Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED		
			A. BUILDING:		
		HAL092181	B. WING		R 01/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	,
			RALEIGH ROAD		
THE COVI	NGTON	RALEIG	H, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
{D 000}	Initial Comments		{D 000}		
	_	sure Section conducted a complaint investigation on 023.			
{D 273}	10A NCAC 13F .0902	(b) Health Care	{D 273}		
	· ,	Health Care assure referral and follow-up ad acute health care needs			
	reviews, the facility fa the primary care prov	is, interviews and record iled to ensure follow up with ider (PCP) for blood sugar itten parameters and a for 2 of 5 sampled			
	The findings are:				
	11/18/22 revealed: -Diagnoses included I mellitus, acute kidney vein thrombosis and r -There were orders for (FSBS) checks three insulin (SSI) with directions.	t #3's current FL-2 dated hyperglycemia, diabetes disease, femoral vein deep heuropathy. If finger stick blood sugar times daily and sliding scale ction to notify the primary or FSBS results greater than			
	instructions to notify to greater than 550.				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL092181	B. WING		01/12/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
THE COVINGTON		RALEIGH ROAD I, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	e 1	{D 273}		
	notifiedOn 11/22/22 at 12:30 551 and there was no was notifiedOn 11/23/22 at 8:30a and there was no doo notified. Review of Resident # revealed: -There was an entry finstructions to notify t greater than 550On 12/20/22 at 5:30a and there was no doo notifiedOn 12/27/22 at 12:30	opm the FSBS result was o documentation the PCP arm the FSBS result was 571 cumentation the PCP was 3's December 2022 eMAR for SSI three times daily and the PCP for FSBS results om the FSBS result was 555 cumentation the PCP was Opm the FSBS result was 50 documentation the PCP			
	revealed: -There was an entry finstructions to notify tigreater than 550On 01/04/23 at 12:30 562 and there was notified. Review of Resident # notes and physician rithere was no docume contacted for FSBS re 11/21/22, 11/22/22, 1 and 01/04/23. Telephone interview was no entry the reverse the reverse that the	3's January 2023 eMAR for SSI three times daily and the PCP for FSBS results Opm the FSBS result was a documentation the PCP 3's electronic progress notification forms revealed entation the PCP was esults greater than 550 on 1/23/22, 12/20/22, 12/27/22 with Resident #3's primary on 01/12/23 at 12:16pm			

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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 273) (D 273) (D 273) Continued From page 2 -She did not know of elevated blood sugars for Resident #3 off handShe would have to check the resident's record at the office for notification notesMAs could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's high blood sugars when she came to the facility each week. Review of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on	DIVISION	n nealth Service Negu	lation				
MAME OF PROVIDER OR SUPPLIER THE COVINGTON SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 273) Continued From page 2 She did not know of elevated blood sugars for Resident #3 off handShe would have to check the resident's record at the office for notification notesMAS could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident #3's record revealed the PCP was notified of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5.58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on			` '	1 ' '			
NAME OF PROVIDER OR SUPPLIER THE COVINGTON STREET ADDRESS, CITY, STATE, ZIP CODE ### ALBIEGH ROAD RALEIGH, NC 27615 CALID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ANDIEAN	or Connection	IBENTI TOATION NOWIBER.	A. BUILDING: _		I COMIT E	L125
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4510 DURALEIGH ROAD RALEIGH, NC 27615 CALLEIGH, NC 27615 CALLEIGH, NC 27615 CALLEIGH, NC 27615 CROSS-REFERENCED TO THE APPROPRIATE OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPIX TAG				D WING		1	
THE COVINGTON A510 DURALEIGH ROAD RALEIGH, NC 27615 CAM ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX PRECIDENCY MUST BE PRECEDED BY FULL PREFIX TAG PREFIX PRECIDENCY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) (D 273) Continued From page 2 (D 273) PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE			HAL092181	D. WING		01/1	2/2023
CALID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CALID SUMMARY STATEMENT OF DEFICIENCIES 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DAY {D 273} Continued From page 2 {D 273} -She did not know of elevated blood sugars for Resident #3 off handShe would have to check the resident's record at the office for notification notesMAs could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/22/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on	THE COVI	NGTON					
REGULATORY OR LSC IDENTIFYING INFORMATION) {D 273} {D 273} {D 273} Continued From page 2 -She did not know of elevated blood sugars for Resident #3 off handShe would have to check the resident's record at the office for notification notesMAs could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's high blood sugars when she came to the facility each week. Review of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on			RALEIGH,	NC 27615			
-She did not know of elevated blood sugars for Resident #3 off handShe would have to check the resident's record at the office for notification notesMAs could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's high blood sugars when she came to the facility each week. Review of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/23/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP	D BE	(X5) COMPLETE DATE
Resident #3 off handShe would have to check the resident's record at the office for notification notesMAs could have faxed a notification or spoke to an on-call providerShe was not able to access the physician's office records at the time of the call. Interview with the Resident Care Coordinator (RCC) on 01/12/23 at 4:05pm revealed the PCP was notified of Resident #3's high blood sugars when she came to the facility each week. Review of Resident #3's record revealed there was no documentation the PCP was notified for FSBS results greater than 550 on 11/21/22, 11/22/22, 11/22/22, 11/22/22, 12/20/22, 12/27/22 and 01/04/23. Interview with the Administrator on 01/12/23 at 5:58pm revealed: -The PCP should have been notified by the MA and notification documented on the resident's eMAR and/or electronic progress noteShe was still learning the electronic record reporting and monitoring process for oversight on	{D 273}	Continued From page	e 2	{D 273}			
staff adherence to documenting contact with the PCP. Attempted telephone follow up interview with Resident #3's PCP on 01/13/22 at 9:56am was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	{D 273}	-She did not know of Resident #3 off handShe would have to complete the office for notification and on-call providerShe was not able to records at the time of Interview with the Resident was notified of Resident was notified of Resident was no documentation FSBS results greater 11/22/22, 11/23/22, 12/01/04/23. Interview with the Adr 5:58pm revealed: -The PCP should have and notification docure MAR and/or electrorshe was still learning reporting and monitor staff adherence to do PCP. Attempted telephone Resident #3's PCP or unsuccessful. Based on observation reviews, it was determined the standard of the standard or the st	elevated blood sugars for heck the resident's record at ion notes. ed a notification or spoke to access the physician's office the call. sident Care Coordinator 4:05pm revealed the PCP ent #3's high blood sugars e facility each week. 3's record revealed there in the PCP was notified for than 550 on 11/21/22, 2/20/22, 12/27/22 and ministrator on 01/12/23 at the been notified by the MA mented on the resident's nic progress note. In the electronic recording process for oversight on cumenting contact with the follow up interview with an 01/13/22 at 9:56am was one, interviews and record	{D 273}			

