STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on August 9-11, 2022.	{D 000}	The Regional Director of Operations has been on site since the last survey (8/11/2022) and will continue to be at the facility regularly for the next 90 days, and then weekly thereafter, to provide oversight of the management of the facility, monitoring of compliance, and to ensure implementation of plans to address and make necessary changes to ensure compliance with management of the facility. We have contracted with a Registered Nurse who has extensive experience in Regulating NC Adult Care Homes. The RN began a mock survey program on 9/10/2022. We also are contracting with an outside Adult Care Home Consultant, to include another Registered Nurse and an Adult Care Administrator who is an approved preceptor with extensive Adult Care Home regulatory experience. These consultants will conduct a comprehensive review of our resident care department and management of the facility within the next 30 days. The information obtained will be used to update our QA policies and procedures The following are additional changes that are in place: 1. A Licensed Practical Nurse with Assisted Living management experience was hired on 8/27/2022 and will start as the Health and Wellness Coordinator on 9/27/2022. Responsibilities will include oversight Resident Care Coordinator, training of personal care aides on personal care skills, as well a quality assurance for resident care and services. She will be in the community at a minimum 4 hours per day (20 hours), and at any other times that is deemed necessary by the nature and needs of the residents and facility. She will be assessing appropriateness for all admissions, discharges, and readmissions. Oversight of Resident Care will be monitored by Health and Wellness Director and Regional Registered Nurse as well as Administrator. 2. The Business Office Manager has completed AIT and will be taking the state licensure exam on 10/04/22 and will have oversight at Sanford Senior Living as designee for administrator. She will be located at Sanford Senior Living starting 09/13/22.	9/10/2022
{D 176}	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation was abated. Noncompliance continues. THIS IS A TYPE A2 VIOLATION Based on observations and interviews, the Administrator failed to ensure the management	{D 176}		

Refer to Plans of Correction for:
10A NCAC 13F.0901(a) Personal Care and Supervision
10A NCAC 13F.0902(b) Health Care
10A NCAC 13F.0904(a)(1) Nutrition and Food Service
10A NCAC 13F.1801(c) Infection Control and Prevention

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sherry Bryson | Executive Director | Addendum | 10/6/2022

STATE FORM 6899 | 4WO212 | If continuation sheet 1 of 75

Reviewed and acknowledged 28 October 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 1	{D 176}		

and total operations of the facility, as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care and supervision, health care, nutrition and food services and infection control and prevention.

The findings are:

Interview with a medication aide (MA) upon entrance to the facility on 08/09/22 at 8:20am revealed the Memory Care Coordinator (MCC) from the separate Special Care Unit (SCU) facility was the supervisor over this facility and was also working at the nearby SCU facility at that time.

Interview with the Administrator on 08/09/22 at 9:00am revealed the MA was the Resident Care Coordinator (RCC) and contact person for the survey.

Second interview with the MA on 08/10/22 at 3:24pm revealed:
-She had been the RCC since 07/28/22.
-Prior to 07/28/22, the MCC from the nearby SCU facility covered as the RCC for this facility.
-She (MA/RCC) was responsible for caring for the residents and supervising the residents and staff.
-She normally worked Monday through Friday and every other weekend 7:00am to 7:00pm on the medication cart.
-Her primary concerns were medication administration and then performing RCC duties including making follow up appointments, filing and faxing requests and orders to the pharmacy.

Interview with a resident on 08/10/22 at 3:09pm revealed:
-There had been no improvement in care and services at the facility since the last survey on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 2	{D 176}		

05/05/22.
-Residents were not showered, not fed and the kitchen was dirty.
-The Administrator was usually at the facility once per week.
-The MCC from the nearby SCU facility was at this facility three times per week on the medication cart because one of the MAs was often late.
-The Administrator and MCC did not walk through the facility and check on things or talk to any of the residents.

Telephone interview with a primary care provider (PCP) on 08/11/22 at 10:33am revealed:
-Communication about the health care needs of residents from staff was poor.
-The primary contact person was the MCC of the nearby SCU facility.
-The MCC coordinated the health care for both facilities.

Interview with the Kitchen Supervisor on 08/11/22 at 1:30pm revealed:
-She was the supervisor for both this facility and the nearby SCU facility.
-Most of the time she was at the nearby SCU facility.
-She did a weekly walk through of the kitchen in this facility.
-There was a problem with roaches and kitchen staff were trying to keep the kitchen clean to get rid of that problem.
-She was aware of the condition of the kitchen.
-She was new as a supervisor and was short dietary staff, so she was still working out the schedule of all things including cleaning and deep cleaning the kitchen.

Interview with the MCC from the nearby SCU

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 3	{D 176}		

facility 08/11/21 at 5:00pm revealed:
-She was not the RCC for the facility; she was the MCC for the nearby SCU facility.
-The facility had not had an RCC since the last survey on 05/05/22 until the MA was promoted to the RCC position on 07/29/22 or 08/01/22.
-She helped with RCC duties for the facility and did not know how much time she spent helping with RCC duties.
-She worked 40 hours per week as the MCC for the nearby SCU facility
-She was only able to complete one day of training with the MA for the RCC role as of today (08/11/22).

