STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 05/25/23 with an exit conference via telephone on 05/26/23.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 9 of 9 fixtures sampled that were readily accessible and used by residents with hot water temperatures ranging from 118 degrees F to 127.9 degrees F. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of up to 6 non-ambulatory residents. Review of the facility's current resident list provided on 05/25/23 revealed the facility's current census was 5 residents.	C 105		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 105	Continued From page 1 Review of the current FL-2s for the 5 residents revealed: -Four of the 5 residents were documented as intermittently disoriented. -One of the 5 residents was documented as constantly disoriented. -Three of the 5 residents had a documented diagnosis of dementia. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -A water temperature of 118.4 degrees Fahrenheit (F) could result in a first degree in 15 minutes and a second degree burn in 20 minutes. -A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. Observation of the third resident bathroom on 05/25/23 at 8:51am revealed: -The third resident bathroom was past the kitchen near two resident rooms. -The hot water temperature at the sink fixture was 124 degrees F with no visible steam. -The hot water temperature at the shower fixture was 122 degrees F with no visible steam. -There were no caution signs posted for the hot water temperatures. Based on observations, interviews, and record reviews, it was determined both residents residing near the third resident bathroom were not interviewable. Observation of the kitchen on 05/25/23 at 8:55am revealed: -The kitchen was beside the living room and open and accessible to residents.	C 105		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

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C 105	Continued From page 2 -The hot water temperature at the sink fixture was 124 degrees F with no visible steam. -There were no caution signs posted for the hot water temperatures. Observation of the master bathroom used by residents on 05/25/23 at 9:00am revealed: -One door of the master bathroom was accessed through the living room and the other door was connected to a resident's bedroom. -The hot water temperature at the first sink fixture was 124 degrees F with no visible steam. -The hot water temperature at the second sink fixture was 124 degrees F with no visible steam. -The hot water temperature at the shower fixture was 120 degrees F with no visible steam. -There were no caution signs posted for the hot water temperatures. Interview with the resident residing in the room connected to the master bathroom on 05/25/23 at 9:10am revealed: -The water temperature was okay because she could adjust it. -She had not been burned by the hot water. Interview with a second resident on 05/25/23 at 9:04am revealed: -The water temperature was not too hot or too cold because he could adjust the temperature. -He had not been burned by the water. Observation of the hall bathroom on 05/25/23 at 9:04am revealed: -The hot water temperature at the first sink fixture was 127 degrees F with no visible steam. -The hot water temperature at the second sink fixture was 127.9 degrees F with visible steam. -The hot water temperature at the shower fixture was 118 degrees F with no visible steam.	C 105		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 105	Continued From page 3 -There were no caution signs posted for the hot water temperatures. Review of the facility's Water Temperature Log for 2023 revealed: -The master bathroom was 119 degrees F in January 2023. -The hall bath was 122 degrees F in January 2023. -The master bathroom and hall bath were 118 degrees F in February 2023. -The hall bath was 123 degrees F in March 2023. -The hall bath was 122 degrees F in April 2023. -The third bath was 119 degrees F in April 2023. -The type of fixture where the hot water temperatures were taken was not listed on the hot water temperature log. -The specific dates the hot water temperature checks were completed, were not documented on the hot water temperature log. Interview with the Supervisor on 05/25/23 at 9:10am revealed: -The hot water temperature was checked monthly. -The last time the hot water temperature had been checked was May 2023 (specific date not provided). -She did not know the required hot water temperature, but the hot water temperature was always within range. -Residents had not complained about the hot water being too hot. -The Resident Care Coordinator (RCC) was the person responsible for checking the hot water temperature. Interview with the Administrator on 05/25/23 at 9:39am revealed: -He completed hot water temperature checks	C 105		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 105	Continued From page 4	C 105		

monthly.
-He had not listed the dates of the hot water temperature checks on the log, but the hot water temperature was completed around the first of each month.
-The hot water temperature required was 100 degrees F to 125 degrees F.
-Residents had not complained about the hot water temperature being too hot.
-He had not contacted a plumber to come to the facility to check the hot water temperature.

Interview with the RCC on 05/25/23 at 9:50am revealed:
-Staff assisted all residents with bathing due to fall risks so staff could adjust the water temperatures.
-Staff assisted one of the 5 residents with toileting.
-The other 4 residents could go to the toilet independently so those residents would be washing their hands independently after toileting.
-No residents had complained of burning their hands with the hot water.
-The Administrator checked the hot water temperature.
-A copy of the hot water temperature log was provided.

Second interview with the Administrator on 05/25/23 at 11:33am revealed he had adjusted the hot water heater temperature at 10:14am from 130 degrees F to 115 degrees F.

Observation of the hall bathroom on 05/25/23 at 5:25pm revealed:
-A "Caution Hot Water" sign was placed on the door of bathroom.
-The hot water temperature at the first sink fixture was 111.7 degrees F.

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 105	Continued From page 5 -The hot water temperature at the second sink fixture was 112 degrees F. -The hot water temperature at the shower fixture was 105 degrees F. Observation of the master bathroom on 05/25/23 at 5:28pm revealed: -A "Caution Hot Water" sign was placed on the door of bathroom. -The hot water temperature at the first sink fixture was 110.3 degrees F. -The hot water temperature at the second sink fixture was 110.1 degrees F. -The hot water temperature at the shower fixture was 106.3 degrees F. Observation of the third resident bathroom on 05/25/23 at 5:32pm revealed: -A "Caution Hot Water" sign was placed on the door of bathroom. -The hot water temperature at the sink fixture was 112 degrees F. -The hot water temperature at the shower fixture was 106.1 degrees F. _____ The facility failed to ensure hot water temperatures for 9 of 9 fixtures sampled in the facility were maintained between 100 - 116 degrees F. All 9 fixtures were accessible to and used by residents, including 3 residents diagnosed with dementia. The hot water temperatures at one of the sink fixtures used by residents was 127.9 degrees F with visible steam. A water temperature of 118.4 degrees F could result in a first degree in 15 minutes and a second degree burn in 20 minutes. A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. This failure of the facility was detrimental to the health, safety, and	C 105		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 105	Continued From page 6 welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/25/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 10, 2023.	C 105		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) who were administering medications had completed the medication administration clinical skills competency validation checklist, the medication aide employment verification, or the medication aide state approved training courses. The findings are:	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 131	Continued From page 7 1. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 12/11/22. -Staff B had passed the MA written exam on 08/13/21. -There was documentation of a medication administration clinical skills competency validation checklist on 01/11/23. -There was no documentation of a MA employment verification form. -There was no documentation of completing the 5-hour, 10-hour, or 15-hour MA state approved training courses. Review of residents' April 2023 and May 2023 electronic medication administration records (eMARs) revealed Staff B documented the administration of medications to residents in April 2023 and May 2023. Based on observations, interviews, and record reviews, Staff B administered the wrong inhaler to a resident diagnosed with chronic lung disease who had a recent hospital emergency department visit for shortness of breath. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration.] Interview with Staff B on 05/25/23 at 7:24pm revealed: -He had completed the 15-hour medication training online. -He did not remember the date he had completed the 15-hour online medication training. -He had administered medication to the residents when scheduled to work. Interview with the Administrator on 05/25/23 at 6:12pm revealed: -Staff B had completed the medication clinical	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 131	Continued From page 8	C 131		

skills checklist.
-Staff B had taken and passed the MA written exam.
-Staff B had administered medication to the residents.

Refer to the interview with the Administrator on 05/25/23 at 6:12pm.