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03/30/22 revealed:

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	≣TED
					l R	,
		HAL092181	B. WING		1	2/2023
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NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
THE COVI	NGTON		RALEIGH ROAD			
	-	RALEIGH	H, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
{D 273}	Continued From page	⇒ 3	{D 273}			
		hypothyroidism status post				
		ession, hypernatremia,				
	peripheral neuropathy					
	gastroesophageal ref	,				
	osteoarthritis, multiple	e sclerosis, and				
	hypertension.	t- the facility was 03/04/21				i
	-The aumission date	to the facility was 03/04/21.				ı
	Review of Resident #	[‡] 2's progress notes dated				
	07/14/22 revealed:	20 prog. 000 notes and a				
	-Resident #2 was bei	ing seen for complaint of				
	breast pain.	,				
	-The primary care pro					
	mammogram for Res	ident #2.				i
	Review of Resident #	2's record revealed there				i
	were no results for a					ı
	Interview with the Res	sident #2 on 01/11/23 at				ı
		ecting a mammagram since				
	this past summer (20)	esting a mammogram since				
	-She did not remember	•				i
	mammogram was do					ı
		g her neurologist every 3				i
	months before coming					i
	1	ner neurologist twice since				i
	her admission.					i
	Interview with Reside	ent Care Coordinator (RCC)				ı
	on 01/12/23 at 4:30pr					
		e for making appointments				
	that the primary care	provider (PCP) ordered.				
	-She started at the fac					
	_	vare of the mammogram				
		en it was requested by the				
	survey team.					
	-The previous RCC sl					
ļ	appointment made or	nce the PCP orders were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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HAL092181			B. WING		01/12/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE COVINGTON			LEIGH ROAD NC 27615			
			PROVIDER'S PLAN OF CORRECTION	1 0/5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{D 273}	Continued From page	e 4	{D 273}			
	-She was not aware of see a neurologist.	of Resident #2 needing to				
	at 8:25am revealed: -The memory care co	ordinator (MCC) left in ledical leave and thought				
	November 2022 on medical leave and thought she would be returning in December 2022. -The RCC had been covering her duties as well as some of the duties of the MCC since the MCC					
		rould have been responsible atment for the mammogram.				
	12:37pm revealed:	vith the PCP on 01/12/23 at P who had ordered the				
	-She reviewed her red found the mammogra	cords for Resident #2 and m order on 07/14/22. / results if a mammogram				
	-The last mammogram for which she had record was done in April 2021She expected when orders were given that the staff would follow through with the orders.					
	Upon request on 01/1 on 01/12/23 at 11:02a	1/23 at 12:56pm and again am, mammogram results for provided by the facility for				
{D 358}	10A NCAC 13F .1004 Administration	e(a) Medication	{D 358}			
	(a) An adult care hor preparation and admi	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments				