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-The MCC from the nearby SCU facility monitored personal care provided for residents daily at this facility.
-She monitored personal care by being at the facility daily looking at and talking with residents.
-If she or the MCC from the nearby SCU facility were not in the facility, the MA called one of them with any resident health care concerns and they followed up with the PCP.
-She and the MCC from the nearby SCU facility were trying every day to ensure the building was clean, staff were present and providing care for residents and health care needs were met.
-They ensured this by having daily meetings with the Maintenance Director and the MA/RCC where they discussed the needs of both facilities.
-The MCC from the nearby SCU facility did most of the meal observations to ensure residents were served nutritious meals and assisted with dignity and respect.
-The Kitchen Supervisor monitored the cleanliness of the kitchen.
-The MCC from the nearby SCU facility monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 4	{D 176}		

the medication cart and eMARs for this facility.
-She had not checked for staff and visitor compliance with completing the COVID-19 screening process, but had monitored compliance with mask wearing by observing staff and visitors during her visits to the facility.
-She instructed the MA/RCC to monitor staff and visitor compliance with mask wearing and completing the screening process.
-The MCC from the nearby SCU facility worked primarily at the nearby SCU facility.
-That was why the MA was promoted to the RCC role for this facility.
-The MCC was in the process of training the MA for the RCC role.
-She and the MCC from the nearby SCU facility were responsible for the oversight of both facilities.
-There was a corporate nurse at the facility for a couple of days in May or June 2022, but she was called away to another facility.

Noncompliance identified at violation level included:

1. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 of 4 sampled residents (#1, #2 and #4) [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision (Unabated Type A2 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to follow up on acute health care needs and coordinated health care for 2 of 4 sampled residents (#2 and #4) who experienced severely low blood sugar levels with poor dietary intake while receiving fast and long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 5	{D 176}		

acting insulin (#4); and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2) [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation)].

3. Based on observations, interviews and record reviews, the facility failed to ensure the kitchen and dining area were clean and protected from contamination related to live and dead roaches; black spots resembling roach excrement; dirt and pink film on the ice machine with accumulated dust on the vent; grease and dust accumulation on the oven and vent; and dirty dishes left in the dining room for two hours after the lunch meal [Refer to Tag 282, 10A NCAC 13F .0904(a)(1) Nutrition & Food Service (Type B Violation)].

4. 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 Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the Coronavirus (COVID-19) pandemic as related to staff not wearing required personal protective equipment (PPE) while in the facility and not completing the required self COVID-19 screening prior to their shifts, not wearing required personal protective equipment (PPE), and failed to remove gloves and perform hand hygiene between patients [Refer to Tag 612, 10A NCAC 13F .1801(c) Infection Control & Prevention (Type B Violation)].

The Administrator failed to ensure the management and total operations of the facility, as evidenced by the failure to maintain substantial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 176}	Continued From page 6 compliance with the rules and statutes governing adult care homes as related to personal care and supervision, health care, nutrition and food services and infection control and prevention. The Administrator's failure resulted in skin breakdown related to delayed incontinence care (Resident #2), two consecutive emergency medical services (EMS) calls for severe hypoglycemia (Resident #4), risk of spread of infectious diseases related to lack of mask wearing and screening upon entrance to the facility, prolonged roach infestation in the kitchen and risk of contaminated beverages from an unclean ice machine. These failures resulted in substantial risk of harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2022.	{D 176}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION	{D 269}	1. On 8/9/2022 and 8/18/2022 the personal care aides and medication aides received training on their responsibilities and accountability for personal care needs of residents as identified in the resident's care plan and other personal care needs the residents may not be able to attend for themselves. Further training will be conducted by a RN consultant within the next 30 days, and	8/29/2022

ongoing on a monthly basis by the Health and Wellness Coordinator.

2. On 8/11/2022 residents were observed by the Regional Director, Regional RN, Administrator and Resident Care Coordinator to ensure their personal care needs were attended to. Any residents identified with unmet needs were immediately cared for, and if necessary, referred to the physician for follow up of health care needs.
3. A Licensed Practical Nurse with Assisted Living management experience was hired on 8/27/2022 and will start as the Health and Wellness Coordinator on 9/27/2022. Responsibilities will include oversight of the Resident Care Coordinator, training of personal care aides on personal care skills, as well a quality assurance for resident care and services. She will be in the community at minimum 4 hours per day (20 hours), and at any other time that is deemed necessary by the nature and needs of the residents and facility. She will be assessing appropriateness for all admissions, discharges, and readmissions
4. On 8/10/2022 implementation of the Administrator/Administrator In Charge and Resident Care Coordinator monitoring of personal care by making observation of residents to ensure their personal care needs are attended to. These

observations shall be completed and documented as complete each day they are on duty. Random Shifts observations shall be completed monthly to ensure all shifts are covered.

5. Point Click Care (an electronic web based medical record system) is being implemented for identifying the personal care needs of residents, documentation and tracking of resident's personal care needs that were performed. Personal Care Aides will be trained on the system.
6. Implementation of Administrator/ Administrator In Charge and Resident Care Coordinator monitoring Point Click Care documentation daily while on duty to ensure documentation is being completed. Any staff identified as not documenting or performing personal care shall receive corrective action up to termination.
7. Implementation of the Administrator/Administrator In Charge, Health and Wellness Director, and Resident Care Coordinator completing random resident record checks to ensure staff are responding to the health care needs of the residents, referring residents to appropriate healthcare providers, administering medications as ordered and notification to responsible party of healthcare changes and needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 7 Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 of 4 sampled residents (#1, #2 and #4). The findings are: Review of the facilities undated policies and procedures for resident care revealed: -Residents' status was communicated using shift report and verbal exchange; walking rounds were encouraged between caregivers at shift change. -Residents were checked every two hours unless indicated otherwise on the resident's service plan. -Incontinence care was given as necessary to residents requiring assistance every two hours. -Residents were to have a full shower/bath according to their needs and preferences, and at least twice per week. -Refusal of necessary hygiene and grooming was reported to the Resident Care Coordinator (RCC) by the caregivers. -Continued refusals of hygiene and grooming was noted in charting notes and the Administrator was notified. -Caregivers monitored the length and condition of the fingernails of residents receiving bathing, dressing, or grooming services. -The Administrator and/or designee scheduled podiatry appointments for nail care other than cleaning or moisturizing. 1. Review of Resident #2's current FL-2 dated 05/10/22 revealed diagnoses included	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: ___ B. WING ___	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 8	{D 269}		

hypertension, type II diabetes mellitus, glaucoma, chronic obstructive pulmonary disease, nutritional anemia, polyneuropathy and unsteady on feet.

