STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from March 14, 2023 to March 17, 2023.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure inside temperatures of 75 degrees F (Fahrenheit) were maintained under winter conditions for resident rooms (rooms E-3, E-9, D-1, D-7, F-2, and C-4). The findings are: Review of the National Weather statistics recorded temperatures for the area where the facility was located on 03/14/23, 03/15/23, and 03/16/23 revealed: -The outside temperature on 03/14/23 from 12:00am to 10:00am was 28 degrees. -The highest temperature for the area on 03/14/23 was 48 degrees F. -The outside temperature on 03/15/23 from 12:00am to 10:00am was 25 degrees F. -The highest temperature for the area on 03/15/23 was 55 degrees F. -The outside temperature on 03/16/23 from 12:00am to 10:00am was 28 degrees F. -The highest temperature for the area on	D 106		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 106	Continued From page 1 03/16/23 was 65 degrees F. According to the National Weather Service a freeze occurs when the temperature drops below 32°F. Freezes and their effects are significant and occur when the air temperature is in the mid-30's. According to the Center for Disease Control and Prevention extended long periods of cold was especially dangerous for older adults with inadequate heating as they were the most at risk. Hypothermia was most likely at very cold temperatures, especially when below freezing. Observations on 03/15/23 at 6:02pm revealed: -There were no thermostats in the hallways on the C, D, E, and F hallways to measure the temperature. -The temperature measuring devices (thermostat) on the C and D hallways were in the linen closet. -There were two thermostats in each linen closet. -The thermostats were located on the wall between two shelves; less than 6 inches from the laundry room with the washer and dryer, and located 2 and 1/2 feet from the furnace. -The temperature reading on the C hallway thermostat was 80 degrees F on one thermostat and 81 degrees F on the second thermostat. -The temperature reading on the D hallway thermostat was 80 degrees F on one thermostat and 82 degrees F on the second thermostat. -There was no thermostat or temperature measuring device on the E and F hallways. Observation of the temperature in resident room E-3 on 03/15/23 at 9:35am revealed: -There was no thermostat or temperature measuring device in resident room E-3. -There was a baseboard heating unit located	D 106		

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 2	D 106		

directly below the window.
-The unit was missing the control knob and could not be turned on.
-The unit was cold to the touch.

Interview with the resident who resided in room E-3 on 03/14/23 at 9:38am revealed:
-The room was cold.
-She was always cold in the room.
-She had a heating pad that she used during the daytime.
-The heating pad helped with her aching back and it kept her warm.

Interview with the family member of the resident who resided in room E-3 on 03/16/23 at 3:15pm revealed:
-The resident moved into the facility in October 2022.
-Since the resident moved into the facility, the major complaint had been that she was cold.
-The bathroom was so cold the resident refused to do personal hygiene care daily, which was not common for the resident.
-She had discussed the issue many times with the Executive Director (ED) and he said that it would be taken care of, but nothing had been done.

Interview with the Assistant Maintenance Director on 03/14/23 at 3:14pm revealed:
-He visited the rooms of residents that had complaints daily.
-A few weeks ago it was warm outside and the air condition system was turned on.
-The resident in room E-3 complained of being cold so he closed the vents in the room and the bathroom.
-When the weather turned cold he forgot to reopen the vents.

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 3 -Because the vents were not opened, no heat was coming in the resident's room or bathroom. -No one made him aware the baseboard heating unit in room E-3 was not working or that the resident did not know how to use the unit. Interview with the ED on 03/16/23 at 4:55pm revealed: -He went to see the resident in room E-3 daily because the family called with a complaint almost daily. -Two weeks ago, it was almost 80 degrees outside, and the air condition was turned on. -The resident complained about being cold so the vents in her room were probably closed. -He had not checked the vents to ensure they were open to receive heat. -Although he was in the resident's room daily, he did not know the control knob on the heater was broken. -He had never checked or instructed the maintenance staff to check the temperature in resident room E-3. Observation of the baseboard heating unit in resident room C-4 on 03/14/23 at 10:48am revealed: -There was a baseboard heating unit attached to the wall, directly underneath the window. -The heating unit had a knob that was designed to turn the heater off and on. -The heating unit was not on and cold to the touch. -There was a portable oil-filled radiator with programmable heat settings. -The 1200-watt heating unit had an attached black cord that extended from the unit and was plugged into the electrical wall outlet. -There was a round knob that could be turned from numbers 1 to 7 printed on the unit.	D 106		

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 4 -Below the knob were two orange switches pushed up towards the ceiling indicating the unit was on. -There was round knob highlighted with orange, which was a 24-hour programmable clock. -The manual instructions for the heater indicated "the heater is hot when in use. To avoid burns, do not let bare skin touch hot surfaces. Use the built-in handle when moving this heater. Keep combustible materials, such as furniture, pillows, bedding, papers, clothes, and curtains at least 3 feet away from the front, top, sides and rear of the heater. Extreme caution is necessary when the heater is used whenever the heater is left unattended. Always unplug heater when not in use." Observation of the room temperature in resident room C-4 on 03/15/23 at 8:01am revealed the temperature in the room was 71 degrees F based on the thermostat attached to the clock near the resident's television. Interview with the resident who resided in room C-4 on 03/15/23 at 8:05am revealed: -He was always cold in his room. -In the winter, it was cold outside and inside. -In the summer, the air conditioner (AC) made his room cold. Observation of resident room D-7 on 03/14/23 at 9:43am revealed: -There was no thermostat in the room. -There was no baseboard heating unit in the room. -The room felt cold, especially near the window, which was located on the side of the resident's bed. Interview with the resident who resided in room	D 106		

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 5 D-7 on 03/14/23 at 9:46am revealed: -There was no heating unit in her room and she was always cold. -There was no thermostat in her room, to show the temperature in the room. -The vents in the ceiling were blowing out cold air, making the room colder. -She was always cold, especially in the evening when sitting near the window. -During the daytime, she did not go near her bed because it was near the window and there was cold air by the window. -During the daytime, she sat in her wheelchair near the entrance door to the room because it was cold by her bed, which was near the window. -She had 3 blankets on her bed to keep her warm at night. -She even went to bed early; around 7:00pm, to get under the covers to warm up. -She sometimes woke up shaking and because her room was so cold. -The room had been cold since moved into the facility on 02/14/23. -She had told medication aide (MA), personal care aide (PCA) and maintenance staff that she was cold, but nothing had been done. Observation of the baseboard heating unit in resident room D-1 on 03/15/23 at 10:10am revealed: -The heating unit had a knob that was designed to turn the heater off and on. -The dial on the heating unit was turned on but not on high. -The heating unit was cold to touch with no heat coming out. -The unit was above the window; the metal on the window was cold to the touch and a breeze of cold air was felt coming through the window.	D 106		

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 6 Interview with the resident who resided in room D-1 03/15/23 at 10:14am revealed: -Her room was "freezing cold." -She was coughing, and had congestion caused by her room being cold. -She had told staff (MA and PCA) the room was cold. -She did not remember maintenance staff coming to her room. -She had observed the unit underneath her window, but did not know it was a heating unit. -She did not know how to work the heating unit. -When she told staff, she was cold they would tell her okay, but she did not know what they did because it was still cold. Observation of the heating unit in resident room E-9 on 03/16/23 at 8:24am revealed: -There was a baseboard heating unit in resident room E-9. -The baseboard heating unit was under the resident's window. -There was a knob that was designed to turn the heater off and on. -The heating unit was not on and was cold to touch. -There was no thermostat in the room. Interview with the resident who resided in room E-9 on 03/16/23 at 8:27am revealed: -She did not like to complain and had not made staff aware her room was cold. -There was no consistency with warmth in her room, when the air condition was on it got colder. Observation of the heating unit in resident room F-2 on 03/15/23 at 8:28am revealed: -There was a baseboard heating unit under the resident's window. -The heating unit was not on and was cold to	D 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 106	Continued From page 7	D 106		

touch.
-There was no thermostat or temperature measuring device in the room.

Interview with the resident who resided in room F-2 on 03/15/23 at 8:28am revealed:
-Her room was cold, but the bathroom was very cold.
-She dreaded when she had to take a shower because the bathroom was cold.

Interview with a PCA on 03/14/23 at 9:58am revealed:
-Residents complained a lot about being cold, especially on the D hallway.
-When residents complained about being cold, she told the MA.
-She did not check the vents and she did not know how to operate the units under the window; she did not know they were for heat.
-She did not provide another blanket for the residents.

Interview with another PCA on 03/15/23 at 10:18am revealed:
-She got complaints all the time about residents' rooms being cold from the residents in rooms D-1, D-6, D-7, D-9 and E-3.
-When the residents told her, they were cold she told the Maintenance Director and/or the Assistant Maintenance Director.
-She did not know the units under the window provided heat; no one had made her aware how to use the units.

Interview with a third PCA on 03/15/23 at 4:09pm revealed:
-Since he worked at the facility, residents on the D hallway, E hallway and F hallway, complained about being cold.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 8 -He did not know what to do, so he told the residents it was going to warm up. -He did not know who to tell when residents complained about being cold. -He had observed the units that were underneath the windows in the residents room, but he did not realize they were baseboard heaters. -He had no idea how to operate the units. Interview with a MA on 03/16/23 at 3:50pm revealed: -When a resident complained about being cold, she turned the temperature up. -She did not check the units in the rooms under the windows to ensure they were on and operating. -She was unaware the units provided heat to the residents. -She left at 11:00pm and was not aware the resident's complained of being cold overnight. Interview with the Assistant Maintenance Director on 03/14/23 at 3:14pm revealed: -When a resident complained about being cold and the heat was on, he checked the vents in the residents' room to ensure they were open. -If the resident complained of being cold and the AC was on, he made sure the vents were closed. -He had not checked the baseboard heating units in all residents' rooms to ensure they were working properly. -He tried to visit each floor of the facility daily to identify problems, but he depended on the staff to let him know when a resident room had problems. Telephone interview with the Maintenance Director on 03/14/23 at 12:25pm revealed: -She normally kept the heat in the facility set at 72 degrees F.	D 106		

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 106	Continued From page 9 -She was unable to recall the MA and PCA telling her residents were cold. -If a resident complained about being cold, she checked the resident's ceiling vents to see if they were opened or closed. -She did not check the baseboard heating units to see if they were on or operable. -She was aware the temperature outside had been in the 20's and there had been freeze warnings for the past few nights. -She had been off work for the past two days and her assistant should be notified when residents complained about being cold. -There was a problem with the facility's thermostats being in the linen closets and obtaining an accurate reading for the residents' rooms. -The thermostats had to be turned up high to get some areas of the facility warm due to the readings coming from the linen closet. -Plans had been discussed to move the thermostats out of the linen closets for a more accurate temperature reading, but as of today's date that plan had not been implemented.	D 106		
D 108	10A NCAC 13F .0311(b)(2) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. This rule apply to new and existing facilities. This Rule is not met as evidenced by:	D 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 108	Continued From page 10 Based on observations and interviews, the facility failed to ensure portable electric heaters were not used in two residents' rooms (rooms E-3 and C-4). The findings are: Review of the National Weather statistics recorded temperatures for the area where the facility was located on 03/14/23, 03/15/23, and 03/16/23 revealed: -The outside temperature on 03/14/23 ranged between 28 and 48 degrees Fahrenheit (F). -The outside temperature on 03/15/23 ranged between 25 and 55 degrees F. The outside temperature on 03/16/23 ranged between 28 and 65 degrees F. 1. Observation of resident room E-3 on 03/15/23 at 9:35am revealed: -There was no thermostat or temperature measuring device in resident room E-3. -The room felt cold, but the bathroom was extremely cold. -The resident had a portable heating unit placed directly behind a chair in the living area of the room; near the bathroom and the bed. -There was a black cord that extended from the portable electric heater to an electrical outlet in the wall. -There was a small red light glowing on the top front panel of the portable heater, indicating the unit was on. -There was warm air blowing from the front of the heater. -The heater control was set on 76. -The heat from the heater could be felt up to 3 feet away from the unit. -There was a warning printed on the back of the unit "the use of such devices may create a fire	D 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 108	Continued From page 11	D 108		

hazard. Plug the unit directly into a 120-volt wall outlet only."

Interview with the resident who resided in room E-3 on 03/14/23 at 9:38am revealed:
-Her room was cold.
-She was always cold in the room.
-She had a portable stand alone heater to keep warm.
-She turned the heater on in the daytime, but made sure to turn it off at night.

Interview with the family member of the resident who resided in room E-3 on 03/16/23 at 3:15pm revealed:
-The resident moved into the facility in October 2022.
-Since the resident moved into the facility the major complaint had been, she was cold.
-The bathroom was so cold the resident refused to do personal hygiene care daily, which was not common for the resident.
-She had discussed the issue many times with the Executive Director (ED) and he said that it would be taken care of, but nothing had been done.
-She got the resident the portable heater because the cold was unbearable.
-No one had told or mentioned to her that portable heaters were not allowed in the facility.

Interview with a personal care aide (PCA) on 03/14/23 at 9:58am revealed:
-The resident in room E-3 had a portable heater to keep warm.
-Everyone was aware she had the heater.
-No one had said the heater was not allowed in the facility.

Interview with a medication aide (MA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 108	Continued From page 12 03/15/23 at 4:13pm revealed: -She gave the resident in room E-3 medications but had not noticed the portable heater. -No one told her that portable heating units were not allowed in the facility. Interview with the ED on 03/16/23 at 4:55pm revealed: -He went to see the resident in room E-3 daily because the family called with a complaint almost daily. -Two weeks ago, it was almost 80 degrees outside, and the air condition was turned on. -The resident complained about being cold so the vents in her room were probably closed. -He had not checked the vents to ensure they were open to receive heat. -He did not know the resident had a portable heating unit in the room. Interview with the Assistant Maintenance Director on 03/14/23 at 3:14pm revealed: -He had been in resident E-3 a few times to adjust the vents. -He had not noticed the portable heating unit. -Portable heaters were not allowed in the facility. -No resident should have a portable heater. Refer to telephone interview with the Maintenance Director on 03/14/23 at 12:25pm. 2. Observation of the baseboard heating unit in resident room C-4 on 03/14/23 at 10:48am revealed: -There was a portable oil-filled radiator with programmable heat settings. -The 1200-watt heating unit had an attached black cord that extended from the unit and was plugged into the electrical wall outlet. -There was a round knob that could turn from	D 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 108	Continued From page 13	D 108		

numbers 1 to 7 printed on the unit.
-Below the round knob was two orange switches pushed up towards to the ceiling indicating the unit was on.
-Both knobs were in the same position and there was no heat coming from the unit.
-There was a round knob highlighted in orange with a 24-hour programmable clock.
-The manual instructions for the heater indicated "the heater is hot when in use. To avoid burns, do not let bare skin touch hot surfaces. Use the built-in handle when moving this heater. Keep combustible materials, such as furniture, pillows, bedding, papers, clothes, and curtains at least 3 feet away from the front, top, sides and rear of the heater. Extreme caution is necessary when the heater is used whenever the heater is left unattended. Always unplug heater when not in use."

Observation of the room temperature in resident room C-4 on 03/15/23 at 8:01am revealed the temperature in the room was 71 degrees, based on the thermostat attached to the clock near the resident's television.

Interview with the resident who resided in room C-4 on 03/15/23 at 8:05am revealed:
-He was always cold in his room.
-In the winter, it was cold outside and inside.
-In the summer, the air conditioner (AC) made his room cold.
-When he moved into the facility 1 and 1/2 years ago, the maintenance person gave him the portable heater because he complained about being cold.
-He used the heater non-stop.

Interview with a PCA on 03/14/23 at 9:58am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 108	Continued From page 14 -The resident in room C-4 had a portable heater. -The heater could be seen from the doorway. -No one had made staff aware that portable heaters were not allowed in the facility. Interview with a MA on 03/16/23 at 5:40pm revealed: -The resident in room C-4 had a portable heater. -The resident had the heater for some time. -The heater was easily viewable. -No one had said the resident could not have the heater. Interview with the ED on 03/16/23 at 4:55pm revealed: -He did not know there was a portable heating unit in resident room C-4. -The maintenance staff should ensure portable heaters were not being used. -There was no system in place for checking the residents' rooms to identify portable heating units. -If a resident complained of being cold the maintenance staff should take care of that. Interview with the Assistant Maintenance Director on 03/14/23 at 3:14pm revealed: -He did not recall visiting resident room C-4 recently. -He did not know the resident used a portable heater. -Portable heating units were not allowed at the facility. -There was no system in place to check residents' rooms to ensure portable heaters were not being used. Refer to telephone interview with the Maintenance Director on 03/14/23 at 12:25pm. Telephone interview with the Maintenance	D 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 108	Continued From page 15 Director on 03/14/23 at 12:25pm revealed: -She normally kept the heat in the facility set at 72 degrees F. -She was not aware that some residents used portable heating units to keep warm. -Portable heating units were not allowed in the facility. -She had not checked the residents' rooms to ensure the units were not being used. -When a resident moved into the facility, they were given a list of things that were not allowed; the portable heaters should be on the list. -There was no system in place for checking residents' rooms to ensure portable heating units were not used. -There was no system in place for checking temperatures in the residents' rooms.	D 108		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimal of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 8 of 8 fixtures (sinks) used by	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 16	D 113		

the residents.

The findings are:

Observation of the facility during the initial tour on 03/14/23 from 9:10am to 11:20am revealed:
-The facility was a 2-story structure with residents' rooms on each floor.
-The floors were divided into wings with each wing consisting of 8 to 10 resident rooms.

Observation of the hot water temperature in resident room B-6 on 03/14/23 at 9:45am revealed the hot water temperature at the sink was 124 degrees F.

Interview with the resident who resided in room B-6 on 03/14/23 at 9:55am revealed:
-He had been in different rooms in the facility during his stay at the facility.
-He showered and groomed independently.
-He had not been burned by the hot water.
-He knew to add cold water to the hot water to adjust to a temperature comfortable to him.

Observation of the hot water temperature in resident room B-4 on 03/14/23 at 9:55am revealed the hot water temperature at the sink was 128 degrees F.

Interview with the resident who resided in room B-4 on 03/14/23 at 9:55am revealed:
-Staff assisted him with his bathing.
-He mostly took a sponge bath.
-He infrequently used the sink for grooming.
-He had not been burned by the hot water.
-He knew to add cold water to the hot water to adjust to a temperature comfortable to him.

Observation of the hot water temperature in the A

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 113	Continued From page 17 Hall spa room sink on 03/14/23 at 10:40am revealed the hot water temperature at the sink was 122 degrees F. Observation of the hot water temperature in resident room A-7 on 03/14/23 at 10:40am revealed the hot water temperature at the sink was 122 degrees F. Interview with the resident who resided in room A-7 on 03/14/23 at 10:40am revealed: -Staff assisted him with his bathing. -He had not been burned by the hot water. Observation of the hot water temperature in resident room C-1 on 03/14/23 at 10:44am revealed the hot water temperature at the sink was 122 degrees F. Interview with the resident who resided in room C-1 on 03/14/23 at 10:50am revealed staff assisted her with his bathing. Review of the facility's most recent hot water temperature log dated 03/06/23 revealed: -There were 2 hot water temperatures documented for each of the 6 wings for a total of 12 temperatures recorded. -There were no times documented on the log. -Temperatures documented on the log ranged from 110 degrees Fahrenheit (F) to 112 degrees F. Recheck of the hot water temperature at the sink in room B-6 on 03/14/23 at 3:50pm revealed a temperature of 120 degrees F. Recheck of the hot water temperature at the sink in room B-6 on 03/15/23 at 1:04pm revealed a temperature of 106 degrees F.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 18 Recheck of the hot water temperature at the sink in room B-4 on 03/14/23 at 3:50pm revealed a temperature of 122 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/14/23 at 3:53pm revealed a temperature of 114 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/15/23 at 1:08pm revealed a temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/15/23 at 1:15pm revealed a temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room A-7 on 03/14/23 at 3:55pm revealed a temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room A-7 on 03/15/23 at 1:15pm revealed a temperature of 108 degrees F. Recheck of the hot water temperature at the sink in room C-1 on 03/15/23 at 3:57pm revealed a temperature of 109 degrees F. Observation of hot water temperatures in resident room D-9 on 03/14/23 at 9:10am revealed, the hot water temperature at the bathroom sink in was 122 degrees Fahrenheit (F). Interview with the resident who resided in room D-9 on 03/14/23 at 9:16am revealed: -The water was hot some days and some days he had to let the water run to get hot water. -If the water was too hot, he added in cold water.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 113	Continued From page 19 Observation of the hot water temperature in resident room E-9 on 03/14/23 at 9:40am revealed the hot water temperature at the sink was 124 degrees F. Interview with the resident who resided in room E-9 on 03/14/23 at 9:43am revealed she was able to add in cold water to adjust the hot water temperature to her comfort. Observation of the hot water temperature in resident room F-10 on 03/14/23 at 9:51am revealed the hot water temperature at the bathroom sink was 124 degrees F. Interview with the resident who resided in room F-10 on 03/14/23 at 9:53am revealed: -She was unaware the hot water temperature was hot. -When she used the hot water, she mixed in cold water to make the temperature comfortable. Interview with a first shift personal care aide (PCA) on 03/14/23 at 11:45am revealed: -No resident had complained to her related to the hot water temperature being too hot. -The maintenance staff checked hot water temperatures randomly. -She assisted residents with showers. -When assisting the residents, she adjusted the hot water temperatures to be comfortable for the resident. Calibration of thermometers on 03/14/23 at 11:30am revealed: -The surveyors' thermometers each read 32 degrees F during calibration with an ice water slurry and needed no adjustment to temperatures. -The facility's thermometer read 32.3 degrees F	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 113	Continued From page 20 with an ice water slurry. Interview with a first shift medication aide (MA) on 03/14/23 at 11:48am revealed no staff or resident had complained about hot water temperatures or having been burned by elevated hot water temperatures. Interview with the Administrator on 03/14/23 at 11:50am revealed: -The Maintenance Director was responsible to ensure hot water temperatures were maintained between 100 degrees F to 116 degrees F. -The Maintenance Director measured hot water temperatures routinely throughout the facility. -The Maintenance Director had not reported elevated hot water temperatures. -He did not know the hot water temperature was elevated above 116 degrees throughout the facility. -He would ensure signs were posted in the residents' bathrooms throughout the facility alerting the residents for elevated hot water temperatures. Interview with the Maintenance Assistant on 03/14/23 at 12:45pm revealed: -He assisted with providing maintenance to the facility. -He did not routinely take the hot water temperatures within the facility, but was familiar with the process. -He did not know the hot water temperatures in the facility were above 116 degrees F. -The facility had a mixing valve for adding cold water to the hot water in the water heater room. -He would make adjustments to the hot water to ensure the maximum hot water temperature was less than 116 degrees F. -He would inform the Administrator when the	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 113	Continued From page 21	D 113		

elevated hot water temperatures were below 116 degrees F.