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MALO92181 B. WING	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MANE OF PROVIDER OR SUPPLIER THE COVINGTON RALEIGH, NC 27615 CAN ID PRECEDIA THAN THE PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES ID PRECEDED BY PILL ID PRECEDIA THAN THAN THE PROVIDER OF THE APPROPRIATE DOTAIN SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE DOTAIN SHOULD BE CROSS-REFERENCED TO BE CROSS-REFERE	HAL092181		B. WING				
CALL COUNTON CALL	NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 01112/2020	
(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE DEFICIENCY) (D 368) Continued From page 5 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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by the primary care provider (PCP) for 3 of 5 sampled residents (#1, #3 and #4) including long acting insulins (#1 and #3), a narcotic pain reliever, an antihypertensive, an over the counter pain reliever, and vitamin supplement (#4). The findings are: 1 Review of Resident #4's current FL-2 dated 01/05/23 revealed diagnoses included dementia, chronic ischemic heart disease, gait and mobility abnormalities, cerebral infarction, hypertension, osteoporosis and gastro-esophageal reflux disease. a. Review of Resident #4's physician's order dated 12/22/22 revealed: -An order to discontinue morphine three times daily (a narcotic pain medication used to treat	THE COVI	NGTON					
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by the primary care provider (PCP) for 3 of 5 sampled residents (#1, #3 and #4) including long acting insulins (#1 and #3), a narcotic pain reliever, an antihypertensive, an over the counter pain reliever, and vitamin supplement (#4). The findings are: 1 Review of Resident #4's current FL-2 dated 01/05/23 revealed diagnoses included dementia, chronic ischemic heart disease, gait and mobility abnormalities, cerebral infarction, hypertension, osteoporosis and gastro-esophageal reflux disease. a. Review of Resident #4's physician's order dated 1/2/22/22 revealed: -An order to discontinue morphine three times daily (a narcotic pain medication used to treat	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE	
-An order to continue as needed morphineAn order for morphine (100mg/5ml) 0.5ml daily at bedtime. Observations of Resident #4's medications on	{D 358}	by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met FOLLOW-UP TO TYF Based on these finding Violation was not abased Based on observation reviews, the facility factor were administered as provider (PCP) for 3 of #3 and #4) including if #3), a narcotic pain rean over the counter proposed in the supplement (#4). The findings are: 1 Review of Resident 01/05/23 revealed dischronic ischemic hear abnormalities, cerebrosteoporosis and gased disease. a. Review of Resident dated 12/22/22 revear-An order to disconting daily (a narcotic pain moderate to severe proposed in the supplement of the severe proposed in the severe proposed	ance with: sed prescribing practitioner I in the resident's record; and on and the facility's policies as evidenced by: PE B VIOLATION ags, the previous Type B atted. as, interviews and record ailed to ensure medications as ordered by the primary care of 5 sampled residents (#1, along acting insulins (#1 and alliever, an antihypertensive, an reliever, and vitamin at #4's current FL-2 dated agnoses included dementia, and the disease, gait and mobility all infarction, hypertension, attro-esophageal reflux at #4's physician's order alled: alled morphine three times medication used to treat ain). as needed morphine. are (100mg/5ml) 0.5ml daily	{D 358}			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	A. BUILDING:		OOMI LETEB	
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		HAL092181	B. WING		1		
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NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
		4510 DUE	RALEIGH ROAD				
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		KALEIGI	1, NC 27615				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE	
IAG			IAG	DEFICIENCY)			
			+				
{D 358}	Continued From page	e 6	{D 358}				
	hand on 01/11/23 at 3	3:47pm revealed:					
		ine 0.25ml prefilled syringes					
	labeled for administra						
		ine 0.25ml prefilled syringed					
	labeled for administra						
	needed for pain or sh						
		hine 0.5ml prefilled syringes.					
	- There were no morpi	nine o.smi premied synnges.					
	Review of Resident #	4's December 2022					
	electronic medication						
	(eMAR) revealed:						
		or morphine 0.5ml daily at					
	_	nat the medication needed a					
	"script".	lat the medication needed a					
	•	cheduled at 8:00pm and had					
	a start date of 12/22/2						
	-There was an "x" ma						
		2/25/22 and 12/26/22.					
		tation morphine 0.5ml was					
	administered 12/27/22	_					
		or morphine 0.25ml three					
		o date of 12/22/22 and					
	8:00am and 2:00pm.	were administered at					
	· ·	entry for morphine 0.25ml					
		a start date of 12/22/22 and					
	stop date of 12/23/22						
	•	tation morphine 0.25ml was					
		im, 2:00pm and 8:00pm on					
	12/23/22.	, 2.00piii ana 0.00piii on					
		12/22/22 was documented					
		ecause the medication was					
	discontinued.	Coduse the medication was					
	u	for morphing 0.25ml avery 4					
	_	or morphine 0.25ml every 4					
	_ ·	pain or shortness of breath.					
		nentation any doses were					
		4/22, 12/25/22 or 12/26/22.					
		or morphine 15mg every 2					
	hours as needed for p	pain crisis or air hunger.					

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-There was no documentation any doses were

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		HAL092181	B. WING		01/1	2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
THE COV	NGTON	4510 DUF	RALEIGH ROAD			
1112 001		RALEIGH	I, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 7	{D 358}			
	-There was no docum	4/22, 12/25/22 or 12/26/22. nentation Resident #4 morphine on 12/24/22, 2.				
	(RCC) on 01/12/23 at -Resident #4 had mo administration from th -MAs should have ad Resident #4 on 12/24 -She did not know wh	rphine available for ne previous order. ministered the morphine to d/22 through 12/26/22.				
	facility's contracted pt 10:08am revealed: -The pharmacy receiv prescription order, wh substance (CS) prescription	with a pharmacist from the harmacy on 01/13/23 at wed an electronic nich was a valid controlled cription order, for morphine aily on 12/15/22 for Resident				
	morphine 0.25ml for I -The pharmacy receive morphine 0.25ml three morphine 0.5ml daily Resident #4The pharmacy did not prescription order for bedtime for Resident new orderThe pharmacy entered was a market moderate to several moderate to several moderate to several moderate days and the several moderate to several moderate to several moderate to several moderate to several moderate moderate and the several moderate moderate to several moderate to several moderate modera	ved the order to discontinue the times daily and to start at bedtime on 12/22/22 for our receive a valid CS morphine 0.5ml daily at #4 and did not dispense the the order onto Resident the that a valid CS is needed. Cotic pain medication used to				

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agitation, sweating and mental status changes if

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Division of	of Health Service Regu	lation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
ANDIEAN	JI CONNECTION	BENTI TOATION NOMBER.	A. BUILDING:		OOWII LETED	
		HAL092181	B. WING		R 01/12/2023	
NAME OF D					01/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE RALEIGH ROAD	=, ZIP CODE		
THE COVI	NGTON		H, NC 27615			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 8	{D 358}			
	stopped abruptly.					
	care provider (PCP) of revealed: -She was not made a starting new or change-She did not remember new orders for Resider-Some changes could	with Resident #4's primary on 01/12/23 at 12:16pm ware of any delays in ged medication orders. er the details of changed or ent #4. d have been made by the				
	Hospice service.					
		computer to access her notes for Resident #4.				
	Nurse on 01/17/23 at -She could not say where a say on the say where say on the say where say on the say of th	hy morphine was not 2 through 12/26/22 because medication passes. e morphine order had been in mostly with transfers, he according to the staff. sed to manage medication supposed to be by staff so she could enter e system and send them to				
	medication aide (MA) unsuccessful.	interview with a second shift on 01/12/23 at 3:29pm was				
	b. Review of Residen dated 01/05/23 revea	it #4's physician's orders lled and order for				

