May or June 2022 due to needed repair. -There were boards in the deck that had been pulled up and there were weeds growing up through the deck that needed to be cut. -Residents always complained about not being able to go outside and have stated to her that going outside was their freedom. -She expressed resident and staff concerns to management and management stated that the deck would be fixed. Interview with the Maintenance Director on 09/08/22 at 5:49pm revealed: -The deck on the side of the facility was closed off so residents could not go out the side door; the deck needed repairs. -He had only worked at the facility for a month and the first thing he was asked to do was to look into getting quotes to repair or replace the deck. He provided quotes to the corporate office. -The last time he spoke to someone at the corporate office, he was told they decided not to rebuild the deck. -The plan was to pour a concrete slab and fence the area in. -He was told there was someone who would

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	them to come out to	-				
	4:56pm revealed; -She was aware of the for residents.	dministrator on 09/08/22 at the scheduled smoking times				
en en en en en en en en en en en en en e	did not fall right afte	and smokers usually wanted				
	-She would look at they could be more	he smoking times and see if accommodating for residents. had issues with the				
	<ul> <li>The residents comp when the deck would</li> <li>She had been in dis</li> </ul>	plained all the time and asked d be fixed. cussions with corporate				
	facility fixed so the s alleviated.	he deck on the side of the moking issues could be add not want to rebuild the				Ç
	deck, but they wante	d to redo the whole side area lere residents could gather	·			TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TANKA TA
	-The corporate office and working on a site side of the facility.	had been getting estimates e plan for the area on the				
-	for residents to go or or to smoke except a resulted in residents feeling like children, a was compromised. T	provide unrestricted access atside of the facility for leisure at scheduled times which becoming edgy, mad, angry, and feeling like their freedom this failure was detrimental to dents and constitutes a Type	The state of the s			
	The facility provided a accordance with G.S	a plan of protection in 131D-34 on 09/08/22 for				

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this violation.  THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2022.  (D 358)  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 medications as ordered for 2 of 2 residents (#5, #6) observed during the medication pass including errors with an antidepressant medication (#8) and errors with crushing medications that should not be crushed (#5); and for 1 of 5 sampled residents (#1) for record review including errors with an as needed order for fast acting insulin.  The findings are:  1. The medication error rate was 9.6% as evidenced by the observation of 3 errors out of 31 opportunities during the 8:00am medication pass on 90908/22.	PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROP	ree !	COMPLETE
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a. Review of Resident #6's current FL2 dated  Completion date 10/20/2022		(a) An adult care he preparation and adm prescription and nor by staff are in accord (1) orders by a licen which are maintaine (2) rules in this Sect and procedures.  This Rule is not met Based on observation reviews, the facility framedications as order #6) observed during including errors with medication (#6) and medications that sho for 1 of 5 sampled rereview including error for fast acting insulin.  The findings are.  1. The medication errevidenced by the obsopportunities during the open open open open open open open ope	eme shall assure that the ininistration of medications, in-prescription, and treatments dance with: used prescribing practitioner d in the resident's record; and tion and the facility's policies as evidenced by: ins, interviews, and record alled to administer red for 2 of 2 residents (#5, the medication pass an antidepressant errors with crushing uld not be crushed (#5); and sidents (#1) for record re with an as needed order for rate was 9.6% as ervation of 3 errors out of 31 he 8:00am medication pass	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Facility will ensure preparation a administration of medication, prescription and non-prescription treatments by staff are in accord with: (1) orders by licensed prescriptioner which are maintained the resident's record; (2) rules in section along with the facilities pand procedures. Medication aide be re-trained in medication administration rules, policies and procedures, by RN Consultant on 10/20/22. New medication aides trained on facility policies and procedures and obtain required certifications before administering medication/treatments. Resident Coordinator and/or Designee to observe at least one med pass we at random, review MARS weekly a random, and monitor for non-compliance and re-train as necessically administration and re-train as necessically.	n, and ance cribing od in this olicies s will will be Care ekly	
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		bipolar disease (GEF bipolar disorder. -There was an order take 1 tablet daily.	d diabetes, gastroesophageal RD), anxiety disorder, and r for desvenlaxafine ER 50mg					
		-The medication aid scanned Resident #I electronic medication (eMAR)The MA scanned detected the eMAR.	e (MA) prepared and 6's medications into the n administration record esvenlaxafine ER 50mg into			:   		
		-Desvenlaxafine ER administered on the administered to Resimedication passThe MA prepared ar medication tablets to -The MA should have	dent #6 during the					
		there was one desver pack medication card there were 19 of 28 ta Attempted telephone	interview with the MA				A CONTRACTOR OF THE PROPERTY O	
		Attempted interview wat 5:17pm unsuccessf	ith Resident #6 on 09/08/22					
		merview with the Res	ident Care Coordinator				8	

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING\_ 09/08/2022 HAL099018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {D 358} {D 358} Continued From page 27 (RCC) on 09/08/22 at 5:15pm revealed: -She expected MAs to administer medications as ordered. -The MAs were responsible for ensuring that Resident #6's desventaxafine was administered as ordered. Interview with the Administrator on 09/08/22 at 6:25pm revealed: -She expected MAs to administer medications to the residents as they were ordered by the provider. -She was not aware that desvenlaxafine was not administered to Resident #6 during the medication pass even though it was documented as administered. -The MAs were responsible for ensuring that Resident #6's desventaxafine was administered as ordered. Attempted telephone interview with Resident #6's mental health provider on 09/08/22 at 8:07am unsuccessful. b. Review of Resident #5's current FL2 dated 05/24/22 revealed: -Diagnoses included arthritis, hearing loss, traumatic brain injury, vascular dementia, and major neurocognitive disorder due to multiple etiologies. -There was an order for aspirin EC (enterio coated) 81mg take one tablet daily. Observation of the medication pass for Resident #5 on 09/08/22 at 8:36am revealed: -The medication aide (MA) prepared and scanned Resident #5's medications into the electronic medication administration record (eMAR).