Observation on 03/14/23 at 1:00pm revealed elevated hot water signs were being posted in all residents' rooms.

Interview with another first shift PCA on 03/14/23 at 2:43pm revealed:
-She assisted residents with showers.
-When assisting the residents, she adjusted the hot water temperatures to be comfortable for the resident.

Interview with a second shift PCA on 03/14/23 at 4:01pm revealed:
-He assisted residents with showers on the second shift.
-When preparing a resident for a shower, he turned on the hot water and mixed in cold water and asked the resident if the water temperature was comfortable.

Telephone interview with the Maintenance Director on 03/15/23 at 12:15pm revealed:
-On yesterday (03/14/23), the Maintenance Assistant made her aware the hot water temperatures were up.
-She checked hot water temperatures last week and did not get any temperatures greater than 115 degrees F.
-When the hot water was not used, it sat in the water tank at a certain temperature.
-The more the hot water was used the hot water temperature would regulate itself.
-Once a week, she calibrated her thermometer with cold water to reset the thermometer.
-The circulating pumps were replaced in the assisted living in January 2023.
-When the water was standing in the water tank,

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 113	Continued From page 22 it was a matter of flushing out the system. Recheck of the hot water temperature at the sink in room B-6 on 03/14/23 at 3:50pm revealed a temperature of 120 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/14/23 at 3:50pm revealed a temperature of 122 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/14/23 at 3:53pm revealed a temperature of 114 degrees F. Recheck of the hot water temperature at the sink in room A-7 on 03/14/23 at 3:55pm revealed a temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room D-9 on 03/14/23 at 3:55pm revealed a temperature of 122 degrees F. Recheck of the hot water temperature at the sink in room E-9 on 03/14/23 at 3:50pm revealed a temperature of 124 degrees F. Recheck of the hot water temperature in resident room F-10 at the sink on 03/14/23 at 3:47pm revealed the hot water was 124 degrees F. Recheck of the hot water temperature at the sink in room B-6 on 03/15/23 at 1:04pm revealed a temperature of 106 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/15/23 at 1:08pm revealed a temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room B-4 on 03/15/23 at 1:15pm revealed a	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 113	Continued From page 23 temperature of 110 degrees F. Recheck of the hot water temperature at the sink in room A-7 on 03/15/23 at 1:15pm revealed a temperature of 108 degrees F. Recheck of the hot water temperature at the sink in room C-1 on 03/15/23 at 3:57pm revealed a temperature of 109 degrees F. _____ The facility failed to ensure hot water temperatures for 8 fixtures used by residents were maintained between 100-116 degrees F. A hot water temperature of 128 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility a plan of protection in accordance with G.S. 131D-34 on 03/14/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2023.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 125	Continued From page 24 Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 sampled medication aides (MA) (Staff C) completed the 5, 10 or 15-hour MA training course and passed the written MA exam within 60 days of hire as a MA. The findings are: Review of Staff C's, medication aide (MA) personnel record revealed: - Staff C was hired on 12/06/22. - Staff C had a medication clinical skills validation completed on 12/20/22. - There was no documentation Staff C completed the 5, 10 or 15-hour MA training course. -There was no documentation Staff C had taken and passed the written MA exam within 60-days of hire as a MA. Observation of Staff C on 03/16/23 at 4:39pm revealed she was administering medications to the residents. Review of residents' March 2023 medication administration record (MAR) revealed there was documentation Staff C administered medication on 9 days in March 2023.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 125	Continued From page 25 Telephone interview with Staff C on 03/17/23 at 6:58pm revealed: -She started working at the facility in December 2022 as a MA. -When she worked, she administered medications to the residents. -She had not completed the 5, 10 or 15-hour MA training course. -She had not taken or scheduled to take the written MA examination. Interview with the Business Office Manager (BOM) on 03/17/23 at 4:03pm revealed: -She did not have documentation Staff C completed the 5, 10 or 15-hour MA training course. -She checked the MA Registry and was unable to find Staff C's name. -When a MA was hired, she was responsible for scheduling the MA training with the nurse consultant. Interview with the Executive Director (ED) on 03/17/23 at 6:50pm revealed: -The BOM was responsible to ensure that staff training was completed including the 5, 10 or 15-hour MA training. -The BOM was supposed to contact the nurse consultant to schedule training. [Refer to tag D 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)] The facility failed to ensure one staff, who worked as a MA and administered medications to residents completed the 5, 10 or 15-hour MA competency training and had taken and passed the MA examination within 60 days from hire which resulted in errors in medication administration. The facility's failure was	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 125	Continued From page 26 detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/20/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 01, 2023.	D 125		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 6 sampled staff (Staff A and E) were tested for tuberculosis (TB) disease upon hire. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -She was hired on 10/04/22. -There was no documentation of a TB skin test having been completed.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 131	Continued From page 27 Interview with Staff A on 03/17/23 at 7:04pm revealed: -She started working at the facility in October 2022. -She had not completed a TB skin test since she started working at the facility. -Today, the Business Office Manager (BOM) informed her about taking the TB skin test. Interview with the BOM on 03/17/23 at 4:03pm revealed: -She was responsible for ensuring staffs' TB skin test were completed. -When new staff were hired, she gave the staff paperwork to take to the health and wellness center to obtain one TB skin test and a second TB skin test. -The staff was supposed to have both TB skin tests completed prior to finishing orientation. -She kept a spreadsheet to remind her of staff who needed to complete TB skin tests so she would follow-up when staff did not return the completed test. -She forgot and did not follow-up on why Staff A did not have a TB skin test. Interview with the Executive Director (ED) on 03/17/23 at 6:50pm revealed: -When a new staff was hired, the BOM was to provide the paperwork needed for the staff to obtain TB skin test. -The BOM was to ensure the TB skin tests were obtained by the time orientation was completed. 2. Review of Staff E's, medication aide (MA), personnel record revealed: -She was hired on 01/06/21. -There was documentation of a TB skin test administered on 01/12/22, but no documentation the test was read.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 131	Continued From page 28 -There was documentation of a second TB skin test administered on 01/28/22, with the date documented as read on 01/30/22, but there was no documentation of the results. Attempted telephone interview Staff E on 03/17/23 at 6:58pm was unsuccessful. Interview with the BOM on 03/17/23 at 4:03pm revealed: -Staff E had two TB skin tests completed by the previous nurse. -She did not realize the nurse did not read the first TB skin test. -She was unaware there no documentation of results on the second TB skin test. -When she received Staff E's TB skin test, she did realize the test was not completed. -She was responsible to ensure TB skin tests were obtained by the time staff completed orientation. -She overlooked Staff E's TB skin tests not being completed. Interview with the Executive Director (ED) on 03/17/23 at 6:50pm revealed: -The BOM was responsible for ensuring TB skin tests were obtained prior to completing orientation. -The BOM should check the TB skin tests to ensure the results were documented. -The BOM was responsible for ensuring TB skin tests were completed before she filed the paperwork.	D 131		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 164	Continued From page 29 Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled medication aides (Staff C) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars (FSBS) and administering insulin. The findings are: Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired on 12/06/22.	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 164	Continued From page 30 -There was no certification of training for the care of diabetic residents. Review of a resident's January 2023 medication administration record (MAR) revealed: -There was documentation Staff C checked the resident's FSBS and/or administered insulin 9 times from 01/01/23 through 01/31/23. -Six of 9 times included documentation of errors with insulin administration. Review of a resident's February 2023 MAR revealed: -There was documentation Staff C checked the resident's FSBS and/or administered insulin 10 times from 02/01/23 through 02/28/23. -Seven of 10 times included documentation of errors with insulin administration. Review of a resident's March 2023 MAR from 03/01/23 through 03/14/23 revealed: -There was documentation Staff C checked the resident's FSBS and/or administered insulin 7 times from 03/01/23 through 03/14/23. -Four of 7 times included documentation of errors with insulin administration. Observation of Staff C on 03/14/23 at 4:55pm revealed: -Staff C was the MA on the second shift. -Staff C administered medications to the residents in the assisted living, including checking FSBS and administering insulin. Telephone interview with Staff C on 03/17/23 at 6:58pm revealed: -She had been a MA at the facility since December 2022. -When she worked as a MA, she checked residents' FSBS and administered insulin if	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 164	Continued From page 31 needed. -Since she started working at the facility, she had not received training related to the care of diabetic residents. Interview with the Business Office Manager (BOM) on 03/17/23 at 5:15pm revealed: -She was responsible for ensuring diabetic training was completed. -When a MA was hired, she contacted the consultant nurse and set-up training. -She was not sure how she missed Staff C's diabetic training. Interview with the Executive Director (ED) on 03/17/23 at 6:50pm revealed: -The BOM was responsible for contacting the nurse consultant and scheduling training for staff. -There was no system in place for checking behind the BOM to ensure staff had the required training including training on the care of diabetic residents.	D 164		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 234	Continued From page 32	D 234		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 2 of 5 residents sampled (Residents # 3 and #5) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1. Review of Resident #1's current FL-2 dated 02/02/23 revealed diagnoses included aspiration pneumonia, sepsis, peripheral artery disease, and left hip replacement.

Review of Resident #1's Resident Register revealed there was an admission date of 06/18/21.

Review of Resident #1's record for a tuberculosis (TB) skin test revealed:
-There was documentation of a TB skin test administered on 05/17/21 and read as negative, but no date read was provided.
-There was no documentation of a second TB skin test for Resident #1.

Review of Resident #1's physician's orders dated 03/06/22 revealed an order to administer a two-step TB purified protein derivative (PPD) 0.1ml intradermally. There were no PPD test results available for review.

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

Interview with the Executive Director (ED) on 03/17/23 at 6:00pm revealed:
-He did not audit residents' admission paperwork

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 234	Continued From page 33	D 234		

for TB compliance.
-The facility's Nurse was responsible to ensure all residents received two TB skin tests upon admission.
-The facility did not currently have a facility Nurse.
-The previous Nurse left the facility two weeks earlier (no exact date provided).
-He contacted Resident #1's previous facility for possible two TB skin tests documentation prior to admission, and the previous facility had documentation of one TB skin test administered on 05/17/21.

2. Review of Resident #3's current FL2 dated 02/18/22 revealed diagnoses included trigeminal neuralgia, carotid artery disease, depression, panic/anxiety syndrome, hypertension, chronic kidney disease stage III hypothyroid, bronchiectasis.

Review of Resident #3's Resident Register revealed an admission date of 02/28/22.

Review of Resident #3's TB skin testing revealed:
-There was documentation of a TB skin test that was read as positive on 02/21/22.
-There was no documentation of a chest x-ray to rule out TB.

Interview with Resident #3 on 03/16/23 at 3:25pm revealed:
-She did not think she had tested positive for TB.
-She had a few TB skin tests, but had not been tested since her admission to the facility.
-She recently had a chest x-ray, but that was due to chest congestion and chronic bronchitis not related to TB disease.

Interview with the Executive Director (ED) on 03/17/23 at 3:38pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 234	Continued From page 34 -When a resident was admitted to the facility, the nurse was responsible for ensuring TB skin tests were to be completed. -There should be at least one TB skin test completed upon admission to the facility. -There should be a second TB skin test completed post admission. -If a resident came with a TB skin test, the nurse should complete a second TB skin test upon admission. -There was no system in place to ensure this process was followed. -He did not know if Resident #3 was positive for TB or negative.	D 234		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 5 of 6 sampled residents (Residents #3, #4, #5, #6, and #9) had a current FL2 completed annually.	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 235	Continued From page 35 The findings are: 1. Review of Resident #9's previous FL2 dated 12/14/21 revealed diagnoses included mild confusion and ataxia. Review of Resident #9's record revealed that Resident #9 did not have an updated FL2 completed since 12/14/21. Review of Resident #9's record revealed there was a current FL2 completed on 03/03/23 by the contracted primary care provider (PCP) with a change to memory care listed for the level of care. Based on observations, interviews, and record review it was determined Resident #9 was not interviewable. Interview with the Executive Director on 03/16/23 at 10:00am revealed: -Resident #9 was currently on hospice. -Resident #9 had declined in mental status over the last 6 months. -Resident #9 was reassessed for a higher level of care by the facilty's contracted PCP. -The facility was in the process of helping Resident #9's family member obtain placement in a Special Care Unit. Refer to the interview with a medication aide (MA) on 03/15/23 at 9:10am Refer to the interview with the ED on 03/17/23 at 6:25pm. 2. Review of Resident #6's current FL2 dated 09/24/21 revealed:	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 235	Continued From page 36 -Diagnoses included dementia, pain in joints, muscle weakness, and muscle spasms. -There were medications orders for 20 medications. Review of Resident #6's record revealed that Resident #6 did not have an updated FL2 completed since 09/24/21. Review of Resident #6's Quarterly Pharmacy Review dated 01/11/23 revealed the Consultant Pharmacist noted Resident #6 needed an updated FL2 and signed physician's orders. Based on observations, interviews, and record review it was determined Resident #6 was not interviewable. Refer to the interview with a medication aide (MA) on 03/15/23 at 9:10am Refer to the interview with the ED on 03/17/23 at 6:25pm. 3. Review of Resident #3's current FL2 dated 02/18/22 revealed diagnoses included trigeminal neuralgia, carotid artery disease, depression, panic/anxiety syndrome, hypertension, chronic kidney disease stage III hypothyroid, bronchiectasis. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 02/28/22. Review of Resident #3's record revealed that Resident #3 did not have an updated FL2 completed since 02/18/22. Interview with the Executive Director (ED) on	D 235		

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D 235	Continued From page 37 03/17/23 at 6:38pm revealed: -He was not aware Resident #3's FL2 had not been updated. -Resident #3's FL2 should have been updated this year. Refer to the interview with a medication aide (MA) on 03/15/23 at 9:10am Refer to the interview with the ED on 03/17/23 at 6:25pm. 4. Review of Resident #4's current FL2 dated 07/15/21 revealed diagnoses included hypertension, type 2 diabetes, hyperlipidemia and chronic obstructive pulmonary disease (COPD). Review of Resident #4's Resident Register revealed an admission date of 11/20/17 Review of Resident #4's record revealed Resident #4 did not have an updated FL2 completed since 07/15/21. Interview with the Executive Director (ED) on 03/17/23 at 6:24pm revealed he was not aware that Resident #4 did not have a current FL2. Refer to the interview with a medication aide (MA) on 03/15/23 at 9:10am. Refer to the interview with the ED on 03/17/23 at 6:25pm. 5. Review of Resident #5's current FL2 dated 09/27/21 revealed diagnoses included dementia with behavioral disturbance, obstructive sleep apnea, and ataxia. Review of Resident #5's Resident Register	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 235	Continued From page 38 revealed an admission date of 06/26/18. Review of Resident #5's record revealed Resident #5 did not have an updated FL2 completed since 09/27/21. Interview with the Executive Director (ED) on 03/17/23 at 6:24pm revealed he was not aware that Resident #5 did not have a current FL2. Refer to the interview with a medication aide (MA) on 03/15/23 at 9:10am. Refer to the interview with the ED on 03/17/23 at 6:25pm. _____ Interview with a medication aide (MA) on 03/15/23 at 9:10am revealed: -The former facility's Nurse was responsible to audit records and ensure residents had current FL2s and medication orders. -She did not know how long an FL2 was supposed to be in effect before it was renewed. -The facility's Nurse had left more than 2 weeks ago. -The facility had a medication aide/Supervisor (MA/S) that had just started assisting with residents' records reviews, but she had not been in this area of the facility yet for audits. Interview with the ED on 03/17/23 at 6:25pm revealed: -He expected FL2s to be completed annually for all the residents. -There was no system in place to ensure FL2's were updated annually. -The facility's Nurse was responsible to ensure that FL2s were current and completed annually. -The facility had been without a Nurse for about two weeks and was in the process of hiring a new	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 235	Continued From page 39 one.	D 235		
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 1 of 5 sampled residents (#4) related to an order for a daily blood pressure (BP) check. The findings are: Review of Resident #4's FL2 dated 07/15/21 revealed diagnoses included hypertension, type 2 diabetes, hyperlipidemia and chronic obstructive pulmonary disease (COPD). Review of Resident #4's signed physician's order dated 10/21/22 revealed an order to check BP daily. Review of Resident #4's January, February, and March 2023 medication administration record (MAR) revealed: -There was an entry to check BP daily. -There was no documentation of BP results. Interview with Resident #4 on 03/16/23 at 3:15pm	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 40	D 276		

revealed:
-Staff did not check her BP daily.
-She was not lightheaded and did not have a headache.

Telephone interview with the Nurse from Resident #4's primary care provider's (PCP) office on 03/17/23 at 11:44am revealed she was not aware that Resident #4's BP was not being checked daily as ordered by the PCP.

Interview with a medication aide (MA) on 03/17/23 at 4:19pm revealed she was not aware that Resident #4 had an order to check BP daily.

Observation of a MA attempting to obtain Resident #4's BP on 03/17/23 at 4:30pm revealed:
-The MA used two different blood pressure machines and both machines resulted in an error reading.
-The MA was unable to obtain a blood pressure for Resident #4.

Interview with the MA/Supervisor (MA/S) on 03/17/23 at 3:15pm revealed:
-She was not aware that Resident #4 had an order to check BP daily.
-She thought that all the residents' vital signs including BP were checked earlier in March 2023.
-The facility's Nurse was previously responsible to ensure that MAs implemented provider orders, but the facility did not currently employ a Nurse.
-The MAs were responsible to implement provider orders, including the order to check Resident #4's BP daily.

Interview with the Executive Director (ED) on 03/17/23 at 6:47pm revealed:
-He was not aware that Resident #4 had an order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 41 to check BP daily or that there was no documentation Resident #4's BP was checked in the last three months. -He expected MAs to implement orders as written by the provider.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 280	Continued From page 42	D 280		

facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 2 of 2 sampled residents (#1 and #9) with LHPS tasks for ambulation with assistive devices (#1 and #9) and oxygen via nasal cannula (#1).

The findings are:

1. Review of Resident #1's current hospital discharge FL2 dated 02/02/23 revealed:
-Diagnoses included sepsis, aspiration pneumonia, altered mental status, and history of total hip replacement.
-There was an order for oxygen (O2) at 2 liters per minute via nasal cannula.

Review of Resident #1's Resident Register revealed an admission date of 06/18/21.

Review of Resident #1's Care Plan dated 07/15/21 revealed:
-Resident #1 was assessed on 07/09/21 by the facility's Licensed Practical Nurse (LPN).
-Resident #1 required extensive assistance with ambulation and transferring.
-The Care Plan was signed by the facility's contracted primary care provider on 07/15/21.

Review of Resident #1's current Care Plan assessment date 02/03/23 revealed:
-The assessment was completed for a return from a hospital stay.
-Resident #1 required extensive assistance to total dependence on staff with ambulation and transferring.

Observation of Resident #1's room during the initial tour on 03/14/23 at 10:22am revealed:
-Resident #1's room had an oxygen concentrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 280	Continued From page 43	D 280		

running and sitting on the floor adjacent to the outside wall.
-Resident #1 was seated in a wheelchair.