Ativan/Benadryl/Haldol/Reglan (ABHR)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL092181		B. WING		R 01/12/2023		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET AL			TE, ZIP CODE		
THE COVINGTON RALEIGH,						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	9	{D 358}			
		cal to wrist daily as needed re bathing (used to treat				
	_	dent #4's medications on 3:47pm revealed there was esident.				
	medication administrative revealed there was an	n entry for ABHR gel 1ml gitation and before bathing /05/23 and no doses				
	Interview with a media 01/12/13 revealed the had not arrived from t	ABHR gel for Resident #4				
	facility's contracted pl 10:08am revealed: -The pharmacy receiv for Resident #4, but tl	vith a pharmacist from the narmacy on 01/13/23 at ved the order for ABHR gel ne order was not on a valid a controlled substance				
	(CS)The pharmacy noted eMAR system that a neededThe pharmacy had notes prescription order and ABHR gel for Resider	in the directions on the CS prescription order was ot received a valid CS d therefore did not dispense on #4.				
	care provider (PCP) or revealed she was not	with Resident #4's primary on 01/12/23 at 12:16pm made aware of any delays nged medication orders.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL092181		B. WING		R 01/12/2023		
THE COVINGTON 4510 DUR			RESS, CITY, STA ALEIGH ROAD NC 27615	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Nurse on 01/17/23 at -ABHR gel was for ag Resident #4. She had recommended not know it had been -Hospice was supposordersAll new orders were communicated to her them into the hospice the pharmacy directly purposesCS orders sent direct hospice were on a various c. Review of Resident 01/05/23 revealed the discontinue the follow 01/06/23: acetaminop times daily (used to tramlodipine 5mg daily pressure), clopidogrep prevent blood clots), so treat depression), so vitamin D3 1000 units supplement). Observations of Resident #4's name accontained in the pack -The list of medication 325mg 2 tablets, amlo 75mg, mirtazapine 7.5 sertraline 50mg and verbere was no morning recommended in the pack -There was no morning recommended in the pack -There was no morning and verbere was no morning recommended in the pack -There was no morning and verbere was no morning recommended in the pack -There was no morning recommended in the pack -Ther	with Resident #4's Hospice 5:11pm revealed: pitation at bath time for ed the medication but did ordered by the PCP. ed to manage medication supposed to be by staff so she could enter system and send them to for clarity and billing tly to the pharmacy by lid CS prescription order. t #4's current FL-2 dated ere were orders to ing medications effective when 325mg 2 tablets three eat chronic pain), (used for high blood 175mg daily (used to sertraline 25mg daily (used sertraline 50mg daily and daily (used as a dent #4's medications on 3:47pm revealed: se pack (MDP) with and a list of medications ages. as included acetaminophen odipine 5mg, clopidogrel 5mg, sertraline 25mg,	{D 358}			

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amlodipine 5mg, clopidogrel 75mg, sertraline

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		1141 000404	B. WING		R	
		HAL092181	B. W(0		01/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ALEIGH ROAD			
THE COVI	NGTON					
		RALEIGH	, NC 27615			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		
TAG	TREGOE TOTAL OTTE	EGG IBERTII TIIVO IIVI GIVIIVI (IIGIV)	TAG	DEFICIENCY)	W (1 L	
			-			
{D 358}	Continued From page	e 11	{D 358}			
	-	g and vitamin D3 1000				
	units.					
		ng MDP pack for 01/11/13				
	that included acetami	nophen 325mg 2 tablets.				
	Review of Resident #	4's January 2023 electronic				
	medication administra	ation record (eMAR)				
	revealed:					
	-There was an entry f	or acetaminophen 325mg				
	two tablets three time	es daily at 8:00am, 2:00pm				
	and 8:00pm with docu	umentation doses were				
	-	3 through 01/11/23 at				
	2:00pm.	3				
	•	or amlodipine 5mg daily at				
	8:00am with documer					
	administered 01/01/2					
		or clopidogrel 75mg daily at				
	8:00am with documer					
	administered 01/01/2					
		or sertraline 25mg daily at				
	8:00am with documer					
	administered 01/01/2					
		<u> </u>				
		or sertraline 50mg daily at				
	8:00am with documer					
	administered 01/01/2	3				
		for vitamin D3 1000 units				
	•	documentation doses were				
	administered 01/01/2	3 through 01/11/23.				
	Interview with a medi	• •				
	01/12/23 at 11:48am					
		ed Resident #4's morning				
	medications on 01/11					
	-She verified the med	lications in the MDP on the				
	resident's eMAR prior	r to administering.				
	-All the medications in	n the MDP were still active				
	on the eMAR.					
	-The Resident Care C	Coordinator (RCC) was				

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responsible for processing new orders.

STATE FORM 6899 17LP12 If continuation sheet 12 of 25

DIVISION	i Health Service Regu	ilation			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	בובט
						1
HAL092181		B. WING		1	2/2023	
		TIAL SOL TO T			1 01/1	2/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4510 DUF	ALEIGH ROAD			
THE COVI	NGTON	RALEIGH	, NC 27615			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	e 12	{D 358}			
	Telephone interview v	with a pharmacist from the				
	facility's contracted pl	harmacy on 01/13/23 at				
	10:08am revealed:	•				
	-The pharmacy did no	ot have a record of an FL-2				
	for Resident #4 with o					
	amlodipine, acetamin	ophen, vitamin D.				
	clopidogrel and sertra					
		y sent via fax or email by the				
	Resident Care Coord					
	reducin dara dada	mater (1100).				
	Telephone interview v	with Resident #4's primary				
	•	on 01/12/23 at 12:16pm				
	revealed:	517 6 17 12/20 at 12:10pm				
		ware of any delays in				
		ged medication orders.				
	-Amlodipine, acetami					
		aline were discontinued.				
		discontinued for quality of				
	end of life.	discontinued for quality of				
	end of file.					
	Telephone intonvious	with Resident #4's Hospice				
	Nurse on 01/17/23 at					
	-She was not notified	•				
		•				
	had been discontinue	rel, sertraline and vitamin D3				
		o be notified by staff of				
		<u> </u>				
	orders written by the	FUP.				
	Attempted tolophone	follow up interview with				
		n 01/13/22 at 9:56am was				
		11 0 1/ 13/22 at 3.30am was				
	unsuccessful.					
	Based on charaction	as intorvious and record				
		ns, interviews and record				
		mined Resident #4 was not				
	interviewable.					
	Defenda tal 1 1 1 1	4				
		terview with a pharmacist				
	from the facility's conf					
	01/13/23 at 10:08am.		1			