2. Review of Staff C's personnel record revealed:
-Staff C was hired as a medication aide (MA) on 04/20/23.
-Staff C had passed the MA written exam on 04/17/07.
-There was no documentation of a MA employment verification form.
-There was no documentation of completing the 5-hour, 10-hour, or 15-hour MA state approved training courses.
-There was no documentation of a medication clinical skills competency validation checklist.

Review of residents' April 2023 and May 2023 electronic medication administration records (eMARs) revealed Staff C documented the administration of medications to residents in April 2023 and May 2023.

Based on observations, interviews, and record reviews, Staff C failed to reorder and obtain refills for a medication used to treat insomnia resulting in the medication being unavailable for administration to a resident for 3 days in May 2023. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration.]

Telephone interview with Staff C on 05/25/23 at 6:34pm revealed:
-She had completed the 15-hour medication training online but could not recall the date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 131	Continued From page 9 -She had not completed the medication clinical skills checklist. -She had administered medication to residents. Interview with the Administrator on 05/25/23 at 6:12pm revealed: -Staff C had not completed the 5-hour, 10-hour, or 15-hour medication training. -Staff C had worked alone during the overnight shift. -Staff C was scheduled to complete the medication clinical skills checklist on 05/29/23. Refer to the interview with the Administrator on 05/25/23 at 6:12pm. _____ Interview with the Administrator on 05/25/23 at 6:12pm revealed: -He thought the 15-hour medication training course and the medication clinical skills checklist could be completed on an online course. -He thought the MA written exam had to be taken and passed before completing the medication clinical skills checklist and the 5-hour, 10-hour, or 15-hour medication training. -He had scheduled for the medication clinical skills checklist to be completed with a registered nurse (RN) on 05/29/23. -He had not scheduled a training with the RN for the 5-hour, 10-hour, or 15-hour medication training. _____ The facility failed to ensure 2 of 3 staff sampled who administered medications met the qualifications to administer medications to residents. Staff B had not completed the 5, 10, or 15-hour MA state approved training courses. Staff B administered the wrong inhaler to a resident diagnosed with chronic lung disease, who had a recent visit to the hospital emergency	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 131	Continued From page 10 department for shortness of breath. Staff C had no documentation of completing the medication administration clinical skills validation checklist or the 5, 10, or 15-hour MA state approved training courses. Staff C failed to ensure a medication for insomnia was available for administration to a resident resulting in missed doses for 3 days. The facility's failure to ensure medication aides met training requirements to administer medications resulted in increased risk for medication errors and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/25/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 10, 2023.	C 131		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 1 of 3 sampled residents (#3) related to a male resident who had wandering behaviors and would come out of his room without wearing clothes at times and on one occasion went into a	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 243	Continued From page 11	C 243		

female resident's room during third shift, tried to get in bed with the resident, and the female resident reported he inappropriately touched her (#3).

The findings are:

Review of Resident #3's current FL-2 dated 05/03/23 revealed:
-Diagnoses included dementia, epilepsy, hepatic encephalopathy, osteopenia, hepatitis, cirrhosis, and severe malnutrition.
-The resident was documented as intermittently disoriented.

Review of Resident #3's previous FL-2 dated 04/25/23 revealed the resident was documented as intermittently disoriented with wandering behaviors.

Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility on 04/27/23.
-The resident was documented as having significant memory loss, must be directed.

Review of Resident #3's current assessment and care plan dated 05/02/23 revealed:
-The resident was ambulatory with no problems and no devices.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.
-The resident required supervision by staff for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of the facility's 24-hour shift communication notes for May 2023 revealed:
-05/01/23 (11:00pm - 7:00am): Resident #3 kept

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 243	Continued From page 12 getting up asking for food. -05/02/23 (7:00am - 3:00pm): Resident #3 was confused more at night, unaware of place and people and he would not stay dressed. -05/04/23 (no shift specified): Resident #3 did not like to be told no; please redirect him when he went to the kitchen. -05/16/23 (no shift specified): Resident #3 was up and down all night; at 5:00am made coffee. -05/16/23 (7:00am - 3:00pm): Resident #3 was sleepwalking; please monitor. -05/17/23 (7:00am - 3:00pm): Staff was to make sure that Resident #3's alarm stayed on so that staff was aware when he exited his room and that he did not go into anyone else's room. -05/19/23 (7:00am - 3:00pm): Resident #3 had mood swings. (no further information documented) -05/22/23 (7:00am - 3:00pm): Resident #3 seemed more confused than usual. Review of Resident #3's mental health provider's (MHP) visit note dated 05/03/23 revealed: -The resident was seen for a tele-visit with the MHP and the facility's Resident Care Coordinator (RCC) present. -Staff reported in the evenings, after the resident had gone to sleep, he would wake up again and come out into the hallway without any clothes on. -The resident was very confused at those times and was not oriented to place, time, or himself during these behaviors. -Staff had to physically redirect him and lead him back to his room but that was typically an easy task. -The MHP increased the resident's Trazodone (used to treat insomnia). Review of Resident #3's MHP visit note dated 05/16/23 revealed:	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 13 -The resident was seen for a tele-visit with the MHP and the facility's RCC present. -Staff reported since the recent medication changes, the resident had been doing much better overall. -The staff noted an incident of the resident sleepwalking, going into another resident's room and attempting to get in bed with her. -The staff were asking about sleepwalking treatment or interventions. -Staff reported the resident had been adjusting well but at night, the resident awakened early and would come out of his bedroom completely naked and confused to place, persons, and time. -The resident needed to be redirected sometimes repeatedly but was done with minimal difficulty. -Staff would be installing an alarm on the resident's bedroom door to indicate when he was sleepwalking at night. Review of a facility staff progress note dated 05/16/23 revealed: -At 5:00am, a female resident came into the living room and stated she was awakened by Resident #3 trying to get in the bed with her. -The female resident reported that had happened several times and she usually stopped Resident #3 at the door and told him that he was in the wrong room. -Resident #3 usually turned around and walked out but that morning, 05/16/23, Resident #3 proceeded to go in the room and tried to get in the bed with the female resident. -The female resident told Resident #3 to get out of her room and do not touch her and Resident #3 then left the room. -The medication aide (MA) spoke with Resident #3 about it and Resident #3 stated he was sleepwalking and did not know what he was doing.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 14 -The MA informed the RCC when she arrived to the facility at 6:30am and then called the Administrator and informed him as well. Observation of Resident #3's room on 05/26/23 at 4:14pm revealed: -The resident opened the door of his room to go inside. -There was small white box door alarm at the top of his bedroom door. -The door alarm did not sound when the door was opened. Interview with Resident #3 on 05/25/23 at 2:02pm revealed: -He had trouble with the layout of the facility. -He had not met his goal yet of not having to "bounce around" the facility in the middle of the night. -For some reason, he wanted to go in the room next door that belonged to a female resident. -He did not know the female resident's name but "the other day" (could not be more specific), he accidentally went in the female resident's room. -He just "tapped" the doorknob to the female resident's room and saw her in the bed. -He did not go to her bed that he recalled. -He had no idea why there was a door alarm on his bedroom door except maybe to "keep track of us". -One of the staff put the alarm on his door in the past month. -He could turn the alarm off himself and he did turn it off at times. -He was not sure how often staff checked on him. Telephone interview with Resident #3's family member on 05/26/23 at 4:14pm revealed: -Resident #3 had dementia. -Resident #3 had problems sleeping at night.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 243	Continued From page 15 -Facility staff reported one morning around 4:00am that Resident #3 was sleepwalking and walked in the resident's room next door. -She could not recall the date when this occurred. -She was not aware Resident #3 was sleepwalking because he did not have a history of sleepwalking. -When the resident lived independently, he slept all day and stayed up all night so she thought that pattern had stuck with him. Interview with the female resident on 05/25/23 at 9:10am revealed: -About a week ago around 5:00am, Resident #3 came into her bedroom through the main door to her bedroom, which was beside his bedroom door. -She was lying in bed sleeping and he came in and woke her up when Resident #3 put both of his hands on her breasts. -She yelled and Resident #3 removed his hands but he did not leave the room immediately. -A staff member came in her room quickly and the Resident #3 left the room. -Resident #3 later reported that he was sleepwalking. -The third shift staff reported the incident to other staff. -After that incident, staff started locking her door that was beside his bedroom door. -There was still access to her room through the master bathroom door in the living room. -She was sure the Administrator was aware of the incident with Resident #3 but the Administrator had not come and talked with her about it. -Staff said they put an alarm on Resident #3's door but she had never heard it alarm. -The incident with Resident #3 was very frightening because he tried to get in bed with her.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 16 -She usually stayed in her room and the morning shift staff almost never checked on her. -Second shift staff usually checked on her about every one hour. -She was not sure how often third shift staff checked on her. Telephone interview with a MA on 05/26/23 at 3:56pm revealed: -She was working on the third shift when the incident with Resident #3 going into the female resident's room occurred. -At 5:00am, she was mopping the floor in the kitchen and the female resident came and said that Resident #3 had come to her room. -She did not hear the female resident yell out. -The female resident reported that Resident #3 tried to get in the bed with her. -The female resident did not mention to her that Resident #3 touched her. -The female resident told Resident #3 that he was in the wrong room. -Resident #3 had just gone back to his room after getting a cup of milk not too long before the incident occurred. -She talked to Resident #3 and he said he was sorry and that he was sleepwalking. -The facility staff locked the female resident's door that was beside Resident #3's door and put an alarm on Resident #3's bedroom door. -She documented the incident in the progress notes. -She notified the RCC, the Administrator, and the families of both residents. -Resident #3 got up "pretty frequently" during the night, at least 3 or 4 times a night. -Sometimes Resident #3 would stand by the table and ask for a snack during the night. -Resident #3 sometimes came out of his room either naked or just wearing his underwear.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 17	C 243		