Review of Resident #1's personal care log sheets for November 2022, December 2022, January 2023, February 2023, and March 2023 revealed Resident #1's level of personal care provided was routinely documented as total dependent for ambulation and transferring.

Review of Resident #1's LHPS evaluations revealed there were no LHPS evaluations available for review.

Interview with a first shift personal care aide (PCA) on 03/16/23 at 11:20am revealed:
-Resident #1 required extensive assistance with transferring from her wheelchair to the bed or bed to wheelchair.
-Resident #1 did not ambulate in her wheelchair independently; staff rolled her to the dining room and anywhere she went outside her room.
-Resident #1 could stand, if supported, and pivot to and from the wheelchair.
-When she helped Resident #1 into bed, she applied Resident #1's oxygen nasal cannula.
-Resident #1 used her oxygen when she was in bed only.

Telephone interview with a representative for the contracted LHPS provider on 03/17/23 at 3:16pm revealed:
-The LHPS nurse came to the facility quarterly.
-The LHPS nurse was available between visits if a resident developed a LHPS task after a quarterly visit.
-Resident #1's last LHPS evaluation was 03/30/22 when the resident did not have any identified LHPS tasks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 280	Continued From page 44 -The facility was responsible to provide a list of residents currently requiring LHPS evaluations. -The LHPS nurse did not go room to room looking for residents with LHPS tasks. -The facility had not added Resident #1 to the list for LHPS review. -There was no documentation from the facility for Resident #1 needing assistance with ambulation or oxygen therapy. Interview with the Executive Director on 03/17/23 at 6:00pm revealed: -The facility's Nurse was responsible for ensuring the residents with LHPS tasks were assessed by the contracted LHPS nurse. -There was currently no system in place to routinely audit resident records for quarterly LHPS evaluations for residents with identified LHPS tasks. Refer to the interview with the Executive Director (ED) on 03/17/23 at 6:00pm. 2. Review of Resident #9's previous FL2 dated 12/14/21 revealed: -Diagnoses included mild confusion and ataxia. -Resident #9 was intermittently disoriented. -Ambulatory status was not indicated. Review of Resident #9's current FL2 dated 03/03/23 revealed: -Diagnoses included Alzheimer's dementia without behavior disturbances, hypertension, congenital scoliosis, and cerebral ataxia. -Resident #9 was intermittently disoriented, needed assistance with bathing and dressing and was incontinent to bladder and bowel. Review of Resident #9's Resident Register revealed an admission date of 12/17/21.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 280	Continued From page 45 Review of Resident #9's care plans revealed there was no care plan available for review. Observation of Resident #9 throughout the facility from 03/14/23 to 03/17/23 revealed: -On 03/14/23 at 10:00am, Resident #9 was seated in a wheelchair next to the front lobby desk. -On 03/14/23 at 12:28pm, Resident #9 was propelled in her wheelchair to her room by the receptionist for her lunch that was to be served in her room. -At 8:10am, the morning person care aide (PCA) woke Resident #9, performed incontinence care, dressed the resident, lifted the resident to her wheelchair and brushed her hair. -At 8:15am, Resident #9 was propelled in her wheelchair to the dining room located on the first floor by the PCA. Review of Resident #9's LHPS evaluations revealed: -There was an LHPS evaluation dated 07/11/22 with no LHPS tasks assigned. Resident #9 ambulated with a standard walker for short distances and wheelchair for long distances. -There was a LHPS evaluation signed by the facility's Nurse dated 10/18/22 with marked LHPS tasks of transferring semi-ambulatory or non-ambulatory and ambulation using assistive devices that required physical assistance. -There were no LHPS evaluations available for review after 10/18/22. Interview with a first shift PCA on 03/17/23 at 3:00pm revealed: -Resident #9 required extensive assistance by staff with transferring from her wheelchair to the bed or bed to wheelchair.	D 280		

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D 280	Continued From page 46 -Staff propelled Resident #9 in her wheelchair to the dining room and anywhere she went outside her room. -Resident #9 had to be lifted by staff from her bed to her wheelchair. Telephone interview with a representative for the contracted LHPS provider on 03/17/23 at 3:16pm revealed: -The LHPS nurse came to the facility quarterly. -The LHPS nurse was available between visits if a resident developed a LHPS task after a quarterly visit. -The facility was responsible to provide a list of residents requiring LHPS evaluations. -The LHPS nurse did not go room to room looking for residents with LHPS tasks. -Resident #9's last LHPS evaluation by the contracted LHPS Nurse was 07/11/22 when the resident did not have any identified LHPS tasks. Based on observations, interviews, and record review, it was determined Resident #9 was not interviewable. Refer to the interview with the Executive Director (ED) on 03/17/23 at 6:00pm. _____ Interview with the ED on 03/17/23 at 6:00pm revealed: -The facility's Nurse was responsible for ensuring the residents with LHPS tasks were assessed by the contracted LHPS nurse. -There was currently no system in place to routinely audit resident records for quarterly LHPS reviews for residents with identified LHPS tasks. -The facility's Nurse was responsible for identifying residents with LHPS tasks and performing LHPS evaluations or adding residents'	D 280		

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D 280	Continued From page 47 names to the list for the contracted LHPS nurse. -The facility's Nurse left 2 weeks ago and he had not assigned a staff member to audit LHPS evaluations for residents.	D 280		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents who were provided meals in their rooms were served non-disposable place settings during meal service. The findings are: Observation during the initial tour of the facility on 03/14/23 from 8:50am through 11:40am revealed: -Eight residents were observed the breakfast meals in their room. -The meal was served on disposable serviceware.	D 287		

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D 287	Continued From page 48 Observation of the lunch meal on 03/14/23 from 12:00pm through 1:13pm revealed: -The dietary aide delivered and served the meals to the residents present in the dining room. -The personal care aides (PCAs) served the meals to the residents who received meals in their rooms. -All residents (19) on the first floor received their lunch meal in their rooms due to repairs currently being done in the first floor dining room. -All residents receiving meals in their room were served their meals on disposable serviceware. -There were eight residents present in the second floor dining room at various times for the meal. -The residents in the dining room were served soup in disposable bowls and dessert on disposable plates. -Six residents on the second floor received their meals in the rooms. -The meal served to residents in their room was served on disposable serviceware. Observation of non-disposable serviceware on hand in the kitchen on 03/14/23 at 1:28pm revealed non-disposable serviceware included 12 bowls, 9 saucers/dessert plates and 15 cups with a handle. Interview with three residents who received their meal in the room on 03/14/23 from 12:55pm to 1:30pm revealed: -Meals served in the rooms were always on non-disposable serviceware. -Disposable serviceware was used for convenience so the containers could be thrown away after the meals. -A second resident resided at the facility for over two years and when the meal was served in the room, disposable serviceware and plastic utensils	D 287		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 287	Continued From page 49	D 287		

had always been used.
-The only thing about the disposable serviceware was when cutting the meat, he had to be careful not to cut through the serviceware.
-In the dining room, he always received glass plates and silverware, but the soup was served in a disposable bowl and dessert was served on a disposable plate; he guessed the facility was out of non-disposable serviceware and needed to buy more.
-This had been the process for maybe two months.

Interview with dietary aide on 03/14/23 at 12:44pm revealed:
-The residents that received meals in their rooms were always served on non-disposable serviceware and plastic disposable utensils.
-It was the facility's protocol and had been that way since she started at least 1 and 1/2 years ago.
-The reason disposable serviceware was used for meal service was due to non-disposable dishes coming up missing and not being returned to the kitchen.
-Residents in the dining room were to be served non-disposable place settings, however there was a shortage of bowls and small plates for dessert.
-Due to the shortage of non-disposable bowls and dessert plates, the residents' soup was served in disposable bowls and desserts were served on disposable plates.

Interview with a second dietary aide on 03/14/23 at 12:51pm revealed:
-He prepared the carts to deliver food to the residents on the first and second floor.
-He put the soup in disposable bowls because the kitchen did not have enough non-disposable

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D 287	Continued From page 50	D 287		

bowls.
-He put the dessert and salad on disposable plates for the same reason.
-When a resident requested to have their meal in the room, the meal was served in disposable containers.
-The beverages were served in disposable cups, the soup was served in disposable bowls, dessert served on disposable plates and utensils were provided that included a napkin with a plastic knife, spoon and fork.
-Serving the meal on disposable place settings had been the facility's process for at least two years for residents who received meals in their rooms.
-No one had ever told him not to use disposable place settings.

Interview with the cook on 03/14/23 at 1:13pm revealed:
-He did not know when or why the process started that residents who received their meals in the rooms were served disposable serviceware, but it had been that way for at least two years.
-There was a problem with non-disposables not being returned to the kitchen, which was the reason why the disposables were used.
-The facility did not have enough non-disposable bowls and dessert plates for all the residents', so they used the disposable.
-The Executive Director (ED) had been made aware of the shortage, but nothing had been done.

Interview with the Dietary Manager (DM) on 03/15/23 at 11:49am revealed:
-She had been the DM for two weeks and was still in training.
-Prior to becoming the DM, she worked at the facility since October 2022, as the cook.

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 287	Continued From page 51 -Serving the residents' meals on disposable serviceware when eating in their rooms had always been the practice of the facility. -She did not know who gave instructions to serve residents disposable serviceware when eating in their rooms, because the facility was using that process when she started. -She had made the ED aware last month that the kitchen was short on non-disposable serviceware, but she had not received any new serviceware. Interview with the ED on 03/17/23 at 10:05am revealed: -He was not aware the kitchen needed non-disposable serviceware. -He had not ordered any non-disposable serviceware for the facility. -He was aware the kitchen was serving meals in disposable serviceware and used plastic utensils, but he had not inquired why. -He thought it was okay to serve residents who ate meals in their rooms with disposable serviceware and plastic utensils to eat with.	D 287		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 298	Continued From page 52	D 298		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to offer or make available three snacks a day and included the snacks on the menu.

The findings are:

Review of the facility's cycle week-at-glance menu for the current week revealed snacks were not listed on the menu.

Observation of the kitchen food storage area on 03/14/23 at 10:45am revealed there were boxes with peanut butter crackers, cookies, and fresh fruit.

Interviews with eleven residents during the initial tour on 03/14/23 from 9:01am through 11:03am revealed:
-The residents had choices of the items they wanted.
-After the meal service, no food of any type was offered or served.
-If the residents got hungry, they had to get their own snacks.
-No one at the facility offered or made the residents aware they could have snacks between meals.
-Some residents were not able to obtain their own snacks and open them up, so it would be nice if the facility staff served snacks.

Interview with a first shift personal care aide (PCA) on 03/14/23 at 11:20am revealed:
-She did not serve snacks to the residents.
-She did not know if snacks were to be served

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 298	Continued From page 53	D 298		

because no one had mentioned to her about snacks.
-She had noticed that most residents had their own snacks in their rooms.

Interview with a second shift PCA on 03/14/23 at 3:50pm revealed:
-No one told her to offer the residents snacks.
-Snacks were sometimes offered during activities, but not all residents participated in activities.

Interview with the cook on 03/14/23 at 1:23pm revealed:
-The kitchen was supposed to prepare a cart with snacks twice daily.
-The PCAs were supposed to come to the kitchen and obtain the cart with the snacks.
-He did not know if the PCAs placed the snacks in a specific location and the residents had to get the snacks or if the PCA went room to room to offer snacks.

Interview with the Dietary Manager (DM) on 03/15/23 at 11:53am revealed:
-She was not aware snacks were not offered.
-She had been the DM for two weeks, and prior to being the DM she worked as the cook since October 2022.
-She was still learning her position, but thought the cook should be making snacks available for the PCA to pick up.
-There was no system in place to ensure this was being done every day, definitely not three times daily.

Interview with the Executive Director (ED) on 0317/23 at 10:05am revealed:
-He was not aware snacks were not offered or served to the residents.
-Each resident at the facility had their own private

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 298	Continued From page 54 room. -The staff were supposed to go to each residents' room and offer the resident a snack. -There was no system in place to ensure snacks were being offered to the residents.	D 298		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered for 2 of 2 sampled residents (#3 and #8) who had orders for a pureed diet (#8) and a mechanical soft (MS) diet (#3). The findings are: 1. Review of Resident #8's current FL2 dated 06/09/22 revealed: -Diagnoses included Alzheimer's disease and irritable bowel syndrome (IBS). -There was an order for a regular diet.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 310	Continued From page 55 Review of a signed physician's order for Resident #8 dated 11/03/22 revealed there was an order to change the diet to pureed; resident may have regular diet snacks. Observation on 03/14/23 at 11:44am revealed there was no diet list posted in the kitchen for any residents. Review of the pureed diet menu for the lunch meal on 03/14/23 revealed residents should be served pureed snickerdoodle cookies, pureed spiced black beans, pureed roasted corn, and pureed chicken tinga and flour tortilla. -The alternative meal was to consist of saltine crackers, pureed chicken tortilla soup, and pureed beef barbacoa aji. Observation of Resident #8's lunch meal service on 03/14/23 from 12:30pm to 1:00pm revealed: -A medication aide (MA) brought the resident's meal from the kitchen and placed it on the table in front of the resident. -Resident #8's meal served was ground beef that was a mechanical soft consistency. -Mashed potatoes were on the resident's plate. -She was served red velvet cake for dessert. -Resident #8 consumed 50% of the ground beef, 100% of the mashed potatoes and 100% of the dessert and did not cough or choke. Interview with the MA on 03/16/23 at 10:50am revealed: -She was aware that Resident #8 had an order for a pureed diet with regular diet snacks. -Resident #8 was currently the only resident on a pureed diet in the Special Care Unit (SCU). -Resident #8 did not have any problems with swallowing food. -Staff noticed in November 2022 that Resident #8	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 310	Continued From page 56	D 310		

would tend to only eat soft foods and her oral intake decreased when she had an order for a regular diet.
-Resident #8's primary care provider (PCP) at the time changed Resident #8's diet to pureed because of her decreased oral intake.
-The kitchen prepared the residents' food and then brought the food to the SCU, including Resident #8's food.
-Sometimes the meat served to Resident #8 would have a mechanical soft consistency and other food on the same plate would be pureed.
-She would sometimes take food back to the kitchen and ask for it to be pureed according to the resident's order if the food was not pureed.

Interview with the Special Care Program Director (SCPD) on 03/16/23 at 11:36am revealed:
-She was aware that Resident #8 was on a pureed diet with regular diet snacks.
-She was not aware that Resident #8 was served food with a mechanical soft consistency during the lunch meal service on 03/14/23.
-The kitchen prepared the residents' food and prepared the special diets.
-She expected staff to take Resident #8's food back to the kitchen and ask the kitchen to puree the food if they saw that Resident #8's food was not pureed when it was served.

Interview with Resident #8's PCP on 03/17/23 at 1:02pm revealed:
-She was not aware until staff informed her on 03/17/23 that Resident #8 was served food with a mechanical soft consistency during the lunch meal service on 03/14/23.
-She expected the facility to serve diets as ordered.

Interview with the Dietary Manager (DM) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 310	Continued From page 57	D 310		

03/17/23 at 10:38am revealed:
-She was not aware that Resident #8 was served food with a mechanical soft diet consistency rather than her ordered diet of pureed consistency during the lunch meal service on 03/14/23.
-There was a list in the kitchen of special diets for residents that resided in the SCU and Assisted Living (AL).

Based on observation, record review and interview, it was determined Resident #8 was not interviewable.

Refer to interview with the DM on 03/17/23 at 10:45am.

Refer to interview with the facility's Corporate Director on 03/17/23 at 9:30am.

Refer to interview with the Executive Director (ED) on 03/17/23 at 10:05am.

2. Review of Resident #3's current FL2 dated 02/18/22 revealed:
-Diagnoses included trigeminal neuralgia, carotid artery disease, depression, panic/anxiety syndrome, hypertension, chronic kidney disease stage III, hypothyroid, and bronchiectasis.
-The diet order was for a regular diet.

Review of Resident #3's speech therapy assessment notes revealed:
-On 06/08/22, the therapist documented speech therapy services were targeting dysphagia.
-The resident reported it took an hour and a half to eat meals due to extended mastication.
-It was recommended to down grade the resident's diet to mechanical soft with gravy.
-On 06/24/22, the therapist observed Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 310	Continued From page 58	D 310		

not served a mechanical soft diet.
-The therapist spoke with the medication aide (MA) and the Dietary Manager (DM).
-On 07/26/22, the resident was able to feed herself but required a meal set-up, intermittent assistance or supervision from another person and a pureed or ground meat diet.
-On 08/23/22, based on the swallowing study assessment and the risk for aspiration (aspiration was when a person accidentally inhales food or liquids into their windpipe or lungs. This can lead to coughing, difficulty breathing, discomfort, pneumonia and sometimes choking and/or death), it was recommended that Resident #3 be given a mechanical soft diet, ground meats.

Review of Resident #3's Senior Living Resident Evaluation and Care plan reassessment dated 10/17/22 revealed:
-The resident did not require any supervision or interventions with eating.
-There was no documentation or update to the care plan to address the speech therapist recommendations for monitoring the resident when eating.
-There was no documentation addressing the resident's diet change.

Review of Resident #3's physician's orders revealed:
-An order dated 08/23/22 with instructions "please change diet to mechanical soft with thin liquids."
-An order dated 10/11/22 for a mechanical soft diet.
-An order dated 10/18/22 for a mechanical soft diet.

Observation on 03/14/23 at 11:44am revealed there was no diet list posted in the kitchen for any residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 310	Continued From page 59 Interview with the cook 03/14/23 at 11:46am revealed: -There was no diet list posted in the kitchen. -The Dietary Manager (DM) trained him how to prepare various diets to the correct consistency. -He did not know the diet ordered for Resident #3; the personal care aide (PCA) was supposed to tell him when he had to prepare a plate for a resident on a special diet (i.e., mechanical soft, pureed, etc.). -Residents in the assisted living ordered a mechanical soft diet had their meat cut-up by the PCA working in the assisted living. -He did not have menus to follow and did not know where the menus were located. Review of the "general/mechanical soft" menu for the breakfast meal on 03/14/23 revealed residents should be served: biscuit & sawmill gravy, cream of wheat, chilled diced pears, cheesy scrambled eggs, grape jelly and orange juice. Observation of Resident #3's breakfast meal service on 03/14/23 at 9:23am revealed: -The resident was served cream of wheat, a biscuit and whole round sausage patty. -There was no gravy to soften the sausage patty and the meat was not ground. Interview with Resident #3 on 03/14/23 at 9:24am revealed: -The facility staff never served her the correct meal. -She had difficulty swallowing her food and it got caught in her throat. -Due to the meals sent to her by the kitchen, she had lost 30 pounds since she was admitted to the facility.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 310	Continued From page 60 -It took her 2 hours to eat her food because the food was not prepared correctly. -She had reported the meals not being correct to the Executive Director (ED) and the nurse, but she continued to get food that she was unable to eat. -The only thing she was going to eat was the cream of wheat for breakfast. -She was not going to be able to eat the sausage patty. -She was not sure about the biscuit because she had not eaten a biscuit in many years. Review of the week-at-glace seven-day menu, week one, revealed: -The lunch meal on 03/14/23 was to consist of: creole baked chicken thigh, angel hair pasta, southern succotash, garlic cheese bread, cappuccino pudding. -The alternate meal was eggplant parmesan and roasted cauliflower. Review of the "general/mechanical soft" menu for the lunch meal on 03/14/23 revealed a resident ordered a mechanical soft diet should be served: snickerdoodle cookies, spiced black beans, creamed corn, and ground chicken tinga and flour tortilla. -The alternative meal was supposed to consist of saltine crackers, chicken tortilla soup, and ground beef barbacoa aji. Observation of Resident #3's lunch meal service on 03/14/23 at 12:53pm revealed the resident was served 2 pieces of 6 inches long by 5 and ½ inch wide whole piece of pork loin meat. -The resident was not given any vegetables, no gravy or sauce to soften the meat. -The meat was whole not cut or grounded.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 310	Continued From page 61 Interview with Resident #3 on 03/14/23 at 12:54pm revealed: -All she could do was laugh when opened the styro-foam container for her lunch meal. -The kitchen had sent her two whole pieces of pork loin meat and did not even attempt to cut the meat up. -She was not going to be able to consume the lunch meal at all today. -She was thankful that her family kept her extra food in the refrigerator in her room because the kitchen staff often sent her food like that. -She had a hard time swallowing food and she had to chew her food for a long time just to swallow food. -To eat that meat would take more than one day. Interview with Resident #3's primary care provider (PCP) on 03/14/23 at 10:45am revealed: -She became the PCP at the facility in January 2023. -She was aware Resident #3 had difficulty swallowing. -She was aware Resident #3 had weight loss and she was very concerned about the weight loss. -She had planned to assess the resident to determine why she was continuing to lose weight. -She was aware the resident was ordered a MS diet. -She expected diets to be served as ordered. -Due to Resident #3's weight loss, she wanted the resident to consume as much food as possible. Interview with the DM on 03/17/23 at 10:45am revealed: -There were menus, but they were not followed. -She was not aware Resident #3's meats had to be grounded. -She thought that mechanical soft diet meant the	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 310	Continued From page 62 meats were cut up or chopped. Refer to interview with the DM on 03/174/23 at 10:45am. Refer to interview with the facility's Corporate Director on 03/17/23 at 9:30am. Refer to interview with the ED on 03/17/23 at 10:05am. _____ Interview with the DM on 03/17/23 at 10:45am revealed: -The cook was not truthful when saying he was not responsible for preparing mechanical soft diets for residents in the assisted living. -The meal should be prepared in the kitchen by the cook and no alterations needed when the food left the kitchen. -She had been the DM for two weeks and was previously the cook at the facility since October 2022. -There were menus, the cook did not know where the menus were kept. -The menus were not used when preparing foods. -She was not aware Resident #3's meats had to be grounded. -She thought that a mechanical soft diet meant the meats were cut up. Interview with the facility's Corporate Director on 03/17/23 at 9:30am revealed: -They partnered with a food service vendor and the menus were recently changed. -The ED should be monitoring the food preparation in the kitchen. -The ED should make sure menus were available and diet orders were posted in the kitchen. -The ED should ensure meals served to	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 310	Continued From page 63 resident's were as ordered by the PCP. Interview with the ED on 03/17/23 at 10:05am revealed: -He did not observed meals prepared by the kitchen to ensure therapeutic diets were served as ordered. -He had no reason why he did not observe the meals to ensure they were accurate. -He had no reason why menus were not being followed for ordered therapeutic diets.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to treat residents with dignity and respect related to a reasonable request for heat when residents' room temperatures were between 58 to 74 degrees causing residents to experience shaking, inability to sleep and develop congestion and coughing due to extreme coldness; and for 1 of 6 sampled residents (Resident # 9) related to not providing beverages during meals and eating utensils forcing the resident to eat with their fingers. The findings are: 1. Observation of the heating unit in resident room E-3 on 03/14/23 at 8:35am revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 64	D 338		

-The heating unit was located directly below the window.
-The heating unit was missing a knob, and a knob was needed to turn the unit on.
-The heating unit was cold to the touch.
-There was no thermostat or temperature measuring device in resident room E-3.

