PRINTED: 05/31/2023 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or contribution	IDENTIFICATION NOWIDEN.	A. BUILDING: _		
		HAL081052	B. WING		R 01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC	2270 OAKL	AND ROAD		
OLDAIT O	ALLIN LIVING LLG	FOREST C	TY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	completed an annual	epartment of Social Services and follow-up surveys and a on on 12/28/22 to 12/30/22 exit conference via			
D 030	10A NCAC 13F .0302 Construction	2 (b) Design And	D 030		
	10A NCAC 13F .0302	2 Design And Construction			
		be planned, constructed, ined to provide the services			
	failed to ensure the be provide services for a	ns and interviews, the facility uilding was maintained to licensed capacity of 44 non-residnet occupying a			
	The findings are:				
	Review of the facility's capacity of 44 resider	s current license revealed a nts.			
	Review of the facility's revealed the current of	s census for 12/28/22 census was 18 residents.			
	revealed: -One of the staff was vacant resident room -The staff gave her m assumed she was a N	ent on 12/28/22 at 9:46am living in the facility in a . edications, so the resident Medication Aide (MA). sure how long the MA had			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL081052	B. WING		R 01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDARC	DEEK LIVING LLC	2270 OAKL	AND ROAD		
CEDAR CREEK LIVING LLC FOREST C		TY, NC 28043	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 030	Continued From page	e 1	D 030		
	been living at the faci	lity.			
	-	ity. ace of residency. with the Administrator on			
	01/04/23 at 10:14am				
	-A MA lived at the fac	was an issue that the MA			
		cause he had open rooms.			
	-	e needed to contact DHSR if			
	a non-resident was liv	ving at the facility.			
D 139	10A NCAC 13F .0407 Qualifications	7(a)(7) Other Staff	D 139		
	(a) Each staff person (7) have a criminal ba in accordance with G	7 Other Staff Qualifications at an adult care home shall: ackground check completed .S. 131D-40 and results person's personnel file;			
	facility failed to ensure D and E and the Ope	as evidenced by: ews and interviews, the e 3 of 5 sampled staff (Staff rations Manager) completed d check prior to working in			
	The findings are:				
	record revealed:	rations Manager's personnel /20/20 as the Operations			
	-There was no signed	d consent for a criminal			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,	- CONSTRUCTION	COMPLETED
			A. Boilbino.		_
		HAL081052	B. WING		R 01/04/2023
		HAL001032			0 1/04/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		KLAND ROAD		
		FOREST	CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 139	Continued From page	2	D 139		
	background check in -There was no docum background check wa 01/20/20.	entation a criminal			
	to hire but did not get of the completed back personnel record.	revealed: ackground completed prior the results or have a copy kground check in her onsent since she was the kground check.			
	Refer to interview with Administrator-in-Char 2:00pm.	n the ge (AIC) on 12/30/22 at			
	Refer to interview with on 01/03/22 at 11:50a	n the Operations Manager ım.			
	Refer to interview with 01/03/22 at 11:52am.	n the Administrator on			
	-There was no signed background check in	consent for a criminal her personnel record.			
	revealed: -She worked at the fa -She could not remen	on 12/30/22 at 9:30am  cility as a PCA.  ber if she signed a consent ck before she was hired.			

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		1141 004050	B. WING		R
		HAL081052	D. WING		01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE	
			, ,	,	
CEDAR C	REEK LIVING LLC		KLAND ROAD		
FOREST		CITY, NC 28043	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( -/
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIE
			+	, , , , , , , , , , , , , , , , , , ,	
D 139	Continued From page	e 3	D 139		
		l consent for a criminal			
		Staff D's personnel record.			
	-She did not know if the	he criminal background			
	check was completed	I prior to her starting work.			
	•				
	Refer to interview with	h the AIC on 12/30/22 at			
	2:00pm.				
	Refer to interview with	h the Operations Manager			
	on 01/03/22 at 11:50a				
	011 0 1/03/22 at 11.30a	3111.			
	Defends intomicus sit	la tha a Administrator an			
		h the Administrator on			
	01/03/22 at 11:52am.				
		personnel record revealed:			
	-Staff E was hired on	05/25/22 as a housekeeper.			
	-There was no docum	nentation a criminal			
	background check wa	as completed before			
	05/25/22.				
	-There was no signed	l consent for a criminal			
	background check in				
	g				
	Interview with Staff F	on 12/30/22 at 9:45am			
	revealed:	011 12/00/22 at 0. 10am			
		ility as a housekeener			
		ility as a housekeeper.			
		ber if he signed a consent			
	_	ck before she was hired.			
		e criminal background			
	check was completed	l before he started work.			
	Refer to interview with				
	Administrator-in-Char	ge (AIC) on 12/30/22 at			
	2:00pm.				
	•				
	Refer to interview with	h the Operations Manager			
	on 01/03/22 at 11:50a	· · · · · · · · · · · · · · · · · · ·			
	5 5 1/55/22 at 11.000				
	Refer to interview with	h the Administrator on			
	01/03/22 at 11:52am.				
	01/03/22 at 11.32aiii.		1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		01	R / <b>04/2023</b>
	ROVIDER OR SUPPLIER	2270 OA	DDRESS, CITY, STATE KLAND ROAD CITY, NC 28043	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 139	revealed: -The Operations Man completing the backg well as herself prior to staff E did not have a completed and a sign personnel recordIf the criminal background and E on 12/30/22.  Interview with the Openation She was responsible criminal background and E on 12/30/22.  Interview with the Openation of the criminal background of the self prior to starting starting work at the factor of the criminal background of the cri	ager was responsible for round checks on all staff as o working in the facility.  udit a few months ago and so Manager, Staff D and riminal background checks ed consent in their round check was not in the as not completed. In the completed on Staff D and revealed:  If or completion of the check on each staff and g work.  aff D and Staff E did not ground check prior to cility.  Ininistrator on 01/03/23 at ager was responsible for ninal background check on each staff and ger was responsible for ninal background check on each staff and ger was responsible for ninal background check on	D 139			
D 150	Training And Competer	(a & b) Personal Care ency	D 150			

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R	
	HAL081052	B. WING		01/04/2023	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CEDAR CREEK LIVING LLC		AND ROAD TY, NC 28043	<b>.</b>		
OVA) ID SLIMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTIO	M (VE)	
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 150 Continued From page	e 5	D 150			
And Competency (a) The facility shall or directly supervise care to residents come care training and come established by the Desof this Rule, "directly duty in the facility to performance of staff training and compete available online at https://info.ncdhhs.goml#80hr, at no cost. training and compete curriculum shall inclu (1) observation and (2) basic nursing skinealth-related tasks; (3) activities of daily skills; (4) cognitive, behav (5) basic restorative (6) residents' rights 131D-21. (b) The facility shall in Paragraph (a) of the six months after hirin September 30, 2022. successful completio competency evaluation maintained in the face	assure that staff who provide staff who provide personal aplete an 80-hour personal apetency evaluation program epartment. For the purpose supervise" means being on oversee or direct the duties. A copy of the 80-hour ncy evaluation program is ov/dhsr/acls/training/index.ht The 80-hour personal care ncy evaluation program de: documentation skills; ills, including special living and personal care ioral, and social care; services; and as established by G.S.  assure that training specified his Rule is completed within ag for staff hired after Documentation of the of the 80-hour training and on program shall be ility and available for review alth Service Regulation and	D 150			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL081052	B. WING		0.	R 1/04/2023
	ROVIDER OR SUPPLIER	2270 OA	ADDRESS, CITY, STATE AKLAND ROAD I CITY, NC 28043	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 150	Continued From page	e 6	D 150			
	facility failed to ensur D) who provided pers documentation of suc 80-hour personal care evaluation program.  The findings are:  Review of Staff D's, p personnel record reve -Staff D's hire date w -There was no docum	ews and interviews, the e 1 of 2 sampled staff (Staff conal care to residents had excessful completion of an e training and competency  personal care aide (PCA), ealed:				
	on 12/30/22 at 2:00pl -She was responsible records related to state notification to the facilinaria (RN) to schedularia (RN) t	e for maintaining all the ff qualifications and lity contracted Registered ule the training. a PCA on 06/28/21. leted the 80-hour personal training because she did ing sure the training was were required to complete care and competency				
	revealed: -She was trained by a hired 06/28/21She also received a	on 01/03/23 at 8:45am another PCA when she was check off from the facility's 3 months after being hired				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				A. BUILDING.		t
		HAL081052	B. WING	B. WING		4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		LAND ROAD CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 150	Continued From page	÷ 7	D 150			
	-The check off consis	ted of bed baths, showers, brief and other personal				
	Attempted telephone contracted RN on 01/ unsuccessful.	interview with the facility's 03/23 at 9:45am was				
	Interview with the Administrator on 01/03/23 at 11:52am revealed: -He was not aware Staff D did not complete the 80-hour personal care and competency trainingThe AIC was responsible for making sure the PCAs received the 80-hour personal care and competency training within 6 monthsThe AIC was responsible for completing audits of staff personnel records to check for mandatory training completion.					
D 176	10A NCAC 13F .0601 Facilities	(a) Management Of	D 176			
		<del>-</del>				
	10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents  (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		R
		HAL081052	B. WING	B. WING	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		LAND ROAD	_	
	OLUMBA DV OT		CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 176	Continued From page	8	D 176		
	maintained, and in su the rules and statutes related to manageme  The findings are:  Interview with Reside revealed: -There were several of months when the per- administered medicat -There was a medicat his medications, but to medicationsHe was concerned the enough qualified staff  Interview with a MA or revealed she was away to administer medicat	ins and interviews, the opensure the overall cons, policies and illity were implemented, betantial compliance with to meet and maintain rules and of the facility.  Int #3 on 12/28/22 at 9:28am occasions in the past few sonal care aide (PCA) cions to him. Ition aide (MA) who prepared the PCA administered his to administer medications.  In 12/29/22 at 10:30am are only MAs were qualified			
	revealed: -He tried to speak to tunauthorized/untraine	the Administrator about			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
		HAL081052	B. WING		01/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
OEDAD O	DEEK I NUNO I I O	2270 OAK	LAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST C	CITY, NC 28043	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCE TO THE APPROPRIES.	D BE COMPL	ETE
				DEFICIENCY)		
D 176	Continued From page	9	D 176			
	that unauthorized and administer his medica -There was no chang	e after he informed the AIC eceive medication from the				
	Interview with another MA on 12/30/22 at 3:45pm revealed: -She prepared and gave medications to one PCA for administration to residents on 4 or 5 occasionsThe PCA administered the 8:00pm medications to Resident #4 most recently on 12/28/22She did not observe the PCA administer the medications to Resident #4 on 12/28/22She documented she administered the medications to Resident #4 on 12/28/22.					
	o1/03/23 at 10:00am -She was notified by a altercation between F on 10/24/22Resident #1 was phy Resident #7She notified the Adm facilityAdministrator notified Services who advised complete Involuntary -Local law enforceme to the local hospital for -Resident #1 returned at 2:30amNotice of Discharge	nd telephone interview on revealed: a MA of a physical Resident #1 and Resident #7 vsically agressive toward hinistrator who came to the desident #1 the Department of Social at the Administrator to Commitment paperwork. The transported Resident #1				
	Resident #1 Notice of	ninistrator declined to give f Discharge paperwork. any PCA's administering				

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Division of	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		CONFLETED		
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		HAL081052	B. WING		01/04/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
05545.0		2270 OA	KLAND ROAD				
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043	1			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	( - /		
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D 176	Continued From page	2 10	D 176				
5							
	medications to reside						
		sical altercations that were					
	•	1 and included 3 other 2, 09/29/22, and 10/24/22.					
		en sent to the hospital for					
		Itercation with the third					
	resident (Resident #7						
	,	, charged from the hospital					
	and came back to the	facility within 24 hours.					
	-	ation had been issued to					
	Resident #1.						
	_	the facility as the AIC,					
		inator, Activity Director, inator and would sometimes					
	cook when needed.	illator and would sometimes					
	-She was licensed as	an Administrator					
		ed her with any resident or					
	facility concerns.	·					
		ıme in "a few days a week"					
	before or after his full	•					
	-She tried to keep up						
	responsibilities as bes	st as she could.					
	Interview with the Adr	ministrator on 01/03/23 at					
	11:54am revealed:	111110110110110110110110110110110110110					
		administer medications to					
	residents.						
	-PCA's were not qual						
	medications to reside						
		administer a resident's					
	medications.	ere was unqualified staff					
	administering medica	•					
	_	thing about the electronic					
	Medication Administra						
	-The AIC and a MA w						
		ication cart and anything					
	related to the pharma						
	-He was notified of th	e 10/24/22 physical					

altercation between Resident #1 and Resident #7

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STATEMEN	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLI	COMPLETED	
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		HAL081052	B. WING		01/0	4/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
CEDAR C	REEK LIVING LLC		KLAND ROAD				
		FOREST	CITY, NC 28043	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE	
D 176	Continued From page	<del>2</del> 11	D 176				
D 1/6	by the AIC.  -He went to the facility Social Services and of Commitment paperwork.  -Local Law Enforcem to the local hospital for the Was not familiar with policy.  -He did not issue a Norm Resident #1.  -He allowed Resident after he was released.  -He did not know he of Resident # 1 back frought -He was concerned the Services would accust a to 1/04/23 at 10:14am.  -He was not able to do time to the facility.  -Staffing had been and the past year.  The Administrator fail management and oper compromised the care to include medication untrained staff, physical toward other resident resident who was physical staffing with the past year.	y, called the Department of completed Involuntary ork for Resident #1. ent transported Resident #1 or evaluation. with the facility's discharge otice of Discharge to #1 to return to the facility of from the hospital. could refuse to accept m the hospital. the Department of Social is him of abandonment. with the Administrator on revealed: evote 100 percent of his	D 176				
	A2 Violation.  The facility provided a	nce with G.S. 131 D-34 on					
	THE CORRECTION I	DATE FOR THE TYPE A2					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL081052	B. WING		01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		AND ROAD		
			TY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 12	D 176		
	VIOLATION SHALL NOT EXCEED FEBRUARY 03, 2023.				
D 226	10A NCAC 13F .0702	2(b) Discharge Of Residents	D 226		
	(b) The discharge of a one of the following re (1) the discharge is not welfare and the reside the facility as docume physician, physician a practitioner; (2) the resident no lon provided by the facility resident's physician, practitioner; (3) the safety of other endangered; (4) the health of other endangered as documphysician assistant or (5) failure to pay the daccommodations by taccording to the resident of the resident of the resident of the pay the daccommodations by taccording to the resident of the resident of the provident of the pay the daccording to the resident of the provident of the pay the daccording to the resident of the provident of the pay the daccording to the resident of the pay th	ecessary for the resident's ent's needs cannot be met in ented by the resident's assistant or nurse.  Ith has improved sufficiently ager needs the services by as documented by the ohysician assistant or nurse or individuals in the facility is individuals in the facility is nented by a physician, or nurse practitioner; costs of services and the payment due date lent contract after receiving ing of discharge for failure			
	reviews, the facility fa of 1 of 1 sampled resi	ns, interviews, and record iled to ensure the discharge idents (Resident #1) who ssive towards three other			