-Resident #3 was a "light walker" and he would come up on you without you knowing it.
-There was a third shift personal care aide (PCA) on duty the night of the incident as well.
-Resident #3 knew how to turn off the alarm on his bedroom door and he would turn it off at times.
-The female resident reported that Resident #3 had wandered into her room before this incident.
-The female resident complained and said it startled her.

Attempted telephone interview on 05/26/23 at 4:10pm with the third shift PCA on duty during the incident with the female resident and Resident #3 was unsuccessful.

Interview with the Supervisor on 05/25/23 at 12:27pm revealed:
-One night, within the last 1 to 2 weeks (could not recall specific date), Resident #3 was going to the dining room but he went into a female resident's room by accident.
-She was not on duty when the incident occurred but the female resident told her that Resident #3 came into her room and was trying to get into the bed with her.
-The female resident reported she was yelling and she was scared and uncomfortable.
-The female resident reported that Resident #3 had been in her room before but the female resident redirected Resident #3 and told him it was not his room.
-The female resident did not report to her that Resident #3 had touched her, just that he tried to get in her bed that night.
-The morning following the incident, staff started locking the female resident's door beside Resident #3's door.
-The morning following the incident, staff also put

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 18	C 243		

an alarm on Resident #3's door so if he came out of his room the alarm would sound but Resident #3 would turn the alarm off.
-Staff checked the female resident's door beside Resident #3's room every morning and every shift to make sure it was locked and Resident #3's door alarm to make sure it was turned on.
-Resident #3 did not usually use the master bathroom that was attached to the female resident's room.
-If he started to turn that way, staff would redirect him.
-Resident #3 only wandered into the female resident's room; she thought it was because of the layout of the facility and their rooms were beside each other.
-There was no specific policy for supervision of residents to her knowledge.
-Staff usually did 2-hour hydration checks on all the residents.
-She was always walking around the facility throughout the day.

Interview with the RCC on 05/25/23 at 11:37am revealed:
-A female resident's bedroom door beside Resident #3's room was locked because the female resident said she did not feel comfortable with the door unlocked beside a male resident's room.
-One night on third shift (she thought it was last week), Resident #3 went to the bathroom and went into the female resident's room by mistake.
-It was on third shift and Resident #3 was just standing there.
-The female resident told Resident #3 that he was in the wrong room.
-Another staff person reported the incident to her but she could not recall which staff.
-She was not aware the female resident said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 19	C 243		

Resident #3 touched her.
-If she had been aware the female resident said she was touched by Resident #3, she would have had a meeting with the Administrator and both residents' families.
-She would have reported it to the residents' healthcare providers because it could be a behavioral issue.
-If she had been aware, she would have been very concerned but she did not know until now.
-There was an alarm on Resident #3's door so staff could be aware when he was up and make sure he did not go into the female resident's room.
-Staff put the alarm on Resident #3's door after the incident to make the female resident feel comfortable because the female resident felt uncomfortable.
-She discussed it with Resident #3 who said he did not remember going into the female resident's room.
-Resident #3 apologized and said he was a little confused.
-Resident #3 had times when he was very confused.
-As far as supervision, staff was "constantly visual" with all of the residents.

Interview with the Administrator on 05/25/23 at 12:45pm revealed:
-A couple of weeks ago, Resident #3 walked into a female resident's room.
-The female resident was concerned and wanted to stop that so they locked her door beside Resident #3's room and they put a door alarm on Resident #3's room door.
-He thought it had happened once or twice.
-He was notified about the incident by the RCC.
-The RCC told him that Resident #3 had just wandered into the female resident's room and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 20 female resident called out to him and Resident #3 walked out but was a little disoriented. -He thought the RCC had spoken with the female resident about the incident. -The female resident had not reported any concerns to him and he was at the facility about 3 times a week. -He had not talked with either resident about the incident. -No one had reported to him that Resident #3 tried to get into bed with the female resident during the incident. -No one had reported to him that the female resident said Resident #3 had touched her during the incident. -He was not aware Resident #3 had been turning off the door alarm on his room door. Telephone interview with Resident #3's MHP on 05/25/23 at 2:59pm revealed: -She had seen Resident #3 twice on 05/03/23 and 05/16/23 for virtual visits since the resident was admitted to the facility. -Facility staff had reported that Resident #3 got a little confused in the afternoons and he acted like he did not know where he was, and he had wandering behavior. -Facility staff reported the resident would come out of his room completely naked. -The resident had insomnia. -On 05/16/23, facility staff reported the resident appeared to be sleepwalking. -She was only told that Resident #3 went into another resident's room and tried to get in the bed with the other resident and staff redirected him. -When staff reported the incident, it did not sound like sleepwalking to her because if the resident was sleepwalking, he could not be redirected that easily.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243	Continued From page 21 -Staff would have to wake the resident up and then redirect him. -Staff did not report anything related to Resident #3 touching anyone inappropriately. -If the resident was cognizant and knew what he was doing then she would be worried that the resident may be having sexual behaviors. -It could be related to his dementia and could be part of sleepwalking. -If Resident #3 was sleepwalking when the incident occurred, he had no clue what he was doing. -If the resident was aware of what he was doing, then she would worry about other residents being safe. -If staff had reported that Resident #3 had touched another resident inappropriately, she may have adjusted his medications to address the sleepwalking. -She discussed the incident with the RCC and it was discussed they may have to put an alarm on Resident #3's door to wake him up if he was sleepwalking out of his room. -She also discussed with the RCC the need for staff to keep an eye on Resident #3's room and do more physical checks on the resident every hour and when they heard something they should go check.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 22	C 246		

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral for 3 of 3 sampled residents (#1, #2, #3) related to failing to implement a home health referral for a resident with a toe wound (#3); failing to notify the podiatrist of increased symptoms for a resident with a foot wound (#2) and a resident with a toe wound (#3); and failing to notify the mental health provider (MHP) of a resident's wandering and physically aggressive behaviors (#1).