Review of Resident #2's current care plan dated 06/08/22 revealed:
-She was ambulatory with assistive device and limited upper extremity strength and range of motion.
-She did not have use of her hands and needed extensive assistance with eating.
-Her skin was normal and there were no skin care needs.
-She had daily incontinence of her bowel and bladder.
-She was disoriented, forgetful and needed reminders.
-She was totally dependent on staff for assistance with toileting, ambulation, transfers, bathing, dressing and grooming.

a. Review of Resident #2's June, July and August 2022 activities of daily living (ADL) logs revealed there was no documentation of toileting assistance.

Observation of Resident #2 on 08/10/22 from 6:03am until 6:30am revealed:
-At 6:03am, she was lying sideways in her bed with her legs hanging over the edge of the bed.
-At 6:08am, the medication aide (MA), entered the resident's room and announced she was going to put some clothes on the resident and get her up into her wheelchair.
-Resident #2 responded, "Okay, thank you."
-There was dried feces on the back of resident's right thigh outside the incontinence brief.
-When the MA removed the incontinence brief, there was dried feces on the right buttock and hip area in addition to a paste consistency of feces

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 9	{D 269}		

over the buttocks.
-There was a quarter sized red, raw open area on the skin of the crease of the right buttock and right thigh.
-There was redness on the buttocks and irritation upon cleaning the buttocks at the gluteal fold with more redness on the right side than on the left side.
-There was a grapefruit sized area of redness on the left hip.
-She was cooperative with staff and did not refuse any care.
-At 6:30am, the MA assisted Resident #2 into her wheelchair and then assisted her to the TV room and told her she would wait there for breakfast.
-The resident's hands and face were not washed.

Interview with the MA on 08/10/22 from 6:03am until 6:30am revealed:
-She and the personal care aide (PCA) worked from 7:00pm until 7:00am.
-She checked all residents at the start of her shift and administered medications.
-The PCA was responsible for checking all residents to make sure they were clean and dry.
-The PCA made sure to assist residents to bed.
-Typically, she and the PCA checked residents throughout the night together.
-Resident #2 was last checked for incontinence at 3:30am on 08/10/22.
-The reddened areas on Resident #2 were not new; she did not know if the primary care provider (PCP) had been notified.

Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed:
-She sometimes checked residents after PCAs completed their rounds.
-If care was not done for a resident, she and the PCA would go back to the resident together.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 10	{D 269}		

-PCAs were expected to check residents every two hours and at change of shift.
-PCAs were expected to check residents for incontinence care needs every two hours and change the resident if needed.
-The third shift PCA on duty 08/09/22 - 08/10/22 did not report finding Resident #2 soiled with dried feces.
-She thought it would take a whole shift for feces to dry on the skin outside and under the incontinence brief.

Interview with the Regional Director of Operations on 08/10/22 at 12:00pm revealed:
-Staff were expected to make sure residents were washed, cleaned and dry.
-Staff were expected to check for incontinence care needs every two hours.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-The MCC from the nearby SCU facility monitored personal care provided for residents at the assisted living (AL) daily.
-The MCC monitored the condition of the residents by being at this facility daily, looking at and talking with residents.

b. Review of Resident #2's June 2022 activities of daily living (ADL) log revealed staff documented nail care was provided daily 06/03/22 through 06/30/22 except on 06/05/22 (refused) and no entries on 06/07/22 and 06/09/22.

Review of Resident #2's July 2022 ADL log revealed staff documented nail care was provided daily 07/01/22 through 07/31/22 except on 07/31/22 where there was no entry.

Review of Resident #2's August 2022 ADL log

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 11	{D 269}		

revealed staff documented nail care was provided on 08/01/22 and 08/02/22; there were no entries for 08/03/22 through 08/08/22.

Observations of Resident #2 on 08/09/22 at 2:10pm revealed:
-She was dressed and sitting in her wheelchair.
-The personal care aide (PCA) attempted to open the resident's clenched left hand.
-There was a foul odor and a moist brown substance on the palm with a slight opening of her left hand.
-The fingernails on her left hand were greater than one half inch long and had a dried brown substance under each nail.
-She complained of pain with movement of her left hand and arm.

Interview with the PCA on 08/09/22 at 2:10pm revealed:
-PCAs tried to wash inside and place something like a rolled-up washcloth between the nails and palm of Resident #2's left hand but she refused.
-When she refused staff would continue to try.
-There was nothing else PCAs did when the resident refused to have her hand washed.
-They had not tried soaking Resident #2's left hand in soapy water.

Observation of Resident #2 on 08/11/22 at 9:07am revealed:
-The Regional Nurse sat down with Resident #2 and explained that she needed to look at her left hand; the resident responded okay and that she could help.
-The Regional Nurse slowly opened the resident's left hand revealing white peeling and macerated skin on the palm and fingers. (Macerated describes skin that has been in contact with moisture too long and can be lighter in color,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 12	{D 269}		

wrinkly and soggy to touch.)
-There was a reddened area on the palm beneath the pinky, ring finger and middle finger.
-There was a moist brown substance between the fingers and a thick dried brown substance under the fingernails.

Interview with the Regional Nurse on 08/10/22 at 12:08pm revealed:
-Residents' skin was checked by PCAs on shower days and with incontinence care.
-When there were areas of skin breakdown the PCA should report to the MA.

Interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 9:15am revealed staff initialed nail care daily on the ADL log because the resident nails were checked daily even if nail care was not provided.

Interview with the Administrator on 08/11/22 at 6:05pm revealed staff were expected to clean and trim residents' nails every week.

c. Review of Resident #2's June 2022 activities of daily living (ADL) log revealed staff documented bathing and skin care was provided daily between 7:00am and 3:00pm 06/02/22 through 06/30/22 except on 06/09/22 where there was no entry.