Division of Health Service Regulation

STATE FORM 6899 KDQU11 If continuation sheet 13 of 81

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			_		R	
		HAL081052	B. WING			4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		AND ROAD			
			ITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 226	Continued From page	e 13	D 226			
	separate occasions w of other residents.	hich endangered the safety				
	The findings are:					
	Review of Resident # 03/03/22 revealed:					
	infection.	dementia and urinary tract				
	<ul><li>-He was intermittently</li><li>-He was ambulatory.</li></ul>	disoriented.				
	Review of Resident # revealed he was adm 02/28/22.	1's Resident Register itted to the facility on				
	toileting, ambulation,	ally dependent with eating, bathing, transfers. d limited assistance with				
	Report dated 09/29/2/ -He asked Resident # facility living roomHe hit Resident #2 w out of his wheelchairHe bent down over F back like he was goin -Another resident pull #2Medication Aide (MA guardian and left a vo -MA called the Admini	the to stop talking while in the with his fist and jerked him Resident #2 and drew his g to hit Resident #2. ed him away from Resident which called Resident # 1's spicemail.				
		istrator and the ed the Department of Social				

Division of Health Service Regulation

1. Review of Resident #2's current FL2 dated

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL081052	B. WING		R 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
CEDARC	REEK LIVING LLC	2270 OA	(LAND ROAD		
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETE
D 226	Continued From page	e 14	D 226		
	kidney disease, histor -He was intermittently	Alzheimer's disease, chronic ry of stroke and depression. roriented. atory with a wheelchair.			
	Review of Resident # revealed an admissio	2's Resident Register n date of 06/03/20.			
	revealed: -The resident was totolleting, bathing, drestransfers.	2's Care Plan dated 2/09/22 ally dependent for eating, ssing, grooming and d extensive assistance with			
	12/02/22 revealed: -Diagnoses included venous stasis ulcersThere was no inform	nt #3's current FL2 dated diabetes, obesity and ation regarding orientation. ory and used a wheelchair.			
	Review of Resident # revealed an admissio				
	Review of Resident # 02/07/22 revealed: -The resident was totatoileting, bathing, drestransfersThe resident was totambulation.	ally independent with eating, ssing, grooming and			
	Report dated 09/29/2 -Resident #1 asked R loud while he was in t	lesident #2 to stop talking so			

Division of Health Service Regulation

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DIVISION	n riealin Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					_	
			B. WING		R	
		HAL081052	b. WING		01/04	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			LAND ROAD			
CEDAR C	REEK LIVING LLC		CITY, NC 28043	3		
			JIII, NC 2004	•		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
D 226	Continued From page	<del>:</del> 15	D 226			
	have to stan talking la	aud				
	have to stop talking lo					
		dent #2 and jerked Resident				
	#2 out of his wheelch					
		wn over Resident #2 like he				
	was going to hit him a	_				
	•	vented Resident #1 from				
	hitting Resident #2 ag					
		Charge (AIC) called the				
	Responsible Party of	Resident #2.				
	-The on-call Social W	orker for the local DSS was				
	also contacted via voi	ce mail.				
	-The AIC called the A	dministrator to inform him of				
	the incident.					
	There was no Inciden	t and Accident Report				
	completed for Reside	nt #3 on 09/29/22.				
	•					
	Review of Resident #	1's Psychiatry Follow Up				
	Note dated 11/30/22 r					
	- He had a history of s	schizophrenia, depression,				
	anxiety, dementia and	The state of the s				
	behavioral disturbanc					
		ent #1 had been having				
		e hit another resident and				
	jerked someone out o					
	jointou componio cui c	Turen Wilderenam.				
	Review of Resident #	1's Psychiatry Follow Up				
	Note dated 12/21/22					
		schizophrenia, adjustment				
	disorder and behavior					
		ent #1 did get upset at times,				
	-	a month and he recently hit				
	someone.					
	Attompted toleraber =	intonvious with Pooldont #41-				
		interview with Resident #1's				
		er on 12/29/22 at 12:15pm				
	was unsuccessful.					
	Interview with the Der	partment of Social Services	1	I .		

Division of Health Service Regulation

(DSS) Guardianship Supervisor on 12/29/22 at

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	n riealth Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
			B. WING		F	
		HAL081052	B. WINO		01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		2270 OAK	LAND ROAD	•		
CEDAR C	REEK LIVING LLC			<b>.</b>		
		FOREST	OITY, NC 28043			Г
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT ORT	ESC IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	MAIL	57.112
				,		
D 226	Continued From page	e 16	D 226			
	40.40					
	12:13pm revealed:					
		an was currently out of the				
	office.					
		Resident #1's guardian of a				
	physical altercation b	etween Resident #1 and				
	Resident #2.					
	-Documentation from	Resident #1's guardian				
	stated Involuntary Co	mmitment paperwork was				
	not completed on 09/29/22Documentation from Resident #1's guardian					
stated Notice of Discharge was discussed with						
		an but was not issued by the				
	facility on 09/29/22.	24				
	idolity off 05/25/22.					
	Interview with the AIC	c on 01/03/23 at 10:00am				
	revealed:	, o., o., oo, <u>o</u> o at roi oo a				
		he 09/29/22 incident by a				
	MA.	no ocizorze moldoni by d				
		t Resident #1 had pulled				
	Resident #2 out of his	•				
		as able to redirect Resident				
	#1 before he continue					
		nistrator who came to the				
	facility.					
	-	nent paperwork was not				
	attempted after this a	Itercation.				
		04/00/00				
		ministrator on 01/03/23 at				
	11:56am revealed:	00/00/00 :				
		e 09/29/22 incident involving				
	Resident #1 and Res					
		ent #3's hair was pulled by				
	Resident #1.					
	-He came to the facili	ty.				
	-He notified DSS.					
	-He did not complete	Involuntary Commitment				
	paperwork.	-				
		Resident #1 and Resident #7				
	individually about the					
		ep an eye on Resident #1.				
	. IS asked stail to het	- μ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ σ	1			

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL081052	B. WING		R 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
CEDAR C	REEK LIVING LLC	2270 OAK	LAND ROAD		
OLDAN O	KEEK EIVING EEG	FOREST (	CITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	D BE COMPLETE
D 226	Continued From page	e 17	D 226		
	-He did not issue a N-He was not familiar vpolicyDischarge policy was provided.	vith the facility discharge			
	10/16/22 revealed: -Diagnoses included				
		7's Care Plan dated e was independent and did ance for all activities of daily			
	Report dated 10/24/2 -Another Resident ha Resident #1 had hit F headAIC was notified of tl AdministratorThe Administrator to c Commitment paperwe -Involuntary Commitment completed and local I Resident #1 to the local 10/24/22.	d reported to a MA that tesident #7 on the top of her ne incident and called the stiffied the DSS who advised omplete Involuntary ork.			
	Interview with Reside revealed: -She was waiting in li medications.	nt #7 on 12/30/22 at 3:15pm ne to receive her			

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
				<del></del>		
					F	₹
		HAL081052	B. WING		01/0	04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
CEDAR C	REEK LIVING LLC	2270 OAK	LAND ROAD			
OLDAN	KLLIK LIVING LLG	FOREST (	CITY, NC 28043	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ΓΊΟΝ	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRI	OPRIATE	DATE
				DEFICIENCY)		
D 226	Continued From page	18	D 226			
	. •					
	-Resident #1 walked	by her and got in front of				
	her.					
	-She told Resident #1	to go to the back of the				
	line.					
	-Resident #1 then hit	her on the top of her head				
	with an open hand aff	ter telling her to, "Shut your				
	mouth".					
	-She reported this to	a MA but was uncertain				
	which MA she reporte	ed this to.				
	-Administrator came t	to the facility and Resident				
	#1 was taken to the h					
		her if she wanted to press				
	charges and she said					
	•	er asked if she wanted to go				
	to the local hospital fo					
	to the local hospital ic	or arrevaluation.				
	Interview with the DS	S Guardianship Supervisor				
	on 12/29/22 at 12:13p	om revealed:				
	-Administrator notified	d the DSS on call Social				
	Worker of the 10/24/2					
	-Administrator notified	d the on call Social Worker				
		mitment paperwork had				
	-	he was leaving Magistrates				
	office.	ne was leaving magiculates				
		Notice of Discharge was				
	discussed with the on	<u> </u>				
	-Notice of Discharge					
	•					
		an but was not issued by the				
	facility on 10/24/22.					
	Intonious with AIC am	12/20/22 at 9:20am and an				
		12/29/22 at 8:30am and on				
	01/03/23 at 10:00am					
		he incident by a MA on				
	10/24/22.	#4 4 4 - bi				
		#1 to go to his room which				
	he did after the incide	··· · · · · ·				
		inistrator who came to the				
	facility.					
	-Administrator notified	d the DSS who advised the				

Division of Health Service Regulation

Administrator to complete Involuntary

STATE FORM 6899 KDQU11 If continuation sheet 19 of 81

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
			D MING		l l	₹
		HAL081052	B. WING		01/0	04/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE ZIP CODE		
CEDAR C	REEK LIVING LLC		LAND ROAD	_		
		FOREST	CITY, NC 28043	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NOFRIATE	D/II E
				,		
D 226	Continued From page	e 19	D 226			
	. •					
	Commitment paperwo					
		nt transported Resident #1				
		or evaluation on 10/24/22.				
	-Resident #1 returned	to the facility on 10/25/22				
	at 2:30am.					
	-MA asked Resident a	#7 several times if she				
	wanted to go to the he	ospital for an evaluation and				
	Resident #7 declined					
	-Notice of Discharge	was discussed with the				
	Administrator but was					
	Interview with the Adr	ministrator on 01/03/23 at				
	11:56am revealed:	Timistrator on 01/00/20 at				
		a 10/24/22 incident by the				
	AIC.	e 10/24/22 incident by the				
	-He went to the facility	y, called the DSS and				
	completed Involuntary	y Commitment paperwork.				
	-Local Law Enforcem	ent transported Resident #1				
	to the local hospital fo	or evaluation.				
	-He was not familiar v	vith the facility discharge				
	policy.					
	-Discharge policy was	s requested but not				
	provided.	·				
	-He did not issue a N	otice of Discharge to				
	Resident #1.	S .				
	-He allowed Resident	#1 to return to the facility.				
		could refuse to accept				
		er his discharge from the				
		cerned DSS would accuse				
	him of abandonment.					
	imii oi abandoninent.					
	Facility Discharge not	licy was requested however				
	was not provided prio	11 10 EXIL UH U 1/U4/23.				
	Attomorted to ! !	intoncious with third at its \$4.5				
	· · · · · · · · · · · · · · · · · · ·	interview with third shift MA				
	on 01/03/23 at 9:28ar	n was unsuccessful.				
		<u> </u>				
	The facility failed to is	sue a Notice of Discharge				

Division of Health Service Regulation

to Resident #1 on 09/29/22 after he hit Resident

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
					R	
		HAL081052	B. WING		01/04/2	2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2270 OAKI	AND ROAD			
CEDAR CI	REEK LIVING LLC	FOREST C	ITY, NC 28043	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 226	Continued From page	20	D 226			
	Resident #7 on top of hand. This failure pla substantial risk for se constitutes a Type A2 The facility provided a accordance with G.S. violation.  CORRECTION DATE	/24/22 after Resident #1 hit her health with an open ced all residents at rious physical harm and Violation. a plan of protection in 131D-2 on 12/29/22 for this				
D 254	10A NCAC 13F .0801	(b) Resident Assessment	D 254			
	(b) The facility shall a each resident is comp following admission a thereafter using an as established by the Department of the percentaining at least the required on the estable assessment to be confollowing admission at be a functional assessive resident's level of functional functioning in Activities of daily living personal hygiene, amptransferring, toileting assessment shall individenced health care processive admission of the processive function of the personal hygiene, and transferring to the resident licensed health care processive for the processive function of the personal hygiene, and the personal hygiene assessment shall individence of the personal hygiene and the perso	and at least annually assessment instrument artment or an instrument artment based on it as same information as lished instrument. The inpleted within 30 days and annually thereafter shall is sment to determine a ctioning to include and, cognitive status and a activities of daily living. It is gare bathing, dressing, bulation or locomotion, and eating. The cate if the resident requires the professional, provider of pmental disabilities or				

Division of Health Service Regulation

resource.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
					F	t
		HAL081052	B. WING		01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		AND ROAD TY, NC 28043	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 254	Continued From page	21	D 254			
	facility failed to ensure (#6) had a completed admission.  The findings are:  Review of Resident # 12/02/22 revealed: -Diagnoses included a encephalopathy, and -Resident #6 was indeally living.  Review of Resident # revealed an admission  Review of Resident # 11/08/21 revealed: -He required assistant dressingHe was independent ambulation, grooming  Review of Resident # was no documentation after 11/08/21.  Review of Resident #	and record reviews the e 1 of 5 sampled residents care plan annually after  6's current FL2 dated  multiple sclerosis, hepatic failure. ependent with all activities of  6's Resident Register n date of 11/04/21.  6's Care Plan dated  ce with bathing and  with eating, toileting, and transfers.  6's record revealed there n of a completed care plan  6's licensed health (LHPS) evaluation dated received oxygen and				

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL081052	B. WING		R <b>01/04/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		LAND ROAD CITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 254	revealed he required dressing and emptyin Interview with the Adron 01/03/23 at 10:00a-She was responsible resident's care plans a She did not know Reupdated care plan corestaff relied on the do Resident #6's record, resident and family multiple Interview with the Adra 11:52am revealed:  The AIC was responsible resident's care plans annually.  He was not aware the an updated care plan and the AIC was responsible to the A	assistance with bathing, g his foley catheter.  Ininistrator-in-Charge (AIC) am revealed: for completing the annually. Isident #6 did not have an iniformation from staff, the embers.  Ininistrator on 01/03/23 at initiative for completing the annually.  Iside the for completing the embers.  Ininistrator on 01/03/23 at initiative for completing the annually.  Iside for completing the annual the second after admission and at Resident #6 did not have after 11/08/21.  Iside for completing chart and the surrection of the second after the last time one was	D 254		
D 292	Service  10A NCAC 13F .0904 (c) Menus In Adult Ca (3) Any substitutions of equal nutritional va	made in the menu shall be lue, appropriate for documented to indicate the	D 292		