The findings are:

1. Review of Resident #2's current FL-2 dated 05/03/23 revealed:
-Diagnoses included sepsis, bacteremia, cardiomyopathies, chronic obstructive pulmonary disease, muscle weakness, acute kidney failure, and paroxysmal atrial fibrillation.
-The resident was semi-ambulatory and continent of bowel and bladder.
-The resident required assistance by staff with bathing and dressing.

Review of Resident #2's Resident Register revealed:
-The resident was admitted to the facility on 05/04/23.
-The resident required assistance for ambulation and toileting.
-The resident used a walker and a wheelchair.
-The resident was documented as being forgetful and needed reminders.

Review of Resident #2's current assessment and care plan dated 05/08/23 revealed:
-The resident was ambulatory with a walker and had limited strength in her upper extremities.
-The resident was documented as oriented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 23	C 246		

forgetful, and needed reminders.
-The resident required supervision by staff for eating.
-The resident required limited assistance by staff for toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #2's podiatry provider's progress note dated 05/06/23 revealed:
-The resident was seen for routine care - calluses on bilateral feet.
-The resident had an eschar (dead tissue with a dark leathery appearance) that was 0.1cm in diameter on her right 5th digit area with no signs of infection, no drainage, no erythema (redness), or edema (swelling).
-The podiatry provider noted it was a pre-ulcerative lesion.
-There was an order to apply Bactroban 2% ointment to the 5th right toe area once a day and cover with a bandaid for 7 days. (Bactroban is a prescription antibiotic ointment used to treat infections.)
-There was an order to contact the podiatry provider if there was any increased redness, increased pain, or drainage.

Observation of Resident #2 on 05/25/23 at 6:41pm revealed:
-The resident's toes on her right foot had all been previously amputated.
-At the amputation site of the 5th toe, there was an open wound approximately 1cm wide.
-The wound bed had a partial scab and the bed of the wound was bright pink.
-The skin surrounding the open area was red and swollen extending approximately one inch from the open wound.

Interview with Resident #2 on 05/25/23 at 6:42pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 24	C 246		

revealed:
-She had previously worn a prosthetic device that had rubbed a sore on the right side of her right foot.
-There had been no Bactroban ointment or any other medication applied to the wound.
-The facility staff had seen the wound and were aware of it.
-The wound on her foot hurt.

Telephone interview with a medication aide (MA) on 05/26/23 at 3:56pm revealed:
-She last saw Resident #2's foot wound on Saturday, 05/20/23.
-The resident's foot would was "pinkish" but she did not report the resident's foot to anyone because the resident did not complain about it.

Review of Resident #2's progress notes and provider visit notes revealed no documentation that the podiatry provider or primary care provider (PCP) had been notified of the increased symptoms of the resident's foot wound.

Interview with the Administrator on 05/25/23 at 6:48pm revealed:
-The Resident Care Coordinator (RCC) was responsible for notifying providers of any changes in a resident's condition.
-The RCC was responsible for implementing orders and making sure referrals were completed.

Telephone interview with the RCC on 05/26/23 at 9:00am revealed:
-She was not working when Resident #2 was seen by the podiatrist on 05/06/23.
-She had not seen the podiatry visit notes in the resident's record.
-Staff on duty were responsible for notifying either

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 25	C 246		

her, the Supervisor, or the Administrator of any concerns about a resident's condition or any changes in a resident's condition.
-If notified of a concern or change in a resident's condition, either she, the Supervisor, or the Administrator would contact the resident's provider.
-No one had reported any issues with Resident #2's foot to her so she had not reported any issues to the resident's podiatry provider or PCP.
-She last saw Resident #2's foot wound this morning, 05/26/23, and it looked like a dry callus scabbing over to her.

Telephone interview with Resident #2's power of attorney (POA)/family member on 05/26/23 at 3:24pm revealed:
-Resident #2's appointment with her PCP was originally scheduled for next week but was moved up to today, 05/26/23, to examine her right foot.
-The PCP prescribed Bactroban topical ointment to the open wound on the right foot and Doxycycline by mouth for the infection.
-Resident #2 had opened that area on her right foot in the past due to wearing ill-fitting shoes.
-He did not know how the area became open and infected again.
-He left the PCP visit summary and orders with the staff at the facility earlier this afternoon when he dropped off Resident #2.
-He was told the facility staff would get both prescriptions filled at the pharmacy.

Telephone interview with the lead pharmacy technician at the facility's contracted pharmacy provider on 05/26/23 at 2:55pm revealed:
-They received new orders for Resident #2 today, 05/26/23.
-They received an order dated 05/26/23 for Bactroban ointment and for Doxycycline (an oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 26	C 246		

antibiotic used to treat infections).

Attempted telephone interview with Resident #2's podiatry provider on 05/26/23 at 1:59pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 05/26/23 at 3:06pm was unsuccessful.

2. Review of Resident #3's current FL-2 dated 05/03/23 revealed:
-Diagnoses included dementia, epilepsy, hepatic encephalopathy, osteopenia, alcoholic hepatitis, alcoholic cirrhosis, severe malnutrition, and alcohol use disorder.
-The resident was documented as intermittently disoriented.

Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility on 04/27/23.
-The resident was documented as having significant memory loss, must be directed.

Review of Resident #3's current assessment and care plan dated 05/02/23 revealed:
-The resident was ambulatory with no problems and no devices.
-The box for pressure areas was checked off under the skin section with no specific information documented.
-The resident was documented as sometimes disoriented, forgetful, and needed reminders.
-The resident required supervision by staff for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #3's podiatry provider's progress note dated 05/05/23 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 246	Continued From page 27 -The resident had a wound on the right great toe measuring 1.5cm x 1.0cm with pinpoint bleeding, no purulent drainage, no pain, and not erythema (redness) noted. -The resident had peripheral neuropathy. -There was an order to contact home health to evaluate and treat wound on right great toe. -Until home health could be available, there was an order to apply Bactroban ointment and bandaid to right great toe every day for 7 days. (Bactroban is a prescription antibiotic ointment used to treat infections.) -If any other questions, contact the podiatry provider. Observation of Resident #3 on 05/25/23 at 2:02pm revealed: -There was a white bandage with tape on the resident's right great toe. -There was a dime-sized light brown stain saturated to the top of the bandage on the left side of the great toe. Interview with Resident #3 on 05/25/23 at 2:02pm revealed: -He had been dealing with calluses on his feet for years. -He "sands" off the calluses at times. -There was blood on the wound that morning, 05/25/23, so he put a bandage on it. -The podiatrist had been to the facility to check his feet but he could not recall when. -His toe wound was bleeding and it hurt when touched. -He was not sure what kind of medication was being put on the wound or when it was applied. Interview with the medication aide (MA) on 05/25/23 at 7:23pm revealed: -He used Triple Antibiotic Ointment for Resident	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 246	Continued From page 28 #3's toe wound. -The resident's toe wound had an opened area and was red and bleeding. -The resident had not complained of pain with the toe wound. Review of Resident #3's provider visit notes and progress notes revealed: -There was no documentation that the resident was seen by home health to evaluate and treat the wound on his right great toe. -There was no documentation that the resident's podiatry provider was notified of the symptoms with Resident #3's right great toe wound. Telephone interview with Resident #3's family member on 05/26/23 at 4:14pm revealed: -When Resident #3 was admitted to the facility, they noticed the wound on his toe. -Resident #3 was seen by a podiatrist and the podiatrist trimmed off some more of the heavy calluses. -She saw the resident's toe wound on Monday, 05/22/23, and it "did not look so good". -The toe wound was getting worse and she thought it might be infected because the resident was picking at it. -The wound had a very light watery, bloody drainage with a tint of faint yellow color. -She let the facility staff know on Monday, 05/22/23. -She thought the facility staff were going to clean up the toe wound and bandage it. Telephone interview with the Resident Care Coordinator (RCC) on 05/26/23 at 9:00am revealed: -She was not working when Resident #3 was seen by the podiatrist. -Staff on duty filed the podiatry visit form with the	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 246	Continued From page 29	C 246		

referral order for home health in the resident's record.
-She had not seen the order for the referral in the resident's record so she had not contacted home health to evaluate the resident's wound.
-The order was overlooked by staff but should have been implemented.
-She was unable to indicate a system to check orders and referrals.