Review of Resident #2's July 2022 ADL log revealed staff documented bathing and skin care was provided daily between 7:00am and 3:00pm 07/01/22 through 07/31/22 except on 07/13/22 and 07/30/22 where there were no entries.

Review of Resident #2's August 2022 ADL log revealed staff documented bathing and skin care was provided between 7:00am and 3:00pm on 08/01/22 and 08/02/22; there were no entries for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 13 08/03/22 through 08/08/22. Review of the facility's undated shower list revealed: -Resident #2's shower days were on Monday, Wednesday and Friday; no shift was documented. -There was a reminder to complete a shower sheet on shower days. -If the resident refused there were instructions to document on the shower sheet and report to the medication aide (MA). Observation of Resident #2 on 08/09/22 at 9:10am revealed: -She was lying in her bed on her left side with a hospital gown on. -There was a urine odor and slight body odor when standing within three feet of the resident. -Her hair and skin were greasy and dull in color. Observation of Resident #2 on 08/09/22 at 11:38am revealed she remained in bed in the hospital gown. Observation of Resident #2 on 08/09/22 at 1:59pm revealed: -She was dressed in regular clothes and sitting up in her wheelchair in her room. -Her skin and hair remained greasy and dull in color. Observation of Resident #2 on 08/10/22 from 6:03am until 6:30am revealed: -Staff dressed the resident in regular clothes after cleaning her incontinence care. -Her face, arms, hands, chest, back, legs and feet were not cleaned or wiped off. -Her hair and skin were greasy and dull in color.	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 14 Observation of Resident #2 on 08/11/22 at 7:48am revealed: -She was dressed and sitting in her wheelchair in the dining room. -Her hair was clean and shiny; her skin was bright and clean. Interview with a resident on 08/11/22 at 1:50pm revealed the staff only showered Resident #2 today (08/11/22) because surveyors were in the facility. Interview with a PCA on 08/10/22 at 9:22am revealed: -Resident #2 was dependent on staff for assistance with all ADLs including bathing, dressing and incontinence care. -PCAs documented showers and refusals of bathing and showering on the shower log. -The log was taken to the MCC in the nearby SCU facility. Interview with a MA on 08/10/22 from 6:03am until 6:30am revealed: -She did not know when Resident #2 was showered last; it would have been documented in the shower book. -Resident #2 was supposed to have a shower on first shift but it was left for third shift staff. -Residents were supposed to be showered three times per week and three of three showers each week were done by third shift. -She had reported to the Administrator on 08/09/22 about resident care tasks not done by first shift staff. -She had reported the same concern before and nothing has changed. Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 9:07am revealed:	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 15 -Resident showers were documented on the electronic chart. -Resident #2 was on the shower sheet for every Monday, Wednesday and Friday. -There was no shift assignment for the showers, so she did not know which shift was responsible for showering the resident. -Shower sheets were completed after each shower by the PCA. -There were only shower sheets dated for 05/04/22 and 05/06/22 in the shower book for Resident #2. Second interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 9:15am revealed: -Staff initialed hygiene daily on the ADL log because hygiene was done daily even if it was not a shower day. -Staff would know the days Resident #2 had a shower because staff usually said who they showered at shift change report. -She thought personal care was being provided for Resident #2, it was just not documented correctly. Interview with the Regional Director of Operations on 08/10/22 at 12:00pm revealed: -Staff were expected to make sure residents were washed, cleaned and dry. -Normally, showers were on a schedule of three times per week. -If there were no initials on the ADL log, the log may not have been completed and there may be paper records. Interview with the Administrator on 08/11/22 at 6:05pm revealed: -Residents should be showered three times weekly.	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 16 -There was a shower schedule which staff followed. -She was not aware that the shower schedule did not indicate a shift assignment for any of the residents' showers. Upon request on 08/10/22, shower sheets or a log sheet for Resident #2 were not available for review. Upon request on 08/10/22, paper records of ADL tasks completed for Resident #2 for August 2022 were not available for review. Attempted interview with Resident #2's family member on 08/11/22 at 8:01am and was unsuccessful. Attempted interview with Resident #2's Primary Care Provider on 08/11/22 at 11:21am and was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #1's current FL-2 dated 03/17/22 revealed: -Diagnoses included urinary tract infection, altered mental status, dementia, depression, benign prostatic hyperplasia, hyperlipidemia, hypertension, Type II diabetes and acute kidney injury. -He was intermittently confused and was semi-ambulatory. -He was continent of bowel and had an indwelling foley catheter. Review of Resident #1's current care plan dated 05/23/22 revealed:	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 17 -He was required supervision with eating. -He required limited assistance with toileting, ambulation, dressing and transferring. -He required total assistance with bathing and grooming. Observation of Resident #1 on 08/09/22 at 9:10am revealed his shirt and pants were dirty, his hair was uncombed and his beard was unkempt and long. Observation of Resident #1 on 08/10/22 at 6:10am - 7:50am revealed: -At 6:10am, Resident #1 was sitting in his wheelchair in the bathroom with no staff present. -He stated that he was getting ready for the day. -At 6:30am, Resident #1 was in his wheelchair in the bathroom; there was no staff present and he was not completing any activities of daily living (ADL) tasks. -At 6:38am, Resident #1 was in his wheelchair in the bathroom asleep. -At 6:45am, Resident #1 was still in his wheelchair, in the bathroom asleep, but easily aroused. -At 7:43am, the staff noted that Resident #1 was not in the dining room for breakfast and went to his room to let him know that it was time to eat. -Resident #1 was still in the bathroom, in his wheelchair, and had not completed any ADL tasks. -Resident #1 was observed to be wearing the same clothes that he was wearing on the day prior (08/09/22), his hair was uncombed, and he was unshaved. -At 7:50am, Resident #1 propelled himself from his bathroom into the dining room for breakfast. Interview with Resident #1 on 08/09/22 at 2:25pm revealed:	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

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

-He usually emptied his foley catheter bag without assistance from the staff.
-He was able to take a shower and get dressed unassisted.
-His brother would cut his hair and shave him, but it had been a while since he visited.

Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed:
-She was not sure who assisted Resident #1 with ADL care because he was usually up in his wheelchair when she arrived for her shift.
-Resident #1 has a history of refusing assistance with ADLs and she would notify the medication aide (MA) for any refusals.

Refer to interview with the Regional Service Director on 08/10/22 at 11:57am.

Refer to interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm.

3. Review of Resident #4's current FL-2 dated 07/18/22 revealed:
-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.
-She was constantly disoriented.

Interview with Resident #4 on 08/11/22 at 11:45am revealed:
-She had only had one shower since being admitted to the facility.
-The staff assisted her with daily sponge baths but would like to have more showers.
-The staff had not offered to assist her with a shower.

Refer to interview with the Regional Service Director on 08/10/22 at 11:57am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: ___ B. WING ___	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 19 Refer to interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm. Interview with the Regional Service Director on 08/10/22 at 11:57am revealed: -Residents should be offered and provided a shower on their scheduled shower days and as needed. -It was the responsibility of the medication aide (MA) and the personal care aide (PCA) to ensure residents were properly groomed and had on clean clothes. Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm: -It was the responsibility of the MA and the PCA to provide assistance with ADLs every 2 hours and as needed. -It was the responsibility of the MA and the PCA to ensure residents were clean and neatly groomed. -It was the responsibility of the MA to notify the MA/RCC of any refusals in ADL care. -It was the responsibility of the MA/RCC to notify the primary care provider (PCP) of refusals. The facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 residents (#1, #2 and #4) which resulted in areas red and open skin on the buttocks and gluteal fold and maceration with peeling skin and a foul odor of the left hand for Resident #2. This failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/22 for	{D 269}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 20 this violation.	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to follow up on acute health care needs and coordinated health care for 2 of 4 sampled residents (#4, #2) who experienced low blood sugar levels with poor dietary intake while receiving fast and long acting insulin (#4); and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2). The findings are: 1. Review of Resident #4's current FL-2 dated 07/18/22 revealed: -Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall. -She was constantly disoriented. Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check the blood sugar 3	{D 273}	1. The resident's physician will be notified when there is an acute episode, such as falls, skin breakdown, and blood pressure, heart rate and blood sugar results according to parameters determined by the resident's physician. The notification, as well as implementation of additional orders, will be documented in the resident's record by RCC/WHD/Medication Aide. 2. Staff will be trained on identifying and what actions to take when acute episodes occur by 9/20/2022. 3. RCC, ED, and or designee will audit 5 residents records weekly to assure acute episodes and changes in residents' condition are reported to the residents' provider. 4. We have completed assessments of all residents to determine who is high risk for falls and have implemented safety measure such as referral for physical therapy, medication review and personal alarms. 5. 8/18/2022 staff received training on responding immediately and reporting falls and other	8/12/2022

accidents and incidents per the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 21	{D 273}		

times a day before meals and check if blood sugar was greater than 450 or less than 80.
-There was an entry to notify the primary care provider (PCP) as needed for blood sugars greater than 450.
-There was an entry to give 1 cup of orange juice as needed for blood sugars less than 60, recheck blood sugar in 15 minutes after drinking the orange juice, and to notify the PCP.
-There was an entry to give ½ cup of orange juice as needed for blood sugars 61 - 80, call the PCP and call emergency medical services (EMS) if the patient becomes unresponsive.
-There were 7 blood sugar values documented that were greater than 450 from 07/20/22 - 07/31/22 with no documentation of notification of the PCP.

Review of Resident #4's August 2022 eMAR revealed:
-There was an entry to check the blood sugar 3 times a day before meals and to see the prn blood sugar check if blood sugar was greater than 450 or less than 80.
-There was an entry to notify the PCP as needed for blood sugars greater than 450.
-There was an entry to give 1 cup of orange juice as needed for blood sugars less than 60, recheck blood sugar in 15 minutes after drinking the orange juice, and to notify the PCP.
-There was an entry to give ½ cup of orange juice as needed for blood sugars 61 - 80 and call the PCP and call EMS if the patient becomes unresponsive.
-There were 2 blood sugar values documented that were greater than 450 from 08/01/22 - 08/11/22 with no documentation of notification of the PCP.
-There were 2 blood sugar values documented that were less than 80 with no documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 22	{D 273}		

notification of the PCP.
-On 08/04/22 at 5:00pm Resident #4's blood sugar was documented as 61.
-On 08/10/22 at 6:43am, Resident #4's blood sugar was documented as 33.

Review of physician's orders for Resident #4 dated 08/10/22 revealed there were orders to decrease Toujeo to 40 units once a day and to discontinue Glipizide. (Toujeo is an injection used to lower blood glucose levels; Glipizide is an oral medication used to lower blood glucose levels.)

Interview with Resident #4 on 08/11/22 revealed:
-She has had a decreased appetite due to nausea that has been occurring off and on but unsure for how long.
-Her blood sugars had been low for a couple of days and on 08/10/22 and 08/11/22 EMS had to be called to get her blood sugars stabilized.
-She had alerted the staff that she was not feeling well but she was not sure if they alerted her PCP.

Telephone interview with Resident #4's responsible party on 08/11/22 at 9:07am revealed:
-She had not been notified of Resident #4's hypoglycemic episodes on 08/10/22 or 08/11/22.
-She was the primary care giver for Resident #4 prior to admission and her blood sugars ranged around 90 - 200.