Division of Health Service Regulation

STATE FORM 6899 17LP12 If continuation sheet 13 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SU COMPLE	
			A. BOILDING			
HAL092181 B. WING		B. WING		01/12	2/2023	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	<u>, </u>	
THE 001	4510 DUR					
THE COVI	NGTON	RALEIGH,	NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 13	{D 358}			
	Refer to interview with Coordinator (RCC) or	h the Resident Care n 01/12/23 at 4:05pm.				
	Refer to interview witl 01/12/23 at 5:12pm.	h the Administrator on				
	11/18/22 revealed dia depression, hyperglyo hypothyroidism, neuro femoral vein deep vei	at #3's current FL-2 dated agnoses included dementia, cemia, acute kidney disease, opathy, thrombocytopenia, in thrombosis, diabetes ools, hypertension and				
	dated 12/08/22 revea every morning and La	nt #3's physician's order aled orders for Lantus 8 units antus 12 units daily at g insulin used to regulate				
	12/22/22 revealed ord	3's physician's order dated ders to discontinue prior art Lantus 12 units twice				
	hand on 01/11/23 at 3 Lantus injection pen v	ent #3's medications on 3:41pm revealed there was a with a label which included and date opened (01/11/23).				
	(eMAR) revealed: -There was an entry f morning with docume	administration record for Lantus 8 units every entation doses were				
	12/23/22.	for Lantus 12 units daily at				

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administered at 8:00pm from 12/09/22 through

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL092181	B. WING		01/12/2023	
		117202101			01/12/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
THE COMMISSION 4510 DUR		RALEIGH ROAD				
THE COVINGTON RALEIGH,		I, NC 27615				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE	
				DEI IGIENGT)		
{D 358}	Continued From page	e 14	{D 358}			
	. •					
	12/23/22.					
	_	for Lantus 12 units twice				
	daily with a start date					
		were administered at				
	· ·	rom 12/27/22 through				
	12/31/22.					
		nentation any dose of Lantus				
		12/24/22, 12/25/22 and				
	12/26/22.					
	Tolonhana intonvious	vith a pharmacist from the				
	-	•				
	10:08am revealed:	harmacy on 01/13/23 at				
		ed the order for Lantus 12				
		esident #3 on 12/22/22.				
	-The order was enter					
		pharmacist and entered on				
	to the eMAR on 12/22	· ·				
		#3 was delivered to the				
	facility on 12/23/22.	Was delivered to the				
	•	ed the new order for Lantus				
		start on 12/23/22 and all				
	,	rs to stop at midnight on				
	12/22/22.					
	-Not getting Lantus co	ould cause high blood sugar				
	levels.	5				
	-High blood sugar lev	els have long term				
	consequences affecti	_				
	multiple other organ f					
	-Lantus was a long-ad	cting insulin that mimicked				
	normal basal levels of	f insulin in the body.				
		interview with a second shift				
	, ,	on 01/12/23 at 3:29pm was				
	unsuccessful.					
		t #3's current FL-2 dated				
		order for Floranex one				
	packet twice daily (a p	probiotic supplement).				

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL 002181 B. WING		R		
		HAL092181	B. WIIVO		01/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4510 DU	RALEIGH ROAD			
THE COVINGTON		H, NC 27615				
			1, 140 27013	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-/	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
		,		DEFICIENCY)		
{D 358}	Continued From page	e 15	{D 358}			
	Review of Resident #	3's physician's order dated				
	01/05/23 revealed an					
	Floranex.	order to discontinue				
	i ioranex.					
	Observation of Posid	ent #3's medications on				
	-					
	no Floranex for the re	3:41pm revealed there was				
	no rioranex for the re	sident.				
	Review of Resident #	21a Navambar 2022				
		administration record				
	(eMAR) revealed:					
	_	or Floranex one packet				
	twice daily with a star					
	-There was documen					
		00pm on 11/16/22 through				
	8:00pm on 11/25/22.					
		26/22 through 8:00am on				
		ere administered with a				
		n pharmacy for the reason.				
		28/22 through 8:00pm on				
	11/30/22, 5 doses we	re documented as				
	administered.					
	Review of Resident #	3's December 2022 eMAR				
	revealed:					
	-There was an entry f	or Floranex one packet				
	twice daily.					
	-There was documen	tation 35 of 62 doses were				
		/01/22 through 12/31/22.				
	-There was documen	tation 27 doses were not				
		efusal (2), delayed (1), will				
		order (1), on hold (13),				
		aiting for pharmacy (8) and				
	difficulty obtaining me	edication (1).				
	-There was documen	tation on 12/29/22 that the				
	PCP was notified of the	he difficulty obtaining the				
	medication.	·				
	Review of Resident #	3's physician's orders				

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revealed there were no orders to hold Floranex

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL092181	B. WING		01/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE COVINGTON			RALEIGH ROAD			
		H, NC 27615				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	2 16	{D 358}			
	between 12/01/22 and	d 12/31/22.				
	revealed: -There was an entry f twice daily with a stop -There was document administered from 01There was document administered due to w hospitalization (1). Telephone interview w facility's contracted pl 10:08am revealed: -The pharmacy did not Resident #3The pharmacy receiv packet twice daily for	tation 4 of 9 doses were /01/23 through 01/05/22. tation 5 doses were not vaiting for pharmacy (4) and with a pharmacist from the harmacy on 01/13/23 at ot dispense Floranex for red the order for Floranex 1 Resident #3 on 11/15/22.				
	stock and upon attem it required prior autho -The Floranex was ev	rentually profiled onto by the pharmacy billing				
		interview with Resident #3's :56am was unsuccessful.				
		ns, interviews and record nined Resident #3 was not				
	Refer to telephone int from the facility's cont 01/13/23 at 10:08am.	· · · · · · · · · · · · · · · · · · ·				
	Refer to interview with Coordinator (RCC) or	_				