Interview with the resident who resided in room E-3 on 03/14/23 at 9:38am revealed:
-She was always cold in the room.
-Her bathroom was extremely cold, so she kept the door closed.
-She complained non-stop about her room and bathroom being cold.

Interview with a family member of the resident who resided in room E-3 on 03/15/23 at 3:44pm revealed:
-Since the resident moved into the facility last October 2022, she had been communicating with the Executive Director (ED) regarding the resident being cold.
-She noticed the resident's room was still extremely cold, especially in the bathroom.
-One of her continuous complaints was her family member was always cold.
-The ED told her that he understood and would take care of it, but nothing was done.
-The bathroom was so cold, her family member did not want to wash and shower in the bathroom, which effected the resident's hygiene.

Interview with the ED on 03/15/23 at 5:15pm revealed:
-He went to see the resident who resided in room E-3 daily because the family called to express concerns.
-The family member told him the room was cold, about two weeks ago when it was warm outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 338	Continued From page 65	D 338		

and the air conditioning (AC) unit was turned on.
-He had maintenance staff close the vents in room E-3 to prevent the AC from coming through.
-He did not instruct the maintenance staff to reopen the vents room E-3.

Observation of the heating unit in resident room D-6 on 03/14/23 at 9:10am revealed:
-The unit was located underneath the window near the bed.
-The knob was designed to turn the heater off and on.

Interview with the resident who resided in room D-6 on 03/14/23 at 9:21am revealed:
-She was always cold in her room.
-Her bed was near the heating unit and her family member turned the knob on high.
-She was still cold, especially at night.
-She had continually complained about being cold to all of the staff.

Observation of resident room D-7 on 03/14/23 at 9:43am revealed:
-There was no heating unit observed in resident's room.
-The center of the room felt cold, but it was much colder near the window, which was on the side of the resident's bed.

Interview with the resident in room D-7 on 03/14/23 at 9:46am revealed:
-There was no heating unit in her room and she was always cold.
-There was no thermostat in her room.
-The vents in the ceiling were blowing out cold air, making the room colder.
-She was always cold, especially at night and when sitting near the window.
-During the daytime, she sat in her wheelchair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 66	D 338		

near the entrance door way of the room and did not go near her bed because it was cold by her bed, which was near the window.
-She had 3 blankets on her bed to keep her warm at night.
-She even went to bed early, around 7:00pm, to get under the covers to warm up.
-She sometimes woke up shaking because her room was so cold.
-The room had been cold since she moved into the facility on 02/14/23.
-She had told the medication aide (MA), personal care aide (PCA) and maintenance staff that she was cold, but nothing had been done.

Observation of the heating unit in resident room D-1 on 03/15/23 at 10:10am revealed:
-The heating unit was underneath the window.
-There was a knob designed to turn the heater off and on.
-The dial on the heating unit was turned on, but not on high.
-The heating unit was cold to the touch.

Interview with the resident who resided in room D-1 03/15/23 at 10:14am revealed:
-Her room was "freezing cold."
-She was coughing, and had congestion that was caused by her room being cold.
-She had told staff (MA and PCA) that her room was cold.
-When she told staff that she was cold, they would tell her okay, she did not know what they did because she was still cold.
-She did not remember maintenance staff coming to her room.

Observation during the initial tour of the facility on 03/14/23 at 9:28am of resident room D-9 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 67 -The heating unit underneath the window, there was knob designed to turn the heater off and on. -The heater was not on because the knob was missing. -The knob was on the table near the resident's recliner. -The heating unit was cold to touch. Interview with the resident who resided in room D-9 on 03/14/23 at 9:32am revealed: -His room was cold. -For two weeks, he asked staff to turn the heat on. -The heater did not work because the knob was broken off. -Being cold was uncomfortable and he had a difficult time sleeping when he was cold. -He had one blanket to cover up with and was not given another one. -He asked staff for another blanket, but he was told the facility did not have a blanket to give him. -Two weeks ago, he told the MA, PCA and anyone that would listen that his heater did not work and he was cold. Interview with the ED on 03/14/23 at 11:10am revealed: -Most residents had a baseboard heating unit in their rooms. -The units had knobs that could be turned for extra heat. -There was at least one room on each hallway that did not have a baseboard heater. -The maintenance staff was to maintain the heating units. -No one had made him aware the knob was broken off the heater in resident room D-9 or that the resident complained about being cold. -He had gone down to resident room D-9 and slid the knob back on the heating unit.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 68	D 338		

-The knob slid back on the heating unit easily and all the resident had to do was put the knob back on.
-He had not checked the temperature in any of the resident's rooms.

Second interview with the resident in room D-9 on 03/14/23 at 2:09pm revealed:
-Today (03/14/23), the ED came to his room and put the knob back on the heating unit.
-It took the ED 4 seconds to put the knob back on, and he had been asking for two weeks to get the unit fixed.

Observation of resident room C-4 on 03/15/23 at 8:01am revealed:
-The temperature in the room was 71 degrees, based on the thermostat attached to the clock.
-There was a baseboard heating unit in the room located directly underneath the window.
-The heating unit was cold to the touch.

Interview with the resident who resided in room C-4 on 03/15/23 at 8:05am revealed:
-He was always cold in his room.
-In the winter, it was cold outside and inside.
-In the summer, the AC made his room cold.
-For two weeks he complained about being cold.
-He told staff the knob on his heating unit was broken, so the heating unit did not work, but nothing was done.

Observation of resident room E-9 on 03/16/23 at 8:24am revealed:
-There was a baseboard heating unit in the room on the wall directly underneath the window.
-The heating unit was cold to touch.
-There was no thermostat in the room.

Interview with the resident who resided in room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 69 E-9 on 03/16/23 at 8:27am revealed: -Her room was cold; she was not aware her room was 62 degrees F. -She did not like to complain and she had not made staff aware her room was cold. -There was no consistency with warm heat; in the winter it was cold, in the summertime the AC was on and it was cold. Observation of resident room F-2 on 03/15/23 at 8:23am revealed: -There was a baseboard heating unit located directly underneath the window. -The heating unit was turned on, and warm to the touch. Interview with the resident who resided in room F-2 on 03/15/23 at 8:28am revealed: -Her room was cold, but the bathroom was very cold. -She dreaded it when she had to take a shower because the bathroom was cold. -She had made maintenance staff, PCA and MAs aware she was cold. Observation of the heating unit in resident room C-1 on 03/15/23 at 10:12am revealed: -There was a baseboard heating unit underneath the window. -The heating unit was not on and was cold to the touch. Interview with the resident who resided in room C-1 on 03/15/23 at 10:12am revealed: -Her room was cold. -She wanted a sweater, but was unable to get it herself. -She did not stay in her room much because it was cold.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 70 Observation of the thermostat on the C hallway on 03/15/23 at 6:02pm -There were two thermostats side by side. -One thermostat had a temperature of 80 degrees F and the second had a temperature of 82 degrees F. -The thermostats were located in the linen closet; placed between two shelves, less than 6 inches from the laundry room with the washer and dryer, and the furnace room was located 2 and 1/2 feet from the thermostat. Observation of the facility's temperature measuring (thermostat) device on 03/15/23 at 6:06pm revealed: -The thermostats on the D hallway was located in the linen closet. -There were two thermostats side by side. -One thermostat had a temperature of 80 degrees F and the second thermostat had a temperature of 82 degrees F. -The thermostats were located on the wall between two shelves; less than 6 inches from the laundry room with the washer and dryer and 2 and 1/2 feet from the furnace. -There was no thermostats or temperature measuring devices on the E and F hallways. Interview with a PCA on 03/14/23 at 9:58am revealed: -Residents complained a lot about being cold, especially on the D hallway. -When residents complained about being cold, she told the MA. Interview with another PCA on 03/15/23 at 10:18am revealed: -She got complaints all the time from the residents in rooms D-1, D-5, D-7, D-8 and E-3 about being cold.	D 338		

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D 338	Continued From page 71 -When the residents told her they were cold she told the Maintenance Director and the Assistant Maintenance Director. Interview with a third PCA on 03/15/23 at 10:20am revealed: -The residents in rooms D-5, D-6, D-7 and D-8 usually complained about being cold. -She had worked at the facility since October 2022, and did not realize the units under the windows were heating units. -She did not know how to operate the units. Interview with a fourth PCA on 03/15/23 at 4:09pm revealed: -He worked at the facility for a couple of months. -Since he worked at the facility, residents on the D, E and F hallways, complained about being cold. -He did not know what to do, so he told the residents it was going to warm up. -He did not know who to tell when residents complained about being cold. Interview with a MA on 03/16/23 at 3:50pm revealed: -When a resident complained about being cold, she went to the thermostat in the linen closet and turned the temperature up. -She left at 11:00pm and was not aware the residents complained of being cold overnight. Telephone interview with another MA on 03/16/23 at 5:40pm revealed: -When residents complained of being cold, she informed maintenance staff that residents were saying they were cold. -Some residents had baseboard heating units on wall, but they did not provide much heat. -If available, she provided the resident with a	D 338		

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D 338	Continued From page 72	D 338		

blanket.
-Blankets were not always available because residents had private rooms and supplied their own bed linen.

Interview with the Assistant Maintenance Director on 03/15/23 at 10:58am revealed:
-When a resident complained about being cold, he checked the vents in the rooms to ensure they open to let the heat flow through.
-About two weeks ago, he closed the vents in several residents' rooms due to the AC being turned on and complaints of being cold.
-He forgot to re-open the vents again when the weather turned cold and the heat was on.

Telephone interview with the Maintenance Director on 03/14/23 at 12:25pm revealed:
-The facilty's heat in residents' rooms could not be controlled individually.
-When it was 60 degrees outside, she kept the heat in the building at 72 degrees.
-If a resident complained they were cold, she turned the heat up to 74 degrees.
-The baseboard heaters were for extra heat.
-She was not aware residents did not use the baseboard heaters.
-She was unable to recall the MA and PCAs telling her that residents were cold.
-If a resident complained about being cold, she checked the resident's ceiling vents to see if they were opened or closed.
-She did not check the baseboard heating units to see if they were on or operable.
-She knew the temperature outside had been in the 20's and there had been freeze warnings for the past few nights.
-She had been off work for the past two days and her assistant should be notified when residents complained about being cold.

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D 338	Continued From page 73 Interview with the ED on 03/15/23 at 4:45pm revealed: -He was not aware that some heating units in residents' rooms did not work. -He had not provided training to staff regarding the operation of the heating units. -He was aware there were three rooms; one on each hallway (D, E, and F) on the second floor that did not have baseboard heating. -He had identified the temperatures on the thermostats were not accurate due to the units being in the linen closet which was located inches from the laundry room and the furnace room. -The heat thermostat was normally set at 74 degrees. -When a resident complained about being cold the heat was turned up to 75. -There had been a plan to move the thermostats out of the linen closets to get a more accurate readings. -However, the plan had not been executed in the assisted living. -Two weeks ago, it was warm outside, and the AC was turned on. -If a resident complained of being cold from the AC, and maintenance staff closed the vents in the individual resident's rooms. -The weather turned cold again, and the vents were not opened up to allow the heat to come through. 2. Review of Resident #9's current FL2 dated 03/03/23 revealed: -Diagnoses included Alzheimer's dementia without behavior disturbances, hypertension, congenital scoliosis, and cerebral ataxia. -Resident #9 was intermittently disoriented, needed assistance with bathing and dressing and was incontinent to bladder and bowel.	D 338		

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D 338	Continued From page 74 -Resident #9 was ordered a regular diet. Review of Resident #9's care plan revealed there was no care plan for review. Review of Resident #9's hospice notes revealed: -On 06/06/22 at 9:47am, Resident #9 had continued involuntary movements and struggled to complete words or sentences. -On 06/14/22 at 12:47pm, Resident #9 continued to be incontinent to bladder and bowel, required maximum assistance with transfers and activities of daily living (ADLS). Due to involuntary movements, the resident had to drink from a toddler's sippy cup to control beverage spills. Resident #9 was disoriented at times. -On 09/09/22 at 10:40am, Resident #9 was seated in a wheelchair at the front desk which was part of her normal routine. She exhibited increased agitated behaviors mainly later in the day. -On 01/05/23 at 5:04pm, Resident #9 was lying in bed. The resident continued to be incontinent to bowel and bladder, required extensive assistance with ADLS, and needed assistance with feeding. -On 03/08/23 at 7:40am, Resident #9 was in bed awake. The resident had a severe tremor of her hands, was non-ambulatory, had slurred speech and could feed herself at times. Observation of lunch service for Resident #9 on 03/14/23 revealed: -At 12:28pm, the front desk receptionist rolled Resident #9 from the front desk to the resident's room. -At 12:30pm, Resident #9 was in seated in her room in her wheelchair in front of a folding television table. -Resident #9's plate contained two one-half inch thick by three-inch round pieces of pork roast ,	D 338		

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D 338	Continued From page 75	D 338		

chunky vegetables and rice. Resident #9 had a 16 ounce plastic cup with a closed lid (sippy cup style) half filled with tea on the tray.
--At 12:45pm, Resident #9 was seated in her wheelchair and the 16 ounce sippy cup on the floor at her feet. The floor was soaked with spilled tea.
-Resident #9 ate one bite of her pork (bit off whole piece), and none of the vegetables.
-No staff were observed in the hallway outside Resident #9's room.
-At 12:50pm, dining staff were observed going down the hallway collecting lunch trays.
-At 1:00pm, Resident #9 was at the front desk seated in her wheelchair; Resident #9's spilled sippy cup was still on the floor beside the television tray she had been dining on.

Interview with the dining staff on 03/17/23 at 8:50am revealed if residents ate in their rooms, the dining staff was still responsible for ensuring the resident had what they needed to eat and provide oversight of the meal.

Interview with the Dietary Manager (DM) on 03/17/23 at 11:05am revealed:
-The dining staff were responsible to set up the dining room, serve plates, and refill beverages.
-The dining staff delivered meals to residents who were served in their rooms, and should check on the rooms to make sure residents were eating or needed any dietary assistance including picking up a cup for a wheelchair bound resident like Resident #9.

Observation of Resident #9 before and during breakfast on 03/17/23 revealed:
-At 7:50am, Resident #9 was resting in her bed,
-At 8:10am, the PCA woke Resident #9, performed incontinent care, dressed the resident,

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D 338	Continued From page 76	D 338		

assisted the resident to her wheelchair and brushed her hair.
-At 8:15am, Resident #9 was wheeled to the dining room on first floor.
-At 8:18am, the PCA filled Resident #9's ounces sippy cup with orange juice and placed the cup in front of Resident #9.
-At 8:18am, there were no utensils or napkin on the breakfast table.
-At 8:20am, Resident #9 had consumed all the orange juice except 1 and 1/2 ounces.
-At 8:28am, Resident #9 was interacting with other residents in the dining room using very slurred speech.
-At 8:35am, Resident #9's sippy cup was empty, and the resident was served a breakfast plate of bacon, scrambled eggs, and a blueberry muffin still in the muffin cooking paper by the dining room staff. The dining staff continued to serve additional residents in the dining room. Resident #9 did not request eating utensils or a napkin.
-At 8:40am, Resident #9 was eating her eggs with her fingers. She gathered a small amount of eggs and placed them in her mouth. She repeated the process slowly. Resident #9 dropped eggs along the entire front of her sweater and picked up the pieces to place them in her mouth. Resident #9 wiped her mouth with the bottom of her blouse.
-At 8:43am, another resident seated at an adjacent tablet asked Resident #9 where her fork was.
-At 8:45am, the resident at the adjacent table told the dining staff Resident #9 did not have a fork or napkin. The dining staff got a place setting of utensils wrapped in a linen napkin for Resident #9.
-At 8:45am, Resident #9 took a bite of her bacon with her fingers.
-At 8:48am, the PCA returned to the dining room and used Resident #9's knife to remove the

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D 338	Continued From page 77	D 338		

muffin from the wrapper and cut it up into pieces.
-At 8:50am, the dining staff was asked by surveyor to refill her cup or offer additional beverage.
-The dining room staff refilled the sippy cup with orange juice.
-At 8:52am, Resident #9 ate a piece of the muffin. Dining staff was present in the dining room.
-At 8:55am, Resident #9 said she was finished and offered rest of the food on her plate to the PCA.
-At 8:58am, the PCA sat down at the table with Resident #9. Resident #9 consumed 6 ounces more of orange juice from the sippy cup.

Interview with the dining staff on 03/17/23 at 8:50am revealed:
-He was responsible to set the tables with utensils and napkins before each meal.
-He was responsible to ensure beverage glasses were filled and refilled if a resident needed a refill.
-He overlooked providing Resident #9's eating utensils.
-He was focused on getting plates out to residents and did not observe Resident #9 eating with her fingers.

Interview with the first shift PCA on 03/17/23 at 8:59am revealed:
-The dining staff were responsible to set up the dining room with a napkin and eating utensils, served the residents' plates, and provided and refilled residents' beverages.
-The PCAs had a lot of residents to care for and the rooms were spread out in the facility and were not routinely responsible to assist with dining needs.
-She sometimes helped with Resident #9's beverage cup to make sure she her beverages was served in the sippy cup due to her shakiness.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 78 -Resident #9 could feed herself but she ate a lot better if somebody helped. Interview with the DM on 03/17/23 at 11:05am revealed: -Resident #9 should have been given a napkin and place setting of utensils before she was served her breakfast. -Other residents should not be expected to ask for a resident's eating utensils. -The PCAs could help to serve or refill beverages if they had time, but they were not expected to. -The Nurse was responsible for ensuring the DM was up to date on a resident's need for assistance with eating. -The facility did not currently have a Nurse of Resident Care Coordinator (RCC) due to recent staff turnover. Interview with the Executive Director (ED) on 03/17/23 at 5:30pm revealed: -The facility did not currently have a Nurse or RCC due to staff turnover. -The Nurse was responsible for continued assessments of residents' needs, including any changes that might require additional care. -He did not know Resident #9 was eating with her fingers. -Resident #9 should not have been eating eggs with her fingers and picking crumbs from her sweater because she had no eating utensils available. -He was aware Resident #9 had experienced a decline in her ability to manage her ADLS. Based on observations, interviews, and record review it was determined Resident #9 was not interviewable. The facility failed to respond with an appropriate	D 338		

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D 338	Continued From page 79 and reasonable response to residents' requests for heat in their rooms which resulted in residents unable to sleep, shaking, coughing and having congestion due to cold temperatures, and Resident #9 eating with her fingers due to no eating utensils provided and not having a beverage available or within reach during her meals. This failure was detrimental to the health, safety and well-being of all residents and constitutes a Type B Violation. _____ The facility a plan of protection in accordance with G.S. 131D-34 on 03/15/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2023.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 344	Continued From page 80	D 344		

orders for 1 of 5 sampled residents (#1) regarding an order for oxygen.

The findings are:

Review of Resident #1's current hospital discharge FL2 dated 02/02/23 revealed:
-Diagnoses included sepsis, aspiration pneumonia, altered mental status, hiatal hernia, and history of total hip replacement.
-There was an order for oxygen (O2) at 2 liters per minute via nasal cannula was ordered.
-The order did not specify if the O2 should be used continuously or as needed (prn).