Division of Health Service Regulation

-The MA crushed the aspirin EC 81mg tablet,

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING; \_ COMPLETED HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {D 358} Continued From page 28 {D 358} placed the crushed tablet in applesauce and administered the applesauce to Resident #5 at 8:36am. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for aspirin EC 81mg, take 1 tablet once daily scheduled at 8:00am and "do not crush" was listed on the eMAR entry. -There was documentation aspirin EC 81mg was administered on 09/08/22 during the 8:00am hour. Observation of the medications on hand for Resident #5 on 09/08/22 at 8:30am revealed that there was one aspirin EC 81mg bubble pack medication card dispensed on 09/02/22 and there were 19 of 28 tablets that remained. Attempted telephone interview with the MA observed during the medication pass on 09/08/22 at 11:24am was unsuccessful. Interview with a second MA on 09/08/22 at 10:50am revealed: -She was aware that aspirin EC was not supposed to be crushed. -She crushed most of Resident #5's medications that were able to be crushed. -Resident #5 was able to swallow a few whole tablets at a time. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/08/22 at 10:25am revealed: -Aspirin EC could not be crushed.

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crushed and admin -The order for asplichanged to a chew would be able to be interview with Resignation of the would not experif aspirin EC was crule thought that as effective if it was crulaterview with the R (RCC) on 09/08/22 -If the medication of she would expect the medicationsThe MAs were resignation as the worder of the medications.	istered, rin EC tablets could be able aspirin tablet and then it crushed.  dent #5's primary care or physician on 09/08/22 at act there to be any side effects ushed and administered. pirin EC would be less ushed and administered.  desident Care Coordinator at 5:16pm revealed: rder indicated "do not crush," he MAs not to crush those				
Interview with the Ad 6:26pm revealed: -She was not aware and administered to medication passShe expected MAs the residents as the providerThe MAs were resp. Resident #5's aspiritordered.  c. Review of Reside 05/24/22 revealed the first fir	dministrator on 09/08/22 at that aspirin EC was crushed Resident #5 during the to administer medications to y were ordered by the consible for ensuring that in was administered as at there was an order for				
	PROVIDER OR SUPPLIER T LIVING OF YADKINY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa -Aspirin EC may no crushed and admin -The order for aspir changed to a chew would be able to be Interview with Resic provider's supervise 11:04am revealed: -He would not expe if aspirin EC was cr -He thought that as effective if it was cr Interview with the R (RCC) on 09/08/22 -If the medication or she would expect if medicationsThe MAs were resi Resident #5's aspirin ordered.  Interview with the A 6:26pm revealed: -She was not aware and administered to medication passShe expected MAs the residents as the providerThe MAs were resi Resident #5's aspirin ordered.  c. 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Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed: -If the medication order indicated "do not crush," she would expect the MAs not to crush those medicationsThe MAs were responsible for ensuring that Resident #5's aspirin EC was administered as ordered.  Interview with the Administrator on 09/08/22 at 6:26pm revealed: -She was not aware that aspirin EC was crushed and administered to Resident #5 during the medication passShe expected MAs to administer medications to the residents as they were ordered by the providerThe MAs were responsible for ensuring that Resident #5's aspirin was administered as ordered.  c. Review of Resident #5's current FL2 dated 05/24/22 revealed that there was an order for potassium ER (extended release) 20mEq take 1	NOF CORRECTION  (X1) PROVIDER SUPPLIER  HALOSPO18  B. WING  PROVIDER OR SUPPLIER  T LIVING OF YADKINVILLE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  -Aspirin EC may not be as effective if it was crushed and administered.  -The order for aspirin EC tablets could be changed to a chewable aspirin tablet and then it would be able to be crushed.  He would not expect there to be any side effects if aspirin EC was crushed and administered.  He would not expect there to be any side effects if aspirin EC was crushed and administered.  