Division of Health Service Regulation

STATE FORM 6899 17LP12 If continuation sheet 17 of 25

DIVISION	n Health Service Negu	ı			_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						,
HAL092181		B. WING		01/1	2/2023	
		11AE032101			01/1	2/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4510 DUR	ALEIGH ROAD			
THE COVI	NGTON	RALEIGH	, NC 27615			
0(1) 15	STIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N	0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
{D 358}	Continued From page	e 17	{D 358}			
	Refer to interview with	h the Administrator on				
	01/12/23 at 5:12pm.	if the Administrator on				
	2. Daview of Deciden	+ #41				
		t #1's current FL-2 dated				
	07/07/22 revealed dia	-				
	iyifipiledema, fiyperte	ension and Type II diabetes.				
	Paview of Pacident #	1's physicians order dated				
		ere was an order for Levemir				
	*	stered each evening at				
		an insulin medication used				
	,	r in people with diabetes.)				
	to control blood sugai	in people with diabetes.)				
	Review of Resident #	1's record on 01/11/23				
		o subsequent physician's				
	order to resume Leve	· · · · · · · · · · · · · · · · · · ·				
	Review of Resident #	1's physician's order dated				
	08/15/22 revealed an					
		start Levemir 14 units each				
	evening at bedtime.					
	J					
	Review of Resident #	1's physician's order dated				
	11/09/22 revealed an	order to discontinue				
	Levemir (no dose indi	icated) and start Levemir 18				
	units. (There was no t	time of administration				
	ordered.)					
	Review of Resident #	1's physician's order dated				
		order for to discontinue				
		icated) and start Levemir 20				
	units every evening a	t bedtime.				
	Review of Resident # 11/17/22 revealed	1's progress note dated				
		tation Resident #1's primary				
		ntacted to clarify the order				
	change to see if the a					
	continued.	· -				

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STATE FORM 6899 17LP12 If continuation sheet 18 of 25