Observation of Resident #1's room during the initial tour on 03/14/23 at 10:22am revealed:
-Resident #1's room had an oxygen concentrator running on the floor adjacent to the outside wall.
-Resident #1 was sitting in a wheelchair.

Review of Resident #1's February 2023 medication administration record (MAR) revealed:
-The was a handwritten entry for O2 (oxygen) at 2 liters as needed for shortness of breath scheduled for prn.
-There was no additional information for administration documented on the MAR.

Review of Resident #1's March 2023 MAR From 03/01/23 to 03/16/23 revealed:
-The was a handwritten entry for O2 (oxygen) at 2 liters as needed for shortness of breath scheduled for prn.
-There was no additional information for administration documented on the MAR.

Review of Resident #1's physician's orders revealed there was no documentation for clarification of O2 prn or continuously.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 344	Continued From page 81 Interview with a first shift personal care aide (PCA) on 03/16/23 at 11:20am revealed: -When she helped Resident #1 into bed, she applied Resident #1's oxygen nasal cannula. -She was told by another PCA (not sure who) that Resident #1 used oxygen as needed when in bed. -Resident #1 did not use her oxygen except when she was in bed. Observation of Resident #1 on 03/16/23 at 11:22am revealed the resident was in her bed with an oxygen nasal cannula in place and the oxygen concentrator running at 1 liter per minute. Interview with the medication aide/Supervisor (MA/S) on 03/16/23 at 11:25am revealed: -The facility's Nurse was responsible to clarify all medication or treatments that were incomplete or not clear. -The facility's Nurse left 2 weeks ago. -The facility's Nurse had entered the O2 order on the February 2023 MAR. -The medication aides (MAs) were responsible to review the upcoming MARs with the current MAR when the pharmacy sent the MAR. -The third shift MA had handwritten on March 2023 MAR for the O2 prn. -The Executive Director (ED) assigned the MA/S the task of medication management and administration oversight last week in the absence of the facility's Nurse. -The MA/S was unable to locate a clarification order for Resident #1's O2 in the resident's record or the unfilled papers in the former facilty's Nurse's office. -She would write an order for clarification to present to the facility's contracted primary care provider (PCP).	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 344	Continued From page 82 Interview with Resident #1's family member on 03/16/23 at 3:00pm revealed: -Resident #1 was extremely hard of hearing and not able to provide information. -Resident #1 had O2 ordered by the hospital physician when she was hospitalized early February 2023. -The hospital called a home health agency to send the O2 concentrator machine to the facility. -Resident #1 used O2 when she was in bed because she had a large hernia that put pressure on her lungs. -Resident #1 did not have shortness of breath when she was sitting upright. -The family member did not know how the facilty managed physician orders. -The family member did not have additional paperwork not provided to the facility. -Resident #1 had seen the facility's contracted PCP since the hospitalization and the facility could contact the PCP if needed. Interview with the contracted PCP on 03/17/23 at 12:00pm revealed: -She had been the facilty's PCP for a few weeks. -She had seen Resident #1 after her hospitalization in early February 2023. -The facility staff had not requested clarification for O2 for Resident #1. -She could be contacted by page, by fax, or by text should the facility need her for orders or order clarification. -She thought Resident #1 was ordered O2 because she had occasional shortness of breath when she was laying down due to a medical condition. Interview with the ED on 03/17/23 at 6:40pm revealed:	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 344	Continued From page 83 -He did not know Resident #1 needed clarification for her oxygen order dated 02/02/23. -The facility's Nurse was responsible for clarification of medication or treatment orders if the order was incomplete or unclear. -The facility's Nurse left 2 weeks ago. -The corporate nurse was supposed to be setting up routine visits and auditing while the facility's Nurse position was being recruited. -He had appointed a MA/S to assist in managing medication and treatment orders and administration of medications. -The MA/S was to freed from routinely staffing a medication cart to allow her time to work on the medication orders.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#6 and #7) observed during the medication pass including errors with an iron supplement (#6) and a medication used to treat osteoporosis, blood	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 358	Continued From page 84	D 358		

pressure medication, and a non-steroidal pain reliever (#7) and 4 of 6 sampled residents for record review (#1, #2, #4, and #5) regarding a protective skin barrier cream, aspirin, and antidepressant (#1); sliding scale insulin, a seizure medication and an iron supplement (#4); a thyroid hormone (#5); and a medication for lung cancer, skin irritation medication, a medication to improve mental function, four nutritional supplements, an anti-acid medication, pain reliever, two medications for nausea/vomiting, topical cream barrier, a medication for gastrointestinal disorders and acid reflux, and a topical cream for dry skin (#2).

Review of Resident #2's current FL2 dated 02/21/23 revealed:

1. The medication error rate was 14% as evidenced by 4 errors out of 28 opportunities during the 8:00am morning medication pass on 03/15/23.

a. Review of Resident #6's current FL2 dated 09/24/21 (no subsequent FL2 available for review) revealed:
-Diagnoses included dementia, pain in joints, muscle weakness, and muscle spasms.
-There was an order for ferrous sulfate 325mg (a vitamin supplement used to treat low iron) one tablet on Monday, Wednesday, and Friday.

Review of Resident #6's Quarterly Pharmacy Review dated 01/11/23 revealed the Consultant Pharmacist noted Resident #6 needed an updated FL2 and signed physician's orders.

Review of Resident #6's most current signed physician's orders dated 05/19/22 revealed there was an order for ferrous sulfate 325mg one tablet

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	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

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D 358	Continued From page 85 on Monday, Wednesday, and Friday. Observation of the morning medication pass on 03/15/23 at 8:50am revealed: -The morning medication aide (MA) in Special Care Unit (SCU) prepared 7 oral medication for administration to Resident #6. -The MA administered 7 oral medications and documented administration on the Medication administration record (MAR) after watching the resident take the medications. Review of Resident #6's March 2023 MAR from 03/01/23 to 03/15/23 revealed: -There was an entry for ferrous sulfate 325mg one tablet on Monday, Wednesday, and Friday scheduled for administration at 8:00am. -There was documentation ferrous sulfate 325mg was administered on 03/13/23 (Monday). -Ferrous Sulfate 325mg was circled by staff and documented as not available on 03/15/23 (Wednesday). Observation of medication on hand for Resident #6 on 03/15/23 at 8:50am revealed there was no ferrous sulfate 325mg on the medication cart or in overstock. Interview with the MA on 03/15/23 at 8:52am revealed: -Resident #6 did not have ferrous sulfate 325mg on the medication cart or in overstock. -The MAs were responsible to order medications prior to the resident running out of medication. -The MAs reordered medications by removing the reorder sticker, affixing the sticker to a re-order sheet and faxing to the contracted pharmacy. -She thought she had reordered the medication on 03/13/23 when she used the last tablet. -Resident #6's ferrous sulfate would be ordered	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 86 today to arrive on 03/17/23. Telephone interview with a pharmacist from the contracted pharmacy on 03/15/23 at 9:15am revealed: -The pharmacy used Resident #1's signed physician's order dated 05/19/22 for the current order for ferrous sulfate 325mg. -The facility was not on automatic monthly refills (cycle fill) for medications. -The facility was expected to reorder medications 2-3 days prior to the resident running out of medication. -Ferrous sulfate 325mg was filled for 12 tablets (one month supply) on 12/26/22 and 02/06/23. -There was no documentation the facility had requested a refill after 02/06/23 until 03/15/23. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. b. Review of Resident #7's current FL2 dated 07/19/21 (no subsequent FL2 available for review) revealed diagnoses included essential hypertension, depression, chronic pain due to injury, and osteoporosis. 1. Review of Resident #7's signed physician's orders dated 05/10/22 revealed there was an order for bisoprolol-hydrochlorothiazide 5-6.25mg (a combination medication used to treat high blood pressure) every day. Review of Resident #7's after visit summary from a second primary care provider (PCP) dated 02/07/23 revealed bisoprolol-hydrochlorothiazide 5-6.25mg was not listed in the current medications for Resident #7.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 87 Observation of the morning medication pass on 03/15/23 at 7:55am revealed: -The medication aide (MA) prepared 6 oral medications including bisoprolol-hydrochlorothiazide 5-6.25mg for administration. -The MA administered the medications and documented administration on the medication administration record (MAR) immediately following observing the resident take the medications. Review of Resident #7's March 2023 medication administration record (MAR) for 03/01/23 to 03/15/23 revealed: -There was an entry for bisoprolol-hydrochlorothiazide 5-6.25mg every day scheduled for administration at 7:00am. -Bisoprolol-hydrochlorothiazide 5-6.25mg was documented as administered every day from 03/01/23 to 03/15/23. Interview with the medication aide/Supervisor (MA/S) on 03/15/23 at 11:00am revealed: -She was the medication aide/Supervisor currently, due to the facility Nurse and Resident Care Coordinator (RCC) position being vacant. -The Executive Director (ED) assigned her to manage residents' medication orders while the Nurse and RCC position was being filled. -She had not seen residents' physician orders, unless the orders were left with her, until this week when she started reviewing residents' record in the absence of the facility Nurse. -She did not know Resident #7's bisoprolol-hydrochlorothiazide 5-6.25mg was missing on the list of resident's medications from the outside PCP and there was no current order for the medication.	D 358		

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D 358	Continued From page 88 Telephone interview with a nurse from Resident #7's second PCP's office on 03/15/23 at 2:00pm revealed: -Resident #7 was brought to the clinic for a visit on 02/07/23 for medication review and a referral to a pain clinic for a sacral injury. -The medication ordered for Resident #7's at the clinic did not include bisoprolol-hydrochlorothiazide 5-6.25mg. -Resident #7 was supposed to return to the clinic after the pain clinic referral visit, but called to cancel the appointment. -The nurse could not confirm Resident #7 should still be taking bisoprolol-hydrochlorothiazide 5-6.25mg. -Resident #7 would have to be seen again before a decision was made by the PCP to continue bisoprolol-hydrochlorothiazide 5-6.25mg. Telephone interview with a representative from Resident #7's outside pharmacy on 03/15/23 at 3:51pm revealed: -Resident #7 had medication filled by the pharmacy from prescriptions ordered by Resident #7's previous PCP and faxed to the pharmacy. -Resident #7's bisoprolol-hydrochlorothiazide 5-6.25mg was filled on 01/24/23 for 90 tablets from an order dated 12/18/22. Telephone interview with Resident #7's family member on 03/15/23 at 3:15pm revealed: -Resident #7 had been using the facility's contracted PCP until February 2023. -Resident #7 wanted to return to her previous PCP for a referral to a pain clinic subsequent to a sacral injury in February 2023. -It was hard for the family member to take the resident to her outside appointments and Resident #7 had agreed to start back using the facility's contracted PCP.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 89 -The family member canceled the follow-up appointment for Resident #7's outside PCP. -Resident #7 purchased her medications from a pharmacy other than the facility's contracted pharmacy because she was able to save money. 2. Review of Resident #7's signed physician's orders dated 05/10/22 revealed there was an order for Celebrex 200mg (a non-steroidal pain reliever) one capsule twice a day. Review of Resident #7's after visit summary from a second PCP dated 02/07/23 revealed Celebrex 200mg once a day was listed in the current medications for Resident #7. Observation of the morning medication pass on 03/15/23 at 8:05am revealed: -The MA prepared 6 oral medications which did not include Celebrex 200mg. -The MA administered the medications and documented administration on the medication administration record (MAR) immediately following observing the resident take the medications. Review of Resident #7's physician's orders revealed there was no order to hold Celebrex available for review. Review of Resident #7's March 2023 MAR from 03/01/23 to 03/15/23 revealed: -There was an entry for Celebrex 200mg twice a day scheduled for administration at 6:00am and 5:00pm. -There was a handwritten note to hold Celebrex while taking another pain medication. -Celebrex 200mg was not documented as administered from 03/01/23 to 03/15/23.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 90 Review of Resident #7's record revealed: -There was a handwritten note to hold Celebrex while taking oxycodone (a pain medication order by a local pain clinic). "These could cause very serious reactions". -The note requested the facility contact a family member with any questions. Interview with the MA/S on 03/15/23 at 11:00am revealed: -Resident #7's family member was very active in Resident #7's care and made and transported the resident to appointments with outside providers. -The note to hold Celebrex 200mg was from the family member. -The facility's Nurse had requested from staff that she be responsible to review the orders for residents. -The facility's Nurse had left the facility within the last month. -She was staffing the medication cart and did not know if the facility's Nurse had contacted any provider to obtain the order to hold Celebrex or if she was acting on the family member's note. -She would try to get an order to verify if Celebrex should be held. Telephone interview with a nurse at the second PCP's office on 03/15/23 at 2:00pm revealed: -Resident #7 was brought to the clinic for a visit on 02/07/23 for medication review and a referral to a pain clinic for a sacral injury. -Resident #7's medications at the clinic included Celebrex 200mg for Resident #7's joint pain. -Resident #7 was supposed to return to the clinic after the pain clinic referral visit but called to cancel the appointment. -The nurse could not confirm Resident #7's Celebrex should be held for any reason.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 91	D 358		

Telephone interview with Resident #7's family member on 03/15/23 at 3:15pm revealed:
-Resident #7 had been using the facility's contracted PCP until February 2023.
-Resident #7 wanted to return to her previous PCP for a referral to a pain clinic after a sacral injury in February 2023.
-The family member took Resident #7 to a pain clinic appointment on 02/08/23 where the family member was given verbal instruction that cautioned about drug interaction for Resident #7's medications.
-The family member made notes from the pain clinic visit and gave them to the facility's Nurse.
-She did not remember if she received addition paperwork from the pain clinic.
-It was difficult for the family member to take the resident to her outside appointments and Resident #7 had agreed to start back using the facility's contracted PCP.
-The family member canceled the follow-up appointment for Resident #7's outside PCP.

Telephone interview with a representative for Resident #7's outside pharmacy on 03/15/23 at 4:00pm revealed:
-Resident #7 had medication filled at the pharmacy for prescriptions faxed to the pharmacy.
-Resident #7's Celebrex was filled on 02/06/23 for 70 capsules.

Observation of medication on hand for administration for Resident #7 on 03/15/23 at 4:00pm revealed there was a full bottle on Celebrex 200mg labeled dispensed 02/06/23 for 70 capsules.

3. Review of Resident #7's signed physician's orders dated 05/10/22 revealed an order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 92	D 358		

risedronate sodium 150mg (used to treat osteoporosis) one tablet every 30 days with water. Take on an empty stomach with nothing by mouth for 30 minutes or do not lay down for 30 minutes.

Review of Resident #7's after visit summary from a second PCP dated 02/07/23 revealed an order for risedronate sodium 35mg take one tablet once WEEKLY in the morning, at least 30 minutes before food or drink.

Observation on the morning medication pass on 03/15/23 at 8:05am revealed:
-The medication aide/Supervisor (MA/S) prepared 6 oral medications not including risedronate sodium 35mg.
-The MA/S administered the medications and documented administration on the medication administration record (MAR) immediately following observing the resident swallow the medications.

Interview with the MA/S on 03/15/23 at 10:15am revealed:
-At 9:00am, she reviewed the medications administered to Resident #7 and discovered she had overlooked administering risedronate sodium 150mg when she administered Resident #7's medications at 8:05am.
-She thought she administered the risedronate sodium 150mg at 9:00am, and documented on the MAR to be within the correct time frame.

Observation on 03/15/23 at 11:00am of the package presented by the MA/S for risedronate sodium administered by the MA/S to Resident earlier (9:00am) revealed:
-The medication was dispensed in the original manufacturer package labeled for risedronate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 93	D 358		

sodium 35mg take one tablet once a week, in the morning at least 30 minutes before food or drink.
-The label indicated a quantity of 4 tablets was dispensed on 04/01/22 from an outside pharmacy provider.

Observation of medication on hand for administration for Resident #7 on 03/15/23 at 4:00pm revealed there were 3 unopened packages containing 4 tablets each (12 tablets = 3 months) in overstock labeled risedronate sodium 35mg take one tablet once weekly in the morning, at least 30 minutes before food or drink and dispensed on 01/19/23.

Review of Resident #7's March 2023 MAR on 03/15/23 at 11:00am revealed:
-The was an entry for risedronate sodium 150mg one tablet every 30 days with water. Take on an empty stomach. Take nothing by mouth or do not lie down for 30 minutes.
-There was documentation on 03/15/23 the medication was administered.

Second interview with the MA/S on 03/15/23 at 11:00am revealed:
-Resident #7 used an outside pharmacy to provide medications.
-The contracted pharmacy maintained a medication profile for residents and generated MARs for residents even if the pharmacy did provide the medication.

-The facility Nurse had requested from staff that the Nurse be responsible to review the orders for residents.
-The RCD had assisted the facility Nurse sometimes.
-She administered Resident #7 risedronate sodium according to the time indicated on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 94	D 358		

MAR.
-She did not identify the risedronate sodium 35mg was the incorrect strength according to the MAR.

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

2. Review of Resident #1's current hospital FL2 dated 02/02/23 revealed diagnoses included altered mental status, degenerative joint disease, total hip arthoplasty (left) and peripheral artery disease.

Review of Resident #1's current FL2 dated 02/02/23 revealed an order for sertraline 25mg (used to treat depression) take one tablet at bedtime.

Review of Resident #1's February 2023 MAR revealed sertraline 25mg at bedtime was handwritten on the MAR, scheduled for administration at 8:00pm and documented as administered daily from 02/03/23 to 02/28/23.

Review of Resident #1's March 2023 MAR from 03/01/23 to 03/15/23 revealed:
-Sertraline 25mg at bedtime was handwritten on the MAR, scheduled for administration at 8:00pm and documented as administered daily from 03/01/23 to 03/13/23.
-Sertraline 25mg was documented not as administered on 03/13/23, 03/14/23 and 03/15/23 due to not available.

Observation of medication on hand for administration for Resident #1 on 03/16/23 at 4:00pm revealed there was no sertraline 25mg available for administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 95 Interview with Resident #1's family member on 03/15/23 at 3:15pm revealed: -Resident #1's received her medications from an outside pharmacy due to cost saving. -Resident #1 was in the hospital and discharged 01/22/23. -Resident #1 was given a bottle of sertraline 25mg filled by the hospital pharmacy on the discharge day. -The family member brought the bottle of sertraline to the facility when she returned Resident #1 to the facility after the hospital discharge on 01/22/23. -She was not given an order for sertraline 25mg unless the order was in the paperwork she gave to the facility upon return to the facility. Telephone interview with a representative from Resident #1's outside pharmacy provider on 03/17/23 at 9:38am revealed the pharmacy had never dispensed sertraline 25mg for Resident #1. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/17/23 at 12:00pm revealed: -The pharmacy did not routinely supply medications for Resident #1. -The pharmacy generated the MARS for all the residents at the facility. -The pharmacy maintained a drug profile based on orders sent to the pharmacy. -The facility should send all medication orders, hospital discharge summaries, and FL2 for the pharmacy to use in maintaining residents' medication profiles and printing current MARs. -There was no order for sertraline 25mg sent to the pharmacy. Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 11:00am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 96 -Resident #1 used an outside pharmacy to provide medications. -Resident #1's family member may have provided the facility with Resident #1's sertraline 25mg, otherwise she did not know how the resident got the medication. -She did not know if the facility's Nurse had sent Resident #1's medication orders to the contracted pharmacy after the resident's hospital discharge on 01/22/23. c. Review of Resident #1's physician's orders dated 02/14/23 revealed an order for Baza Protect 12% (a skin protectant and moisture barrier) apply topically to buttocks every shift. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for Baza Protect Cream apply topically to buttocks every shift, scheduled for application on 7-3 shift, 3-11 shift, and 11-7 shift. -Baza Protect cream was documented as applied 10 out of 42 opportunities from 02/15/23 to 02/28/23. -There was no documentation of application on 02/18/23, 02/19/23, 02/24/23, 02/25/23. Review of Resident #1's March 2023 MAR from 03/01/23 to 03/15/23 revealed: -There was an entry for Baza Protect Cream apply topically to buttocks every shift, scheduled for application on 7-3 shift, 3-11 shift, and 11-7 shift. -Baza Protect Cream was not documented as applied from 03/01/23 to 03/16/23 for all 3 shifts. Observation of Resident #1's medication on hand for administration on 03/16/23 at 4:00pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 97 -There was a tube of Baza Protect Cream dispensed from an outside pharmacy on 02/15/23 for 142 grams. -The tube was half empty. Telephone interview with a representative from Resident #1's outside pharmacy provider on 03/17/23 at 9:38am revealed the pharmacy filled Baza Cream on 02/15/23 for 142 grams which should last one month. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/17/23 at 9:20am revealed: -The pharmacy did not routinely supply medications for Resident #1. -The pharmacy generated the MARs for all the residents at the facility and added Baza Protect Cream on the February 2023 MAR -The pharmacy maintained a drug profile based on orders sent to the pharmacy. -The facility should send all medication orders, hospital discharge summaries, and FL2 for the pharmacy to use in maintaining residents' medication profiles and printing current MARs. Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 11:00am revealed: -Resident #1 used an outside pharmacy to provide medications. -The contracted pharmacy maintained a medication profile for residents and generated MARs for residents even if the pharmacy did provide the medication. Interview with Resident #1's primary care provider (PCP) on 03/17/23 at 11:00am revealed: -She observed Resident #1's bottom today (03/17/23) and her bottom had no skin breakdown.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 98 -Staff should continue to apply BAZA protective cream to her bottom to prevent skin breakdown from incontinence but staff should be using BAZA each shift to protect the skin from breakdown. Based on observations, interviews and record review, it was determined Resident #1 was not interviewable. Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 11:00am revealed: -She was the medication aide/Supervisor currently, due to the facility Nurse and Resident Care Coordinator (RCC) position being vacant. -The Executive Director (ED) assigned her to manage residents' medication orders while the Nurse and RCC position was being filled. -The contracted pharmacy maintained a medication profile for residents and generated MARs for residents even if the pharmacy did provide the medication. -The facility was responsible to send orders to the facility's contracted pharmacy in order to maintain a current drug profile and updated MARs. -The facility's Nurse had requested from staff that the Nurse be responsible to review the orders for residents. -The RCC had assisted the facility's Nurse with processing resident's medication orders. -The facility's Nurse and the RCC had left the facility within the last month. -She had been assigned by the Executive Director (ED) within the last week to help manage residents' medications; she was also still staffing the medication cart. -She had not seen residents' physician orders, unless the orders were left with her, until this week when she started reviewing residents' record in the absence of the facility Nurse.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 99	D 358		

Interview with the Executive Director (ED) on 03/17/23 at 6:00pm revealed:
-The facility's Nurse and Resident Care Coordinator (RCC) positions were currently vacant.
-The facility's Nurse would routinely be responsible to ensure medications were administered and ordered.
-He did not know residents' medications were not being administered as ordered.
-The facility had arranged for assistance from a Corporate Nurse in the interim while the facility Nurse position was being filled.
-There was a MA/S that had been assigned to help oversee medication administration will the Nurse and RCC position was vacant.