He thought that aspirin EC would be less effective if it was crushed and administered.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed:  If the medication order indicated "do not crush," she would expect the MAs not to crush those medications.  -The MAs were responsible for ensuring that Resident #5's aspirin EC was administered as ordered.  Interview with the Administrator on 09/08/22 at 6:26pm revealed:  -She was not aware that aspirin EC was crushed and administered to Resident #5 during the medication pass.  -She expected MAs to administer medications to the residents as they were ordered by the provider.  -The MAs were responsible for ensuring that Resident #5's aspirin was administered as ordered.  C. Review of Resident #5's current FL2 dated of 05/24/22 revealed that there was an order for potassium ER (extended release) 20mEd take 1	NO FORRECTION  ALBURDANCE:  HALO99018  ALBURDANCE:  HALO99018  BERNIFICATION NUMBER:  HALO99018  BERNIFICATION NUMBER:  HALO99018  STREET ADDRESS, CITY, STATE, ZIP CODE  409 HARRISON AVENUE YADKINVILLE, NC 27085  SUMMARY STATEMENT OF DEFICIENCIES  LEACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 29  Continued From page 29  Aspirin EC may not be as effective if it was crushed and administered.  The order for aspirin EC tablets could be changed to a chewable aspirin tablet and then it would be able to be crushed.  Interview with Resident #5's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed:  He would not expect there to be any side effects if aspirin EC was crushed and administered.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed:  He thought that aspirin EC would be less effective if it was crushed and administered.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed:  -The MAs were responsible for ensuring that Resident #5's aspirin EC was administered as ordered.  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Review of Resident #5's current FL2 dated 05/24/22 revealed that there was an order for potessium ETR (extended release) 20/EME take 1	ANY OF PERCENCIES  OF CORRECTION  OF PROVIDER OR SUPPLIER  ABUILDING:  HAL 099018  STREET ADDRESS, CITY, STATE ZIP CODE  409 HARRISON AVENUE  YADKINVILLE, NC 27055  SUMMARY STATEMENT OF DEPICIENCIES  IN CONTROL OF STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  IN CONTROL OF STATEMENT OF DEPICIENCIES  IN CONTROL OF STATEMENT OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS  ID PROVIDERS PLAN OF CORRECTION  PROVIDERS PLAN OF CORRECTION  PROVIDERS  ID PROVIDERS  PROVIDERS PLAN OF CORRECTION  PROVIDERS  PROVIDERS PLAN OF CORRECTION  PROVIDERS  DEPOCRATION  PROVIDERS  PROVIDERS PLAN OF CORRECTION  PROVIDERS  PROVI

SIAIENI	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(1/0)		1 310	MAPPROV
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	(A2) MULTIP A. BUILDING	LE CONSTRUCTION ::	(X3) DAT COM	E SURVEY IPLETED
<del></del>		HAL099018	B. WING			R
NAME OF	PROVIDER OR SUPPLIER	STREET	DDDCDQ ASS.		09/	08/2022
PATRIO <sup>®</sup>	T LIVING OF YADKIN\	ALLE A09 HAD	DURESS, CITY, RISON AVEN	STATE, ZIP CODE		
		YADKIN	/ILLE, NC 27	IUE 1056		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFINITIONS	ID ID			
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO	ON SHOULD BE	(X5) COMPLE DATE
(D 358)	Continued From pa	ge 30	{D 358}	DEFICIENCY	0	
	Observation of the r #5 on 09/08/22 reve	medication pass for Resident	( 555)			
	-The medication aid	e (MA) prepared and				
	Scallied Kesident #	5's medications into the				
	electronic medicatio (eMAR).	n administration record			:	
	-The MA crushed the	potassium ER 20mEq				
	rantar bidoen lije til	ISDEC ISDICT IS CONTRACT.				•
- 1	and administered the at 8:36am.	⇒ applesauce to Resident #5				
	Review of Resident #	#5's September 2022 eMAR				
1	i w s wellery,	<b>.</b>				
] •	There was an entry:	for potassium ER 20mEq,				
١,	rave i rabier duce da	ily scheduled at 8:00am and sted on the eMAR entry.				
1 -	There was documen	Itation that notes sium CD	Ì		1	
! ~	20mEq was administi 3:00am hour.	ered on 09/08/22 during the				
.	2.00d()( )[0U].					
	Observation of the me	edications on hand for	1			
, r	resident #5 on 09/08	/22 at 8:30 am royania - 145				
,	TO STOCK TO THE THE THE	ium ER 20mEq bubble pack ensed on 09/02/22 and there				
V.	ere 19 of 28 tablets	that remained.	f			
Α	ttempted telephone i	nterview with the MA				
, 0,	pactage antille fue M	BOIDSTON NOOS OF DOMONOS				
a	11:24am was unsuc	cessful.				
ln	terview with a second	d MA on 09/08/22 at				
116	rovam revealed.					