Division of Health Service Regulation

This Rule is not met as evidenced by:

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPI	
		HAL081052	B. WING		0	R 1/ <b>04/2023</b>
	ROVIDER OR SUPPLIER REEK LIVING LLC	2270 OA	ADDRESS, CITY, STATE  AKLAND ROAD  CCITY, NC 28043	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 292	Based on observation interview the facility fa substitutions made to The findings are:  Observation of the direction of the lunch	n, record review and ailed to document any the menu.  Ining room and kitchen 2/28/22 at 10:00am of a food substitution list ook on 12/28/22 at 10:05am  a substitution list for menu.  Interest of the substitution list of the substitution list for menu.  Interest of the substitution list for	D 292			

Division of Health Service Regulation

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL081052	B. WING		01	R / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	-	
CEDAR C	REEK LIVING LLC		KLAND ROAD			
		FOREST	CITY, NC 28043			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 292	Continued From page	e 24	D 292			
	biscuit, a cake square servedLima beans and a bithe lunch meal service.  Observation of lunch 12:00pm revealed the steak, mashed potate white bread, a cake swater, tea and cranbe. Interview with a resid revealed: -He was offered sand something other than the was often served the menu.  Interview with a secon 9:50am revealed something other than the was on the secon to what was on the secon than the was on the second than the was on the secon than the was on the second than the was of the wa	meal service on 12/29/22 at the meal consisted of beef ones, lima beans, a slice of equare or vanilla pudding, erry juice.  The mean of 12/28/22 at 9:10am of the mean of the				
	menuStaff should write an menu boardStaff should keep re	y food substitutions on the cord of food substitutions.				
D 298	substitutions.  10A NCAC 13F .0904 Service	4(d)(2) Nutrition And Food	D 298			
		Nutrition And Food Service ts in Adult Care Homes:				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	O CONNECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COWII LETED
		HAL081052	B. WING		R 01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CEDAR C	DEEK LIVING LLC	2270 OAK	LAND ROAD		
CEDAR C	REEK LIVING LLC	FOREST (	CITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D 298	Continued From page	25	D 298		
	(2) Foods and bevera residents' diets shall to all residents as sna	ges that are appropriate to be offered or made available acks between each meal for s per day and shown on the			
		s and interviews, the facility s were served three times			
	The findings are:				
	revealed:	ent on 12/28/22 at 9:10am nacks on a daily basis or cks in his room.			
	9:50am revealed:	nd resident on 12/28/22 at two times daily at 10:00am			
	10:00am, 2:00pm and -The facility did not al -Some of the employe numerous times for th personal monies.  Interview with a perso 12/30/22 at 1:45pm re -Some of the employe	ovided to the residents at 17:00pm. Ways have snacks available. Les have bought snacks Le residents using their			

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	i Health Service Regu		1		ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ILED
					R	
		HAL081052	B. WING		1	4/2023
		11AE001002			01/0-	+/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2270 OA	KLAND ROAD			
CEDAR CI	REEK LIVING LLC	FOREST	CITY, NC 28043			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 298	Continued From page	26	D 298			
2 200		3.20				
	personal monies.					
	-It had been over a m	onth since snacks were				
	available to give to th	e residents.				
		ok on 12/28/22 at 10:05am				
	revealed:	f				
		fered three times a day.				
	- The facility did not al	ways have snacks available.				
	Intorvious with the Adr	ministrator in Chargo on				
		ministrator in Charge on				
	12/29/22 at 10:55am					
		fered three times a day.				
		snacks when available				
		e not always available.				
		as aware snacks were not				
	always available.					
		ld her snacks were too				
		ost residents had their own				
	snacks in their rooms					
	-Several employees b	_				
	residents using their p	personal monies.				
	Interview with the Adr 11:56 am revealed:	ministrator on 01/03/23 at				
		provide snacks to the				
		ı				
	residents three times					
		facility did not always have				
	snacks available.					
		m when snacks were not				
	available, and he wou					
		ber a time when staff had				
		acility did not have snacks				
	available.					
D 317	10A NCAC 13F .0905	5 (d) Activities Program	D 317			
	10A NCAC 13F .0905					
		least 14 hours of a variety				
	of planned group activ	vities per week that include				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			B. WING			R
		HAL081052	B. WING	-	01	/04/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
CEDAR C	REEK LIVING LLC		KLAND ROAD CITY, NC 28043			
	OUR MARK OF			DDOL/(DEDIO DI ANI OF	000000000000000000000000000000000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 317	Continued From page	27	D 317			
	interaction, group acc	e socialization, physical complishment, creative d knowledge, and learning of				
	failed to ensure a min	ns and interviews, the facility himum of 14 hours of a ties were provided each				
	The findings are:					
	posted on the wall in revealed: -There were multiple calendar for each day -The activities listed of scheduled between 1 and end times ranging each activitySome of the activities included snacks up to	or from 12/01/22 to 12/31/22. On the calendar were 0:00am to 8:00pm with start g from 1 hour to 2 hours for as listed on the calendar of three times a day, board of, movies, bingo, crafts and a				
	9:06am and 10:13am -The activities on the doneThey played bingo o from a local church vi -The only group activ -The activity calendar followed.	calendar were not being nce a week and the pastor sited every Wednesday. ity they played was bingo. was posted but it was not				
	Interview with a medi	cation aide (MA) on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL081052	B. WING		01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		AND ROAD ITY, NC 28043		
	OLIMAN DV OT				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 317	Continued From page	e 28	D 317		
	12/29/22 at 10:30am -Activities were not be was on the monthly a -The residents played -A preacher came one -The Administrator-in- Activity Director (AD)The AIC did not have with the residentsShe did not ask the r activities.  Interview with the AIC revealed: -She had her certifica -She was responsible conducting activitiesShe was aware the of week of activities was residentsShe did not have the the residents because responsibilitiesRegular activities tha a week and a preache visited Wednesday ni Interview with the Adr 11:54am revealed: -The residents should week for activities bei -The AIC was also the -He was not aware th	revealed: eing done according to what ctivity calendar. It bingo when it was offered. ce a weekCharge (AIC) was also the etime to do the activities residents to participate in Con 12/30/22 at 9:30am  Ition as an AD. Iti			
	were not offered to th	e residents.			
D 338	10A NCAC 13F .0909	Resident Rights	D 338		
	10A NCAC 13F .0909	Resident Rights			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (			E SURVEY PLETED
			A. BUILDING:			
		HAL081052	B. WING		01	R / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
OEDAD O	DEEK LIVING LLO	2270 OA	KLAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 29	D 338			
	all residents guarante	hall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained d without hindrance.				
	This Rule is not met TYPE A2 VIOLATION					
	reviews, the facility far were protected from president and neglect (Residents #2, #3, an another resident (Resident #6 resident (Resident #6 a qualified medication	ns, interviews, and record illed to ensure all residents obysical abuse by another related to three residents id #7) being assaulted by sident #1) and ensuring a by received medications from a aide instead from a PCA) and housekeeper.				
	The findings are:					
	03/03/22 revealed:					
	Review of Resident # revealed an admissio					
	toileting, ambulation, -The resident required bathing, dressing and Review of Resident # Report dated 09/29/2	ally dependent with eating, bathing, transfers. d limited assistance with I grooming.				

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Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL081052	B. WING		01/04/202	23
			<u> </u>		1 0170-7202	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CEDAR C	REEK LIVING LLC	2270 OA	KLAND ROAD			
OLDAIL O	KLEK EIVING EEG	FOREST	CITY, NC 28043			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		MPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	57112
				· · · · · · · · · · · · · · · · · · ·		
D 338	Continued From page	e 30	D 338			
	facility living room.					
		rith his fist and jerked him				
	out of his wheelchair.	nur riio not ana jorkoa min				
		Resident #2 and drew his				
	back like he was goin					
	•	led him away from Resident				
	#2.	,				
	-The Medication Aide	(MA) called Resident # 1's				
	guardian and left a vo	picemail.				
	-The MA called the Ad	dministrator and the				
	Administrator contact	ed Department of Social				
	Services (DSS).					
	Interview with a Residueled:	dent on 01/03/22 at 3:25pm				
		e living room and witnessed				
		Resident #1 and Resident				
	#2.					
	-He said Resident #1	jerked Resident #2 out of				
	his wheelchair onto th	-				
	-He told Resident #1	to stop and sit down.				
	-He stated Resident #	‡2 was not hurt.				
	Interview with MA on	12/29/22 at 10:30am				
	revealed:					
	-Resident #1 pulled R					
	wheelchair onto the fl					
	-Resident #2 was uni	njurea. IC to inform her of the				
	incident	ic to inform her of the				
	-The AIC contacted th	ne Administrator				
		me to the facility to talk with				
	Resident #1.	ino to the lacinty to talk with				
	ROSIGOTIC # 1.					
	Review of Resident #	1's Psychiatry Follow Up				
	Note dated 11/30/22					
		schizophrenia, depression,				
	anxiety dementia and					

Division of Health Service Regulation

behavioral disturbances.

-Staff reported Resident #1 has been having

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL081052	B. WING		R 01/04/2023	
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
CEDAR CREEK LIVING LLC		LAND ROAD CITY, NC 28043	3		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPL	ETE
jerked someone Review of Resid Note dated 12/2 - He has a histordisorder and bell -Staff reported Firmaybe once or the someone.  Attempted teleph Provider on 12/2 unsuccessful.  Interview with Din 12/29/22 at 12:11 -Resident #1's goffice The facility notive incident involvining -Documentation stated Involuntation stated Involuntation stated Notice of Resident #1's guidacility.  Telephone interviolation (AIC) on 01/03/2 - She was notified Resident #1 pull wheelchair Another Resident #1 before he continued in the continued	and he hit another resident and out of their wheelchair.  ent #1's Psychiatry Follow Up 1/22 revealed: y of schizophrenia, adjustment navioral disturbances. desident #1 gets upset at times, wice a month and he recently hit  none interview with Mental Health 9/22 at 12:15pm was	D 338			

Division of Health Service Regulation

attempted after this altercation.

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		1141 004050	B. WING		R	
		HAL081052			01/04	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2270 OAKI	AND ROAD			
CEDAR C	REEK LIVING LLC		ITY, NC 28043			
	OUR MAR DV OT		· ·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF		DATE
				DEFICIENCY)		
D 338	Cantinuad Francisco	. 22	D 338			
ט טטס	Continued From page	9 32	D 336			
	-She was not aware o	of staff monitoring Resident				
	#1 after incident.	ŭ				
	Interview with the Adr	ministrator on 01/03/23 at				
	11:56am revealed:					
	-He was notified of the	e 09/29/22 physical				
		Resident #1 and Resident				
	#2.					
	-He did know that Res	sident #3's hair was pulled				
	by Resident #1.	·				
	-He did not know that	Resident #3 was hit in the				
	head by Resident #1.					
	-He came to the facili	ty.				
	-He notified DSS.					
	-He did not complete	Involuntary Commitment				
	paperwork.	-				
	-He spoke with both F	Resident #1 and Resident #7				
	individually about the	incident.				
	-Resident #2 was unh	narmed.				
	-He asked staff to kee	ep an eye on Resident #1.				
	-He did not issue a No	otice of Discharge.				
		-				
	2. Review of Resider	nt #2's current FL2 dated				
	12/02/22 revealed:					
	-Diagnoses included	Alzheimer's disease, chronic				
	kidney disease, histor	ry of stroke and depression.				
	-He was intermittently	oriented.				
	-He was semi-ambula	atory with a wheelchair.				
	Review of Resident #	_				
	revealed an admissio	n date of 06/03/20.				
	Review of Resident #	2's Care Plan dated 2/09/22				
	revealed:					
		ally dependent for eating,				
	toileting, bathing, dres	ssing, grooming and				
	transfers.					
	-The resident required	d extensive assistance with				
	ambulation.					

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			1 Orav	ITAL TROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HAL081052	B. WING		01/0	R 94/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		2270 OAI	KLAND ROAD			
CEDAR CI	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page		D 338			
	Report dated 09/29/2 -Resident #1 asked R loud while he was in t -Resident #2 told Res have to stop talking lo -Resident #1 hit Resid #2 out of his wheelch -Resident #1 bent down was going to hit him a -Another resident pre hitting Resident #2 ag -The AIC called the R Resident #2The on-call Social W also contacted via voi -The AIC called the A the incident.  Interview with Medical	desident #2 to stop talking so the living room. sident #1 that he did not bud.  dent #2 and jerked Resident air.  wn over Resident #2 like he again.  vented Resident #1 from gain.  esponsible Party of the local DSS was bee mail.  dministrator to inform him of tion Aide (MA) #1 on				
	10:00am revealed: -She was notified of the	desident #2 out of the oor. njured. C to inform her of the ne Administrator. with AIC on 01/03/23 at the 09/29/22 incident				
	between Resident #1 The MA informed her Resident #2 and pulle -Another Resident wa #1 before he hit Resident	and Resident #2 by a MA. that Resident #1 had hit ed him out of his wheelchair. is able to redirect Resident				

facility.

attempted.