3. Review of Resident #2's hospital discharge FL2 dated 02/21/23 revealed:
-Diagnoses included dementia, dysarthria, encephalopathy, metastasis to lymph nodes, paroxysmal atrial fibrillation, hematuria, arteriosclerosis of aorta, malnutrition, metastatic neoplasm, failure to thrive, cellulitis, supraventricular tachycardia, anemia, altered mental status, hypokalemia, acuter systolic and diastolic heart failure, cardiomyopathy, congestive heart failure, vitamin D deficiency and osteoporosis.
-The resident was hospitalized from 02/12/23 through 02/21/23.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 02/21/23.

a. Review of Resident #2's current FL2 dated 02/21/23 revealed orders for medications included acetaminophen extra strength 500mg, 2 tablets (1000mg) every 8 hours as needed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 100	D 358		

moderate pain (used to treat pain); desitin 13% cream (zinc oxide) 1 application topically two times daily (used to treat minor skin irritation); donepezil 10mg once daily in the evening (used to help improve mental function in people with dementia); emollient extra strength 1 application as needed (used to treat dry skin); erlotinib 100mg (tarceva) 100mg daily (take on empty stomach 1 hour before meals and 2 hours after) (used to treat small cell lung cancer); feeding supplement liquid 237 mLs two times daily between meals (used nutrition at risk individuals); loperamide 2mg, 2 capsules (4mg) every 8 hours as needed for diarrhea (used to treat diarrhea), magnesium 200mg once daily (used to treat acid indigestion); multivitamin once daily (supplement to treat malnutrition); non formulary apply 1 application topically every 4 hours as needed for rash to buttocks); ondansetron 4mg (zofran) 1 tablet (4 tablets) every 8 hours as needed for nausea or vomiting (used to treat nausea/vomiting); prochlorperazine 10mg 1 tablet every 6 hours as needed for nausea/vomiting) (used to treat nausea/vomiting); saccharomyces boulardii 250mg 1 capsule two times daily (used to treat gastrointestinal disorders); vitamin B-12 1,000mcg every evening (used to treat vitamin B-12 deficiency); vitamin C 100mg every evening (used to treat vitamin C deficiency).

Review of Resident #2's physician's order revealed there was an order to discontinue donepezil 10mg dated 03/09/23.

A request on 03/14/23 at 11:01am and 03/15/23 at 9:01am for Resident #2's February 2023 medication administration record (MAR) from 02/21/23 through 02/28/23 revealed:
-There was no MAR available for review from 02/21/23 through 02/28/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 101 -There was no documentation medications were administered as ordered from 02/21/23 through 02/28/23. Observation of Resident #2's medications on hand on 03/16/23 at 4:16pm revealed: -Acetaminophen extra strength 500mg, 2 tablets (1000mg) every 8 hours was available for administration. The medication was filled and dispensed on 02/21/23 and for a quantity of 90 tablets, with 90 tablets remaining. -Desitin 13% cream (zinc oxide) 1 application topically two times daily was available for administration. The medication was filled and dispensed on 02/21/23. The tube had been opened and indention's from usage. There was 3/4 of a tube remaining. -Donepezil 10mg once daily in the evening was not available for administration (medication discontinued on 03/09/23). -Emollient extra strength 1 application as needed for dry skin was not available for administration. -Erlotinib 100mg (tarceva) 100mg by mouth daily (take on empty stomach (1 hour before meals and 2 hours after) was available for administration. The medication was filled and dispensed on 02/22/23 for a quantity of 30 tablets, with 11 tablets remaining. -Feeding supplement liquid 237 mLs two times daily between meals was available for administration. The supplement was filled and dispensed on 02/22/23 for quantity of 15. The supplement was filled and dispensed on 03/01/23 for quantity of 60, with 30 remaining. -Loperamide 2mg, 2 capsules (4mg) every 8 hours as needed for diarrhea was available for administration. The medication was filled and dispensed on 02/21/23 for a quantity of 30 tablets, with 30 tablets remaining. -Magnesium 200mg once daily was available for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 102	D 358		

administration. There were two bubble packs of magnesium available for administration. The medication was filled and dispensed on 02/16/23 for a quantity of 28 tablets, with 26 tablets remaining. The second bubble pack was filled and dispensed on 02/21/23 for a quantity of 30 tablets, with 15 tablets remaining.
-Multivitamin once daily was available for administration. The medication was filled and dispensed on 02/09/23 for a quantity of 28 tablets, with 10 tablets remaining.
-Non formulary barrier cream apply 1 application topically every 4 hours as needed for rash to buttocks was not available for administration.
-Ondansetron 4mg (zofran) take 4 of the 1mg tablets every 8 hours as needed for nausea or vomiting was available for administration. The medication was filled and dispensed on 02/21/23 for a quantity of 120 tablets with 120 tablets remaining.
-Prochlorperazine 10mg 1 tablet every 6 hours as needed for nausea/vomiting was available for administration. The medication was filled and dispensed on 02/21/23 for a quantity of 30 tablets, with 30 tablets remaining.
-Saccharomyces boulardii 250mg 1 capsule two times daily was available for administration. The medication was filled and dispensed on 02/21/23 for a quantity of 60 tablets, with 16 tablets remaining.
-Vitamin B-12 1,000mcg every evening was available for administration. The medication was filled and dispensed on 02/21/23 for a quantity of 30 tablet, with 11 tablets remaining.
-Vitamin C 100mg every evening was not available for administration.

Telephone interview with a pharmacist at the facility's contract pharmacy on 03/17/23 at 9:11am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 103 -Prior to 02/21/23, the pharmacy had not dispensed medications for Resident #2. -The pharmacy filled and dispensed Resident #2's medications as follows: -Acetaminophen filled and dispensed on 02/21/23 and for a quantity of 90 tablets. -Desitin was not filled and dispensed at the pharmacy. -The medication was profiled only so the medication would be printed on the MAR. -Donepezil 10mg was filled and a quantity of 30 tablets were dispensed on 02/21/23. -Emollient was not dispensed by the pharmacy. -Erlotinib 100mg (tarceva) was filled and a quantity of 30 tablets were dispensed on 02/22/23. -Loperamide 2mg was filled and a quantity of 30 tablets were dispensed on 02/21/23. -Magnesium 200mg filled and a quantity of 30 tablets were dispensed on 02/21/23. -Multivitamin was not dispensed by the pharmacy. -Non formulary was not available for administration. -Ondansetron 4mg (zofran) was filled and a quantity of 30 tablets were dispensed on 02/21/23. -Prochlorperazine 10mg was filled and a quantity of 30 tablets were dispensed on 02/21/23. -Saccharomyces boulardii 250mg was filled and a quantity of 60 tablets were dispensed on 02/21/23. -Vitamin B-12 1,000mcg was filled and a quantity of 30 tablets were dispensed on 02/21/23. -Vitamin C 100mg had not been dispensed by the pharmacy. Telephone interview with a pharmacist from previous pharmacy that dispensed Resident #2's medications on 03/17/23 at 2:43pm revealed: -The pharmacy filled and dispensed Resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 104	D 358		

#2's multivitamin on 02/09/23 for a quantity of 28 tablets.
-The pharmacy filled and dispensed Resident #2's magnesium on 02/16/23 for a quantity of 28 tablets.
-The magnesium was dispensed without the pharmacy knowing the resident no longer resided at the facility.

Interview with Resident #2 on 03/14/23 at 10:41am revealed:
-She was recently admitted to the facility, exact date unknown.
-She was administered medications daily.
-She was unable to recall if her medications were administered every day last month, but she believed they were administered.
-She did not know her medications.
-She depended on staff to administer her medications as ordered.
-If she was not administered a medication as ordered, she would not know it.

Interview with Resident #2's responsible person on 03/17/23 at 10:19am revealed:
-Resident #2 was admitted to the facility directly from the hospital.
-The previous facility sent some medications, but she was not sure of the names of the medications.
-She did not know the quantity of the medications that were sent from the previous facility.
-No one at the facility had discussed with her about Resident #2's medications.
-One evening when visiting Resident #2, she observed the MA administer donepezil.
-She had not been present or observed the resident's other medications being administered.

Interview with the first shift medication aide (MA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 105 on 03/16/23 at 4:21pm revealed: -If Resident #2's February 2023 MAR was in the MAR book, then she administered the medications. -She was unable to recall administering the resident's medications in February 2023. Interview with the second shift MA on 03/17/23 at 2:54pm revealed: -She did not know where Resident #2's February 2023 MAR was located. -When a resident was admitted, the MA on duty sent the orders to the pharmacy. -The nurse reviewed the FL2 and hand wrote the MARs on carbon paper. -The top page of the carbon paper was the physician's order sheet. -The last page of the carbon paper was the MAR for the current month. -She was unable to locate the carbon paper of the MAR. -Medications were documented as administered using the current carbon MAR that was hand written by the nurse. -The next month, the pharmacy printed the MARs. -At the end of the month the hand-written MARs were taken out of the medication administration MAR book and placed in the resident's record. -The process she used to switch old MARs with the new MARs was: she took one resident's MARs out of the MAR book; she put the old MARs in the resident's record and put the new MARs in the MAR book. -She did not pull all MARs and file them in the resident's record because that caused her to make a mistake and maybe file the MARs in the wrong resident's record. -They had checked all the resident's records and were unable to find Resident #2's February 2023	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 106	D 358		

MAR.
-Without a MAR it could not be determined if Resident #2's medications were administered from 02/21/23 through 02/28/23.

Interview with the MA/S on 03/15/23 at 3:10pm revealed:
-Resident #2 should have a MAR for February 2023, documenting medications were administered.
-She could not say for certain Resident #2 had a February 2023 MAR because the nurse was supposed to prepare the MAR for the MA to document medications administered.
-At the end of the month the MAR was removed from the MAR book and put in the resident's record.
-She searched all the residents records and was unable to find Resident #2's February 2023 MAR.
-MAR/medication cart audits were completed weekly by the nurse.
-She did not know if the nurse checked to ensure all residents had a current MAR.
-Without a MAR for February 2023 it could not be determined Resident #2's medications were administered as ordered.

Interview with the Executive Director (ED) on 03/17/23 at 6:18pm revealed:
-He did not know where Resident #2's February 2023 MAR was at.
-At the end of the month, the MA was responsible for removing the last month's MARs from the MAR book, and putting them in the resident's record.
-When a resident was admitted to the facility and new orders were received; the MA on duty should send a copy to the pharmacy and add the medication to the MAR.
-New orders should be checked by the nurse or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 107	D 358		

Resident Care Director (RCD) and put on the new order tracking log.
-The new order tracking log was checked on a continuously bases to ensure no new orders were missed.
-When there was no nurse the ED or a MA should be assigned as the designated persons to track orders.
-He had no idea what happened to Resident #2's February 2023 MAR.
-At the end of the month, the new MAR should be placed in the MAR book and the last month's MAR should be removed and filed in the resident's record.

b. Review of Resident #2's current FL2 dated 02/21/23 revealed there was an order for erlotinib 100mg (tarceva) 1 tablet once daily (take 1 tablet on an empty stomach 1 hour before a meal or 2 hours after every day) (used to treat small cell lung cancer).

Review of Resident #2's physician's order sheet dated 02/24/23 revealed an order for erlotinib 100mg 1 tablet by mouth daily, 1 hour before meals or 2 hours after.

Review of Resident #2's medication orders revealed there were no orders that changed or increased erlotinib 100mg from once daily.

Review of Resident #2's March 2023 MAR from 03/01/23 through 03/14/23 revealed:
-There was an entry for erlotinib 100mg (tarceva) scheduled for administration at 10:00am and 4:00pm.
-There was documentation erlotinib 100mg was administered twice daily from 03/06/23 through 03/15/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 108 Review of Resident #2's physician's orders revealed there was no order for erlotinib 100mg twice daily. Observation of Resident #2's medications on hand at the facility on 03/16/23 at 4:16pm revealed: -Erlotinib 100mg was available for administration. -According to the medication instruction label erlotinib 100mg was to be administered once daily, 1 hour before meals or 2 hours after. -The medication was filled and dispensed on 02/22/23 for a quantity of 30 tablets. -There were 11 tablets remaining. Interview with Resident #2 on 03/17/23 at 4:17pm revealed: -Daily her stomach was upset, especially in the morning. -She could not say the upset stomach had increased lately. Interview with Resident #2's responsible person on 03/17/23 at 10:19am revealed: -Resident #2 was ordered erlotinib 100mg for cancer treatment. -The medication was ordered by the oncologist. -Resident #2 had been on the medication for a few years. -The medication had always been ordered once daily. Telephone interview with the nurse at Resident #2's oncologist's office on 03/17/23 at 3:12pm revealed: -Resident #2 had been ordered erlotinib 100mg once daily for cancer treatment. -The oncologist ordered erlotinib 100mg once daily. -Review of the oncologist notes showed erlotinib	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 109 100mg had never been ordered twice daily. Telephone interview with a pharmacist at the facility's contract pharmacy on 03/17/23 at 9:11am revealed: -The pharmacy received an order dated 02/21/23 for erlotinib 100mg once daily, 1 tablet, 1 hour before meals or 2 hours after a meal. -The pharmacy filled and dispensed Resident #2's erlotinib 100mg (tarceva) on 02/22/23 for a quantity of 30 tablets. -The pharmacy received a physician's order sheet dated 02/24/23 for erlotinib 100mg once daily, 1 tablet, 1 hour before meals or 2 hours after a meal. -The pharmacy had not received an order that changed erlotinib from once daily. -The medication had a side effect of stomach discomfort and nausea. -If the resident consumed twice the dosage the side effects would be increased causing more stomach discomfort. Interview with Resident #2 on 03/14/23 at 10:41am revealed: -She was recently admitted to the facility, exact date unknown. -She was administered medications daily. -She had been treated with a cancer medication, but she did not know the name of the medication. -She did not know the dosage or instructions for administering the medication. Interview with the facility's primary care provider (PCP) on 03/17/23 at 12:52pm revealed: -When Resident #2 was admitted to the facility she reviewed the medications. -She signed the physician's order sheet on 02/24/23 showing that she agreed with the hospital discharge medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 110 -Erlotinib 100mg was ordered by the oncologist to be administered once daily. -She had not changed the medication to twice daily. Interview with the MA on 03/17/23 at 12:27pm revealed: -When she was trained, she was told the third shift MA was supposed to administer Resident #2's morning medications. -She did not administer Resident #2's erlotinib during her shift. -The third shift MA was responsible for administering the medication in the morning and the second shift administered the 4:00pm dose of the medication. Interview with the second shift MA on 03/17/23 at 2:54pm revealed: -She administered Resident #2's erlotinib at 4:00pm because it was written on the MAR. -At the beginning of the month, erlotinib was on the MAR for once daily. -About one week into the month, someone changed the MAR to administer the medication twice daily. -She did not see a medication order for erlotinib twice daily, but that did not mean an order did not existed. Telephone interview with the third shift MA on 03/16/23 at 5:20pm revealed: -When she worked, she administered Resident #2's morning medications that were scheduled before 7:00am. -She did not administer erlotinib because the medication was scheduled at 10:00am. Interview with the MA/S on 03/15/23 at 3:10pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 111 -When she worked as a MA on the medication cart, she administered Resident #2's erlotinib at 10:00am. -She was aware Resident #2's erlotinib was written twice on the MAR. -She did not see the order for erlotinib twice daily, but she administered the medication as written on the MAR. -When medication orders were received, the MA on duty should fax the order to the pharmacy and hand write the order on the MAR. Interview with the Executive Director (ED) on 03/17/23 at 6:18pm revealed: -He did not know Resident #2's erlotinib was administered twice instead once daily as ordered. -When new orders were received the MA on duty should send a copy to the pharmacy and add the medication to the MAR. -If there was an order for erlotinib twice daily, the order should be in the resident's record. -The order should have also been sent to the pharmacy. -The nurse or RCD should check the new order tracking log continuously to ensure no new orders were missed. -When there was no nurse the ED or a MA should be assigned designated persons to track orders. -He had no idea what happened to Resident #2's February 2023 MAR. -At the end of the month, the new MAR should be placed in the MAR book and last month MAR should be removed and filed in the resident's record. c. Review of Resident #2's current FL2 dated 02/21/23 revealed there was an order for vitamin C 100mg chew (vitafusion power C gummies) 1 tablet in the evening (used to treat vitamin C deficiency).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 112 Review of Resident #2's physician's order sheet (POS) dated 02/24/23 for vitamin C 100mg chew in the evening. Review of Resident #2's March 2023 MAR from 03/01/23 through 03/16/23 revealed: -There was an entry for vitamin C 100mg 1 tablet in the evening scheduled at 8:00pm. -There was documentation vitamin C 100mg was not administered with staff circled initials and no reason documented why vitamin C was not administered. Observation of Resident #2's medications on hand at the facility on 03/16/23 at 4:16pm revealed vitamin C 100mg was not available for administration. Interview with Resident #2's responsible person on 03/17/23 at 10:19am revealed: -Resident #2 was diagnosed as failure to thrive. -The resident had been ordered a variety of supplements to help improve her health. -The supplements included vitamin C. -If the facility had a difficult time getting the vitamin C, they should have made her and the physician aware. Telephone interview with a pharmacist at the facility's contract pharmacy on 03/16/23 at 4:49pm revealed: -The pharmacy received an order dated 02/21/23 for vitamin C 100mg in the evening. -The pharmacy had a difficult time getting the medication because it was chewable (gummy). -The pharmacy initially tried to fill the medication on 02/21/23 but was unable. -The facility was notified the pharmacy was having a difficult time filling the medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 113 -The pharmacy had a second request from the facility to fill the medication on 03/15/23. -The pharmacy notified the facility on 02/22/23 and 0/15/23 that they were having difficulty filling the order for vitamin C 100mg. Interview with the facility's PCP on 03/17/23 at 12:52pm revealed: -She was not aware Resident #2 was not administered vitamin C. -If the pharmacy was having a hard time getting the medication, the facility should let her know after the first missed dose of the medication. -She expected medications to be administered as ordered. Interview with a second shift MA on 03/16/23 at 4:39pm revealed: -When a medication was not available for administration, she circled her initials. -She was supposed to document on the back of the MAR the reason why her initials were circled. -She was aware Resident #2 did not have vitamin C for administration and she circled her initials but did not document on the back of the MAR. -She did not know why the vitamin C was not delivered by the pharmacy because she had not contacted the pharmacy to inquire why the medication was not delivered. -She had not told the ED or MA/S that Resident #2 was not administered vitamin C because the medication was not delivered by the pharmacy. -She thought the MA/S did MAR and medication cart audits twice weekly. -When the audits were done, medications on the MAR were checked to ensure they were available for administration. Interview with the second shift MA on 03/16/23 at 2:54pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 114 -She was aware Resident #2 did not have vitamin C available for administration. -She contacted the pharmacy on 03/15/23 to request a refill for vitamin C. -She was unable to find the fax that showed she requested the refill. -Last month, she told the nurse that Resident #2 did not have vitamin C and the nurse said she would fix it. -The nurse left the facility two weeks ago and Resident #2 still did not have vitamin C. -She had not contacted the pharmacy to inquire why the medication was not dispensed by the pharmacy. -She had not made the ED aware the medication was not available. Interview with the MA/S on 03/17/23 at 8:58am revealed: -If the medications were not available the MA should contact the pharmacy and inquire why. -If there was no response from the pharmacy, the MA should contact the pharmacy again the next day. -The MA should let the first shift MA know she was unable to get Resident #2's vitamin C. -The MA should also ask someone about getting the medication over-the-counter. -If a resident was out of a medication for 3 days the MA should let someone (ED or nurse) know she could not get the medication. -The nurse was supposed to do weekly medication cart and MAR audits. -The third shift did weekly audits to check the MARs with the medications. Interview with the ED on 03/17/23 at 6:04pm revealed: -He did not know Resident #2 vitamin C had not been administered since the resident moved into	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 115	D 358		

the facility.
-MAR and medication cart audits should be done daily before each shift ends.
-The MA coming on duty should be checking the MARs for holes, circled initials and ensuring medications were available for administration.
-If the MA identified a medication was not available the nurse and the ED should be notified.