	~~···~~,	otassium ER should not be				
-S   the	he crushed most of I at were able to be cru	Resident #5's medications				
-R	esident #5 was abla	to swallow a few whole				
tal	olets at a time.	Andriow a rew muole				
Ва	sed on observations	, interviews, and record				
of Health	Service Regulation	orriews, and record				

Division	<u>of Health Service Re</u>	gulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` `	E CONSTRUCTION	(X3) DATE S COMPL	
		HAL099018	B. WING		09/08	3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		409 HARI	RISON AVEN	UE		
PAIRIOT	LIVING OF YADKINV	ILLE YADKINV	ILLE, NC 27	055		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{D 358}	Continued From pa	ge 31	{D 358}			
	reviews, it was dete not interviewable.	ermined that Resident #5 was			ni na grabada proprinci de la compansa de la compansa de la compansa de la compansa de la compansa de la compa	
	facility's contracted 10:25am revealed: -Potassium ER cou -Potassium ER ma	ald not be crushed. y not be as effective if it was				
		ssium ER tablets could be sium capsule which could be				
·	provider's supervis 11:04am revealed:					
	if potassium ER wa -He thought that po	ect there to be any side effects as crushed and administered. otassium ER would be less rushed and administered.				
The state of the s	(RCC) on 09/08/22 -If the medication of	Resident Care Coordinator 2 at 5:16pm revealed: order indicated "do not crush," the MAs not to crush those				
		sponsible for ensuring that ssium ER was administered as				
- Andrewski de Maria de Maria de Maria de Maria de Maria de Maria de Maria de Maria de Maria de Maria de Maria	6:26pm revealed:	Administrator on 09/08/22 at re that potassium ER was				
The second secon	crushed and admir the medication pas	nistered to Resident #5 during				
	the residents as the provider.	ey were ordered by the				
Division of	-The MAs were re Resident #5's pota lealth Service Regulation	sponsible for ensuring that assium was administered as			· · · · · · · · · · · · · · · · · · ·	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_ COMPLETED HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {D 358} Continued From page 32 (D 358) ordered. 2. Review of Resident #1's current FL2 dated 07/19/22 revealed: -Diagnoses included hyperglycemia and a below knee amputation of both legs. -There was an order for Humalog (a fast-acting insulin to treat high blood sugar) kwikpen 100units/ml inject 3 units subcutaneously 4 times daily as needed (PRN) for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. Review of Resident #1's July 2022 electronic medication administration record (eMAR) from 07/05/22 to 07/31/22 revealed: -There was an entry for Humalog kwikpen 100units/ml, inject 3 units subcutaneously 4 times PRN for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. -On 07/15/22, PRN Humalog was not administered, but should have been for a blood glucose result of 589. -On 07/16/22, PRN Humalog was not administered, but should have been for a blood glucose result of 512. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Humalog kwikpen 100units/ml, inject 3 units subcutaneously 4 times PRN for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. -On 08/04/22, PRN Humalog was not administered, but should have been for a blood glucose result of 464. -On 08/06/22, PRN Humalog was not administered, but should have been for a blood glucose result of 471. -On 08/10/22, PRN Humalog was not

Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ECONSTRUCTION		E SURVEY PLETED
		HAL099018	B. WING			R 08/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DATDIAT	T BUING OF VARIOUS	400 LIAM	RISON AVENU			
FAIRIOI	LIVING OF YADKINV	l has booking	ILLE, NC 270			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLET DATE
{D 358}	Continued From pa	ge 33	(D 358)			<del></del>
and problems of the second second second second second second second second second second second second second	administered, but s glucose result of 47 -On 08/16/22, PRN administered, but s glucose result of 55 -On 08/17/22, PRN administered, but si glucose result of 58 -On 08/19/22, PRN administered, but si glucose result of 59 -On 08/26/22, PRN administered, but si glucose result of 47 Observation of the Resident #1 on 09/0 there was one Humadministration.	hould have been for a blood 7. Humalog was not hould have been for a blood 7. Humalog was not hould have been for a blood 3. Humalog was not hould have been for a blood 7. Humalog was not hould have been for a blood 9. medications on hand for 18/22 at 3:58pm revealed that alog kwikpen available for				
	09/08/22 at 3:30pm -She was not aware order for Resident #	there was a PRN Humalog	47,			
	normally administer scheduled Humalog	ed in addition to their regularly Id be recorded on the eMAR				**************************************
	3:40pm revealed: -She was not aware order for Resident#	ld be recorded on the eMAR	7777			**************************************
	revealed:	ent #1 on 09/08/22 at 5:18pm administered insulin PRN	·			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:  COMPLETED  R  O9/08/2022  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  PATRIOT LIVING OF YADKINVILLE  409 HARRISON AVENUE  YADKINVILLE, NC 27055  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR I.SC IDENTIFYING INFORMATION  (EACH CORRECTIVE ACTION SHOULD BE  COMPLETED	_		<u>i of Health Service Re</u>						_