Telephone interview with a medication aide (MA) on 08/11/22 at 4:36pm revealed:
-She contacted EMS for Resident #4 on the morning of 08/10/22 and again on 08/11/22 due to hypoglycemia.
-EMS came to the facility and stabilized Resident #4's blood sugar and no emergency room visit was required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 23	{D 273}		

-She had not contacted Resident #4's responsible party due to not having a contact number.
-She faxed a physician's communication form to Resident #4's PCP on 08/10/22 and 08/11/22 regarding the hypoglycemia episodes with no new orders received.
-Resident #4's blood sugar had been dropping around 4:00am - 5:00am over the past 2 days.
-She was not aware of Resident #4 having a decreased appetite.

Interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 11:00am revealed:
-Resident #4 had an appointment with her PCP on 08/10/22 in the afternoon and the PCP reviewed her blood sugars at that time.
-Resident #4's PCP had not been made aware of the hypoglycemic episode that occurred on 08/11/22.
-Resident #4 had not been feeling well for approximately 2 - 3 days and she had not notified the PCP.

Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:
-She has communicated with Resident #4's PCP on different occasions in reference to her blood sugars.
-Resident #4 was being seen by two different PCPs; 1 was the facility's PCP and the other was the PCP she had prior to admission.
-She communicated Resident #4's abnormal blood sugars with the facility's provider.
-She had not documented the communication with Resident #4's PCP in her record due to it being an oversight.
-It was the responsibility of the MA to notify the MA/RCC or the MCC to for abnormal blood sugars.
-It was the responsibility of the MA/RCC or the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 24 MCC to notify the PCP either by fax or telephone with the abnormal blood sugars. -It was the responsibility of the MA, the MA/RCC and the MCC to document all communication with the PCP in the resident's chart. -It was the responsibility of the MA to notify the resident's responsible party for changes in conditions. Attempted telephone interview with a third MA on 08/11/22 at 3:15pm was unsuccessful. Attempted telephone interview with a fourth MA on 08/11/22 at 3:21pm was unsuccessful. Attempted telephone interview with Resident #4's PCP on 08/11/22 at 9:34am was unsuccessful. Attempted telephone interview with a second PCP for Resident #4 on 08/11/22 at 2:18pm was unsuccessful. 2. Review of Resident #2's current FL-2 dated 05/10/22 revealed diagnoses included hypertension, type II diabetes mellitus, glaucoma, chronic obstructive pulmonary disease, nutritional anemia, polyneuropathy and unsteady on feet. a. Observation of Resident #2 on 08/10/22 at 6:08am revealed: -There was a quarter sized red, raw open area on the skin of the crease of the right buttock and right thigh. -There was redness and irritation with cleaning on the buttocks at the gluteal fold with more redness on the right side. -There was a grapefruit sized area of redness on the left hip. -She yelled out "ow, that hurts" with turning onto her side and when her buttocks were cleaned	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 25	{D 273}		

with a wipe.

Interview with the medication aide (MA) on 08/10/22 at 6:08am revealed:
-The reddened areas on Resident #2 were not new; she did not know how long exactly it had been there.
-The resident complained of pain each time she was moved while staff provided care.
-She did not know if the primary care provider (PCP) had been notified.
-She had not contacted the PCP.

Telephone interview with Resident #2's PCP on 08/11/21 at 10:33am revealed she was not notified for increased pain and anxiety with care or skin breakdown.

Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 9:07am revealed:
-Resident #2 frequently refused care due to pain; she did not like to be moved.
-She did not know about red or open areas on the resident's buttocks.

Interview with the Regional Nurse on 08/10/22 at 12:08pm revealed:
-When it was observed that a resident had areas of skin breakdown the PCA reported to the MA.
-The MA or RCC notified the PCP and documented in the resident's record.
-If the RCC was not available to assist the MA, then the MA would notify the Administrator.

Interview with the Regional Nurse on 08/10/22 at 4:21pm revealed there was no documentation Resident #2's PCP was notified of skin care concerns.

b. Review of Resident #2's primary care provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 26	{D 273}		

(PCP) fax notification dated 06/08/22 revealed at 5:57am, the PCP was faxed a note that the resident had an unwitnessed fall at 5:40am and was sent to the emergency room (ER).

Review of Resident #2's ER discharge instructions dated 06/08/22 revealed:
-The resident was seen for a fall with abrasions to her right shoulder and left ankle and right hip pain.
-Instructions included follow up with her primary care provider within two to four days.

Review of Resident #2's incident report dated 06/08/22 revealed:
-The resident had an unwitnessed fall and was found in the TV room by another resident.
-She had a hematoma (location not documented) and a skin tear on her right elbow.

Review of Resident #2's PCP fax notification dated 06/08/22 revealed at 9:49pm, the PCP was faxed a note that the resident had an unwitnessed fall and was sent to the ER.

Review of Resident #2's ER discharge instructions dated 06/08/22 revealed:
-The resident was seen for a fall with a closed head injury.
-There were no instructions for follow up with the PCP.

Review of Resident #2's PCP visit notes revealed the resident was last seen on 05/25/22 for a routine visit.