4. Review of Resident #4's FL2 dated 07/15/21 revealed diagnoses included hypertension, type 2 diabetes, hyperlipidemia and chronic obstructive pulmonary disease (COPD).

a. Review of a signed physician's order dated 10/21/22 revealed there was an order for insulin Novolog flexpen (a rapid-acting insulin used to lower elevated blood sugar levels) inject subcutaneously three times a day, no insulin if finger-stick blood sugar (FSBS) < 150, 151-180 give 4 units, 181-220 give 6 units, 221-260 give 8 units, 261-300 give 10 units, 301-340 give 12 units, FSBS > 341 give 14 units.

According to the American Diabetes Association (ADA), untreated hyperglycemia (high levels of glucose in the blood) could result in ketoacidosis (diabetic coma). Additionally, too much insulin could cause hypoglycemia (low levels of glucose in the blood) which could result in seizures or death.

Review of Resident #4's January 2023 medication administration record (MAR) revealed:
-There was an entry for insulin Novolog flexpen inject subcutaneously three times a day per sliding scale insulin (SSI), no insulin if FSBS < 150, 151-180 give 4 units, 181-220 give 6 units, 221-260 give 8 units, 261-300 give 10 units, 301-340 give 12 units, FSBS > 341 give 14 units

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 116	D 358		

with scheduled administration times of 6:30am, 2:00pm and 7:00pm.
-Resident #4's FSBS ranged from 89-228.
-There were 9 of 93 opportunities when SSI should have been administered or the incorrect amount of SSI was documented as administered with examples as follows:
-On 01/01/23, Resident #4's FSBS was documented as 193 and SSI was documented as held at 7:00pm when 6 units should have been administered.
-On 01/25/23, Resident #4's FSBS was documented as 171 and SSI was documented as held at 7:00pm when 4 units should have been administered.
-On 01/26/23, Resident #4's FSBS was documented as 211 and 8 units of SSI was documented as administered at 7:00pm when 6 units should have been administered.

Review of Resident #4's February 2023 MAR revealed:
-There was an entry for insulin Novolog flexpen inject subcutaneously three times a day per SSI, no insulin if FSBS < 150, 151-180 give 4 units, 181-220 give 6 units, 221-260 give 8 units, 261-300 give 10 units, 301-340 give 12 units, FSBS > 341 give 14 units with scheduled administration times of 6:30am, 2:00pm and 7:00pm.
-Resident #4's FSBS ranged from 100-258.
-There were 7 of 28 opportunities scheduled at 6:30am where it could not be determined how much SSI should have been administered because there was no documentation of SSI or FSBS on the MAR on 02/08/23, 02/10/23, 02/11/23, 02/12/23, 02/13/23, 02/14/23 and 02/17/23.
-There were 6 of 28 opportunities scheduled at 2:00pm where it could not be determined how

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 117 much SSI should have been administered because there was no documentation of insulin or FSBS on the MAR on 02/10/23, 02/14/23, 02/18/23, 02/24/23, 02/26/23 and 02/27/23. -There were 2 of 28 opportunities scheduled at 7:00pm where it could not be determined how much SSI should have been administered because there was no documentation of insulin or FSBS on the MAR on 02/11/23 and 02/21/23. -There were 10 of 84 opportunities when SSI should have been administered or the incorrect amount of SSI was documented as administered with examples as follows: -On 02/06/23, Resident #4's FSBS was documented as 184 and SSI was documented as held at 7:00pm when 6 units should have been administered. -On 02/19/23, Resident #4's FSBS was documented as 198 and SSI was documented as held at 7:00pm when 6 units should have been administered. -On 02/23/23, Resident #4's FSBS was documented as 184 and 8 units of SSI was documented as administered at 7:00pm when 6 units should have been administered. Review of Resident #4's March 2023 MAR from 03/01/23 to 03/14/23 revealed: -There was an entry for insulin Novolog flexpen inject subcutaneously three times a day per SSI, no insulin if FSBS < 150, 151-180 give 4 units, 181-220 give 6 units, 221-260 give 8 units, 261-300 give 10 units, 301-340 give 12 units, FSBS > 341 give 14 units with scheduled administration times of 6:30am, 2:00pm and 7:00pm. -Resident #4's FSBS ranged from 95-242. -There were 2 of 14 opportunities scheduled at 6:30am where it could not be determined how much insulin should be administered because	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 118	D 358		

there was no documentation of insulin or FSBS on the MAR on 03/05/23 and 03/07/23.
-There were 2 of 14 opportunities scheduled at 2:00pm where it could not be determined how much insulin should be administered to because there was no documentation of insulin or FSBS on the MAR 03/04/23 and 03/05/23.
-There were 1 of 13 opportunities scheduled at 7:00pm where it could not be determined how much insulin should be administered to because there was no documentation of insulin or FSBS on the MAR on 03/05/23.
-There were 9 of 41 opportunities when SSI should have been administered or the incorrect amount of SSI was documented as administered with examples as follows:
-On 03/02/23, Resident #4's FSBS was documented as 242 and SSI was documented as held at 7:00pm when 8 units should have been administered.
-On 03/06/23, Resident #4's FSBS was documented as 202 and SSI was documented as held at 2:00pm when 6 units should have been administered.
-On 03/14/23, Resident #4's FSBS was documented as 217 and SSI was documented as held at 2:00pm when 6 units should have been administered.

Observation of Resident #4's medications on hand on 03/17/23 at 11:05am revealed that there was one Novolog flexpen pre-filled insulin syringe available for administration.

Interview with Resident #4 on 03/16/23 at 3:15pm revealed:
-She thought there were a couple of instances where she refused FSBS checks and insulin within the last few months.
-There were times where staff said she needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 119	D 358		

insulin, but she told them she did not want it.
-Staff checked her FSBS three times daily.

Telephone interview with a representative from the facility's contracted pharmacy on 03/17/23 at 9:08am revealed that Resident #4 was "profile only" in the pharmacy's system and no medications were ever dispensed for Resident #4.

Telephone interview with a pharmacy technician from Resident #4's pharmacy on 03/17/23 at 9:40am revealed that the pharmacy had never dispensed Novolog insulin for Resident #4.

Based on interviews with multiple pharmacies and staff, it could not be determined from where Resident #4's insulin was dispensed.

Telephone interview with the Nurse from Resident #4's Primary Care Provider's (PCP) office on 03/17/23 at 11:43am revealed she was not aware there were errors with Resident #4's Novolog insulin administration over the last few months.

Attempted telephone interview with Resident #4's PCP on 03/17/23 at 11:45am unsuccessful.

Interview with a medication aide (MA) on 03/17/23 at 2:46pm revealed:
-She was not aware there were errors with Resident #4's Novolog insulin administration or that there were multiple days on the MAR in which there was no documentation for Resident #4's FSBS or insulin.
-She did not know why there were days on the MARs where there was no documentation for Resident #4's Novolog insulin.
-The MAs were responsible to administer medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 120 -She had administered insulin to Resident #4. -Resident #4 sometimes refused her Novolog insulin. Interview with a second MA on 03/17/23 at 4:18pm revealed: -She was not aware there were any medication errors with Resident #4's medications, including Novolog insulin. -She had administered Novolog insulin to Resident #4. -She did not know why there were days on the MARs where there was no documentation for Resident #4's Novolog insulin. -MAs were responsible to administer medications as ordered. Interview with the MA/Supervisor on 03/17/23 at 3:10pm revealed: -She thought that Resident #4's pharmacy dispensed the Novolog flexpen that was available on the medication cart for administration. -She was not aware there were any errors with Resident #4's Novolog insulin. -The MAs were responsible to administer medications as ordered. -MAR audits were not currently being done. b. Review of Resident #4's FL2 dated 07/15/21 revealed there was an order for ferrous sulfate 325mg (used to treat low iron levels) twice daily take with orange juice. Review of a signed physician's order dated 10/21/22 revealed there was an order for ferrous sulfate 325mg take 1 tablet every 2 days with 4 ounces (oz) of orange juice. Review of Resident #4's January 2023 Medication Administration Record (MAR)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 121	D 358		

revealed:
-There was an entry for ferrous sulfate 325mg tablet take 1 tablet every 2 days with 4 oz of orange juice scheduled for administration at 6:00am.
-There was documentation ferrous sulfate 325mg tablet was administered daily instead of the ordered dose of every two days from 01/01/23 to 01/31/23.

Review of Resident #4's February 2023 MAR revealed:
-There was an entry for ferrous sulfate 325mg tablet take 1 tablet every 2 days with 4 oz of orange juice scheduled for administration at 6:00am.
-There was documentation ferrous sulfate 325mg tablet was administered on 02/01/23 and 02/02/23 and every three days thereafter instead of the ordered dose of every two days from 02/05/23 to 02/28/23.

Review of Resident #4's March 2023 MAR from 03/01/23 to 03/14/23 revealed:
-There was an entry for ferrous sulfate 325mg tablet take 1 tablet every 2 days with 4 oz of orange juice scheduled for administration at 6:00am.
-There was documentation ferrous sulfate 325mg tablet was administered every three days instead of the ordered dose of every two days from 03/01/23 to 03/14/23.

Observation of Resident #4's medications on hand on 03/17/23 at 11:05am revealed:
-There were 54 of 100 ferrous sulfate 325mg tablets dispensed on 02/01/23 available for administration.
-If ferrous sulfate 325mg was administered as ordered, there should be 78 of 100 tablets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 122 available for administration. Interview with Resident #4 on 03/16/23 at 3:16pm revealed: -She was able to identify ferrous sulfate based on the red color of the medication tablet. -She did not know how often she was administered ferrous sulfate. Telephone interview with a representative of Resident #4's pharmacy on 03/17/23 at 9:41am revealed that the pharmacy dispensed 100 ferrous sulfate tablets on 02/01/23. Telephone interview with the Nurse from Resident #4's PCP's office on 03/17/23 at 11:44am revealed: -She was not aware Resident #4's ferrous sulfate was administered daily in January 2023 instead of the ordered dose schedule of every two days. -She was not aware Resident #4's ferrous sulfate was administered every three days in February and March 2023 instead of the ordered dose schedule of every two days. Attempted telephone interview with Resident #4's PCP on 03/17/23 at 11:48am unsuccessful. Interview with a MA on 03/17/23 at 2:47pm revealed: -She was not aware Resident #4's ferrous sulfate was not administered as ordered in January, February and March 2023. -MAs were responsible to administer medications as ordered. Second interview with the MA/S on 03/17/23 at 3:10pm revealed: -She was not aware that there were any errors with Resident #4's ferrous sulfate.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 123	D 358		

-The MAs were responsible to administer medications as ordered.
-MAR audits were not currently being done.

c. Review of Resident #4's FL2 dated 07/15/21 revealed there was an order for lamotrigine 200mg (a medication used to stabilize mood) take 1 and 1/2 tablets at 8:00am and 2:00pm.

Review of Resident #4's signed physician's order dated 10/21/22 revealed an order for lamotrigine 200mg take 1 and 1/2 tablets (300mg) at 8:00am and 2:00pm.

Review of Resident #4's January 2023 Medication Administration Record (MAR) revealed:
-There was an entry for lamotrigine 200mg take 1 and 1/2 tablets (300mg) scheduled for administration at 8:00am and 2:00pm.
-There was no documentation lamotrigine was administered on 01/02/23 at 2:00pm, 01/11/23 at 2:00pm, 01/17/23 at 8:00am, 01/18/23 at 2:00pm, 01/23/23 at 2:00pm, 01/25/23 at 2:00pm and 01/27/23 at 8:00am.

Review of Resident #4's February 2023 MAR revealed:
-There was an entry for lamotrigine 200mg take 1 and 1/2 tablets (300mg) scheduled for administration at 8:00am and 2:00pm.
-There was no documentation lamotrigine was administered on 02/11/23 at 8:00am, 02/14/23 at 2:00pm, 02/24/23 at 2:00pm, 02/26/23 at 2:00pm and 02/27/23 at 2:00pm.

Review of Resident #4's March 2023 MAR from 03/01/23 to 03/14/23 revealed:
-There was an entry for lamotrigine 200mg take 1 and 1/2 tablets (300mg) scheduled for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 124	D 358		

administration at 8:00am and 2:00pm.
-There was documentation lamotrigine was administered as ordered from 03/01/23 to 03/14/23.

Observation of Resident #4's medications on hand on 03/17/23 at 11:05am revealed there were 53 of 60 doses (79.5 of 90 tablets) of lamotrigine 300mg available for administration that were dispensed on 03/09/23.

Interview with Resident #4 on 03/16/23 at 3:16pm revealed that she thought she was being administered her lamotrigine as ordered by her provider.

Telephone interview with a representative from Resident #4's pharmacy on 03/17/23 at 9:41am revealed:
-The pharmacy dispensed 60 doses (90 tablets) of lamotrigine 300mg on 02/02/23.
-The pharmacy dispensed 60 doses (90 tablets) of lamotrigine 300mg on 03/09/23.

Attempted telephone interview with Resident #4's PCP on 03/17/23 at 11:48am unsuccessful.

Interview with a MA on 03/17/23 at 2:47pm revealed:
-Her normal process for reordering residents' medications was to re-order them 2 or 3 days before they completely ran out.
-She let her Supervisor know if a medication had run out.
-She was not aware that there was no documentation for lamotrigine on Resident #4's MARs for 7 times in January 2023 and for 5 times in February 2023.

Interview with the MA/S on 03/17/23 at 3:10pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 125 revealed: -She was not aware that there was no documentation for lamotrigine on Resident #4's MARs for 7 times in January 2023 and for 5 times in February 2023. -MAs were responsible to administer medications as ordered and to accurately document administration of medications. -MAR audits were not currently being done. Interview with a second MA on 03/17/23 at 4:19pm revealed: -She was not aware that there was no documentation for lamotrigine on Resident #4's MARs for 7 times in January 2023 and for 5 times in February 2023. -She did not know why and she was not certain if lamotrigine was administered to Resident #4 or not on the days that there was not documentation on the MARs. Interview with the Executive Director (ED) on 03/17/23 at 6:21pm revealed: -He was not aware that there was no documentation for lamotrigine on Resident #4's MARs for 7 times in January 2023 and for 5 times in February 2023. -MAs were responsible to administer medications as ordered, including documentation of administration on the MAR. _____ Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 11:00am revealed: -She was the MA/Supervisor currently, due to the facility Nurse and Resident Care Director's (RCD) position being vacant. -The facility was responsible to send orders to the facility's contracted pharmacy in order to maintain a current drug profile and updated MARs. -Both the facility's Nurse and the RCD had left the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 358	Continued From page 126	D 358		

facility within the last month.
-She had been assigned within the last week to help manage residents' medications, but she was also still staffing the medication cart.
-She had not seen residents' physician orders, unless the orders were left with her, until this week when she started reviewing residents' records in the absence of the facility Nurse.

Interview with the Executive Director (ED) on 03/17/23 at 6:22pm revealed:
-He was not aware there were any errors with Resident #4's medications.
-The facility's Nurse and RCD positions were currently vacant due to staff turnover.
-The facility Nurse would routinely be responsible to ensure medications were administered as ordered.
-MAs were currently responsible to administer medications as ordered.
-He did not know residents' medications were not being administered as ordered.
-The facility had arranged for assistance from a corporate nurse in the interim while the facility Nurse position was being filled.
-There was a medication aide/Supervisor that had been assigned to help oversee medication administration.

5. Review of Resident #5's FL2 dated 09/27/21 revealed:
-Diagnoses included dementia with behavioral disturbance, obstructive sleep apnea, and ataxia.
-There was an order for levothyroxine sodium 50mcg tablet (used to treat hypothyroidism) take one tablet every day.

Review of a signed physician's order dated 10/13/22 revealed there was an order for levothyroxine sodium 50mcg tablet take one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 127 tablet every day. Review of Resident #5's January 2023 Medication Administration Record (MAR) revealed: -There was an entry for levothyroxine sodium 50mcg tablet take 1 tablet every day scheduled for administration at 6:00am. -Levothyroxine sodium 50mcg was not documented as administered on 01/12/23, and for 5 consecutive days from 01/16/23 - 01/20/23 and on 01/22/23. Review of Resident #5's February 2023 MAR revealed: -There was an entry for levothyroxine sodium 50mcg tablet take 1 tablet every day scheduled for administration at 6:00am. -Levothyroxine sodium 50mcg was not documented as administered on 02/04/23, 02/07/23 and 02/26/23. Review of Resident #5's March 2023 MAR from 03/01/23 to 03/14/23 revealed: -There was an entry for levothyroxine sodium 50mcg tablet take 1 tablet every day scheduled for administration at 6:00am. -Levothyroxine sodium 50mcg was documented as administered. Observation of Resident #5's medications on hand on 03/16/23 at 10:35am revealed there were 18 of 30 levothyroxine sodium tablets available for administration dispensed on 12/26/22 and 30 of 30 levothyroxine sodium tablets available for administration dispensed on 03/09/23. Based on interviews and record review, it was determined that Resident #5 was not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 128 interviewable. Telephone interview with a representative of the facility's contracted pharmacy on 03/17/23 at 9:08am revealed the pharmacy dispensed 30 levothyroxine sodium tablets for Resident #5 to the facility on 12/26/22, 01/18/23 and 03/09/23 which was a 30-day supply. Interview with Resident #5's primary care provider (PCP) on 03/17/23 at 1:02pm revealed: -She was not aware there was no documentation on the MAR to determine if Resident #5's levothyroxine sodium was administered as ordered for 5 consecutive days from 01/16/23 to 01/20/23 or on 01/12/23, 01/22/23, 02/04/23, 02/07/23 and 02/26/23. -She expected the facility to administer medications as ordered. Interview with a medication aide (MA) on 03/16/23 at 11:00am revealed: -She was aware there was no documentation on the MAR to determine if Resident #5's levothyroxine sodium was administered as ordered for 5 consecutive days from 01/16/23 to 01/20/23 and on 01/12/23 and 01/22/23. -She was not sure if one of the MAs may have administered Resident #5's levothyroxine sodium and forgotten to document administration or if the levothyroxine sodium was not administered on the days that were not documented on the MAR. Interview with the Special Care Program Director (SCPD) on 03/16/23 at 11:35am revealed: -She was not aware there was no documentation on the MAR to determine if Resident #5's levothyroxine sodium was administered as ordered for 5 consecutive days from 01/16/23 to 01/20/23 and on 01/12/23 and 01/22/23.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 129 -She was not aware there was no documentation to determine if Resident #5 was administered levothyroxine sodium on 02/04/23, 02/07/23 and 02/26/23. -MAs were responsible to administer medications as ordered. Second interview with the MA/Supervisor on 03/17/23 at 3:10pm revealed: -She was not aware there was no documentation on the MAR to determine if Resident #5's levothyroxine sodium was administered as ordered for 5 consecutive days from 01/16/23 to 01/20/23 or on 01/12/23 and 01/22/23. -She was not aware there was no documentation to determine if Resident #5 was administered levothyroxine sodium on 02/04/23, 02/07/23 and 02/26/23. -MAs were responsible to administer medications as ordered. Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 11:00am revealed: -She was the MA/Supervisor currently, due to the facility Nurse and Resident Care Director's (RCD) position being vacant. -The facility was responsible to send orders to the facility's contracted pharmacy in order to maintain a current drug profile and updated MARs. -Both the facility's Nurse and the RCD had left the facility within the last month. -She had been assigned within the last week to help manage residents' medications, but she was also still staffing the medication cart. -She had not seen residents' physician orders, unless the orders were left with her, until this week when she started reviewing residents' records in the absence of the facility Nurse. Interview with the Executive Director (ED) on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 130 03/17/23 at 6:22pm revealed: -He was not aware there were any errors with Resident #5's medications. -The facility's Nurse and RCD positions were currently vacant due to staff turnover. -The facility Nurse would routinely be responsible to ensure medications were administered as ordered. -MAs were currently responsible to administer medications as ordered. -He did not know residents' medications were not being administered as ordered. -The facility had arranged for assistance from a corporate nurse in the interim while the facility Nurse position was being filled. -There was a medication aide/Supervisor that had been assigned to help oversee medication administration. _____ The facility failed to administer medications as ordered to a resident who had a diagnosis of lung cancer and was ordered a chemotherapy medication to be administered once daily, but the facility administered the medication twice daily resulting in the resident complaining of an upset stomach which was a side effect of this medication which could worsen the symptoms if not administered correctly (#2); errors observed during the medication pass including errors receiving a blood pressure medication without a current order, not administering a medication used to treat osteoporosis which could place the resident at risk for bone loss and fractures, and not administering a non-steroidal pain reliever placing the resident at risk for increased pain (#7); and a resident not receiving the correct doses of sliding scale insulin which placed the resident at risk for elevated or low blood sugars (#4). This failure placed residents at substantial risk of serious physicial harm, pain and neglect	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 131 which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/16/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 16, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 367	Continued From page 132	D 367		

interviews, the facility failed to ensure the accuracy of medication administration records (MARs) for 1 of 6 sampled residents (#9) related to a medication for anxiety.