MAME OF PROVIDER OR SUPPLIER  PATRIOT LIVING OF YADKINVILLE  SIMMARY STATEMENT OF DEFICIENCIES  PREPAX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE  PREPAX TAG  CROSS-REFERENCED TO THE APPROPRIATE  (PACH) DEFICIENCY MUST BE PRECEDED BY FULL TAGE  (PACH) DEFICIENCY  (PACH) DEFICIE	-	STATEME AND PLAI	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
### STREET ADDRESS, CITY, STATE, ZIP CODE #### 499 HARRISON AVENUE ### YADKINVILLE 100 PT ADKINVILLE 100 PT ADKINVILLE, NO 27095  ### YADKINVILLE, NO 27095  ### YADKINVILLE, NO 27095  ### YADKINVILLE, NO 27095  ### ADMINVILLE,				HAL099018	B. WING		na		
PATRIOT LIVING OF YADKINVILLE  (AS) ID PREFIX (ASCH DEPICIENCY MUST BE PRECEDED BY FILL PROVIDED TO PREFIX (ASCH DEPICIENCY MUST BE PRECEDED BY FILL PROVIDED TO PREFIX (ASCH DEPICIENCY MUST BE PRECEDED BY FILL PROVIDED TO PREFIX TAG (CROSS-REFERENCED TO MEADER APPROPRIATE DEFICIENCY)  (D 358)  (D 358)  (D 358)  CONTINUED From page 34 and scheduled insulin three times a day. His blood sugar was normally high.  Interview with Resident #1's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed: His would expect the MAs to administer the PRN Humalog as ordered if it was ordered. He did not know if the facility had contacted Resident #1's blood sugar being greater than 450.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 4:40pm revealed: She was aware of the PRN Humalog order for Resident #1's PCP of the blood sugar being greater than 450, because she was not aware of the high blood sugars. Mas were responsible to administer medications as ordered to include Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1's PRN Humalog order for Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as ordered.  Altempted telephone interview with Resident #1's		NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	STATE, ZIP CODE	1 00	TOULGEL	
SALID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PERCECTED BY HILL REQUIATORY OR LSC IDENTIFYING INFORMATION)  (D 358)  (D		PATRIO	T LIVING OF YADKINV	ILLE 409 HARI	RISON AVE	NUE			
and scheduled insulin three times a day.  -His blood sugar was normally high.  Interview with Resident #1's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed:  -He would expect the MAs to administer the PRN Humalog as ordered if it was orderedHe did not know if the facility had contacted Resident #1's PCP (primary care provider) about Resident #1's blood sugar being greater than 450.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 4:40pm revealed: -She was aware of the PRN Humalog order for Resident #1She did not notify Resident #1's PCP of the blood sugar being greater than 450, because she was not aware of the high blood sugarsMAs were responsible to administer medications as ordered to include Resident #1's PRN Humalog orderMAs were expected to be aware of the PRN Humalog order for Resident #1.  Interview with the Administrator on 09/08/22 at 6:25pm revealed: -She was not aware there were two instances in July 2022 and seven instances in August 2022 where Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAttempted telephone interview with Resident #1's		PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVI	D BE	(X5) COMPLETE DATE	
Interview with Resident #1's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed: -He would expect the MAs to administer the PRN Humalog as ordered if it was orderedHe did not know if the facility had contacted Resident #1's PCP (primary care provider) about Resident #1's blood sugar being greater than 450.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 4:40pm revealed: -She was aware of the PRN Humalog order for Resident #1She did not notify Resident #1's PCP of the blood sugar being greater than 450, because she was not aware of the high blood sugarsMAs were responsible to administer medications as ordered to include Resident #1's PRN Humalog orderMAs were expected to be aware of the PRN Humalog order for Resident #1.  Interview with the Administrator on 09/08/22 at 6:25pm revealed: -She was not aware there were two instances in July 2022 and seven instances in August 2022 where Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as orderedMAs were responsible to administer medications as ordered.		(D 358)	Continued From pa	ge 34	{D 358}				-
provider's supervisor physician on 09/08/22 at 11:04am revealed:  He would expect the MAs to administer the PRN Humalog as ordered if it was ordered.  He did not know if the facility had contacted Resident #1's PCP (primary care provider) about Resident #1's blood sugar being greater than 450.  Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 4:40pm revealed:  -She was aware of the PRN Humalog order for Resident #1.  -She did not notify Resident #1's PCP of the blood sugar being greater than 450, because she was not aware of the high blood sugars.  -MAs were responsible to administer medications as ordered to include Resident #1's PRN Humalog order.  -MAs were expected to be aware of the PRN Humalog order for Resident #1.  Interview with the Administrator on 09/08/22 at 6:25pm revealed:  -She was not aware there were two instances in July 2022 and seven instances in August 2022 where Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as ordered.  -MAs were responsible to administer medications as ordered.  Attempted telephone interview with Resident #1's			and scheduled insu -His blood sugar wa	lin three times a day. s normally high.					Section of the sectio