-Involuntary Commitment paperwork was not

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILANC	N GORREGHOR	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
		HAL081052	B. WING		R 01/04/2023
NAME OF D			DECC CITY CTA	TE ZID CODE	1 01/04/2023
NAME OF FI	ROVIDER OR SUPPLIER		DRESS, CITY, STAT LAND ROAD	I E, ZIP CODE	
CEDAR C	REEK LIVING LLC		CITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 338	Continued From page	= 34	D 338		
	-She did not know if F by staff after the alter	Resident #1 was monitored cation.			
	11:56am revealed:	ministrator on 01/03/23 at se 09/29/22 incident involving			
	Resident #1 and Res -He did come to the fa	ident #2.			
	Interview with a resident on 01/03/22 at 3:25pm revealed:				
		jerked Resident #2 out of			
	his wheelchair onto the -He told Resident #1				
		nt #3's current FL2 dated			
		diabetes, obesity and			
		nation regarding orientation. tory and used a wheelchair.			
	Review of Resident # revealed an admissio	date of 10/26/21.			
	Review of Resident # 02/07/22 revealed:				
	-The resident was tot toileting, bathing, drestransfers.	ally independent with eating, ssing, grooming and			
	-The resident was tot ambulation.	ally dependent for			
	Interview with Reside revealed:	ent #3 on 12/29/22 at 9:23am			

-Over a month ago he observed Resident #1 force Resident #2, who was in a wheelchair, into

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2270 OAKLAND ROAD FOREST CITY, NC 28043   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 35  Resident #2's roomHe observed Resident #1 would not allow Resident #2 to come out of his roomHe asked Resident #1 why he pushed Resident #2 into his room and would not let him outResident #1 told him he would do whatever he	STATEMEN <sup>*</sup>	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2270 OAKLAND ROAD FOREST CITY, NC 28043   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 35  Resident #2's roomHe observed Resident #1 would not allow Resident #2 to come out of his roomHe asked Resident #1 why he pushed Resident #2 into his room and would not let him out.						R		
CEDAR CREEK LIVING LLC    CAU   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    D 338   Continued From page 35   D 338   Resident #2's room.   -He observed Resident #1 would not allow   Resident #2 to come out of his room.   -He asked Resident #1 why he pushed Resident #2 into his room and would not let him out.			HAL081052	B. WING		1	3	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338 Continued From page 35  Resident #2's roomHe observed Resident #1 would not allow Resident #2 to come out of his roomHe asked Resident #1 why he pushed Resident #2 into his room and would not let him out.	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE			
FOREST CITY, NC 28043  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338 Continued From page 35  Resident #2's room.  -He observed Resident #1 would not allow Resident #2 to come out of his room.  -He asked Resident #1 why he pushed Resident #2 into his room and would not let him out.	CEDAR C	REEK LIVING LLC	2270 OA	KLAND ROAD				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 338  Continued From page 35  Resident #2's room.  -He observed Resident #1 would not allow Resident #2 to come out of his room.  -He asked Resident #1 why he pushed Resident #2 into his room and would not let him out.	OLDAN O	TEER EIVING EEG	FOREST	CITY, NC 28043				
Resident #2's roomHe observed Resident #1 would not allow Resident #2 to come out of his roomHe asked Resident #1 why he pushed Resident #2 into his room and would not let him out.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COM	PLETE	
-He observed Resident #1 would not allow Resident #2 to come out of his roomHe asked Resident #1 why he pushed Resident #2 into his room and would not let him out.	D 338	Continued From page	e 35	D 338				
wanted to do.  -Resident #1 then lunged forward and grabbed his hair and "snatched" his head backward.  -He told Resident #1 to "get his hands out of his hair."  -Resident #1 proceeded to hit him in the back of the head with his fist.  -The MA intervened and removed Resident #1 from the room.  -The MA asked if he was ok but did not ask him what happened.  Interview with the MA on 12/29/22 at 10:30am revealed:  -Several months ago, Resident #1 and Resident #3 had a physical altercation.  -She observed Resident #1 charge forward and pull Resident #3's hair.  -She notified the Administrator-in-Charge (AIC)She did not complete an incident/accident reportShe did not contact DSS.  Review of a Care Note dated 08/16/22 for Resident #3 revealed:  -The incident between Resident #1 and Resident #3 occurred on 08/16/22.  -Resident #3 told Resident #1 he could not force Resident #2 go to his room and tell him to not come out.  -Resident #1 proceeded to walk up behind Resident #1 and grab him by the hair.  -A PCA and a MA had to make Resident #1 let go		Resident #2's roomHe observed Reside Resident #2 to come -He asked Resident # #2 into his room and -Resident #1 told him wanted to doResident #1 then lun his hair and "snatchee -He told Resident #1 hair." -Resident #1 proceed the head with his fistThe MA intervened a from the roomThe MA asked if he w what happened.  Interview with the MA revealed: -Several months ago, #3 had a physical alte -She observed Resid pull Resident #3's hai -She notified the Adm -She did not complete -She did not contact I  Review of a Care Not Resident #3 revealed -The incident between #3 occurred on 08/16 -Resident #2 go to his come outResident #3 and grab	out of his room.  If why he pushed Resident would not let him out.  The would do whatever he ged forward and grabbed d' his head backward.  Ito "get his hands out of his led to hit him in the back of and removed Resident #1  Was ok but did not ask him  Resident #1 and Resident ercation.  Eent #1 charge forward and fr.  Ininistrator-in-Charge (AIC).  It an incident/accident report.  DSS.  It dated 08/16/22 for  In Resident #1 and Resident /22.  It dident #1 he could not force room and tell him to not led to walk up behind him by the hair.	D 536				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.12510.		R	
		HAL081052	B. WING		01/04/202	3
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
2270 OAK			AND ROAD			
CEDAR CREEK LIVING LLC FOREST C		ITY, NC 28043	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	X5) IPLETE ATE
D 338	Continued From page	36	D 338			
	revealed there was a completed when the a Resident #1 and Resi	on 12/30/22 at 10:26am care note that had been altercation occurred between dent #3 on 08/16/22.				
	11:54am revealed: -He was not aware of the incident between Resident #1 and Resident #3 when it occurredHe found out about the incident between Resident #1 and Resident #3 about a month later when there was another incident with Resident #1 and two more residents.  4. Review of Resident #7's current FL2 dated 10/16/22 revealed: -Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attackShe was orientedShe was ambulatory.					
	Review of Resident # revealed an admissio	<u> </u>				
		7's Care Plan dated e was independent and did ance for all activities of daily				
	Report dated 10/24/2/ -Another Resident rep #1 hit Resident #7 on -The AIC was notified the Administrator.	oorted to a MA that Resident the top of her head. of the incident and called tified the DSS who advised omplete Involuntary				

Division of Health Service Regulation

-Involuntary Commitment Paperwork was

STATE FORM 6899 KDQU11 If continuation sheet 37 of 81

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					- 1 ,	<b>-</b>
		HAL004052	B. WING		I	7
		HAL081052			1 01/0	04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
2270 OAKI		LAND ROAD				
CEDAR C	REEK LIVING LLC	FOREST (	CITY, NC 28043	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
				BEI IOIENOT)		
D 338	Continued From page	e 37	D 338			
	completed and local I	aw enforcement transported				
	Resident #1 to the loc	cal hospital for evaluation on				
	10/24/22.					
	-Resident #1 returned	to the facility on 10/25/22				
	at 2:30am.	•				
	Interview with a residence revealed:	ent on 01/03/22 at 3:25pm				
		eive his medications when a				
	physical altercation took place between Resident					
	#1 and Resident #7.	ook place between resident				
		ent #1 and Resident #7				
		nt #1 hit Resident #7 on the				
	top of her head with a	•				
	-He reported the incid	ient to the MA.				
	Interview with Reside revealed:	nt #7 on 12/30/22 at 3:15pm				
	-She was waiting in li	ne to receive her				
	medications.					
		by her and got in front of				
	her.	2, a gere e.				
		to go to the back of the				
	line.	to go to ano zuen et ane				
	-Resident #1 then hit	her on the top of her head				
		ter telling her to shut her				
	mouth.	9				
		a MA but is uncertain which				
	MA she reported this					
	-The Administrator ca					
		en to the hospital by the				
	police.	in to the hospital by the				
	•	ked her if she wanted to				
	press charges and sh					
		she wanted to go to the				
	local hospital for an e					
	iocai nospital for an e	valualiOII.				
	Interview with DSS C	uardianship Supervisor on				
	12/29/22 at 12:13pm					
	ובובטובב מנ וב. וטpiii	i c v cal <del>c</del> u.	1			1

Division of Health Service Regulation

-She was uncertain if Notice of Discharge was

STATE FORM 6899 KDQU11 If continuation sheet 38 of 81

Division of	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL081052	B. WING		01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STAT	FE ZIP CODE	
INAIVIL OI	TOVIDEIT OIT GOL I EIEIT		KLAND ROAD	ie, zif cobe	
CEDAR C	REEK LIVING LLC		CITY, NC 28043		
1	OLIMAN DV OT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
D 338	Continued From page	e 38	D 338		
	discussed with the or				
	-Notice of Discharge				
		an on 10/25/22 but was not			
	issued by the facility.				
	Interview with AIC on	12/29/22 at 8:30am and on			
	01/03/23 at 10:00am				
		he incident by a MA on			
	10/24/22.	•			
	-She notified the Adm	ninistrator who came to the			
	facility.				
		d the DSS who advised the			
	Administrator to comp	· · · · · · · · · · · · · · · · · · ·			
	Commitment paperwo				
		ent transported Resident #1			
		or evaluation on 10/24/22.			
	at 2:30am.	d to the facility on 10/25/22			
		dent #7 several times if she			
		ospital for an evaluation and			
	Resident #7 declined				
	· ·	was discussed with the			
	_	ninistrator declined to give			
		f Discharge paperwork.			
		ministrator on 01/03/23 at			
	11:56am revealed:				
		e 10/24/22 incident by the			
	AIC.				
		ity, called the DSS and y Commitment paperwork.			
		ent transported Resident #1			
		or evaluation on 10/24/22.			
	-He did not issue a N				
	Resident #1.	otice of Discharge to			
	1	t #1 to return to the facility.			
		could refuse to accept			
	Resident # 1 back an	•			

of abandonment.

Department of Social Services would accuse him

STATE FORM 6899 KDQU11 If continuation sheet 39 of 81

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING	<del></del>	
		HAL081052	B. WING		R 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 0110112020
TVAINE OF T	2270 OAK			12, 211 0002	
CEDAR CREEK LIVING LLC			ITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	: 39	D 338		
	on 01/03/23 at 9:28ar				
	12/02/22 revealed dia	t #6's current FL2 dated agnoses included multiple athy, and hepatic failure.			
	Review of Resident # revealed an admission	<u> </u>			
	Review of Resident #6's Care Plan dated 11/08/21 revealed: -He required assistance with bathing and dressingHe was independent with eating, toileting,				
	ambulation, grooming and transfers.  Interview with Resident #6 on 12/28/22 at 9:46am and 12/29/22 at 2:50pm revealed: -The MAs were preparing medication and allowing the PCA's or the housekeeper administer the medicationThis happened during 1st (7:00am - 3:00pm) and 2nd (3:00pm - 11:00pm) shifts.				
	-PCA's have brought several times before. -Last week the house medication to him. -He did not recognize was being given and what it was.				
	was medication for tre depression.	per returned, he replied it eatment of his severe			

Division of Health Service Regulation

trained to administer medications.

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	or riealth Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	EIED
					F	>
		HAL081052	B. WING			)4/2023
		HAL001032			1 01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2270 OAK	LAND ROAD			
CEDAR C	REEK LIVING LLC		CITY, NC 28043	3		
			7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
,,,,		,	1,710	DEFICIENCY)		
D 338	Continued From page	e 40	D 338			
	-He did not want non-	medical staff to have				
	access to his private					
	-					
	-	a violation of his rights.				
	·	arcotics three times a day				
	and still is in pain and					
	actually received the					
		CA or housekeeper really				
	gave him all of his me					
	-He informed the Administrator-in-Charge (AIC)					
	sometime in November 2022 but the PCA still					
	gave him his medicat					
		eceive all of the medications				
		sekeeper, then he would not				
	receive his medication	ns.				
	Interview with the Adr	ministrator-in-Charge on				
	12/30/22 at 9:30am re	evealed:				
	-Only MAs could adm	inister medications to				
	residents.					
	-After the MA observe	ed a resident take a				
	medication, the MA w	as to document the				
	administration on the	eMAR.				
	-The MAs knew they	were not to give medications				
	to the PCA's to admir	•				
	-She was unaware of	any PCA's administering				
	medications to reside	· ·				
	Interview with the Adr	ministrator on 01/03/23 at				
	11:54am revealed:					
	-	dminister medications to				
	residents.					
	-PCA's are not qualifi	ed to administer				
	medications to reside					
		y administer a resident's				
	medications.	, adminiotor a resident s				
		re was unqualified staff				
	administering medica	uon to the residents.				
	The feiture of the facili	lity to analyze regidents are				
		lity to ensure residents are				
	iree of physical abuse	e related to an incident that				1

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STATE FORM 6899 KDQU11 If continuation sheet 41 of 81

DIVISION	n nealth Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					l _	
			D WING		F	
		HAL081052	B. WING	<del></del>	01/0	4/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	KIE, ZIF GODE		
CEDAR CREEK LIVING LLC 2270 OAK		LAND ROAD				
		FOREST	CITY, NC 28043	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 338	Continued From page	<u>.</u> 41	D 338			
2 000	Continued From page	2 7 1	2 000			
	occurred on 08/16/22	! involving Resident #1 and				
	Resident #3, an incide	ent that occurred on				
	09/29/22 involving Re	esident #1 and #2 and an				
		d on 10/24/22 involving				
	Resident #1 and Resi					
	residents (Residents #2, #3 and #7) being physically assaulted. The facility failed to ensure a resident (Resident #6) received medications from a trained MA. This failure placed all					
residents in the facility at substantial risk		•				
		n and abuse and constitutes				
		I and abuse and constitutes				
	a Type A2 Violation.					
	The facility provided a	nlan of protection in				
		•				
		. 131D-21 on 12/29/22 for				
	this violation.					
	000000000000000000000000000000000000000					
	CORRECTION DATE					
		NOT EXCEED FEBRUARY				
	3, 2023.					
D 359	10A NCAC 13F .1004	1 (b) Medication	D 359			
	Administration	,				
	10A NCAC 13F .1004	Medication Administration				
	(b) The facility shall a	assure that only staff				
		ents in Rule .0403 of this				
	Subchapter shall adm					
		tion of medications for				
	administration.	tion of medications for				
	aummstration.					
	This Rule is not met					
	Based on record review	ew and interviews, the				

Division of Health Service Regulation

STATE FORM 6899 KDQU11 If continuation sheet 42 of 81

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		HAL081052	D. WING		01/04/2023	_
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
I CEDAR CREEK LIVING LLC			LAND ROAD CITY, NC 28043	,		
0/0.15			<del></del>	PROVIDER'S PLAN OF CORRECTION	N O(5)	$\dashv$
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	E
D 359	Continued From page	<del>2</del> 42	D 359			
		e Staff B, personal care aide o administer medications to				
	The findings are:					
	according to state rule administer medication -Documentation will be administers medicated facility Medication Ad -Staff will provide documentations.  1. Interview with a result of the medications.  1. Interview with a result of the medications when a personal distribution of the medications administered medications ready his medications.  -He was concerned the medications of the medications.	res revealed: constrated competency es may prepare and ns. de provided by staff who cons to the residents on the ministration Record (MAR). deumentation on the MAR sidents taking the sident on 12/28/22 at deccasions in the past few constraints of the pas				
	revealed: -She spoke with a PC morning of 12/29/2The PCA verbalized medications the even -Only MAs were quali medications to reside	ing on 12/28/22. ified to administer nts.				
	Interview with a PCA	on 12/20/22 at 2:11nm	1			

Division of Health Service Regulation

revealed:

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Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		R 01/04	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CEDAR C	DEEK LIVING LLC	2270 OAK	LAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST (	CITY, NC 28043	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 359	Continued From page	: 43	D 359			
	-She never administe resident.	red medications to a				
	-She was not aware of administering medical	of any non-qualified staff tions to residents.				
	Interview with a housekeeper on 12/30/22 at 8:02am revealed:					
	-He had not administered medications to any residents.					
	-He was not aware of medications to reside	any PCA's administering nts.				
	Refer to the interview 9:30am.	with the AIC on 12/30/22 at				
	Refer to the interview 01/03/23 at 11:54am.	with the Administrator on				
	2. Review of Resider 10/10/22 revealed:	nt #4's current FL2 dated				
	-Diagnoses included of -She was constantly of	dementia and chronic pain. disoriented.				
	revealed:	on 12/30/22 at 1:43pm				
	time, two days ago.	ations to Resident #4 one				
	#4's medications.	rve him administer Resident				
		ger to administer she could only take them				
		any other non-trained staff				
	that were administering.  He was not trained a					
			1	1		

revealed:

Interview with a MA on 12/30/22 at 3:45pm

-She had prepared medications for a PCA to administer to residents on 4 or 5 occasions.