MANE OF PROVIDER OR SUPPLIER THE COVINGTON 4510 DURALEIGH ROAD RALEIGH, NC 27615 (M1) D SUMMARY STATEMENT OF DEFICIENCIES DE PROVIDERS, CITY, STATE, ZPP CODE REPEIX REQUILATORY OR LSD (DENTIFYING INFORMATION) REPEIX TAG CONTINUED FROM THE APPROPRIATE DATE TAG CONTINUED FROM THE APPROPRIATE DATE CONTINUED FROM THE APPROPRIATE DATE CONTINUED FROM THE APPROPRIATE DATE CHORD THE WAS ACCUMENTATION OF THE APPROPRIATE DATE OFFICIAL STATE OFFI THE APPROPRIATE DATE OFFI THE WAS ACCUMENTATION OF THE APPROPRIATE DATE OFFI THE WAS ACCUMENTATION OF THE APPROPRIATE DATE There was documentation Levernin 12 units was not administered and evening at 8:00pm on 11/0/1/22 through 11/0/1/22	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER THE COVINCTON **SITEMATE ADDRESS, CITY, STATE_ZIP CODE** **4510 DURALEIGH ROAD RALE(R), NC 27615 **PROVIDER OR SUPPLIER **GENERAL FOR MUST BE PRECEDED BY PULL REFORMATION) (D. 3588) **Continued From page 18 Review of Resident #1's electronic medication administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units to be injected at bedtime. -There was documentation Levemir 12 units was administered each evening at 8:00pm from 11/0/22 through 11/0/32 and been discontinued. -There was a computerized entry for Levemir 14 units to be injected as bedtime. -There was documentation Levemir 14 units was administered each evening at 8:00pm from 11/0/4/22 through 11/0/9/22. -There was a computerized entry for Levemir 14 units to be injected as bedtime. -There was documentation Levemir 14 units was administered each evening at 8:00pm from 11/0/4/22 through 11/0/9/22. -There was a computerized entry for Levemir 14 units to be injected each day. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 12 units as administered each day at 8:00pm from 11/0/4/22 through 11/0/22 through 11/10/23 at 10:08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10:03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinued between the facility in August 2022 for the go live date on 10:03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22.							
Main Dural Eight Road RALEIGH, NC 27615 SUMMARY STATEMENT OF DEFICIENCIES Deficiency Must see Precisions Cach Deficiency Must see Precisions Cach Deficiency Must see Precisions Deficiency Deficiency Deficiency Deficiency Date Deficiency Date Deficiency Date Deficiency Date Date Deficiency Date Date Deficiency Date			HAL092181	B. WING			
CALL	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
(MA) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCISM (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (D 368) Continued From page 18 Review of Resident #1's electronic medication administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units was not administered record evening at 8:00pm on 11/01/22 through 11/03/22 -There was a computerized entry for Levemir 14 units to be injected at beatime. -There was a computerized entry for Levemir 14 units to be injected at beatime. -There was a computerized entry for Levemir 14 units to be injected at beatime. -There was a computerized entry for Levemir 14 units to be injected at beatime. -There was a computerized entry for Levemir 14 units to be injected at beatime. -There was a computerized entry for Levemir 18 units to be injected at beatime. -There was a computerized entry for Levemir 18 units to be injected at beatime. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 18 units to be injected each day. -There was documentation Levemir 18 units was administered each day at 8:00am from 11/11/22 through 11/17/22 in addition to the Levemir 12 units at 8:00pm for a total of 7 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10-03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22.	THE COVINGTON 4510 DUR			ALEIGH ROAD			
REEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Review of Resident #1's electronic medication administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units to be injected at bedtime. -There was a computerized entry for I units was administered each evening at 8:00pm on 11/01/22 through 11/10/32 and from 11/10/9/22 hocause the medication had been discontinued. -There was a computerized entry for Levemir 14 units to be injected at bedtime. -There was a computerized entry for Levemir 14 units to be injected at bedtime. -There was a computerized entry for Levemir 18 units to be injected at bedtime. -There was a computerized entry for Levemir 18 units to be injected at bedtime. -There was a computerized entry for Levemir 18 units to be injected at bedtime. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 12 units at 8:00pm for a total of 7 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10.08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10-03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22.			RALEIGH,	NC 27615			
Review of Resident #1's electronic medication administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units to be injected at bedtime. -There was documentation Levemir 12 units was administered each evening at 8:00pm on 11/01/22 through 11/03 and from 11/10/22 through 11/17/22. -There was documentation Levemir 12 units was not administered 11/04/22 through 11/109/22 because the medication had been discontinued. -There was a computerized entry for Levemir 14 units to be injected at bedtime. -There was a computerized entry for Levemir 14 units was administered each evening at 8:00pm from 11/04/22 through 11/09/22. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 18 units to be injected each day. -There was a computerized entry for Levemir 18 units to be injected each day. -There was documentation Levemir 18 units was administered each day at 8:00am from 11/11/22 through 11/17/22 in addition to the Levemir 12 units at 8:00pm for a total of 7 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10-03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
administration record (eMAR) for November 2022 revealed: -There was a computerized entry for Levemir 12 units to be injected at bedtime. -There was documentation Levemir 12 units was administered each evening at 8:00pm on 11/01/22 through 11/03 and from 11/10/22 through 11/17/22. -There was documentation Levemir 12 units was not administered 11/04/22 through 11/09/22 because the medication had been discontinued. -There was a computerized entry for Levemir 14 units to be injected at bedtime. -There was a computerized at 8:00pm from 11/04/22 through 11/09/22. -There was a computerized entry for Levemir 18 units to be injected each evening at 8:00pm from 11/04/22 through 11/09/22. -There was a computerized entry for Levemir 18 units to be injected each day. -There was documentation Levemir 18 units was administered each day at 8:00am from 11/11/22 through 11/17/22 in addition to the Levemir 12 units at 8:00pm for a total of 7 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/13/23 at 10:08am revealed -The pharmacy began reconciling medication orders for pending contract with the facility in August 2022 for the go live date on 10-03-22. -The Levemir order at the time of reconciliation for Resident #1 was discontinue Levemir 12 units and start Levemir 14 units each night at bedtime which was dated 08/11/22.	{D 358}	Continued From page	e 18	{D 358}			
-They never had an order for Levemir 12 units for Resident #1. Telephone interview with Resident #1's primary	{D 356}	Review of Resident # administration record revealed: -There was a comput units to be injected at -There was documen administered each ev 11/01/22 through 11/0 through 11/17/22There was documen not administered 11/0 because the medicati -There was a comput units to be injected at -There was documen administered each ev 11/04/22 through 11/0 -There was a comput units to be injected each ev 11/04/22 through 11/17 -There was a comput units to be injected each dathrough 11/17/22 in a units at 8:00pm for a Telephone interview v facility's contracted pl 10:08am revealed -The pharmacy began orders for pending co August 2022 for the garders for pending co August 2022 for the garders for Resident #1 was cand start Levemir 14 which was dated 08/17-They never had an ordersident #1.	erized entry for Levemir 12 bedtime. tation Levemir 12 units was rening at 8:00pm on 03 and from 11/10/22 tation Levemir 12 units was 14/22 through 11/09/22 on had been discontinued. erized entry for Levemir 14 bedtime. tation Levemir 14 units was 19/22. erized entry for Levemir 18 ach day. tation Levemir 18 units was 19/22. erized entry for Levemir 18 ach day. tation Levemir 18 units was 19/24 at 8:00am from 11/11/22 ddition to the Levemir 12 total of 7 days. With a pharmacist from the harmacy on 01/13/23 at 19/20 in reconciling medication 19/20 in reconciling medication 19/20 in reconciling medication 19/20 in the time of reconciliation 19/20 in the time 19/20 in the time of reconciliation 19/20 in the time 19/20 in the	{D 356}			

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revealed:

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
					R	
		HAL092181	B. WING			2/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	-	
THE COVI	NGTON	4510 DU	RALEIGH ROAD			
111L COVI		RALEIGH	I, NC 27615			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 19	{D 358}			
	-Levemir 12 units at be and 14 units was star Resident #1 and show administrationLevemir was a long a meant to be administed. There was little chan bloodsugar readings is adjusted his insulin be was important he be as prescribed to ensurcontrolledShe did not remember clarification of any Leven could have been mad linterview with the Resident #1 was still each evening at bedtities and reading at least each even with the regard Levemir orderThe PCP gave her the could not remember with did not document the Refer to telephone interest from the facility's continual to the condition of the facility's continual to the facility is continual	pedtime was discontinued ted in August 2022 for all not be on the eMAR for acting insulin and was not ered twice daily. ge in Resident #1's in November, but she ased on the values, so it administered the medication are his blood sugar was er being contacted for vemir order, but contact le with her office. Sident Care Coordinator 4:05pm revealed: receiving Levemir 12 units are in October 2022. We the order was continued ared in August 2022. #1's PCP on 11/17/22 and ling clarification of the expectation of the what that order was, and she PCP's response. Serview with a pharmacist tracted pharmacy on the Resident Care	[5 550]			
	01/12/23 at 5:12pm.	Ture Authinionator on				