blood sugar being greater than 450, because she was not aware of the high blood sugars.  -MAs were responsible to administer medications as ordered to include Resident #1's PRN Humalog order.  -MAs were expected to be aware of the PRN Humalog order for Resident #1.  Interview with the Administrator on 09/08/22 at 6:25pm revealed;  -She was not aware there were two instances in July 2022 and seven instances in August 2022 where Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as ordered.  -MAs were responsible to administer medications as ordered.  Attempted telephone interview with Resident #1's			provider's supervisor 11:04am revealed: -He would expect the Humalog as ordered -He did not know if the Resident #1's PCP (Resident #1's blood 450.  Interview with the Resident #1's aware of the Resident #1.	er physician on 09/08/22 at e MAs to administer the PRN d if it was ordered, he facility had contacted (primary care provider) about sugar being greater than esident Care Coordinator at 4:40pm revealed; he PRN Humalog order for					
PCP on 09/08/22 at 7:33am unsuccessful.			blood sugar being gr was not aware of the -MAs were responsit as ordered to include Humalog order. -MAs were expected Humalog order for R Interview with the Ad 6:25pm revealed: -She was not aware: July 2022 and seven where Resident #1 higreater than 450 and given as ordered. -MAs were responsib as ordered. Attempted telephone	reater than 450, because she high blood sugars, ble to administer medications a Resident #1's PRN  to be aware of the PRN esident #1.  ministrator on 09/08/22 at there were two instances in instances in August 2022 and a blood glucose of PRN Humalog was not ble to administer medications interview with Resident #1's					
			PCP on 09/08/22 at 7	:33am unsuccessful.					

INTERPRINT OF PROVIDER OR SUPPLIER  HALOSSO118  SINAMAY STATESTADORESS, GTY, STATE, ZIP CODE  409 HARRISON AVENUE  YADKINVILLE, NO 27055  PROVIDER OR SUPPLIER  STREET ADDRESS, GTY, STATE, ZIP CODE  409 HARRISON AVENUE  YADKINVILLE, NO 27055  PROVIDERS PLAN OF CORRECTION  GEACH PERCIPSION SIZE SEPRECEDED BY FULL  FREGULATORY OR LSC IDENTIFYING INFORMATION)  10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)  10A NCAC 13F .1801 (infection Prevention & Control Program (temp)  10A NCAC 13F .1801 INFECTION  PREVENTION AND CONTROL PROGRAM  (c) When a communiciable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility is IPCP, related policies and procedures, and published guidance insectives specific to the communiciable disease outbreak has been identified, or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility is IPCP, related policies, and procedures, and follow published published guidance or directives specific to the communicative disease outbreak or emerging infectious disease threat have been issued in writing by the NODHIHS or local health department by 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 DHI-IS) were implemented and meintained to provide protection to residents during the global coronavirus (COVID-19) pandernic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommended guidance remains posted at the facility and is followed. Completion date 10/77/2022		of Health Service Re	egulation			(X3) DATE SURVEY
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if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.  This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		policies and proce	a legued by the CDC: however		of the facility surfaced notice	rior and
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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: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		il guidance di une	cuves specific to the		procedures, and follow publis	ned
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: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		COMMunicable dis	ing infectious disease threat		guidance issued by the CDC, N	ICDHHS,
local health department, the specific guidance or directives shall be implemented by the facility.  This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		boyo boon issued	in writing by the NCDHHS or		and local health department	Based on
department, the specific guidance of directives shall be implemented by the facility.  This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,			in whiting by the Nobilinia a		and local fleater department.	ed on
Shall be implemented by the facility.  This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		denortment the e	pecific guidance or directives			
This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		chall be implemen	ated by the facility.	Ì	September 30, 2022, facility v	vill
This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		Stiali de implemen	ned by the facility.		discontinue screening station	s at both
This Rule is not met as evidenced by: Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  In accordance with the CDC/CMS recommendation the facility will: provide guidance (e.g., posted signs at entrances) about recommended actions for visitors and employees who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Resident Care Coordinator and/or Designee will ensure recommended guidance remains posted at the facility and is followed. Completion date 10/7/2022				1	front and side entrances of th	e huilding
Based on observations, record reviews, 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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		This Rule is not n	not as evidenced by:			
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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  Review of Health Service Regulation.		Reced on obsense	ations record reviews, and	1.		