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DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R	,
		HAL081052	B. WING		1	
		HAL081052	1		01/0	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
2270 OAK		LAND ROAD				
CEDAR C	REEK LIVING LLC	FOREST O	ITY, NC 28043	3		
(V4) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N.	(VF)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 359	Continued From page	44	D 359			
	. •					
		the PCA and sometimes				
	took medications bett					
		ed the 8:00pm medications				
	to Resident #4 most r					
		the PCA administer the				
	medications to Reside					
	medications to Reside					
	medications to Reside	ent #4 on 12/28/22.				
	Review of resident #	1's electronic Medication				
	Review of resident #4's electronic Medication Administration Record (eMAR) dated 12/28/22					
	revealed:	d (elviAit) dated 12/20/22				
		Hydroxyzine (used to treat				
	itching) 25mg capsule					
	8:00pm.	was daministered at				
	•	Eliquis (used to prevent				
		olet was administered at				
	8:00pm.	olet was administered at				
	-	Seroquel (an antipsychotic				
		sorder) 25mg tablet was				
	administered at 8:00p					
		Gabapentin (used to treat				
		ules (200mg total) was				
	administered at 8:00p					
	-The MA documented	Oxycodone (an opioid used				
		evere pain) 10mg/325mg				
	tablet was administer	ed at 8:00pm.				
	-The MA documented	Doxycycline (used to treat				
	bacterial infections) 1	00mg tablet was				
	admnistered at 8:00p					
		Klonopin (used to treat				
	=	izures) 0.5mg tablet (take ½				
	tab for .25mg) was ac	lministered at 8:00pm.				
		with the AIC on 12/30/22 at				
	9:30am.					
	Defende the interest	with the Administrator or				
	01/03/23 at 11:54am.	with the Administrator on				

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
		1141 004050	B. WING		F	
		HAL081052	B. W		01/0	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2270 OAI	KLAND ROAD			
CEDAR CREEK LIVING LLC		CITY, NC 2804:	3			
	OLIMANA DV OT					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 359	Continued From page	15	D 359			
D 339	Continued From page	<del>: 4</del> 5	D 339			
	3. Review of Residen	t #6's current FL2 dated				
	12/02/22 revealed:					
	-Diagnoses included	multiple sclerosis,				
	encephalopathy, and	hepatic failure.				
	-An order for baclofer	n (a medication used to treat				
	muscle spasticity) 10	mg, two times a day.				
	-An order for klonoping	n (a medication used to				
	prevent seizures) 0.5	mg, ⅓ a tablet two times a				
	day.					
		a medication used to reduce				
	•	nervous system) 25mg, two				
	times a day.					
		(a mediation used to treat				
	low potassium) 10mE	•				
	~ ,	a medication used to treat				
	. ,	6.25mg, two times a day.				
		n (a medication used to relax				
		adder) 5mg, three times a				
	day.					
	• .	ntin (a medication used to				
		mg, 2 capsules, three times				
	a day.					
		a medication used to treat				
	•	n), 15mg every day with				
	food.					
		ta (a medication used to				
	-	ng, 3 capsules every day.				
		(a medication used for pain),				
	325mg, 2 tablets ever	•				
	•	medication used to treat				
	high cholesterol), eve					
		medication used to treat				
	-	the heart), 40mg every day.				
		(a medication used to treat				
	high blood pressure),					
		a medication used to thin				
	the blood), 81mg eve					
		a medication used to treat				
		6.25mg two times a day.				
	-An order for regretor	(a medication used to treat				

Division of Health Service Regulation

STATE FORM 6899 KDQU11 If continuation sheet 46 of 81

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
					R	)
		HAL081052	B. WING		1	
		HAL061032			1 01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		2270 OAK	LAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST (	CITY, NC 28043	3		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 359	Continued From page	<del>-</del> 46	D 359			
	. •					
	epilepsy), 200mg two					
	-An order for Pepcid (	(a medication used to treat				
	stomach problems) 2	0mg two times a day as				
	needed.					
	-	one (a medication used to				
	treat pain), three time	es a day.				
		nt #6 on 12/28/22 at 9:46am				
	and 12/29/22 at 2:50p					
	-The MAs were prepa					
	allowing the PCA's or	•				
	administer the medical					
		g 1st (7:00am - 3:00pm)				
	and 2nd (3:00pm - 11					
	_	appened to him last week.				
	•	his medication to him				
	several times before.					
	-Last week the house	keeper brought his				
	medication to him.	e e e				
		a certain medication he				
		asked the housekeeper				
	what it was.					
		plied he did not know but				
	would ask the MA.					
		per returned, he replied it				
	was medication for tre	eatment of his severe				
	depression.	b				
	trained to administer	se a housekeeper was not				
	-He did not want non-					
	access to his private					
		arcotics three times a day and was concerned if he				
	-					
	actually received the					
		PCA or housekeeper really			ĺ	
	gave him all of his me					
		ninistrator-in-Charge (AIC) er 2022 but the PCA still				
	sometime in Novemb	er 2022 but the PCA still				

Division of Health Service Regulation

gave him his medications.

-He felt if he did not receive all of the medications

STATE FORM 6899 KDQU11 If continuation sheet 47 of 81

DIVISION	n Health Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	
			B WING		R	
		HAL081052	B. WING		01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
				,		
CEDAR C	REEK LIVING LLC		LAND ROAD			
		FUREST	OITY, NC 28043	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	NEGOLATORT OR L	SO DENTI TING IN ORWATION)	TAG	DEFICIENCY)	MAIL .	]
				,		
D 359	Continued From page	e 47	D 359			
		ekeeper, then he would not				
	receive his medication	ns.				
	Review of Resident #					
	electronic Medication	Administration Record				
	(eMAR) revealed:					
	-There was an entry f	or baclofen 10mg, two times				
	a day documented as	administered by a MA from				
	12/01/22 to 12/29/22.					
	-There was an entry f	or klonopin 0.5mg, ½ a				
	tablet, two times a da	y documented as				
	administered by a MA	from 12/01/22 to 12/29/22.				
	-There was an entry f	or Vistaril 25mg, two times a				
		dministered by a MA from				
	12/01/22 to 12/29/22.	•				
	-There was an entry f	or KlorCon 10mEq, two				
		ted as administered by a				
	MA from 12/01/22 to					
		or Coreg 6.25mg, two times				
		Iministered by a MA from				
	12/01/22 to 12/29/22.	miniciolog by a wirtholl				
		or Ditropan 5mg, two times				
		Iministered by a MA from				
	12/01/22 to 12/29/22.	ministered by a MA nom				
		or gabapentin 100mg, 2				
	•					
		a day documented as				
		from 12/01/22 to 12/29/22.				
	-	or Mobic 15mg every day				
		d as administered by a MA				
	from 12/01/22 to 12/2					
	-There was an entry f	•				
		ocumented as administered				
	by a MA from 12/01/2					
	-	or Tylenol 325mg, 2 tablets				
	• •	d as administered by a MA				
	from 12/01/22 to 12/2					
	-There was an entry f	· -				
		nistered by a MA from				
	12/01/22 to 12/20/22		1		ļ	1

Division of Health Service Regulation

-There was an entry for Lasix 40mg every day

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Division c	of Health Service Regu	ilation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
						R
		HAL081052	B. WING		01/	04/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	TE, ZIP CODE		
			KLAND ROAD	- <b>,</b>		
CEDAR CI	REEK LIVING LLC		CITY, NC 28043	3		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE DATE
TAG	KEGULATURT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	OPRIATE	DAIL
			+			+
D 359	Continued From page	∍ 48	D 359			
	documented as admir 12/01/22 to 12/29/22.	nistered by a MA from				
		for Norvasc 10mg every day				
		nistered by a MA from				
		for aspirin 81mg every day				
	_	inistered by a MA from				
	12/01/22 to 12/29/22.					
	_	for Tegretol 200mg two times				
	_	s administered by a MA from				
	12/01/22 to 12/29/22.					
	_	for Pepcid 20mg at bedtime inistered by a MA from				
	12/01/22 to 12/29/22.	-				
		for norco 7.5/325mg three				
	times a day as neede					
	administered by a MA					
	12/29/22.					
	Refer to the interview 9:30am.	with the AIC on 12/30/22 at				
	Refer to the interview	with the Administrator on				
	01/03/23 at 11:54am.					
		ministrator-in-Charge on				
	12/30/22 at 9:30am re	evealed: ninister medications to				
	residents.	illister medications to				
	-After the MA observe	ed a resident take a				
	medication, the MA w					
	administration on the					
		were not to give medications				
	to the PCA's and other	•				
	administer to the resid					
	-Sne was unaware of medications to reside	f any PCA's administering				
	liledications to reside	illo.				
	Interview with the Adr	ministrator on 01/03/23 at				

Division of Health Service Regulation

11:54am revealed:

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL081052	B. WING		01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CEDARC	REEK LIVING LLC	2270 OA	LAND ROAD		
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 359	Continued From page	e 49	D 359		
	-MAs were trained to residentsPCA's were not qual medications to reside -No PCA or other und administer a resident'	administer medications to ified to administer ents. qualified staff should ever 's medications. ere were unqualified staff			
D 367	10A NCAC 13F .1004 Administration	4(j) Medication	D 367		
	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 Based on record revie	as evidenced by: ews and interviews the			

Division of Health Service Regulation

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	, 50.1 <u>5</u> 1.10.1		
		HAL081052	B. WING		R 01/04/202	3
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		AND ROAD			
	_	FOREST C	TY, NC 28043	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	X5) IPLETE ATE
D 367	Continued From page	<del>2</del> 50	D 367			
	facility failed to ensure	e the electronic medication s (eMAR) were accurate for ents (#1, #2, #3, #4, #5, #6				
	The findings are:					
	on the eMARThere would be no b	revealed:				
	infection.	dementia and urinary tract				
	-An order for simvastatin (to treat high cholesterol) 40mg by mouth dailyAn order for Symbicort (to treat chronic obstructive pulmonary disease) 160/4.5mg one puff by mouth twice dailyAn order for Klonopin (to treat panic disorder) 4mg by mouth at bedtime.					
	-An order for metform levels) 1000mg by moreon -An order for paroxeti panic attacks and any -An order for aspirin (a heart attack or strok-An order for glipizide levels) 5mg, ½ tab (2	in (to treat high blood sugar buth at bedtime. ne (to treat depression, kiety) 40mg by mouth daily. to reduce the risk of having ke) 81mg by mouth daily. (to treat high blood sugar 5mg) by mouth twice daily. am (to treat anxiety) 1mg by				
	07/26/22 revealed an	ent physician order dated order for Voltaren (to treat 6, apply to head areas twice				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		R 01/04/2023
		11AE001032			01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC	2270 OA	KLAND ROAD		
CLDAN	KLLK LIVING LLC	FOREST	CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	51	D 367		
	07/29/22 revealed an	ent physician order dated order for Mobic (to treat to severe pain) 7.5mg by			
	Review of a subseque 09/30/22 revealed an klonopin 4mg by mou				
	Review of a subsequent physician order dated 10/17/22 revealed an order for hydrocortisone (to reduce pain, itching and swelling) 1%, apply to left elbow three times daily.				
	11/29/22 revealed an	ent physician order dated order for Depakote (to treat Omg by mouth at bedtime.			
	-	ent physician order dated order for Depakote 500mg			
	(eMAR) revealed: -There was an entry formouth daily documen being administered or	1's November 2022 Administration Record or simvastatin 40mg by ted as not recorded as n 11/29/22 and 11/30/22 at			
	puff by mouth twice di recorded as being add 11/30/22 at 8:00pm. -There was an entry for mouth at bedtime doc	or Symbicort 160/4.5mg one aily documented as not ministered on 11/29/22 and or metformin 1000mg by sumented as not recorded to an 11/20/22 and 11/20/22			
	at 8:00pm. -There was an entry f	on 11/29/22 and 11/30/22 or glipizide 5mg, ½ tab ce daily documented as not			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING			R 04/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE		
			LAND ROAD	,		
CEDAR C	REEK LIVING LLC		ITY, NC 28043	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 367	Continued From page	÷ 52	D 367	,		
D 367	11/30/22 at 8:00pmThere was an entry f three times daily doct being administered of 11/29/22 and 11/30/2: -There were no comm medications were not Review of Resident # electronic Medication (eMAR) revealed: -There was an entry f puff by mouth twice d recorded as being ad 12/25/22 at 8:00amThere was an entry f mouth daily documen being administered of 8:00am	for lorazepam 1mg by mouth fumented as not recorded as in 11/27/22 at 1:00pm and on 2 at 8:00pm. The nents related to why the recorded.  It's December 2022 Administration Record  For Symbicort 160/4.5mg one aily documented as not ministered on 12/24 and  For paroxetine 40mg by the das not recorded as in 12/24/22 and 12/25/22 at	D 367			
	daily documented as administered on 12/2-8:00am.  -There was an entry f (2.5mg) by mouth twirecorded as being ad 12/25/22 at 8:00am.  -There was an entry f three times daily docubeing administered of 8:00am and 12/24/22.  -There was an entry f daily documented as administered on 12/2-9:00am.	for glipizide 5mg, ½ tab ce daily documented as not ministered on 12/24/22 and for lorazepam 1mg by mouth umented as not recorded as in 12/24/22 and 12/25/22 at and 12/25/22 at 2:00pm. for Mobic 7.5mg by mouth not recorded as being 4/22 and 12/25/22 at ments related to why the				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL 094052	B. WING		R
		HAL081052			01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
OEDAD O		2270 OAF	KLAND ROAD		
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043	<b>;</b>	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFIGIENCE)	
D 367	Continued From page	÷ 53	D 367		
	Refer to interview with	n Medication Aide (MA) on			
	12/29/22 at 10:00am.	Tivicaloation / tide (W/X) on			
	12/20/22 at 10:00am.				
	Refer to interview witl	n the Administrator in			
	Charge (AIC) on 12/3				
	3 ( -)				
	Refer to interview with	n a second MA on 01/03/23			
	at 9:28am.				
	Refer to interview with	n the Administrator on			
	01/03/23 at 11:54am.				
		t #7's current FL2 dated			
	10/16/22 revealed:				
	_	non-ST-elevation myocardial			
		n, cerebral aneurysm and			
	transient ischemic att				
	mouth daily.	to treat heartburn) 20mg by			
	-An order for Plavix (t	o prevent blood clots			
	,	plood vessels) 75mg by			
	mouth daily.	need veesele, reing sy			
	_	(to treat depression and			
	anxiety) 150mg by mo	,			
		min gummies (to treat			
	vitamin deficiencies) l	oy mouth daily.			
	-An order for Protonix	(to relieve heartburn) 40mg			
	by mouth twice daily.				
	-An order for carvedile	`			
	-	angina) 3.125mg by mouth			
	twice daily.				
		(to treat chronic health			
	failure) 24/26mg by m				
		am (to treat anxiety) 0.5mg			
	by mouth three times				
		ntin (to treat nerve pain)			
	400mg by mouth thre	-			
	-An order for ipratropi	` ·			
	symptoms of lung dis	eases) 0.06% , two sprays			