Interview with the Administrator on 05/25/23 at 6:48pm revealed the RCC was responsible for implementing orders and making sure referrals were completed.

Attempted telephone interview with Resident #3's podiatry provider on 05/26/23 at 1:59pm was unsuccessful.

3. Review of Resident #1's FL-2 dated 02/20/23 revealed:
-Diagnoses included dementia with behaviors and Alzheimer's.
-Resident #1 was ambulatory.
-Resident #1 had was constantly disoriented.

Review of Resident #1's care plan dated 02/20/23 revealed:
-Resident #1 could become combative and aggressive.
-Resident #1 could become verbally aggressive.
-Resident #1 was unaware of the current time and place.

Review of Resident #1's mental health provider (MHP) visit notes dated 02/15/23 revealed:
-Resident #1 was admitted for services on 02/15/23.
-Resident #1 had been experiencing sundowning symptoms as early as 11:00am or 12:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 246	Continued From page 30 -Resident #1's mood was not stable, and he was not easily redirected by staff. -Resident #1 was hard to redirect even if he was not in a bad mood. -Resident #1 had been physically aggressive with the staff at his previous facility. -There had been none of these behaviors noted at this facility but the resident was getting more anxious. -Seroquel 75mg was discontinued and Seroquel 100mg three times daily and Trazodone 50mg at night were prescribed. (Seroquel is an antipsychotic. Trazodone is used for sleep.) -Please alert MHP for any gait disturbance, sedation, or behavioral changes. -Continue to monitor mood and behavioral symptoms as indicated. -Please contact the MHP with any increases in target symptoms, dangerous behaviors, and/or adverse response to medications. Review of Resident #1's MHP visit notes dated 03/14/23 revealed: -Resident #1 had not been sleeping at night. -He had experienced agitation in the afternoons. -Resident #1 had been given medication as needed to treat agitation and the medications were effective but if not given consistently while experiencing agitation. -Resident #1 experienced agitation in the evenings. -Resident #1 was confused and disorganized. -Please alert MHP for any gait disturbance, sedation, or behavioral changes. -Continue to monitor mood and behavioral symptoms as indicated. -Please contact the MHP with any increases in target symptoms, dangerous behaviors, and/or adverse response to medications.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 246	Continued From page 31 Review of Resident #1's MHP visit notes dated 04/12/23 revealed: -Staff reported since last visit the resident had been doing better overall. -The Resident Care Coordinator (RCC) noted the resident had still been waking up between 1:00am - 3:00am and stayed up all night. -The resident had not been having behaviors and there was no new behavioral concerns at that time. -During the tele-visit, the resident was not agitated or restless. -The resident was unable to answer questions due to advancing dementia. -The staff had no acute concerns about the resident's behaviors. Review of Resident #1's MHP visit notes dated 04/19/23 revealed: -Staff reported the resident got agitated to the point of not taking oral prn (as needed) medication for agitation. -The resident had advancing dementia and associated symptoms of having some agitation and restlessness at times. -Staff requested the prn oral medication be changed to a prn topical medication for extreme agitation. Review of Resident #1's MHP visit notes dated 05/16/23 revealed: -Staff report since last visit, the resident had good and bad days. -The resident had emotional outbursts and crying. -Staff noted that on a different occasion, the resident walked up to staff with his fists balled up and was acting like he wanted to fight staff. -The resident's prn gel for agitation had not been effective and when he got agitated he refused his medications completely.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 246	Continued From page 32	C 246		

-The resident had not been sleeping consistently and woke up during the night.
-Staff was obtaining urine for a urinalysis to rule out urinary tract infection so no medication changes.
-The resident's mood and behaviors were to be monitored and redirection offered as necessary.
-The MHP noted to contact her with any increase in symptoms.

Interview with a resident on 05/25/23 at 9:10am revealed:
-Resident #1 got "real physical" with staff.
-Resident #1 had come into her room several times through the master bathroom door.
-Resident #1 came into her room last night and a personal care aide (PCA) came into the room to get the resident out of her room.
-Resident #1 pushed the PCA against the wall and the resident finally left her room.
-She was frightened of Resident #1 because of what she observed when Resident #1 pushed the PCA against the wall in her room.

Review of the facility's 24-hour shift communication note dated 05/25/23 (7:00am - 3:00pm) revealed staff documented to please monitor Resident #1; he was displaying behaviors and being abusive.

Telephone interview with a medication aide (MA) on 05/26/23 at 3:56pm revealed:
-Resident #1 threatened to hit her and had even swung his fist at her once (could not recall when) but he missed and did not make contact.
-She had not seen Resident #1 actually hit anyone but he would swing at staff and threaten to hit staff.

Interview with the Supervisor on 05/25/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 246	Continued From page 33 12:27pm revealed: -Resident #1 got lost and wandered into other rooms in the facility. -She was not aware of Resident #1 going into another resident's room. -Resident #1 had gone to the door of another resident's bedroom and she redirected him. -Resident #1 got agitated and would swing at staff, grab staff, and threaten staff. -Resident #1 had not hit her but she had observed Resident #1 hit the RCC on Monday, 05/22/23. -Yesterday, 05/24/23, she observed Resident #1 throw a blue, metal cup and hit the RCC on the arm with the cup. -The RCC was not hurt. -On Monday, 05/22/23, or Tuesday, 05/23/23, she observed Resident #1 hit a second staff member on the shoulder with a cup. -When Resident #1 was combative and aggressive, she could sometimes redirect the resident but sometimes the resident was still combative and aggressive. -She had not observed Resident #1 be combative or aggressive toward other residents. -She could not recall if Resident #1's MHP had been contacted about the resident hitting staff or throwing and hitting staff with objects. Interview with the RCC on 05/25/23 at 11:37am revealed: -Resident #1 was "very, very confused" and he got agitation when staff was trying to provide care to the resident. -Resident #1 would curse and tell staff he was going to kill them. -Resident #1 would ball up his fist and try to hit staff. -Resident #1 was not aggressive toward residents.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 246	Continued From page 34 -Resident #1 could sometimes be redirected and sometimes not. -She denied that Resident #1 had actually hit her or any other staff. -Resident #1 walked around inside the facility a lot and he got lost if he was on his own. -Resident #1 was easy to redirect when he was lost in the facility. -Staff on duty were responsible for notifying a resident's provider of any change in condition or any concerns about the resident. Interview with Resident #1's family member on 05/25/23 at 8:14am revealed: -She had known Resident #1 to wake up in the middle of the night and would become restless. -Resident #1 had been verbally aggressive with staff sometimes but not towards other residents. -She had not been informed of Resident #1 wandering into another resident's room or pushing staff. Interview with Resident #1's MHP on 05/25/23 at 2:58pm revealed: -She first saw Resident #1 for a visit on 02/15/23. -Resident #1 had presented with some aggression. -Resident #1 had yelled at the staff. -Resident #1's medication was adjusted. -Resident #1 would stay up late until 3:00am and sleep late into the next day. -She had not received any reports of Resident #1 wandering or going into other residents' rooms. -She had not been informed of Resident #1's recent physical aggression towards staff prior to 05/25/23. -She was notified by the staff on 05/25/23 at 11:03am of Resident #1 being aggressive with staff. -She would have adjusted Resident #1	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 35 medications had she known about his being physically aggressive towards staff. The facility failed to ensure the acute and routine health care needs were met for 3 sampled residents. The facility failed to implement a home health referral for Resident #3's toe wound as ordered by the podiatry provider resulting in the resident's toe wound symptoms worsening with bleeding and causing pain to the resident. Resident #2's foot wound had worsening symptoms that were not reported to the podiatry provider resulting in the resident's wound becoming infected and painful requiring a topical and an oral antibiotic for infection. Resident #1 was exhibiting aggressive behaviors toward staff, including hitting two staff with a metal cup and pushing another staff against the wall but the facility failed to notify the resident's mental health provider. The facility's failure resulted in substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/26/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 25, 2023.	C 246		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 284	Continued From page 36	C 284		

supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 2 sampled residents (#2) with an order for a regular diet with meats cut up into small pieces and a nutritional supplement.

The findings are:

Review of Resident #2's current FL-2 dated 05/03/23 revealed:
-Diagnoses included sepsis, muscle weakness, cardiomyopathies, chronic obstructive pulmonary disease, acute kidney failure, obstructive hypertrophic cardiomyopathy, bacteremia, and paroxysmal atrial fibrillation.
-There was an order for a controlled carbohydrate, no added salt, regular diet.
-There was an order for a dietary supplement.
-The order for the dietary supplement did not have a frequency for how often the supplement should be given.

Review of Resident #2's diet order form dated 05/08/23 revealed there was an order for a regular diet, cut up meats into small pieces.

Observation of the kitchen area on 05/25/23 at 9:19am revealed:
-There was not a residents' diet list posted.
-There were 3 chocolate dietary supplement drinks on one of the shelves in the refrigerator.
-There was a case of 12 vanilla dietary supplement drinks on a shelf in the pantry.

Observation of the lunch meal on 05/25/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 284	Continued From page 37 12:05pm revealed: -Resident #2 consumed her meal independently. -She was fed a plain hotdog on a bun, apple sauce, potato homefries and a diet soda. -The hot dog was served whole, not cut up into small pieces. -She consumed all her lunch meal. Observation of the kitchen area on 05/25/23 at 12:13pm revealed: -There was a residents' diet list posted. -Resident #2's diet was listed as regular diet; consistency was not listed. Interview with Resident #2 on 05/25/23 at 2:25pm revealed: -The staff served a lot of carbohydrates. -Her meats were never cut up when served to her. -If she had a problem swallowing her food, she would cut it up. -She was to drink dietary supplements. -She asked for a dietary supplement to drink but was not given one. -She needed to drink the dietary supplement because it provided extra protein. Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed there was no dietary supplement listed on the eMAR. Interview with a medication aide (MA) on 05/25/23 at 7:24pm revealed: -Resident #2 had not requested a dietary supplement to drink. -He had offered her dietary supplements to drink but did not remember when he last offered. -The resident's family brought in the dietary supplements.	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 284	Continued From page 38 Interview with a Resident Care Coordinator (RCC) on 05/25/23 at 2:06pm revealed: -She was not familiar with Resident #2's diet order, only her likes and dislikes of food. -Resident #2 did not have an order to receive supplements to her knowledge. -She had not reviewed the residents' diet orders for supplements. -The supplement in the pantry belonged to a former resident and would be discarded. -The resident diet list was updated upon changes to a resident's diet. -The resident's primary care provider (PCP) would be contacted if the staff saw an issue with a resident's eating habits. -She was responsible for updating the residents' diet list. -She updated the residents' diet list and posted it today, 05/25/23.	C 284		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure resident rights were maintained and exercised for 1 of 3 sampled residents (#2) as related to the resident being fearful and uncomfortable due to a male resident wandering into her room and trying to get in bed with her; the resident being uncomfortable in	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 311	Continued From page 39 common areas with the male resident; and fear of retaliation from a staff member who the resident reported spoke to her and treated her without dignity and respect. The findings are: Review of Resident #2's current FL-2 dated 05/03/23 revealed: -Diagnoses included sepsis, bacteremia, cardiomyopathies, chronic obstructive pulmonary disease, muscle weakness, acute kidney failure, and paroxysmal atrial fibrillation. -The resident was semi-ambulatory and continent of bowel and bladder. -The resident required assistance by staff with bathing and dressing. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 05/04/23. -The resident required assistance for ambulation and toileting. -The resident used a walker and a wheelchair. -The resident was documented as being forgetful and needed reminders. Review of Resident #2's current assessment and care plan dated 05/08/23 revealed: -The resident was ambulatory with a walker and had limited strength in her upper extremities. -The resident was documented as oriented, forgetful, and needed reminders. -The resident required supervision by staff for eating. -The resident required limited assistance by staff for toileting, ambulation, bathing, dressing, grooming, and transferring.	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 311	Continued From page 40 a. Review of Resident #2's facility progress note dated 05/16/23 revealed: -At 5:00am, Resident #2 came into the living room and stated she was awakened by a male resident trying to get in the bed with her. -Resident #2 reported that had happened several times and she usually stopped the male resident at the door and told him that he was in the wrong room. -The male resident usually turned around and walked out but that morning, 05/16/23, the male resident proceeded to go in the room and tried to get in the bed with Resident #2. -Resident #2 told the male resident to get out of her room and not to touch her and the male resident then left the room. -The medication aide (MA) spoke with the male resident about it and the male resident stated he was sleepwalking and did not know what he was doing. -The MA informed the Resident Care Coordinator (RCC) when she arrived to the facility at 6:30am and then called the Administrator and informed him as well. Interview with Resident #2 on 05/25/23 at 9:10am revealed: -About a week ago around 5:00am, a male resident came into her bedroom through the main door to her bedroom, which was beside his bedroom door. -She was lying in bed sleeping when the male resident came in her room and woke her up when the male resident put both of his hands on her breasts. -She yelled and the male resident removed his hands but he did not leave the room immediately. -A staff member came in her room quickly and the male resident left the room. -The male resident later reported that he was	C 311		

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C 311	Continued From page 41	C 311		

sleepwalking.
-The third shift staff reported the incident to other staff.
-After that incident, staff started locking her door that was beside his bedroom door.
-There was still access to her room through the master bathroom door in the living room.
-She was sure the Administrator was aware of the incident with the male resident but the Administrator had not come and talked with her about it.
-Staff said they put an alarm on the male resident's door but she had never heard it the alarm sound.
-The incident with the male resident was very frightening because he tried to get in bed with her.
-She did not have a television in her room and she would like to watch television in the living room but she was not comfortable going to the living room because of the male resident.
-When she went to the dining room to eat breakfast, she was very uncomfortable when she had to sit beside the male resident who tried to get into her bed.

Interview with the male resident on 05/25/23 at 2:02pm revealed:
-He had trouble with the layout of the facility.
-He had not met his goal yet of not having to "bounce around" the facility in the middle of the night.
-For some reason, he wanted to go in the room next door that belonged to a female resident (Resident #2).
-He did not know the female resident's name but "the other day" (could not be more specific), he accidentally went in the female resident's room.
-He just "tapped" the doorknob to the female resident's room and saw her in the bed.