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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  President Health Service Regulation.		intenviews the fac	allity failed to ensure		recommendation the facility	will:
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 to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  The Staff Service Regulation  entrances) about recommended actions for visitors and employees who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Resident Care Coordinator and/or Designee will ensure recommended guidance remains posted at the facility and is followed. Completion date 10/7/2022		recommendations	and guidance established by		provide guidance (e.g., poste	d signs at
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pandemic as related to screening of staff.  The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  Close contact with someone with COVID-19. Resident Care Coordinator and/or Designee will ensure recommended guidance remains posted at the facility and is followed. Completion date 10/7/2022		during the global	coronavirus (COVID-19)		symptoms of COVID-19, or ha	₃ve had
The findings are:  Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  COVID-19. Resident Care Coordinator and/or Designee will ensure recommended guidance remains posted at the facility and is followed. Completion date 10/7/2022		pandemic as rela	ted to screening of staff.			
Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,  Outcome of Health Service Regulation			-	1		
Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		The findings are:				ramator
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and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,	1	Review of the CD	C Interim Infection Prevention			iains
Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		and Control Reco	ommendations for Healthcare		posted at the facility and is fo	ollowed
dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,		Personnel (HCP)	During the COVID-19 Pandemi	ic		JIIO VI Cu.
established a process to identify anyone entering the facility, regardless of their vaccination status,		dated 02/02/22 rd	evealed facilities should have	1	Completion date 10/7/2022	
the facility, regardless of their vaccination status,		established a pro	cess to identify anyone entering	1		1
Discion of Haalih Service Regulation		the facility, regard	dless of their vaccination status,		<u> </u>	
Division of Health Get weet Regulation sheet 36 of 4	Division of					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(Y3) DAT	E SURVEY
· ····································	OF COUNTRY IOM	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
<del></del>		HAL099018	B. WING			R
AME OF I	PROVIDER OR SUPPLIER	2	<del>'</del>		09.	08/2022
				TATE, ZIP CODE		
PATRIOT	LIVING OF YADKINV		rison aveni ILLE, NC 276			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF	CORDECTION	T
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPLE DATE
(D 612)	Continued From pa	- · · · · · · · · · · · · · · · · · · ·	{D 612}			
	who has a positive to covid-19, or clo exposure to COVID	test for COVID-19, symptoms se contact/higher risk -19.				
	Health and Human COVID-19 Infection Long-Term Care Far-NCDHHS recommend families, and visitors of COVID-19 infection associated with pote	nue to screen all who enfer				The state of the s
	revealed: -There was a self-sc men's and women's -There was hand sar	staff/visitor screening				
for the control of th	copy area of the faci On 09/01/22, there was a staff or visitor. On 09/02/22, there was a staff or visitor. On 09/02/22, there was a staff or visitor. On 09/03/22, there was a staff or visitor. On 09/03/22, there was completed. On 09/04/22, there was completed. On 09/05/22, there was completed and	vere 3 COVID-19 screening I there was no her the person who screened vere 2 COVID-19 screening I there was no her the person who screened vere no COVID-19 screening vere no COVID-19 screening vere no COVID-19 screening vas 1 COVID-19 screening there was no				
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	<u>or Health Service Re</u> T of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	7
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:_		COMPLETED	
		HAL099018	B. WING		R 09/08/2022	
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 51	TATE, ZIP CODE		
		409 HARE	RISON AVENL			
PATRIOT	LIVING OF YADKIN	VILLE YADKINV	ILLE, NC 270			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE   COMPLETE	11.
{D 612}	Continued From pa	age 37	{D 612}			
{D 612}	was a staff or visitor on 09/06/22, thereforms completed a documentation who was a staff or visitor on 09/07/22, thereforms completed a documentation who was a staff or visitor of the 9:15am and 10:30.  There were 6 staff or of the facility on 09/07/22, she did not scree facility on 09/07/22. She knew she ne her shift, but she for their shift, but she for their shift, or their shift, should have prior to their shift.	or. e were 5 COVID-19 screening and there was no either the person who screened or. e were 2 COVID-19 screening and there was no either the person who screened or.  facility on 09/07/22 between am revealed; f in the facility. g the main front door a side to enter and exit.  CA on 09/07/22 at 11:47am en when she first came into the 2. eded to screen prior to starting orgot to screen.  Resident Care Coordinator, 2 at 11:49am revealed; e screened in the front lobby				
	-She was respons for COVID-19, but been screening da	ible for ensuring staff screened ishe did not know staff had not ally				
	-There was a CO\	VID-19 testing log in the where they may have been				
	log revealed: -There was a place name, COVID-19	VID-19 testing and temperature to enter the date, staff's test results, and temperature. creening questions for staff on mperature log.				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R HAL099018 B. WING 09/08/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **409 HARRISON AVENUE** PATRIOT LIVING OF YADKINVILLE YADKINVILLE, NC 27055 SLIMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) {D 612} Continued From page 38 {D 612} Interview with a medication aide (MA) on 09/07/22 at 11:58am revealed: -She came into the facility through the side door; a lot of staff came into the facility through the side door. -There was no COVID-19 screening station at the side door. -She forgot to screen for COVID-19 when she started her shift because she usually worked at the sister facility. Interview with the Executive Vice President of Operations on 09/07/22 at 12:04pm revealed: -She forgot to screen for COVID-19 because she entered the facility through the side door. -Staff told her they had been screening for COVID-19 at the facility; she did not know staff had not screened prior to starting their shift on 09/07/22. -The Administrator had planned for all staff to enter the facility through the front door where the COVID-19 screening station was set up. -There were staff who entered the facility through the side entrance, but they should enter through the front entrance. -There was a screening station set up in the lobby at the front entrance to the facility, but there was not a screening station set up for staff at the side entrance. Interview with a housekeeper on 09/07/22 at 12:24pm revealed: -She did not screen for COVID-19 when she came in the facility today on 09/07/22. -She had been screening for COVID-19 by checking her temperature and completing a questionnaire, but she stopped about a month ago when staff started taking a weekly COVID-19 test.