Telephone interview with a pharmacist from the

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Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
HAL092181 B. WING			01/12/2023		
			I		1 01/12/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE COVI	NGTON		RALEIGH ROAD		
RALEIGH,		, NC 27615			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-/
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TAG	REGULATORT OR I	LOCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MATE
{D 358}	Continued From page	e 20	{D 358}		
	facility's contracted pl	harmacy on 01/13/23 at			
	10:08am revealed:				
		ed orders into their system,			
	a pharmacist reviewe				
	entered the order onto				
		pproved the order on the			
	eMAR.	o enter, discontinue and			
	modify orders directly				
		sed to enter orders; the			
		as intended to be pharmacy			
	driven.	as intended to be pharmacy			
	unven.				
	Interview with the Res	sident Care Coordinator			
	(RCC) on 01/12/23 at				
		cation administration record			
		ed the delay in starting			
	medications.	, G			
	-Every time there was	s a medication refill the			
	eMAR system reset th	he medication entry and			
	required her to approv	ve the medication for each			
	refill for the medicatio	n to be active on the eMAR.			
	-She was responsible	for sending medication			
	orders to the facility's	contracted pharmacy.			
		ssed the order and entered			
	the medication on the	• •			
		for approving medication			
		e eMAR by the pharmacy.			
		s not entered on the eMAR			
		e called the pharmacy to			
	follow up.	40/00/00 ***			
		om 12/22/22 did not come			
	through on the eMAR 12/27/22.	system for approval until			
		ted pharmacy was closed on			
	12/23/22 through 12/2				
		e ability to enter orders on			
		en the medication was in			
	the facility and availal				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL092181	B. WING		R 01/12/2023	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
THE COVINGTON		ALEIGH ROAD				
RALEIGH,			DROUBERIO BLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	21	{D 358}			
	5:12pm revealed: -The RCC was responded in the second was entered into the second representation of the second representation of the second representation in the second representation	the eMAR when the order system by the pharmacy. ility to make changes to the cation orders to be accurate				
	The facility failed to administer medications as ordered by the primary care provider (PCP) for 3 of 5 sampled residents resulting in Resident #4, who was receiving hospice care, not receiving scheduled morphine for 3 days and Resident #3, who had diabetes mellitus, not receiving Lantus for 3 days which was detrimental to the health, safety and wellbeing of these residents and constitutes an Unabated Type B Violation.					
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/13/23 for this violation.					
{D 465}	10A NCAC 13F .1308 (a) Staff shall be presufficient number to nesidents; but at no tile one staff person, who training requirements Section, for up to eight second shifts and 1 hadditional resident; and	me shall there be less than meets the orientation and in Rule .1309 of this nt residents on first and our of staff time for each and one staff person for up to shift and .8 hours of staff	{D 465}			

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Division of Health Service Regulation					T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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HAL092181		B. WING		01/12/2023		
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
THE COVI	NGTON		RALEIGH ROAD			
		RALEIGH	I, NC 27615			
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IAG			IAG	DEFICIENCY)		
45 445						
{D 465}	Continued From page	e 22	{D 465}			
	This Rule is not met	as evidenced by:				
		ns, record reviews, and				
	interviews, the facility					
		staff were always present to				
		sidents in the special care				
	unit (SCU), for 1 of 9					
	(),	•				
	The findings are:					
	Review of the facility'	s license effective 01/01/23				
		as licensed for a capacity of				
		0 beds for the assisted living				
	(AL) area and 60 bed	_				
	(AL) area and oo bed	is for the GGG.				
		cility on 01/11/23 at 9:00am				
	revealed:					
	-	ulti-level facility consisting of				
	` •	d floor, first and second				
	floors).	t (SCU) was located on the				
		accessible by locked doors to				
		gh the elevator access which				
		ad access to enter the first				
	floor.	ad added to criter the mat				
		SCU census on 01/11/23				
	was 21 residents.	200 3011040 311 317 11723				
	Review of the facility's	s resident census report,				
		t sheet, and staff timecards				
	dated 01/01/23 revea					
	-One first shift out of	3 first shifts sampled was				
		on for 21 SCU residents.				
		is 21 which required 21 aide				
	hours on first and sec	cond shifts.				
	-The first shift assigni	ment had two PCAs				
	assigned to the SCU.					
	-Staff timecards had a					
		rovided on SCU for first shift				
	for a shortage of 5 ho					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			125		R
	HAL092181 B. WING		01/12/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
THE COVINGTON 4510 DUR			ALEIGH ROAD		
THE COVI	NGTON	RALEIGH	, NC 27615		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 465}	Continued From page	23	{D 465}		
	revealed there were u	on 01/11/23 at 10:00am usually enough staff on duty ay; if there was a shortage, it			
	4:30pm revealed: -The medication aides shifts 7:00am to 7:00p both weekdays and w -The personal care ai shifts Monday - Friday 3:00pm-11:00pm 2nd 3rd shift)The PCAs worked 12 7:00pm and 7:00pm to 12 There were MAs and facility to help cover to 12 There was not a Specifor the facility that she seen the Resident Care	des (PCAs) worked 8-hour y (7:00am-3:00pm 1st shift, shift and 11:00pm-7:00am 2-hour shifts, 7:00am to o 7:00am, on the weekends. I PCAs working from a sister the shifts. cial Care Unit Coordinator e knew about; she had only			
	at 8:25am revealed: -She made the sched assignment sheetsShe made sure they number of staff to covresidentsThe SCU staff based staff on 1st and 2nd shiftThe assignment sheefloor/area the staff we lif staff called out, the coverage for their shirting-The staff on duty could be staff who received	were running the right ver the census of the I on the census now was 4 shifts and 3 staff on third et would designate which ere assigned to work. ey would try and find			

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let her know as well.

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MALE OF PROVIDER OR SUPPLIER THE COVINGTON SUMMARY STATEMENT OF DEPICIENCES TAG SUMMARY STATEMENT OF DEPICIENCES TAG SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) (D 465) Confued From page 24 -The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the floor as a staff member if needed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4510 DURALEIGH ROAD RALEIGH, NC 27615 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE [EACH CORSS-REFERENCED TO THE APPROPR	HAL092181		B. WING					
RALEIGH, NC 27615 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) {D 465} Continued From page 24 -The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the								
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) {D 465} Continued From page 24 -The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the	I THE COVINGTON							
-The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the	PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
	{D 465}	-The salaried staff, such as the Resident Care Coordinator or herself the ED, could work the		{D 465}	DEFICIENC	YY)		

Division of Health Service Regulation

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