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C 311	Continued From page 42 Telephone interview with a MA on 05/26/23 at 3:56pm revealed: -She was working on the third shift when the incident with a male resident going into Resident #2's room occurred. -There was a third shift personal care aide (PCA) on duty the night of the incident as well. -At 5:00am, she was mopping the floor in the kitchen and Resident #2 came and said that a male resident had come to her room. -She did not hear Resident #2 yell out. -The female resident reported that the male resident tried to get in the bed with her. -Resident #2 did not mention to her that the male resident touched her. -Resident #2 told the male resident that he was in the wrong room. -The male resident had just gone back to his room after getting a cup of milk not too long before the incident occurred. -She talked to the male resident and he said he was sorry and that he was sleepwalking. -The facility staff locked Resident #2's door that was beside the male resident's door and put an alarm on the male resident's bedroom door. -She notified the RCC, the Administrator, and the families of both residents. -The male resident got up "pretty frequently" during the night, at least 3 or 4 times a night. -The male resident sometimes came out of his room either naked or just wearing his underwear. -The male resident was a "light walker" and he would come up on you without you knowing it. -The male resident knew how to turn off the alarm on his bedroom door and he would turn it off at times. -The female resident reported that the male resident had wandered into her room before this incident.	C 311		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 311	Continued From page 43 -The female resident complained and said it startled her. Attempted telephone interview on 05/26/23 at 4:10pm with the third shift PCA on duty during the incident with Resident #2 and the male resident was unsuccessful. Interview with the Supervisor on 05/25/23 at 12:27pm revealed: -One night, within the last 1 to 2 weeks (could not recall specific date), a male resident was going to the dining room but he went into Resident #2's room by accident. -She was not on duty when the incident occurred but Resident #2 told her that the male resident came into her room and was trying to get into the bed with her. -Resident #2 reported she was yelling and she was scared and uncomfortable. -Resident #2 reported that the male resident had been in her room before and Resident #2 redirected the male resident and told him it was not his room. -Resident #2 did not report to her that the male resident touched her, just that he tried to get in her bed that night. -The morning following the incident, staff started locking Resident #2's door beside the male resident's door. -The morning following the incident, staff also put an alarm on the male resident's door so if he came out of his room the alarm would sound but the male resident would turn off the alarm. Interview with the RCC on 05/25/23 at 11:37am revealed: -Resident #2's bedroom door beside a male resident's room was locked because the female resident said she did not feel comfortable with the	C 311		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

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C 311	Continued From page 44 door unlocked beside the male resident's room. -One night on third shift (she thought it was last week), the male resident went to the bathroom and went into Resident #2's room by mistake. -It was on third shift and the male resident was just standing there. -Resident #2 told the male resident that he was in the wrong room. -Another staff person reported the incident to her but she could not recall which staff. -She was not aware Resident #2 said the male resident touched her. -Staff put the alarm on the male resident's door after the incident to make Resident #2 feel comfortable because Resident #2 felt uncomfortable. -She discussed it with the male resident and he apologized and said he was a little confused. Interview with the Administrator on 05/25/23 at 12:45pm revealed: -A couple of weeks ago, a male resident walked into Resident #2's room. -Resident #2 was concerned and wanted to stop that so staff locked her door beside the male resident's room and put a door alarm on the male resident's room door. -He thought it had happened once or twice. -He was notified about the incident by the RCC. -The RCC told him that the male resident had just wandered into Resident #2's room and Resident #2 called out to him and the male resident walked out but was a little disoriented. -Resident #2 had not reported any concerns to him and he was at the facility about 3 times a week. -He had not talked with either resident about the incident. -No one had reported to him that the male resident tried to get into bed with Resident #2	C 311		

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C 311	Continued From page 45	C 311		

during the incident.
-No one had reported to him that Resident #2 reported the male resident had touched her during the incident.

Telephone interview with Resident #2's MHP on 05/25/23 at 2:59pm revealed:
-She saw Resident #2 once on 05/08/23 for a virtual visit since the resident was admitted to the facility.
-On 05/16/23, facility staff reported a male resident went into another resident's room and tried to get in the bed with the other resident and staff redirected him.
-She did not recall or see in her visit notes documentation that staff specified the male resident had gone into Resident #2's room.
-Facility staff had not reported any of Resident #2's concerns about the male resident going into her room.
-Facility staff had not told her that Resident #2 reported the male resident had touched her when he tried to get in bed with her.
-If that was the case, she would be worried about Resident #2's safety and sexual assault and how that could affect Resident #2's emotional status or cause her anxiety.

b. Interview with Resident #2 on 05/25/23 at 9:10am revealed:
-She had concerns about the Resident Care Coordinator (RCC), who usually worked on first shift.
-She had issues with episodes of diarrhea due to a past surgery.
-When she had incontinent episodes of diarrhea, the RCC would tell her to clean up after herself.
-She had not reported this because she was afraid the RCC would retaliate against her verbally because the RCC raised her voice at the

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 311	Continued From page 46	C 311		

resident.
-The RCC was never nice to her because the RCC always found fault in what the resident did.
-The Supervisor also worked first shift and usually did the cooking.
-The Supervisor had not done anything bad to her, but she was afraid to voice her concerns to the Supervisor because the Supervisor was the RCC's friend.
-She did not have any concerns about staff on other shifts.

Interview with the Supervisor on 05/25/23 at 12:27pm revealed:
-Resident #2 usually ate breakfast in the dining room.
-All residents who ate breakfast usually ate in the dining room.
-She usually sat at the table with the residents and she usually sat on one side of Resident #2.
-She did not recall the male resident who tried to get in bed with Resident #2 sitting beside Resident #2 at the dining room table.
-Resident #2 had not reported to her that she was uncomfortable at the dining room table.

Interview with the RCC on 05/25/23 at 11:37am revealed:
-All residents were allowed to eat in their room if they wanted to.
-Staff encouraged Resident #2 to eat in the dining room because if not, the resident would lay in bed all day.
-There were no assigned seats in the dining room; residents could sit where they wanted to sit.
-The assistance that Resident #2 required was "touch and go" depending on who was working.
-If there was a new staff person, the resident wanted help with everything.