Telephone interview with a medication aide (MA) on 08/11/22 at 4:33pm revealed:
-She remembered Resident #2 falling twice in the same day, but she could not remember the time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 27 of day she fell on her shift. -She faxed notifications to the resident's PCP, but the date of notification would have been the date the PCP came to the facility. -The PCP visited the facility every Wednesday. -She did not know when the resident was last seen by the PCP. Telephone interview with Resident #2's PCP on 08/11/21 at 10:33am revealed: -Fax notifications were sent to the PCP's office. -Staff normally notified her when she was at the facility (weekly) when a resident needed a follow up visit after being treated in the ER. -She was not notified for a follow up visit after Resident #2 was treated in the ER for falls on 06/08/22. -She had not seen Resident #2 since 05/25/22. -Staff had not communicated any reason for her to be seen prior to her 90 day follow up visit. Upon request on 08/09/22 and 08/10/22, an incident report for 06/08/22 at 5:40am was not available for review. c. Review of Resident #2's Physician's Orders dated 05/10/22 and 07/06/22 an order to check weights every 15th of the month. Review of Resident #2's June, July and August 2022 electronic medication administration records revealed: -There was an entry for monthly weights with no documented weight results. -On 06/15/22, there was no entry. -On 07/15/22, there was documentation the medication aide (MA) was physically unable to weigh the resident. Observation of Resident #2's weight on 08/10/22	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 28 at 12:34pm revealed: -The resident weighed 89 pounds in the chair scale. -She was cooperative with staff during the transfer from her bed to the chair scale. Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed: -Resident #2 refused to be weighed. -Resident #2 frequently refused care and yelled out in pain. -Staff did not always document accurately. -MAs were responsible for weighing residents. -The RCC was responsible for checking that MAs obtained the residents' weights. -If a resident refused a weight it would have been documented on the electronic medication administration record (eMAR) with a circle around the initials. Telephone interview with Resident #2's primary care provider (PCP) on 08/11/21 at 10:33am revealed: -She was not notified for follow up refusing weights. -Resident #2 was supposed to be followed by hospice. -Normally, with residents receiving hospice services, the hospice nurse followed up on any concerns. -The Memory Care Coordinator (MCC) at the nearby Special Care Unit (SCU) facility usually contacted her for changes in condition and any needed follow up with the PCP. Interview with the MA/RCC on 08/11/21 at 11:08am revealed she normally contacted Resident #2's PCP for any concerns about the resident.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 29 Interview with the Regional Nurse on 08/11/22 at 12:00pm revealed Resident #2 was not on hospice. Interview with the Regional Nurse on 08/10/22 at 4:21pm revealed there was no documentation Resident #2's PCP was notified of weight concerns. Upon request on 08/10/22, documentation of a weight for Resident #2 prior to 08/10/22, was not available for review. Interview with the MA/RCC on 08/10/22 at 3:24pm revealed: -She had been the RCC since 07/28/22. -She and the MCC from the nearby SCU facility contacted the PCP with resident concerns. -Contact with the PCP was documented in the resident's electronic progress notes. -There was no documentation Resident #2's PCP was notified weights were not obtainable. Upon request on 08/09/22 and 08/10/22, there were no electronic progress notes or faxed primary care provider notifications related to weights, for Resident #2 available for review. Attempted interview with Resident #2's family member on 08/11/22 at 8:01am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. The facility failed to follow up on acute health care needs and coordinated health care for 2 residents (#2 and #4) which resulted in Resident #4 requiring evaluation and treatment by emergency	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 273}	Continued From page 30 medical services (EMS) on two consecutive mornings for severely low blood sugar levels with poor dietary intake while received fast and long acting insulin; and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2). This failure resulted in substantial risk of serious injury and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation.	{D 273}		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement physician's orders for 2 of 4 sampled residents (#1, #4) related to obtaining monthly weights and weekly blood pressures (#1) and compression stockings (#4). The findings are: 1. Review of Resident #1's current FL-2 dated	D 276	1. All physician orders will be implemented upon receipt. 2. All residents who are unable to stand for weights will be weighed using a sitting/wheelchair scale monthly. Staff will be trained on how to use the sitting/wheelchair scale and competence will be validated by return-demonstration; this will be done by RCC/HWD/ Medication Aide. 3. All residents' blood pressures and heart rates will be monitored and documented monthly. All measures outside the ordered parameters will be reported the resident's provider by RCC/HWD/medication aide. 4. Compression hose have been ordered for Resident #4. All staff will be trained on the correct donning and removal of the	10/15/2022

Coordinator will audit 5 records each week and make random observations throughout the week to assure all physician orders are being implemented and documented.

6. We have completed assessments of all residents to determine who is high risk for falls and have implemented safety measure such as referral for physical therapy, medication review and personal alarms.
7. 8/18/2022 staff received training on responding immediately and reporting falls and other accidents and incidents per the facility policy.
8. The Regional Health Director and Regional Director of Operations have been on site for the past two weeks to ensure implementation of corrective actions and will continue to be in the facility on an ongoing basis. When not available in the facility there will be weekly remote calls to discuss personal care and review implemented systems to ensure ongoing compliance. Any staff identified in violation of noncompliance of procedures and/or violation of residents' right shall receive corrective action up to termination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 31 03/17/22 revealed: -Diagnoses included urinary tract infection, altered mental status, dementia, depression, benign prostatic hyperplasia, hyperlipidemia, hypertension, Type II diabetes and acute kidney injury. -He was intermittently confused and was semi-ambulatory. -He was continent of bowel and had an indwelling foley catheter. Review of Resident #1's current care plan dated 05/23/22 revealed: -He required supervision with eating. -He required limited assistance with toileting, ambulation, dressing and transferring. -He required total assistance with bathing and grooming. a. Review of Resident #1's signed physician's orders dated 05/23/22 revealed there was an order for weights to be obtained monthly on the 15th of each month. Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for monthly weights to be obtained on the 15th of the month on the 7:00am - 7:00pm shift. -It was documented on 06/15/22 that the monthly weight was not obtained due to "unable to get resident on the scale." Review of Resident #1's July 2022 eMAR revealed: -There was an entry for monthly weights to be obtained on the 15th of the month on the 7:00am - 7:00pm shift. -It was documented on 07/15/22 that the monthly	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 32 weight was not obtained due to "physically unable to take." Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed it was the responsibility of the medication aide (MA) to obtain and document resident's weights. Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed: -She was not aware that Resident #1's monthly weights were not completed as ordered from June 2022 - present. -There was a sitting scale that Resident #1 could transfer to so that weight could be obtained. -It was the responsibility of the MA to obtain the weights and document them on the eMAR. -It was her responsibility to ensure that the weights were completed and documented on the eMAR. -She had not completed this task because she transitioned into the MA/RCC role approximately 2 weeks ago. -The PCP had not been notified of Resident #1's weight not being obtained. Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed: -It was the responsibility of the MA to obtain weights and document the results on the eMAR. -It was the responsibility of the MA and the MA/RCC to monitor resident's weights and notify the PCP of weight gains or losses. -She could not remember the last time she reviewed the monthly weights. -The staff should have used the sitting scale to obtain Resident #1's weight. -It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain a weight.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 33	D 276		

-It was the responsibility of the MA/RCC or the MCC to notify the PCP of abnormal weight changes or inability to obtain the weights as ordered.
-The PCP had not been notified of Resident #1's weight not being obtained.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-It was the responsibility of the MA to obtain the resident's weights and document the values in the eMAR.
-It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain the weight and document on the eMAR.
-It was the responsibility of the MA/RCC or the MCC to monitor the weights and to notify the PCP of abnormal findings or the inability to get the weight.