Division of	of Health Service Re	egulation			· · · · · · · · · · · · · · · · · · ·	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	DP CORRECTION	DERTE IONIONI TOMBER	A. BUILDING:			
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NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
PATRIOT	LIVING OF YADKINV	711 1 <b>(=</b>	LISON AVENU LLE, NC 270			
NA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)	
(X4) ID PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE DATE DATE	
TAG	REGOLATORI GIVE		ino	DEFICIENCY)		
{D 612}	Continued From pa	age 39	{D 612}			
•	-When staff completed the weekly COVID-19					
	test, staff had to ch	eck and record their				
	temperatures and their COVID-19 test results;					
	they were not screening for any other signs or					
	symptomsShe thought she only needed to screen for					
	temperature on the COVID-19 testing form.		•			
, The state of the	-She did not know she needed to continue to					
	complete the COVID-19 screening questionnaire daily prior to working her shift.					
	daily phot to working her stills.					
	Interview with the Administrator on 09/07/22 at			1		
	1:41pm revealed: -Staff was supposed to screen for COVID-19					
	daily before startin					
	-She expected staff to continue to screen for					
	COVID-19 althoug	h they were documenting their				
	temperatures on tr	ne COVID-19 testing log. Instructed staff to enter the front				
Andreas de la companya de la company	door to screen.		•			
	-Staff set up a screening station today on					
	09/07/22, for staff to self-screen if they enter the facility through the side door.					
		staff had not been screening				
	for COVID-19 daily	y.				
	-The RCC was res	sponsible for ensuring staff ID-19 prior to starting their shift		2 1		
	screened for COV	10-10 phor to starting their ornit	•			
{D912	G.S. 131D-21(2) [	Declaration of Residents' Rights	{D912}			
	G.S. 131D-21 De	claration of Residents' Rights				
1	Every resident sha	all have the following rights:				
		e and services which are riate, and in compliance with				
-		nd state laws and rules and				
	regulations.					
	This Rule is not r	net as evidenced by:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
<del>/</del>		HAL099018	B. WING		R	
NAME OF PROVIDER OR SUPPLIER STREET AD			DDRESS, CITY, STATE, ZIP CODE		1 09/08/2022	
PATRIOT	LIVING OF YADKINV		RISON AVE			
		YADKINV	ILLE, NC 2	7055		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 40  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 nutrition and food and residents' rights.  The findings are:  1. Based on record observations, record reviews,		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	EACTION SHOULD BE TO THE APPROPRIATE	
				Facility to have dietary staff re-train person on modified diets and to consistencies by facilities Food Sevendor on 11/02/2022. Dietary Manager viewed online training formodified diets and texture consistencies on 10/12/2022. In-sevendor on 10/12/2022.		
	and merviews, the ratherapeutic diet was resident (#4) with an sweets (NCS), puree to Tag 310, 10A NCA & Food Service (Type	scrity failed to ensure a served for 1 of 1 sampled order for a no concentrated diet with no bread. [Refer C 13F .0904(e)(4) Nutrition e B Violation)].		training to be done twice yearly with all dietary staff and online twill be provided throughout the The Dietary supervisor has also with Speech Pathologist, with Yalley Home Health on puree textures.	early and alline training the year. also worked ith Yadkin	Kenting
1   2   V	2. Based on observations and interviews, the facility failed to ensure resident rights were maintained related to providing unrestricted access for all residents to go outside of the facility when they requested and for residents to smoke when they requested. [Refer to Tag 338, 10A NCAC 13F .0909 Residents' Rights (Type B //iolation)].		The state of the s	and consistencies. Resident Care Coordinator and/or Designee to special diet report and/or new dorders. Administrator and/or Deto review diet orders and view the presentation for at least one meaweekly. Completion date 11/02/	c Care ee to review ew diet or Designee ew the e meal	
						·