in each nostril three times daily.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
,		.52	A. BUILDING:	A. BUILDING:		
			D WING			R
		HAL081052	B. WING	<del></del>	01	/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E, ZIP CODE		
		2270 OA	KLAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
D 367	Continued From page	e 54	D 367			
	overactive bladder) 5 -An order for senna-p	nin (to treat symptoms of an mg by mouth at bedtime. llus (to treat constipation) by				
	mouth at bedtime.	oine (to treat depression and				
	-	5 mg by mouth at bedtime.				
		(to treat symptoms of pain)				
	1%, apply to knee thr					
		ent physician order dated order for Requip (to treat				
		0.5mg by mouth at bedtime.				
	i arkinson s discase)	o.ong by modifi at bedime.				
		ent physician order dated				
		order for oxycodone (used				
	to relieve pain) 10mg	by mouth four times daily.				
	Review of a subseque	ent physician order dated				
		order for nystatin (to treat				
	fungal infection) 5ml l	by mouth four times daily.				
	Review of a subseque	ent physician order dated				
		order for trazodone (to treat				
	, , ,	ia 2 tablets (200mg) by				
	mouth at bedtime.					
	Review of Resident #	7's November 2022				
	electronic Medication	Administration Record				
	(eMAR) revealed:					
		for Protonix 40mg by mouth				
	_	ed as not recorded as being				
	administered on 11/2	9/22 and 11/30/22 at				
	8:00pm.	for carvedilol 3.125mg by				
		cumented as not recorded as				
		n 11/29/22 and 11/30/22 at				
	8:00pm.					
	· ·	or Entresto 24/26mg by				
		cumented as not recorded as				
		n 11/29/22 and 11/30/22 at				

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
					R
		HAL081052	B. WING		01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	•
TWINE OF T	NOVIBER OR GOLF EIER		LAND ROAD	, 2.11 3322	
CEDAR C	REEK LIVING LLC		CITY, NC 28043	•	
			7111, NC 20043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	e 55	D 367		
	8:00pm.				
	_	for lorazepam 0.5mg by			
		ily documented as not			
		ministered on 11/29/22 and			
	11/30/22 at 8:00pm.				
		for gabapentin 400mg by			
		ily documented as not			
		ministered on 11/29/22 and			
	11/30/22 at 8:00pm.	for invotranium 0.06% two			
	sprays in each nostril	for ipratropium 0.06%, two			
	documented as not re				
	administered on 11/2	<u> </u>			
	8:00pm.	9/22 and 11/30/22 at			
		for oxybutynin 5mg by mouth			
	_	ed as not recorded as being			
	administered on 11/2				
	8:00pm.	0,== 0.10 1.700,== 0.1			
		for senna-plus by mouth at			
		as not recorded as being			
	administered on 11/2	<u> </u>			
	8:00pm.				
		for mirtazapine 15 mg by			
	_	cumented as not recorded			
	as being administered	d on 11/29/22 and 11/30/22			
	at 8:00pm.				
	-There was an entry f	for Voltaren (to treat			
	symptoms of pain) 1%	%, apply to knee three times			
	daily documented as	not recorded as being			
	administered on 11/2	9/22 and 11/30/22 at			
	8:00pm.				
	_	for Requip 0.5mg by mouth			
	at bedtime document administered on 11/2	ed as not recorded as being 9/22 and 11/30/22 at			
	8:00pm.				
	•	for trazodone 100mg via 2			
	tablets (200mg) by m				
	documented as not re	ecorded as being			
	administered on 11/2	9/22 and 11/30/22 at			

Division of Health Service Regulation

8:00pm.

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DIVISION	i Health Service Regu	allon				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
ANDILAN	O CONTROLLONG	IDENTIFICATION NOMBER.	A. BUILDING: _		OOWII LL	.125
					R	
		HAL081052	B. WING		01/04	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		2270 OAKL	AND ROAD			
CEDAR C	REEK LIVING LLC		ITY, NC 28043	<b>.</b>		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 367	Continued From page	: 56	D 367			
	-There were no comm medications were not administered.	nents related to why the recorded as being				
	Refer to interview with 10:00am.	n the MA on 12/29/22 at				
	Refer to interview with 9:30am.	n the AIC on 12/30/22 at				
	Refer to interview with at 9:28am.	n a second MA on 01/03/23				
	Refer to interview with 01/03/23 at 11:54am.	n the Administrator on				
	12/02/22 revealed: -Diagnoses included rencephalopathy, and -An order for baclofer muscle spasticity) 10r -An order for klonopin	hepatic failure. ı (a medication used to treat				
	-An order for Vistaril (activity in the centeral times a dayAn order for KlorConlow potassium) 10mE -An order for Coreg (a high blood pressure) (a high blood pressure) (a high blood pressure) (b high blood pressure) (b high blood pressure) (c	a medication used to reduce nervous system) 25mg, two  (a medication used to treat q, two times a day. a medication used to treat 6.25mg, two times a day. a (a medication used to relax idder) 5mg, three times a latin (a medication used to mg, 2 capsules, three times				

Division of Health Service Regulation

Review of Resident #6's previous physician's

STATE FORM 6899 KDQU11 If continuation sheet 57 of 81

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL081052	B. WING		01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
TO WILL OF T	NOVIBER OR GOLF EIER		LAND ROAD		
CEDAR C	REEK LIVING LLC		CITY, NC 28043	•	
			TIT, NC 20043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	BE COMPLETE
D 367	Continued From page	e 57	D 367		
	orders dated 11/04/22	? royoolod:			
		n 10mg, two times a day.			
		n 0.5mg, ½ a tablet, two			
	times a day.	1 0.01119, /2 a tablet, two			
	_	25mg, two times a day.			
		10mEq, two times a day.			
		5.25mg, two times a day.			
		n 5mg, two times a day.			
		ntin 100mg, 2 capsules,			
	three times a day.	<b>3</b> , 1			
	-				
	Review of Resident #	6's November 2022 eMAR			
	revealed:				
	_	for baclofen 10mg, two times			
	-	s blank on 11/29/22 and			
	11/30/22 at 8:00pm.				
	_	for klonopin 0.5mg, ½ a			
		y documented as blank on			
	11/29/22 and 11/30/2	•			
	-	for Vistaril 25mg, two times a			
	11/29/22 at 8:00pm.	plank on 11/27/22 and			
	-There was an entry f	for KlorCon 10mEq, two			
	times a day documen	ited as blank on 11/29/22			
	and 11/30/22 at 8:00p				
	_	for Coreg 6.25mg, two times			
	-	s blank on 11/29/22 and			
	11/30/22 at 8:00pm.				
		for Ditropan 5mg, two times			
	_	s blank on 11/29/22 and			
	11/30/22 at 8:00pm.	for gabapentin 100mg, 2			
	_	s a day documented as blank			
		0/22 at 2:00pm and 8:00pm.			
		nents related to why the			
	medications were not				
	5415415715 WOTO 1101				
	Review of Resident #	6's December 2022 eMAR			

Division of Health Service Regulation

-There was an entry for baclofen 10mg, two times

STATE FORM 6899 KDQU11 If continuation sheet 58 of 81

Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL081052	B. WING		01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADL	ORESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC	2270 OAK	AND ROAD		
CEDAR C	REEK LIVING LLC	FOREST C	ITY, NC 28043	3	
0(1) 15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	T	PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	( - /
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 367	Continued From page	<del>2</del> 58	D 367		
		11 1 10/00/00 1			
		s blank on 12/29/22 at			
	8:00pm.				
		for klonopin 0.5mg, ½ a			
	tablet, two times a da	y documented as blank on			
	12/29/22 at 8:00pm.				
	-There was an entry f	or Vistaril 25mg, two times a			
		olank on 12/29/22 at 8:00pm.			
	•	for KlorCon 10mEq, two			
		ited as blank on 12/29/22 at			
	8:00pm.	ited as blank on 12/29/22 at			
		ion Conon C OFman, true times			
		for Coreg 6.25mg, two times			
	-	s blank on 12/29/22 at			
	8:00pm.				
	-There was an entry f	or Ditropan 5mg, two times			
	a day documented as	s blank on 12/29/22 at			
	8:00pm.				
	•	or gabapentin 100mg, 2			
	_	a day documented as blank			
	on 12/29/22 at 2:00p	•			
		nents related to why the			
	medications were not	•			
	medications were not	recorded.			
	56	1.144			
	Refer to interview with	n MA on 12/29/22 at			
	10:00am.				
	Refer to interview with	h the AIC on 12/30/22 at			
	9:30am.				
	Refer to interview with	h a second MA on 01/03/23			
	at 9:28am.				
	Refer to interview with	h the Administrator on			
	01/03/23 at 11:54am.				
	01/00/20 at 11.04alli.				
	4 Daview -f D: !	4 #0lla augmant El O deted			
		t #2"s current FL2 dated			
	12/02/22 revealed:				
	_	Alzheimer's disease, high			
	blood pressure, depre	ession, high cholesterol,			

Division of Health Service Regulation

chronic kidney disease.

enlarged prostate, urinary incontinence and

STATE FORM 6899 KDQU11 If continuation sheet 59 of 81

Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					<sub>F</sub>	,
		HAL081052	B. WING		1	)4/2023
		1			1 01/0	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		KLAND ROAD			
		FOREST	CITY, NC 28043	1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
1,10		,	17.0	DEFICIENCY)		
D 367	Continued From page	÷ 59	D 367			
	-An order for Citalogr	am (to treat depression)				
	20mg daily.	am (to troat depression)				
	-An order for Flomax	(to treat urinary				
	incontinence) 0.4mg	•				
		to treat high cholesterol)				
	80mg daily.					
		र (to treat gastric reflux)				
	40mg daily.					
		(to reduce the risk of a heart				
	attack or stroke) 81m					
	magnesium) 400mg t	sium Oxide (to treat low				
	, ,	o treat high blood pressure)				
	5/20mg two times dai					
	•	to treat high blood pressure)				
	3.125mg two times da					
		B-12 (supplemental B				
	Vitamin) 1,000mcg da					
	-An order for Metopro	olol (to treat high blood				
		nilure) 25mg two times daily.				
		ol (used to treat elevated				
	blood sugar) 5mg dai	ly.				
	Review of Resident #	2's December 2022 eMAR				
	revealed:					
	-	for Magnesium Oxide 400mg				
		nented as not recorded as				
	•	n 12/24/22 and 12/25/22 at				
	8:00am.					
		for Lotrel 5/20mg two times				
	•	not recorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.	for Metoprolol 25mg two				
		ed as not recorded as being				
	administered on 12/2	_				
	8:00am.	3.14 12/20/22 40				

-There was an entry for Citalopram 20mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at

STATE FORM 6899 KDQU11 If continuation sheet 60 of 81

Division of	of Health Service Regu	ılation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL081052	B. WING		R 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	•
CEDAR C	REEK LIVING LLC		KLAND ROAD CITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 60	D 367		
	documented as not re administered on 12/2 8:00am.  -There was an entry findocumented as not re administered on 12/2 8:00am.  -There was an entry findocumented as not re administered on 12/2 8:00am.  -There was an entry findocumented as not re administered on 12/2 8:00am.  -There was an entry findocumented as not re administered on 12/2 8:00am.  -There was an entry finding documented as administered on 12/2 8:00am.  -There was an entry finding documented as administered on 12/2 8:00am.  -There were no comminedications were not administered.  Refer to interview with 12/29/22 at 10:00am.  Refer to interview with 9:30am.  Refer to interview with 3:28am.  Refer to interview with 3:28am.	for Lipitor 80mg daily ecorded as being 4/22 and 12/25/22 at for Glucotrol 5mg daily ecorded as being 4/22 and 12/25/22 at for Aspirin 81mg daily ecorded as being 4/22 and 12/25/22 at for Vitamin B-12 1,000mcg not recorded as being 4/22 and 12/25/22 at for Vitamin B-12 1,000mcg not recorded as being 4/22 and 12/25/22 at for When the trecorded as being 4/22 and 12/25/22 at for When the trecorded as being 4/22 and 12/25/22 at for When the trecorded as being 4/22 and 12/25/22 at for When the trecorded as being the Medication Aide (MA) on the AIC on 12/30/22 at for When the Administrator on the Adminis			
	5. Review of Resider	nt #3's current FL2 dated			

12/02/22 revealed:

-Diagnoses included diabetes and obesity.