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

Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/11/22 at 9:02am was unsuccessful.

Attempted telephone interview with a second MA on 08/11/22 at 3:15pm was unsuccessful.

Attempted telephone interview with a third MA on 08/11/22 at 3:21pm was unsuccessful.

b. Review of Resident #1's signed physician's orders dated 05/23/22 revealed there was an order for weekly blood pressure checks to be completed every Monday and to notify the primary care provider (PCP) if the systolic blood pressure (SBP) was greater than 200 or less than 90, if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 34	D 276		

diastolic blood pressure (DBP) was greater than 110 and if heart rate was greater than 140 or less than 50.

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 06/20/22 and 06/27/22 with no reasons documented for the omission.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 07/18/22 and 07/25/22 with no reasons documented for the omission.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 08/01/22 and 08/08/22 with no reasons documented for the omission.

Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed it was the responsibility of the medication aide (MA) to obtain and document resident's blood pressures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 35	D 276		

Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:
-She was not aware that Resident #1's weekly blood pressures were not completed as ordered by the PCP.
-It was the responsibility of the MA to obtain the blood pressures and document them on the eMAR.
-It was the responsibility of the MA/RCC to ensure that the blood pressures were completed and documented on the eMAR.

Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:
-She was not aware that Resident #1's weekly blood pressures were not completed as ordered by the PCP.
-It was the responsibility of the MA to obtain the blood pressures and document the results on the eMAR.
-It was the responsibility of the MA/RCC or the MCC to ensure the weekly blood pressures were completed as ordered.
-It was the responsibility of the MA/RCC or the MCC to notify the PCP of abnormal values or the inability to obtain the blood pressures as ordered.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-It was the responsibility of the MA to obtain the resident's blood pressure and document the values in the eMAR.
-It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain the blood pressure and document on the eMAR.
-It was the responsibility of the MA/RCC or the MCC to monitor the blood pressure and to notify the PCP of values outside of the parameters.

Based on observations, record reviews, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 36	D 276		

interviews, it was determined that Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's PCP on 08/11/22 at 9:02am was unsuccessful.

Attempted telephone interview with a second MA on 08/11/22 at 3:15pm was unsuccessful.

Attempted telephone interview with a third MA on 08/11/22 at 3:21pm was unsuccessful.

2. Review of Resident #4's current FL-2 dated 07/18/22 revealed:
-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.
-She was constantly disoriented.

Review of a signed physician's order for Resident #4 dated 07/19/22 revealed there was an order for compression stockings to bilateral lower extremities to be applied every morning and removed at bedtime.

Review of a provider's prescription for Resident #4 revealed:
-There was a pharmacy provider's prescription faxed from the pharmacy to the facility on 07/20/22 at 3:22pm.
-The pharmacy provider's prescription was for the facility to record the measurements of Resident #4's bilateral lower extremities so that the pharmacy could send the appropriate size compression stockings.
-The pharmacy provider's prescription was filed in Resident #4's record with no information documented on the prescription.

Observation of Resident #4 on 08/10/22 intermittently between 3:05pm - 4:30pm revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 37	D 276		

she was not wearing the compression stockings to bilateral lower extremities.

Observations of Resident #4 on 08/11/22 intermittently between 7:55am - 5:00pm revealed she was not wearing the compression stockings to bilateral lower extremities.

Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 07/25/22 - 07/31/22.

Review of Resident #4's August 2022 eMAR revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 08/01/22 - 08/10/22.

Interview with Resident #4 on 08/11/22 at 11:45am revealed she had not worn the compression stockings since being admitted to the facility.

Interview with a personal care aide (PCA) on 08/10/22 at 3:00pm revealed:
-She provided personal care assistance for Resident #4 on this morning (08/10/22) that included assistance with bathing and dressing.
-She did not apply compression stockings to Resident #4's lower extremities after getting her dressed for the day (08/10/22.)
-She was not aware that Resident #4 had an order for the compression stockings, and she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL053031	A. BUILDING: _____ B. WING _____	R 08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD SENIOR LIVING	1107 CARTHAGE STREET SANFORD, NC 27350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 38 never seen Resident #4 with compression stockings on. Interview with a second PCA on 08/10/22 at 3:05pm revealed she was not aware of Resident #4's order for compression stockings and she had not seen Resident #4 wear the compression stockings. Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed: -She was not aware that Resident #4 did not have the compression stockings on today (08/10/22) or yesterday (08/09/22.) -Resident #4 wore the compression stockings for edema in her bilateral lower extremities. -She knew that Resident #4 wore the compression stockings one day last week because she remembered removing them at bedtime one night. -It was the responsibility of the 1st shift MA to apply Resident #4's compression stockings in the morning. -It was the responsibility of the 2nd shift MA to remove Resident #4's compression stockings at bedtime. Second interview with the MA/RCC on 08/11/22 at 11:55am revealed resident #4's compression stockings were usually kept on the medication cart however she was not able to locate them. Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed: -She had been assisting with MA/RCC responsibilities at the assisted living (AL) facility while the MA/RCC position was vacant. -She was not aware that Resident #4's pharmacy provider's prescription for the compression hoses	D 276		