The findings are:

Review of Resident #9's current FL2 dated 03/03/23 revealed:
-Diagnoses included Alzheimer's Dementia without behavior disturbances, hypertension, congenital scoliosis, and cerebral ataxia.
-There was an order for lorazepam 0.5mg (a schedule IV controlled substance used to treat anxiety) one tablet every 6 hours as needed (prn).

Review of Resident #9's controlled substance count sheet (CSCS) revealed:
-There were 30 lorazepam 0.5mg tablets dispensed on 01/02/23 along with a CSCS.
-There were 3 lorazepam 0.5mg tablets signed out on the CSCS from 01/01/23 to 01/31/23.
-There were 9 lorazepam 0.5mg tablets signed out on the CSCS from 02/01/23 to 02/28/23.
-There was 1 lorazepam 0.5mg tablets signed out on the CSCS from 03/01/23 to 03/16/23.

Review of Resident #9's medication administration record (MAR) for January 2023 compared to the CSCS for 30 lorazepam 0.5mg tablets dispensed on 01/02/23 revealed:
-There was an entry for lorazepam 0.5mg one tablet every 6 hours as needed for anxiety/agitation on the MAR.
-There were 2 lorazepam 0.5mg tablets signed out on the CSCS but not documented for administration and effectiveness on the MAR as follows:
-On 01/15/23 at 7:00pm, and on 01/23/23 at 7:00pm, 1 lorazepam 0.5mg was signed out on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 367	Continued From page 133	D 367		

the CSCS and not documented for administration and effectiveness on the MAR.

Review of Resident #9's MAR for February 2023 compared to the CSCS for 30 lorazepam 0.5mg tablets dispensed on 01/02/23 revealed:
-There was an entry for lorazepam 0.5mg one tablet every 6 hours as needed for anxiety/agitation on the MAR.
-There were 3 lorazepam 0.5mg tablets signed out on the CSCS but not documented for administration and effectiveness on the MAR as follows:
-On 02/16/23 at 6:00pm, on 02/17/23 at 6:00pm, and on 02/18/23 at 7:00pm, 1 lorazepam 0.5mg was signed out on the CSCS and not documented for administration and effectiveness on the MAR.

Observation of medication on hand for administration on 03/17/23 at 4:05pm revealed there were 17 tablets remaining in a bubble card labeled as dispensed on 01/03/23 for 30 tablets correctly matching the inventory count on the CSCS.

Interview with the medication aide/Supervisor (MA/S) on 03/17/23 at 4:15pm revealed:
-Medication aides (MAs) were responsible to sign out controlled medications on the CSCS when the medications were prepared.
-The MA should document administration of prn medications when the resident was administered the medication.
-The MA should document effectiveness of the prn medication on the MAR after one hour (including controlled medications).
-MAs completed medication cart controlled medications count audits between shifts, but they only checked for the quantity on hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 367	Continued From page 134	D 367		

documented on the CSCS for medications that matched the quantity of the medication on hand.
-The facility's Nurse was responsible to audit residents' MARs for missed medications, documentation of prn medications, and MAR accuracy.
-The facility's Resident Care Coordinator (RCC) routinely assisted the facility's Nurse with MAR audits.
-The facility's Nurse position and RCC position were vacant for more than 2 weeks (prior to 03/17/23).
-She had been asked by the Executive Director (ED) to assume some of the duties of the facilty's Nurse and RCC in the interim period while the facilty was recruiting for RCC and Nurse positions.
-The MA/S had not audited any MARs compared to CSCS logs for accurate documentation of prn controlled medications, including the date and time of administration as well as the effectiveness, due to working the medication carts.

Interview with the ED on 03/17/23 at 6:30pm revealed:
-The MAs were supposed to document administration of all prn medications on the MAR when the medication was administered.
-One hour later, the MA would document the effectiveness of the prn medication after the resident was evaluated.
-He did not know Resident #9 had prn lorazepam 0.5mg signed out as administered on the CSCS and administration and effectiveness not documented on the MARs.
-The facility's Nurse and RCC were responsible to ensure medication were administered and documented correctly (including prn medications).
-There was not a facility Nurse or RCC currently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 367	Continued From page 135 available at the facility. -The corporate nursing staff was coming to the facility to help with medication and health care concerns for residents. -The ED had assigned a MA/S to monitor medication orders, administration, documentation and relieving her duties for medication cart staffing. -There was a Corporate Area Manager currently dedicating most of her time on-site to assist with hiring a facility's Nurse and RCC and arranging routine corporate nursing staff visits for audits, including medication administration and documentation. Based on observations, interviews, and record review, it was determined Resident #9 was not interviewable.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 136 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) who self-administered medications had orders to self-administer medications for pain/fever medication, acid reflux, nerve pain/seizures, anti-depressant, a thyroid medication, anti-anxiety, bronchospasm, stool softener, acid reflux, eye drops, inhaler, dry mouth, minor skin irritation, and skin barrier cream. The findings are: Review of Resident #3's current FL2 dated 02/18/22 revealed: -Diagnoses included trigeminal neuralgia, carotid artery disease, depression, panic/anxiety syndrome, hypertension, chronic kidney disease stage III hypothyroid, bronchiectasis. -There was no documentation related to the resident's disorientation status. -Medication orders included aspirin 81mg once daily (used to treat pain/fever), esomeprazole 40mg once a day (used to acid reflux), gabapentin 100mg three times daily (used to treat nerve pain/seizure disorder), gabapentin 100mg 2 tablets (=200mg) at bedtime, sertraline 25mg once daily (used to treat anti-depression), levothyroxine 50mcg once daily (used to treat low thyroid hormone), alprazolam 0.25mg three times daily as needed for anxiety (PRN) (a controlled substance), docusate sodium 100mg once daily as needed for constipation, ondansetron 4mg every 8 hours as needed for nausea, Proair 90mcg inhale 2 puffs every 6 hours as needed for wheezing, sennosides 8.6mg once daily (used to treat constipation), and albuterol solution 3mls take 1.25mg (3mls) via nebulizer every 6 hours as needed for wheezing.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 137 Review of Resident #3's physician's order revealed: -There was an order dated 03/23/22 that changed sennosides 8.6mg to as needed. -There was an order dated 06/23/22 for desitin 13% cream (used to treat skin irritation). -There was an order dated 09/16/22 for rosuvastatin 10mg sprinkles once daily (used to treat high cholesterol and prevent heart attack). -There was an order dated 10/04/22 for alprazolam 0.25mg take 1/2 tablet twice daily. -There was an order dated 10/27/22 that changed gabapentin to 100mg in the morning and 200mg at bedtime. -There was an order dated 10/27/23 for sodium chloride at bedtime (used to treat low amount of sodium in the blood). -There was an order dated 11/10/23 for alprazolam 0.25mg 1 tablet three times daily as needed for anxiety. -There was an order dated 11/15/23 that changed to alprazolam 0.25mg ½ tablet (0.125mg) to scheduled twice daily. Observation of Resident #3's medications on hand on the medication cart on 03/16/23 at 3:05pm revealed Resident #3 did not have any medications on the medication cart. Observation of Resident #3's medications on hand in the resident's room on 03/16/23 at 3:07pm revealed: -The resident's medications were in pill bottles, in various locations in her room. -The resident had medications in a purse that was hanging from her walker near the reclining chair where the resident was sitting. -There were medications on a side table on the right side of the reclining chair.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 138 -There were medications on the floor (left side of the reclining chair) between the chair and another side table -There was a side table on the left side of the reclining chair and medications were on the top of that table. -There was observed a locked box with medications. -The resident had the key to the box around her neck. -The resident pulled four pill bottles from a purse that was hanging from her walker. -Each pill bottle had a white cap. -The label on one pill bottle had instructions for alprazolam 0.25mg ½ tablet twice daily as needed for anxiety. -The label on three pill bottles had instructions for alprazolam 0.25 three times daily as needed for anxiety. -Hand written on top of each white cap was an initial. -The first pill bottle had the letter "G" hand written on the cap. There were capsules inside the bottle. The medication identified inside the bottle was gabapentin 100mg. -The second pill bottle had the letter "S" hand written on the cap. There were tablets inside the bottle. The medication identified inside the bottle was sertraline 25mg. -The third pill bottle had a small letter "s" hand written on cap. There were large oblong tablets inside the bottle. The medication identified inside the bottle was sodium chloride. -The fourth pill bottle had the letter "A" hand written on the cap. There were several small circular tablets and half tablets inside the bottle. The medication identified inside the bottle was alprazolam. -Medications inside the locked container included aspirin 81mg and alprazolam 0.25mg ½ tablet	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 139	D 375		

(0.125mg).
-Other medications included levothyroxine 50mcg; aspirin 81mg; docusate 100mg; ondansetron 4mg; proair 90mcg; albuterol solution 3mLs 1.25mg nebulizer, colace 100mg, desitin, simethicone 80mg, nutritional supplement, A & D ointment, systane, mylanta, and biotene for dry mouth.

Review of Resident #3's physician's orders revealed:
-There were no orders for the resident to self-administer her own medications.
-There were no orders in the resident's record for simethicone 80mg, nutritional supplement, A & D ointment, systane, mylanta, and biotene for dry mouth.

Review of Resident #3's February and March 2023 medication administration record (MAR) revealed there was a hand written note on the MAR the resident self-administered her medications.

Interview with Resident #3 on 03/16/23 at 3:27pm revealed:
-She was able to self-administer her own medications.
-The nurse assessed her last month, and the nurse said she was able to self-administer her medications.
-She did not want the facility staff administering her medications because they never got it right.
-When facility staff administered her medication; the morning medications were administered after 10:00am, and some days not administered at all unless she asked for them.
-The facility staff would wake her up after 9:30pm to administer bedtime medications.
-There was no consistency and staff often mixed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 140 up her medications with another resident's medications; she had to tell them that was not her medication and refused the medication. -She had to wait for long periods of time to get PRN medication; including anxiety medication, which caused her more anxiety. -She put the initials on the top of the pill bottles to remember the medication that she put in the bottles. -She was unable to explain why she disposed of the containers of the medication were in when dispensed from the pharmacy. -Lately, she was anxious and nervous, so she was "pinching" off the alprazolam. -What she meant by pinching off the alprazolam was, she took the alprazolam 0.25mg, ½ tablet three times daily, because it worked better for her and helped with her anxiety. -When taking alprazolam she did not take more than ordered; she created a system that worked best for her by cutting the 0.25mg in half, and then she cut the ½ tablet in half and took it twice daily. -She also took a ½ tablet of the 0.25mg alprazolam at bedtime. -At the end of the day she did not take more than what was ordered. -Although, her medications were not in the containers from the pharmacy and they were not organized, she still had knowledge of what to take and when to take it. -She did not have orders for some medications because if she was allowed to self-administer her medications, then she was able to take what she wanted. Interview with Resident #3's family member on 03/16/23 at 3:38pm revealed: -Resident #3 had a system of how she took her medications.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 141 -The resident took her own medications at home and knew what she was taking. -When facility staff administered Resident #3's medications she always complained to her that the staff did not administer the medication on time or sometimes not at all. -The staff woke the resident up late at night to administer medications or they tried to administer the resident the wrong medication. -She did not know that Resident #3 needed orders for all medications administered. -The facility's nurse had assessed Resident #3 and told the resident she could self-administer her medication; she did not know the nurse had to obtain an order from the resident's physician to self-administer. Interview with Resident #3's primary care provider (PCP) on 03/14/23 at 10:43am revealed: -She had been the PCP at the facility since January 2023. -She was told by Resident #3 and the medication aide (MA) that Resident #3 self-administered her own medications. -She had not assessed Resident #3 to ensure the resident was competent enough to self-administer her own medications. -She preferred the facility staff had control over monitoring and administering Resident #3's medications to ensure the medications were administered as ordered. Interview with the MA supervisor on 03/15/23 at 4:01pm revealed: -Resident #3 self-administered her medications. -The resident had been assessed by the facility's nurse to ensure she could self-administer her medications. -The nurse was supposed to get an order from the PCP for the resident to self-administer her	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 142	D 375		

medications.
-There was no system in place to ensure the nurse obtained the order for the resident to self-administer medications.
-The resident was not monitored to ensure medications were taken as ordered.
-The facility did not have a system in place to ensure the resident had all medications ordered on hand or to ensure there were orders for all medications in the resident's room.

Interview with a first shift MA on 03/17/23 at 12:27pm revealed:
-She had worked at the facility since February 2023 and she did not administer medication to Resident #3.
-The resident self-administered her own medications.

Interview with a second shift MA on 03/15/23 at 3:20pm revealed:
-Resident #3 self-administered her own medications.
-She had not seen an order for the resident to self-administer her medications.
-The nurse was responsible for assessing the resident and obtaining the order.
-Resident #3 had self-administered her own medication for almost 2 months.

Interview with the Executive Director (ED) on 03/17/23 at 5:54pm revealed:
-He did not know Resident #3 did not have an order to self-administer her own medications.
-The facility's Nurse did an evaluation on residents who self-administered medications.
-The assessments should be done quarterly.
-The nurse was responsible for obtaining an order for medications without orders and self-administer orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 375	Continued From page 143 Attempted telephone interview with the previous facility's Nurse on 03/17/23 at 10:40am was unsuccessful.	D 375		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 1 of 3 sampled residents (#3) related to anti-anxiety medication. The findings are: Review of Resident #3's current FL2 dated 02/18/22 revealed: -Diagnoses included depression and panic/anxiety syndrome -Medication orders included alprazolam (a Schedule IV controlled substance) 0.25mg three times daily as needed for anxiety (PRN). Review of Resident #3's physician's order revealed: -There was an order dated 10/04/22 for alprazolam 0.25mg take 1/2 tablet twice daily. -There was a physician's order sheet dated	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

(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 392	Continued From page 144 10/11/22 for alprazolam 0.25mg 1/2 tablet (0.125mg) twice daily PRN for anxiety. -There was an order dated 11/10/22 for alprazolam 0.25mg 1 tablet three times daily PRN for anxiety. -There was an order dated 11/15/22 for alprazolam 0.25mg ½ tablet (0.125mg) twice daily. Review of Resident #3's January 2023 medication administration record (MAR) revealed: -There was an entry for alprazolam 0.25mg 1/2 tablet twice daily scheduled for administration at 9:00am and 5:00pm. -There was documentation the alprazolam 0.25mg 1/2 tablet was administered twice daily from 01/01/23 through 01/31/23. Review of the facility's controlled substance count sheet (CSCS) book for January, February and March 2023 revealed there were no CSCS sheets for Resident #3's alprazolam 0.25mg 1/2 tablet (0.125mg) twice daily. Observation of Resident #3's medications on hand on the medication cart on 03/16/23 at 3:05pm revealed the resident did not have any alprazolam on the medication cart. Observation of Resident #3's medications in her room on 03/16/23 at 3:07pm revealed: -There was bottle of alprazolam with at least 8 whole tablets and 2 half tablets remaining. -The bottle of alprazolam was kept in the resident's purse. -There was a bubble packed container of alprazolam 0.25mg, with instructions to take 1/2 tablet (0.125mg) three times daily PRN for anxiety. -There was a quantity of 30 tablets dispensed,	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 392	Continued From page 145 and there were 28 tablets remaining. Interview with Resident #3 on 03/16/23 at 3:27pm revealed: -She had administered her alprazolam since February 2023. -Prior to last month, facility staff administered her alprazolam. -They never administered the medication on time, which gave her more anxiety. -She took half of a 0.25mg tablet of alprazolam twice daily and took another 1/2 tablet at bedtime. -She did not know how many tablets she had when she initially started administering her alprazolam. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/17/23 at 9:13am revealed: -The pharmacy did not fill Resident #3's medications. -The pharmacy had medication orders but they were for profile only to show the medications on the MAR. -When the pharmacy dispensed controlled medications the supplied the facility with CSCS's for documentation of the controlled medications. -Resident #3's alprazolam came from another pharmacy. Telephone interview with a pharmacist at the pharmacy used to fill Resident #3's medications on 03/17/23 at 4:38pm revealed: -The pharmacy filled Resident #3's medications. -The pharmacy had an order dated 11/10/22 for alprazolam 0.25mg take 1/2 tablet twice daily. -The order replaced the previous as needed orders for alprazolam. -The pharmacy did not provided a CSCS for alprazolam.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041065	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HOUSE SENIOR LIVING	3896 N. ELM STREET GREENSBORO, NC 27455

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D 392	Continued From page 146 Interview with the medication aide (MA) supervisor on 03/15/23 at 4:01pm revealed: -Resident #3 self-administered alprazolam for almost two months and CSCS documentation was completed. -Prior to the resident administering her medications, the MA administered medications to the resident. -The MAs were supposed to document medication like alprazolam on the MAR and on the CSCS. -The CSCS should be in the resident's record; if not she had no idea where it was located. -Resident #3 used a private pharmacy to fill her medications. -There was no system in place for documentation to show how many alprazolam the resident had prior to self-administering her medications. Interview with the Executive Director (ED) on 03/17/23 at 5:54pm revealed: -When a controlled drug was administered, the MA was supposed to document on the CSCS. -At the end of the month, the CSCS should be in the resident's record. -He did not know where Resident #3's CSCS was located. -The facility did not have have a CSCS for Resident #3 for the past two months because the resident self-administered the alprazolam.	D 392		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been	D 406		

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D 406	Continued From page 147 informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on pharmacy review recommendations for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's FL2 dated 02/18/22 revealed: -Diagnoses included trigeminal neuralgia, carotid artery disease, depression, panic/anxiety syndrome, hypertension, chronic kidney disease stage III hypothyroid, bronchiectasis. -There was an order for tobramycin (used to treat or prevent infections)300mg nebulizer once daily. -There was an order for alprazolam (used to treat anxiety) 0.25mg three times daily as needed (PRN). Review of a physician's order for Resident #3 dated 10/11/22 revealed: -There was an order for tobramycin 300mg nebulizer changed from once daily to every day PRN for shortness of breath. -There was an order for alprazolam 0.25mg ½ tablet twice daily as PRN for anxiety. -There was an order dated 11/10/22 that changed alprazolam 0.25mg ½ tablet from PRN to schedule twice daily. Review of a pharmacy medication issue report for Resident #3 dated 10/18/22 revealed: -The pharmacist recommended discontinuing PRN tobramycin nebulizer due to lack of use or	D 406		

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D 406	Continued From page 148	D 406		

documentation on the MAR.
-The pharmacist recommended discontinuing alprazolam 0.25mg ½ tablet twice daily as needed for anxiety.

Review of a pharmacy medication issue report for Resident #3 dated 01/11/22 revealed:
-The pharmacist recommended discontinuing PRN tobramycin nebulizer due to lack of use or documentation on the MAR.
-The pharmacist recommended discontinuing alprazolam 0.25mg ½ tablet twice daily as needed for anxiety due to lack of use or documentation on the MAR.

Review of Resident #3's orders in the record revealed there was no documentation the Primary Care Physician (PCP) had been made aware of the pharmacist recommendations.

Telephone interview with the pharmacist from the resident's private pharmacy on 03/17/23 at 5:25pm revealed:
-There were two orders for alprazolam 0.25mg ½ tablet on the MAR.
-One order was for PRN and the other order was scheduled twice daily.
-To avoid an error administering alprazolam, there should be clarification as to take the PRN off the MAR, due to the scheduled alprazolam replacing the PRN order.
-She sent the recommendations to the Executive Director's (ED) email address and to the Resident Care Coordinator (RCC).

Interview with the ED on 03/17/23 at 6:34pm revealed:
-The previous RCC was responsible for following up on pharmacy recommendations.
-The RCC left two weeks ago, and he had no

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D 406	Continued From page 149 idea recommendations were not followed-up. -If there was no RCC, the ED was responsible for following up on recommendations. -No one had followed up on Resident #3's pharmacy recommendations.	D 406		