STATE FORM 6899 KDQU11 If continuation sheet 61 of 81

Division of Health Service Regulation				1 Ordiv	AITROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		URVEY ETED
		HAL081052	B. WING		01/0	2 4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			LAND ROAD	,		
CEDAR C	REEK LIVING LLC		CITY, NC 28043	1		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
D 367	Continued From page	÷ 61	D 367			
	-An order for Prozac (daily.	(to treat depression) 20mg				
	-An order for Flomax incontinence) 0.4mg					
	, .	to treat high blood pressure)				
	40mg daily.	,				
		(to treat high triglycerides)				
	1,200mg daily.	(to treat anxiety) 7.5mg two				
	times daily.	to treat anxiety) 1.5mg two				
	-An order for Metform	in (to treat diabetes)				
	1,000mg two times da	-				
		to treat high blood pressure)				
	25mg two times daily	ı (to treat diabetes) given per				
	sliding scale three tim	· · · · · · · · · · · · · · · · · · ·				
	-An order for Oxycode	one/Acetaminophen (to treat				
	-	ain) 10/325mg four times				
	daily.  -An order for Gahane	ntin (to treat nerve pain)				
	600mg three times da					
	•	(to help prevent blood clots)				
	20mg daily.					
	<ul><li>-An order for Lasix (to 20mg daily.</li></ul>	decrease fluid in the body)				
		(to treat diabetes) 1.5mg by				
	injection weekly.	, , ,				
		3's December 2022 eMAR				
	revealed:	7 1 1 40 1 1				
	<ul> <li>There was an entry f documented as not re</li> </ul>					
	administered on 12/2	•				
	8:00am.					
	-There was an entry f					
	documented as not re	•				
	administered on 12/2	4/22 and 12/25/22 at	1			i

-There was an entry for Prozac 20mg daily documented as not recorded as being

STATE FORM 6899 KDQU11 If continuation sheet 62 of 81

DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
					_	_
			D MINO		F	
		HAL081052	B. WING		01/0	04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
			LAND ROAD	,		
CEDAR C	REEK LIVING LLC					
		FUREST	CITY, NC 2804	3		Т
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG	TREGOE TOTAL OTTE	100 IDENTIFICATION OF THE ONLY	TAG	DEFICIENCY)	1000	
						+
D 367	Continued From page	e 62	D 367			
	administered on 12/2	1/22 and 12/25/22 at				
	8:00am.	4/22 and 12/23/22 at				
		or Flomax 0.4mg daily				
	documented as not re					
	administered on 12/2	S .				
	8:00am.	4/22 and 12/25/22 at				
	-There was an entry f	or Varalta 20mg daily				
	documented as not re					
	administered on 12/2	•				
	8:00am.	4/22 and 12/25/22 at				
		: Fi-l- Oil 4 000 II				
		or Fish Oil 1,200mg daily				
	documented as not re	<u> </u>				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.					
		or Buspar 7.5mg two times				
	•	not recorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.					
		or Metformin 1,000mg two				
	•	ed as not recorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.					
	-There was an entry f	or Toprol 25mg two times				
	daily documented as	not recorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.					
	-There was an entry f	or Gabapentin 600mg three				
	<del>_</del>	ed as not recorded as being				
	administered on 12/2	•				
	8:00am and 2:00pm.					
	· ·	or Novolog per sliding scale				
		umented as not recorded as				
	•	n 12/24/22 and 12/25/22 at				
	7:00am, 11:00am, an					
	-There was an entry f					
	<del>_</del>	ophen 10/325mg four times				
		not recorded as being				
	administered on 12/2					
		4/22 and 12/20/22 at				
	7:00am and 1:00pm.		1			

Division of Health Service Regulation

-There was no comments related to why the

STATE FORM 6899 KDQU11 If continuation sheet 63 of 81

Division of	<u>of Health Service Regu</u>	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B. WING		R	
		HAL081052	B. WING		01/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		2270 OA	KLAND ROAD			
CEDAR C	REEK LIVING LLC		CITY, NC 28043			
	OUR MAR DV OT		· ·		.,	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		
				DEFICIENCY)		
D 207	0 " 15	00	D 207			
D 367	Continued From page	e 63	D 367			
	medications were not	recorded as being				
	administered .	3				
	Refer to interview with	h Medication Aide (MA) on				
	12/29/22 at 10:00am.	` ,				
	Refer to interview with	h the AIC on 12/30/22 at				
	9:30am.					
	o.ooanii					
	Refer to interview with	h a second MA on 01/03/23				
	at 9:28am.					
	dt 0.20diii.					
	Refer to interview with	h the Administrator on				
	01/03/23 at 11:54am.					
	01/00/20 at 11:0 fail.					
	6. Review of Resider	nt #4's current FL2 dated				
	10/10/22 revealed:					
		dementia, chronic pain and				
	neuropathy.	р				
	-An order for Norvaso	to treat high blood				
	pressure) 10mg daily	•				
		decrease fluid in the body)				
	10mg daily.	,,				
		ntin (to treat nerve pain)				
		al of 200mg) three times				
	daily.	3,				
		to treat high blood pressure)				
	50mg daily.	,				
		one (to treat moderate to				
	severe pain) 10/325m	ng three times daily.				
		(to treat insomnia) 10mg				
	every night.	, ,				
	-An order for Eliquis (	to help prevent blood clots)				
	2.5mg two times daily					
		el (to treat mood disorders)				
		12.5mg) two times daily.				
		n (to treat panic attacks)				
		of 0.25mg) every night.				

Review of Resident #4's November 2022

STATE FORM 6899 KDQU11 If continuation sheet 64 of 81

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					F	<b>,</b>
		HAL081052	B. WING		1	)4/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE ZIR CODE		
NAME OF T	NOVIDEN ON 301 1 EIEN		KLAND ROAD	KIL, ZII OODL		
CEDAR CREEK LIVING LLC			CITY, NC 2804:	3		
0/0.15	STIMMADA ST				TION	0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
				BEI IOIENOT)		
D 367	Continued From page 64		D 367			
	electronic Medication	Administration Record				
	(eMAR) revealed:					
		for Seroquel 12.5mg two				
		ted as not recorded on				
	11/29/22 and 11/30/2					
		for Eliquis 2.5mg two times not recorded on 11/29/22				
	and 11/30/22 at 8:00p					
		for Klonopin 0.25mg every				
	night documented as not recorded on 11/29/22					
	and 11/30/22 at 7:00p	om.				
	_	for Oxycodone 10/325mg				
	1	umented as not recorded on				
	11/29/22 and 11/30/2	•				
	_	for Gabapentin 200mg three				
	11/29/22 and 11/30/2	ted as not recorded on				
		ents related to why the				
	medications were not					
	Review of Resident # revealed:	4's December 2022 eMAR				
	-There was an entry f	or Lasix 10mg daily				
	documented as not re	ecorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.					
	-There was an entry f					
	documented as not readministered on 12/2	<u> </u>				
	8:00am.	4/22 and 12/25/22 at				
		for Norvasc 10mg daily				
	documented as not re					
	administered on 12/2	<del>-</del>				
	8:00am.					
	_	for Eliquis 2.5mg two times				
	_	not recorded as being				
	administered on 12/2	4/22 and 12/25/22 at				
	8:00am.	for Coroguel 12 Fma has				
	i - mere was an entry 1	for Seroquel 12.5mg two				

Division of Health Service Regulation

times daily documented as not recorded as being

STATE FORM 6899 KDQU11 If continuation sheet 65 of 81

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			1		1 _	_
			P WING		F	
		HAL081052	B. WING		01/0	14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE. ZIP CODE		
			LAND ROAD	•		
CEDAR C	REEK LIVING LLC		SITY, NC 28043	2		
			T T, NC 20043			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
17.0		,	17.0	DEFICIENCY)		
			+			
D 367	Continued From page	e 65	D 367			
	administered on 12/2	1/22 and 12/25/22 at				
	8:00am.	4/22 and 12/25/22 at				
		or Gabapentin 200mg three				
		ed as not recorded as being				
	administered on 12/2	•				
	8:00am and 2:00pm.	4/22 and 12/25/22 at				
		or Oxycodone 10mg/325				
	<del>_</del>					
		umented as not recorded as				
		n 12/24/22 and 12/25/22 at				
	8:00am and 2:00pm.					
		ents related to why the				
	medications were not	recorded as being				
	administered .					
	Defends intensionalist	h Madiaction Aida (NAA) an				
		h Medication Aide (MA) on				
	12/29/22 at 10:00am.					
	Defends intensionalist	h the AIC on 12/20/22 of				
		h the AIC on 12/30/22 at				
	9:30am.					
	Defends intensionalist	h a second MA on 01/03/23				
		n a second MA on 01/03/23				
	at 9:28am.					
	Defends intensionalist	h tha Administrator an				
		h the Administrator on				
	01/03/23 at 11:54am.					
	7 Davious of Davidor	nt #5's current FL2 dated				
		it #5 s current FL2 dated				
	12/02/22 revealed:	biolo blacel concerns biolo				
	•	high blood pressure, high				
		d glucose, panic disorder,				
	swelling and obesity.	and a construction of the second of				
	•	decrease fluid in the body)				
	60mg daily.	"				
		n (to replace Potassium)				
	20meq daily.	""" OTT (				
		il/HCTZ (to treat blood				
	=	ention) 20/12.5mg daily.				
	-An order for Norvaso					
	pressure) 5mg every	night.				

Division of Health Service Regulation

-An order for Vistaril (used to treat anxiety) 25mg

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL081052	B. WING		R 01/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CEDAR C	REEK LIVING LLC		(LAND ROAD			
		FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 367	Continued From page	e 66	D 367			
	two times dailyAn order for Prilosec 20mg daily.	(used to treat gastric reflux)				
	Review of Resident # revealed:	5's December 2022 eMAR				
	-There was an entry f					
	documented as not readministered on 12/2	•				
	8:00am.					
		or Klor-Con 20meq daily				
	documented as not readministered on 12/2-8:00am.	•				
	-There was an entry f	or Lisinopril/HCTZ				
		mented as not recorded as n 12/24/22 and 12/25/22 at				
	-There was an entry f	or Vistaril 25mg two times not recorded as being 4/22 and 12/25/22 at				
	8:00am.					
	-There was no comm medications were not administered .	ents related to why the recorded as being				
	Refer to interview with 12/29/22 at 10:00am.	h Medication Aide (MA) on				
	Refer to interview with 9:30am.	h the AIC on 12/30/22 at				
	Refer to interview with at 9:28am.	h a second MA on 01/03/23				
	Refer to interview with 01/03/23 at 11:54am.	h the Administrator on				
	Interview with a MA o	n 12/29/22 at 10:00am				

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revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		HAL081052	B. WING		01	R / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	•	
CEDAR	DEEK LIVING LLC	2270 OAF	KLAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 67	D 367			
	of the eMAR's and if the documentation was read to a commentation was read to a commentation was read to a commentation were not a commentation were not a commentation were not a commentation was read to a comm	documented as anoths of November and aported this to the AIC. Its were completed on and the AIC.  Son 12/30/22 at 9:30am for checking eMAR's and her. The blanks where no ecorded in the months of mber, and she did address onsible.				
	9:28am revealed: -She worked as a MA -Both days were very -She administered me but forgot to documenthemShe was reminded b she needed to documenting Interview with the Adr 11:54am revealed: -One of the MAs and checking the eMAR's -He was not aware th	edications to all residents, nt she had administered  y the AIC on 12/26/22 that nent, but she had not gotten ng it yet.  ministrator on 01/03/23 at  the AIC were responsible for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
						R
		HAL081052	B. WING		01	/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CEDAR C	REEK LIVING LLC		KLAND ROAD CITY, NC 28043			
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF	CORRECTION	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From page	e 68	D 367			
		ere had been missing December 2022 eMAR for				
D 375	10A NCAC 13F .1005 Medications	5(a) Self-Administration Of	D 375			
	Medications  (a) An adult care hor who are competent a self-administer their n requirements are med (1) the self-administra physician or other perprescribe medications documented in the re (2) specific instruction	nedications if the following :: ation is ordered by a rson legally authorized to s in North Carolina and				
	This Rule is not met Based on observatior interviews, the facility sampled residents (R physician's order to s related to treat pain, deficiencies (Residen eye irrigation, wart re pain relief (Resident # The findings are:  Review of the facility's Policies and Procedu	ns, record reviews, and failed to ensure 2 of 7 esidents #5 and #7) had a elf-administer medications vitamin and mineral transfer to the service of the serv				

Division of Health Service Regulation

STATE FORM 6899 KDQU11 If continuation sheet 69 of 81

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION (X3) DATE SU NG: (X3) DATE SU	
					R
		HAL081052	B. WING		01/04/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		(LAND ROAD		
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 375	Continued From page 69		D 375		
	"Self-Administration is	s ordered by Physician."			
	12/02/22 revealed: -Diagnoses included hyperlipidemia.	nt #5's current FL2 dated hypertension and ation listed regarding his			
	Observation of Resident #5's bedroom on 12/28/22 at 9:17am revealed:  -A bottle of Vitamin C (a medication to treat vitamin C deficiency) 500mg tablets on his dresser.  -A bottle of Vitamin D (a medication to treat vitamin D deficiency) 5,000 international units (IU) on his dresser.  -A bottle on Tumeric (a medication used to treat pain) 200mg capsules on his dresser.				
	Interview with Resident #5 on12/28/22 at 9:17am revealed: -He self-administered one Vitamin C 500mg tablet dailyHe self-administered one Vitamin D 5,000 IU tablet dailyHe self-administered one Tumeric 200mg capsule daily.				
		5's current FL2 dated ere was no order for Vitamin eric.			
	and December 2022	5's Medication d (MAR) for November 2022 revealed there were no Vitamin D or Tumeric.			
	Interview with a medi	cation aide (MA) on			

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12/29/22 at 3:56pm revealed:

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Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
		HAL004052	B. WING		R	
		HAL081052			01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		2270 OAI	KLAND ROAD			
CEDAR C	REEK LIVING LLC		CITY, NC 28043	3		
					1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 075	0 " 15	70	D 075			
D 375	Continued From page	e 70	D 375			
	-Resident #5 did not h	nave an order to				
	self-administer medic					
		any medications he kept in				
	his room.	any medications he kept in				
	1115 100111.					
	Telephone interview v	with the				
	I	ge (AIC) on 01/03/23 at				
	10:00am revealed:	ge (AIC) on 0 1/03/23 at				
		2 :1 :1//5				
	-She was not aware F					
	self-administering me					
		nave a physician's order to				
	self-administer any m	edications.				
		h the Administrator on				
	01/03/23 at 11:54am.					
	0 D	1 #71 FI O d-1-1				
		t #7's current FL2 dated				
	10/16/22 revealed:	a				
	_	non-ST-elevation myocardial				
		n, cerebral aneurysm and				
	transient ischemic att	ack.				
	-She was oriented.					
	-She was ambulatory					
	Observation of Reside					
	12/30/22 at 3:15pm re					
		200mg tablets (to ease mild				
	pain) on the bedside	table.				
	-A bottle of Tiger balm	ո (to alleviate pain) pain				
	relieving ointment on					
		bottle of ear wax removal				
	drops from her bedsic					
	•	bottle of eye itch relief drops				
	from her bedside table					
		bottle of wart remover from				
	her bedside table dra					
	noi bodoide table dia	<del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>				
	Interview with Reside	nt #7 revealed at 3:15nm				

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revealed:

-She self-administered Ibuprofen 200mg

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		R <b>01/04/2023</b>	
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
CEDAR CE	REEK LIVING LLC	2270 OAK	LAND ROAD			
OLDAN OI	LEK LIVING LEG	FOREST (	OITY, NC 28043	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 375	Continued From page 71		D 375			
	occasionallyShe self-administereShe self-administere occasionallyShe self-administere occasionallyShe self-administere occasionallyShe self-administere occasionally.  Review of Resident # 10/16/22 revealed the lbuprofen, Tiger balm eye itch relief drops o  Review of Resident # Administration Record December of 2022 refor lbuprofen, Tiger balm eye itch relief drops or telephone interview with the 4:00pm revealed: -She was aware that a counter medications in -Resident #7 did not have self-administer any more representations.  Interview with the Administration that should be also relief administering metalications and relief administering metalications and relief administering metalications and relief administering metalications and relief administering metal	d tiger balm occasionally. d ear wax remover rarely. d wart remover  d eye itch relief drops  7's current FL2 dated ere were no orders for , ear wax removal drops, r wart removal drops.  7's Medication d (MAR) for November and evealed there were no orders falm, ear wax removal drops, r wart removal drops.  with the AIC on 12/30/22 at  Resident #7 had over the n her room. have a physician's order to edications.  Administrator on 01/03/23  ministrator on 01/03/23 at icy for self-administration of all be followed.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or dorace mon	IDENTIFICATION NOMBER.	A. BUILDING: _			
		HAL081052	B. WING		01/0	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
05040.0		2270 OAKL	AND ROAD			
CEDAR C	REEK LIVING LLC	FOREST C	ITY, NC 28043	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 400	Continued From page	÷72	D 400			
D 400	10A NCAC 13F .1009	(a)(1) Pharmaceutical Care	D 400			
	(a) An adult care hone of a licensed pharmace practitioner for the procare at least quarterly require more frequent monitoring visits or of are medication problems which include (1) an on-site medication problems which include (1) an on-site medication which includes the folication (A) the review of informeter and the prescribed and ensure effects, potential and or interactions, and midentified and reported prescribing practitions (B) making recommendations and ensuring prescribing practitions of the prescribing practitions of the prescribing practitions and ensuring prescribing practitions are the prescribing practitions and ensuring prescribing practitions are the prescribing practitions and the prescribing practitions are the prescribing practitions are the prescribing practitions and the prescribing practitions are the prescribed and the prescribing practitions are the prescribed and the prescribing practitions are the prescribing prescribing practitions are the prescribing practitions are the prescribing prescribing practitions are the prescribing practitions are the prescribing prescribing prescribing practitions are the prescribing prescribing practitions are the prescribing practitions are the prescribing prescribing prescribing prescribing prescribing prescribed and prescribed	evision of pharmaceutical of the Department may be visits if it documents during the investigations that there earns in which the safety of sisk.  Involves the identification, action of medication related des the following:  Ition review for each resident lowing:  Imation in the resident's coses, history and physical, wital signs, physician's so, laboratory values and action records, including liministration records, to actions are administered as that any undesired side actual medication reactions are did to the appropriate er; and and actions for change, if desired medication and that the appropriate er is so informed; and results of the medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			_
		HAL081052	B. WING		01	R / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
05040.0		2270 OA	KLAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 400	Continued From page	÷73	D 400			
	facility failed to ensure reviews were completed residents (Residents). The findings are:  Review of the undate Procedures revealed: -A licensed Pharmaci to perform an on-site -The on-site medication residents every 90 days.  1. Review of Resider 12/02/22 revealed diagrams.	ews and interviews, the e quarterly pharmacy ted for 6 of 7 sampled #1, #2, #3, #5, #6, and #7).  d Medication Policies and st or Registered Nurse was medication review. on review was for all eys.				
	Review of Resident # revealed an admissio					
	revealed: -Two pharmacy review -The first was in June -The second was in D -There was no pharm March of 2022.					
		terview with the facility's st on 12/28/22 at 3:42pm.				
	Refer to telephone int	terview with the				

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		HAL081052	B. WING		01/04/2023	
		HALU61032			01/04/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
0====	DEEK I D/DIO I I O	2270 OA	KLAND ROAD			
CEDAR CREEK LIVING LLC FOREST			CITY, NC 28043	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
D 400	Continued From page	e 74	D 400			
	Administrator-in-Char	ge (AIC) on 01/03/23 at				
	10:00am.	ge (/ 110) 511 6 1/65/25 at				
	Defer to intensious with	h the Administrator on				
	01/03/23 at 11:54am.					
	01/05/25 at 11.54aiii.					
	2 Review of Resider	nt #3's current FL2 dated				
		agnoses included diabetes				
	and cognitive impairn	~				
	ana segimure impaiin					
	Review of Resident #	3's Resident Register				
	revealed an admissio	•				
	Review of Resident #	3's pharmacy reviews				
	revealed:	os phannacy reviews				
		ws were completed in 2022.				
	-The first was in June					
	-The second was in D	December of 2022.				
	-There was no pharm	acy review completed in				
	March of 2022.					
	-There was no pharm	acy review completed in				
	September of 2022.					
		terview with the facility's				
	contracted Pharmacis	st on 12/28/22 at 3:42pm.				
	5					
		terview with the AIC on				
	01/03/23 at 10:00am.					
	Refer to interview with	h the Administrator on				
	01/03/23 at 11:54am.					
	0 1/00/20 at 11.04aiii.					
	3. Review of Resider	nt #5's current FL2 dated				
	0	agnoses included high blood				
		nolesterol and elevated blood				
	sugar.					
	3					
	Review of Resident #	5's Resident Register				
	revealed an admissio					

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DIVISION	n nealth Service Regul	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		HAL081052	B. WING		1	4/2023
NAME OF D	DOVIDED OD CUDDUED	CTDEET ADD	DECC OITY OTA	TE 7/D 000E		
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	I E, ZIP CODE		
CEDAR CREEK LIVING LLC			LAND ROAD			
			ITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D 400	Continued From page	<del>;</del> 75	D 400			
	Review of Resident #srevealed:	5's pharmacy reviews				
	-Two pharmacy reviev	ws were completed in 2022.				
	-The first was in May					
	-The second was in N					
	-There was no pharm March of 2022.	acy review completed in				
		acy review completed in				
	September of 2022.					
	-	erview with the facility's at on 12/28/22 at 3:42pm.				
	Refer to telephone int 01/03/23 at 10:00am.	erview with the AIC on				
	Refer to interview with 01/03/23 at 11:54am.	n the Administrator on				
	03/03/22 revealed:	t #1's current FL2 dated				
	<ul> <li>Diagnoses included of infection.</li> </ul>	dementia and urinary tract				
	<ul><li>-He was intermittently</li><li>-He was ambulatory.</li></ul>	disoriented.				
	Review of Resident # revealed an admission	S .				
	Review of Resident # revealed:	1's pharmacy reviews				
		eted on 06/01/22 and a				
	review was completed					
		re completed or provided for				
	-	erview with the facility's st on 12/28/22 at 3:42pm.				
			1	I .		

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Refer to telephone interview with the AIC on

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Division of	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_		1 _	_
			D. WING		R	
		HAL081052	B. WING	<del></del>	01/0	4/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE 710 CODE		
NAME OF FI	NOVIDER OR SUFFLIER			II E, ZIF CODE		
CEDAR C	REEK LIVING LLC	2270 OAK	LAND ROAD			
025/110	X	FOREST (	CITY, NC 28043	3		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 400	Continued From nego	. 76	D 400			
D 400	Continued From page	e 70	D 400		ļ	
	01/03/23 at 10:00am.				ļ	
					ļ	
	Refer to interview with	h the Administrator on				
	01/03/23 at 11:54am.				ļ	
	01/03/23 at 11.34aiii.					
	C Daview of Davidon	. + #71 FL O deted				
	-	it #7's current FL2 dated			ļ	
	10/16/22 revealed:				ļ	
	_	non-ST-elevation myocardial			ļ	
		n, cerebral aneurysm and				
	transient ischemic att	ack.			ļ	
	-She was oriented.					
	-She was ambulatory	<b>'.</b>				
	Review of Resident #	7's Resident Register				
	revealed an admissio					
					ļ	
	Review of Resident #	7's pharmacy reviews				
	revealed:	r o priarriady roviews			ļ	
		eted on 11/29/21 and a				
	review was complete					
		re completed or provided for			ļ	
	2022.				ļ	
	56441					
	•	terview with the facility's				
	contracted Pharmacis	st on 12/28/22 at 3:42pm.				
		terview with the AIC on			ļ	
	01/03/23 at 10:00am.					
					ļ	
	Refer to interview with	h the Administrator on			ļ	
	01/03/23 at 11:54am.					
	6 Review of Resider	nt #6's current FL2 dated			ļ	
	12/02/22 revealed:	J J Jan. J. II. L L dated				
	-Diagnoses included	multiple sclerosis				
	encephalopathy, and					
		•				
	-He was semi-ambula	atory.				
	-He was oriented.					

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Review of Resident #6's Resident Register

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL081052	B. WING		01	R / <b>04/2023</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	1 0.	104/2020
CEDAR C	DEEK LIVING LLC		KLAND ROAD			
CEDAR C	REEK LIVING LLC	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 400	Continued From page	e 77	D 400			
	revealed an admissio	n date of 11/04/21.				
	Review of Resident # revealed: -A review was completedThere were no other provided for 2022.  Refer to telephone into contracted Pharmacist Refer to telephone into Administrator-in-Chart 10:00am.  Refer to interview with	6's pharmacy reviews eted on 05/25/22 and a d on 12/05/22. reviews were completed or terview with the facility's et on 12/28/22 at 3:42pm. terview with the ege (AIC) on 01/03/23 at				
	Pharmacist on 12/28/ -According to the pharmacist who had be the facility had only be monthsShe was aware the purposed to occur evolving facilitiesShe was unsure why had not been providing facility every 3 month.  Telephone interview was 10:00am revealed: -The pharmacist came of residents in the facility every and revealed: -She was not aware of for pharmacy reviews	with the facility's contracted 22 at 3:42pm revealed: rmacy records, the been providing reviews for een reviewing them every 6 charmacy review was ery 3 months in assisted of the previous Pharmacist ag pharmacy reviews for the sas required.  With the AIC on 01/03/22 at the to review the medications sility every 6 months. Of the regulation requirement a every 3 months.				
		ministrator on 01/03/23 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		В
		HAL081052	B. WING		R 01/04/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CEDAR C	REEK LIVING LLC		AND ROAD		
			ITY, NC 28043		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 400	Continued From page	<del>2</del> 78	D 400		
	contracted pharmacyHe thought they were quarterly reviews but	e supposed to be doing			
D 453	10A NCAC 13F .1212 and Incidents	P(d) Reporting of Accidents	D 453		
	Incidents (d) The facility shall is department of social s G.S. 108A-102 and the	Reporting of Accidents and mmediately notify the county services in accordance with the local law enforcement by law of any mental or act or exploitation of a			
	facility failed to notify of Social Services (DS	and record reviews, the the local county Department SS) for an incident involving ent (Resident #3) who was			
	The findings are:				
	Review of Resident # 12/02/22 revealed dia and obesity.	3's current FL2 dated agnoses included diabetes			
	revealed: -Over a month ago he	nt #3 on 12/29/22 at 9:23am e observed Resident #1 no was in a wheelchair, into			

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DIVISION	n nealth Service Regu	lation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		, ,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			D WING		R		
		HAL081052	B. WING		01/0	4/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE			
	10115211 011 001 1 21211						
CEDAR C	REEK LIVING LLC		(LAND ROAD				
		FOREST	CITY, NC 28043	3			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIE	DATE	
				, , , , , , , , , , , , , , , , , , ,			
D 453	Continued From page	<del>.</del> 79	D 453				
	Resident #2's room.						
	-He observed Reside						
	Resident #2 to come						
		1 why he pushed Resident					
	#2 into his room and	would not let him out.					
	-Resident #1 respond	ed "I'll do whatever the					
	*expletive* I want."						
	-Resident #1 then lun	ged forward and grabbed					
	his hair and "snatched	d" his head backward.					
	-He told Resident #1	to "get his *expletive* hands					
	out of his hair."	5					
	-Resident #1 proceed	ing to hit him in the back of					
	the head with his fist.	3					
		1A) intervened and removed					
	Resident #1 from the	•					
		vas ok but did not ask him					
	what happened.	vas ok but did flot ask fillfi					
	wнат паррепец.						
	Intonuious with a MA a	n 12/29/22 at 10:30am					
	revealed:	11 12/29/22 at 10.30aiii					
		Decident #4 and Decident					
		Resident #1 and Resident					
	#3 had an altercation.						
		ent #1 "charge forward" and					
	pull Resident #3's hai						
		conversation that occurred					
	between Resident #1						
		inistrator-in-Charge (AIC).					
		e an incident/accident report					
	because she thought						
		OSS because she thought					
	the AIC would do it.						
	Interview with the Adu	ılt Home Specialist (AHS)					
	for the local DSS on 1						
	revealed:						
	-She was not notified	of the incident between					
	Resident #1 and Resi	dent #3 when it occurred.					
		an incident/accident report					
	from the facility.						

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DIVISION	of Health Service Regu	liation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	HAI 084052 B. WING			R		
		HAL081052	B. WC		01/04/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			LAND ROAD			
CEDAR C	REEK LIVING LLC					
		FUREST	CITY, NC 28043			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
TAG	TREGOE TOTAL OIL	EGG IBERTII TIIVO IIVI GRUMATION,	TAG	DEFICIENCY)	W/112	
D 453	Continued From page	e 80	D 453			
		10/00/00 1 10 00				
		c on 12/30/22 at 10:26am				
	revealed:					
		ere supposed to fill out an				
	incident/accident repo					
	altercations occur bet					
		ample available for staff on				
	how to write an incide	ent/accident report.				
	-Staff was supposed	to complete an				
	incident/accident repo	ort immediately after the				
	altercation between re	esidents occurred.				
	-She was supposed t	o receive the				
	incident/accident repo	ort so she could notify the				
		SS or the local Police				
	Department if needed					
		that day, but if she had				
	_	ident report would have				
	been completed.	•				
	•	cident/accident report				
		ercation that had occurred				
	between Resident #1					
		d of the altercation between				
		ident #3 when the incident				
	occurred.					
	occurrou.					
	Interview with the Adr	ministrator on 01/03/23 at				
	11:54am revealed:					
		ercation occurred between				
		ways be reported to DSS.				
		notification to DSS of the				
		Resident #1 and Resident #3				
	had not occurred.	Conditt # 1 and Nesident #3				
	nau noi occulted.					

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