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C 311	Continued From page 47 -If the RCC was working, Resident #2 knew that the RCC was aware the resident could do for herself. -Resident #2 had 5 to 6 bowel movements after she ate a meal. -If the resident had an incontinent accident, the resident could wipe and clean herself. -Staff would clean the bathroom. -She thought the resident had behavior issues because the resident was "addicted to medication". -No residents had voiced any concerns about the way staff treated them. Interview with the Administrator on 05/25/23 at 12:45pm revealed: -He usually went to the facility about 3 times a week. -He expected staff to report anything happening with the residents to him. -Resident #2 had not reported any concerns to him. -He thought a lot of Resident #2's issues stemmed from the frequency she was asking for pain medications. -No residents had reported any concerns about the way they were treated by staff. _____ The facility failed to protect the rights of Resident #2 as related to the resident being afraid and uncomfortable in the facility due to a male resident with wandering behaviors coming in her room on more that one occasion. Resident #2 reported on one occasion, the male resident came into her room while the resident was sleeping, tried to get in bed with her, and touched her. Resident #2 was afraid of retaliation by the Resident Care Coordinator, who the resident reported spoke to her in a raised voice and would not assist her with incontinence care. The	C 311		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 311	Continued From page 48 facility's failure to protect the resident's rights was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/25/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 10, 2023.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#2, #3) including errors with a medication used to treat insomnia (#2), a medication used to treat breathing problems (#3), a medication used to treat inflammation (#3), and failure to implement orders for a prescription strength antibiotic ointment for two residents with foot wounds (#2, #3).	C 330		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 49 The findings are: 1. Review of Resident #2's current FL-2 dated 05/03/23 revealed diagnoses included sepsis, bacteremia, cardiomyopathies, chronic obstructive pulmonary disease, muscle weakness, acute kidney failure, and paroxysmal atrial fibrillation. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/04/23. a. Review of Resident #2's podiatry provider's progress note dated 05/06/23 revealed: -The resident was seen for routine care - calluses on bilateral feet. -The resident had an eschar (dead tissue with a dark leathery appearance) that was 0.1cm in diameter on her right 5th digit area with no signs of infection, no drainage, no erythema (redness), or edema (swelling). -The podiatry provider noted it was a pre-ulcerative lesion. -There was an order to apply Bactroban 2% ointment to the 5th right toe area once a day and cover with a bandaid for 7 days. (Bactroban is a prescription antibiotic ointment used to treat infections.) Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed there was no entry for Bactroban 2% ointment as ordered on 05/06/23 and none was documented as administered. Observation of Resident #2's medications on hand on 05/25/23 at 6:53pm revealed there was no Bactroban 2% ointment available for administration.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 50 Observation of Resident #2 on 05/25/23 at 6:41pm revealed: -The resident's toes on her right foot had all been previously amputated. -At the amputation site of the 5th toe, there was an open wound approximately 1cm wide. -The wound bed had a partial scab and the bed of the wound was bright pink. -The skin surrounding the open area was red and swollen extending approximately one inch from the open wound. Interview with Resident #2 on 05/25/23 at 6:42pm revealed: -She had previously worn a prosthetic shoe that had rubbed a sore on the right side of her right foot. -There had been no Bactroban ointment or any other medication applied to the wound. -The facility staff had seen the wound and were aware of it. -The wound on her foot hurt. Telephone interview with a medication aide (MA) on 05/26/23 at 3:56pm revealed: -She last saw Resident #2's foot wound on Saturday, 05/20/23. -The resident's foot wound was "pinkish" but she did not report the resident's foot to anyone because the resident did not complain about it. -She was not aware of an order for Bactroban ointment for Resident #2. Interview with the Administrator on 05/25/23 at 6:48pm revealed: -The Resident Care Coordinator (RCC) was responsible for implementing and sending new medication orders to the pharmacy. -The pharmacy staff usually put the new orders	C 330		

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

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C 330	Continued From page 51	C 330		

into the eMAR system.
-He was not aware of the Bactroban ointment order for Resident #2.
-He relied on the RCC to ensure medications were administered as ordered.

Telephone interview with the RCC on 05/26/23 at 9:00am revealed:
-She was not working when Resident #2 was seen by the podiatrist on 05/06/23.
-The MA on duty at the time an order was received was responsible for faxing the order to the pharmacy.
-She was not aware of the order for Resident #2's Bactroban ointment because the order was filed in the resident's record.
-She had not seen the order in the resident's record.
-The order was overlooked by staff but should have been implemented.
-She was unable to indicate a system to check medication orders.
-She last saw Resident #2's foot wound that morning, 05/26/23, and it looked like a dry callus scabbing over.

Telephone interview with the Administrator on 05/26/23 at 3:23pm revealed Resident #2 was seen by her primary care provider (PCP) today, 05/26/23, and a new medication was prescribed for her foot wound.

Telephone interview with the lead pharmacy technician at the facility's contracted pharmacy provider on 05/26/23 at 2:55pm revealed:
-They did not receive an order for Bactroban ointment for Resident #2 dated 05/06/23.
-They received new orders for Resident #2 today, 05/26/23.
-They received an order dated 05/26/23 for

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	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 52 Bactroban ointment and for Doxycycline (an oral antibiotic used to treat infection). Telephone interview with Resident #2's power of attorney (POA)/family member on 05/26/23 at 3:24pm revealed: -Resident #2's appointment with her PCP was originally scheduled for next week but was moved up to today, 05/26/23, to examine her right foot. -The PCP prescribed Bactroban topical ointment to the open wound on the right foot and Doxycycline by mouth for the infection. -Resident #2 had opened that area on her right foot in the past due to wearing ill-fitting shoes. -He did not know how the area became open and infected again. -He left the PCP visit summary and orders with the staff at the facility earlier this afternoon when he dropped off Resident #2. -He was told the facility staff would get both prescriptions filled at the pharmacy. Attempted telephone interview with Resident #2's podiatry provider on 05/26/23 at 1:59pm was unsuccessful. Attempted telephone interview with Resident #2's PCP on 05/26/23 at 3:06pm was unsuccessful. b. Review of Resident #2's current FL-2 dated 05/03/23 revealed an order for Trazodone 50mg at bedtime. (Trazodone is used to treat insomnia.) Review of Resident #2's FL-2 dated 04/07/23 from a previous facility revealed a diagnosis of insomnia. Review of Resident #2's physician's orders revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 53 -There was a prescription dated 05/03/23 for Trazodone 50mg take 1 tablet at bedtime. -The prescription was written for 30 tablets to be dispensed with no refills. -There was a prescription dated 05/16/23 for Trazodone 50mg take 1 tablet at bedtime for insomnia. -There was a note at the bottom of the prescription indicating this was a refill order for the current dose of scheduled Trazodone. Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone 50mg 1 tablet at bedtime for insomnia scheduled for 8:00pm. -Trazodone 50mg was documented as administered from 05/04/23 - 05/16/23 and 05/21/23 - 05/24/23. -Trazodone 50mg was documented as not administered from 05/17/23 - 05/20/23 due to no medication in the facility, needed refill, and waiting on refill. Observation of Resident #2's medications on hand on 05/25/23 at 6:53pm revealed: -There was a supply of Trazodone 50mg tablets with a cycle start date of 05/23/23 with instructions to take 1 tablet daily at bedtime for insomnia. -There were 26 of 30 Trazodone 50mg tablets remaining. Telephone interview with the lead pharmacy technician at the facility's contracted pharmacy provider on 05/26/23 at 2:55pm revealed: -They dispensed 13 Trazodone 50mg tablets for Resident #2 on 04/10/23 (prior to admission to this facility). -They dispensed 17 Trazodone 50mg tablets for	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 54 Resident #2 on 04/17/23 (prior to admission to this facility). -There were no refills on the Trazodone. -The facility did not notify the pharmacy they were out of Trazodone and needed it refilled until a new supply of 30 tablets was sent out on 05/19/23 with a cycle start date of 05/23/23. Interview with Resident #2 on 05/25/23 at 6:42pm revealed: -She always had problems with sleeping at night. -She was supposed to get Trazodone every night but she had not received it every night and she did not know why. -She still had problems sleeping. Telephone interview with a medication aide (MA) on 05/26/23 at 3:56pm revealed: -She did not recall if Resident #2 had been out of Trazodone. -If the medication was not available, she would have documented waiting on refill on the eMAR. -If medication refills were needed, the Resident Care Coordinator (RCC) would get the refills. -Resident #2 did not sleep at night. Telephone interview with the RCC on 05/26/23 at 9:00am revealed: -She did not recall Resident #2 being out of Trazodone. -The MA on duty was responsible for reordering medications before the medications ran out. -She did not recall anyone reporting the resident was out of medication or needed refills. Telephone interview with the Administrator on 05/26/23 at 3:23pm revealed: -The RCC was responsible for medication refills and getting medications from the back-up pharmacy when needed.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 55 -Medications should be available for administration. Attempted telephone interview with Resident #2's primary care provider (PCP) on 05/26/23 at 3:06pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 05/03/23 revealed diagnoses included dementia, epilepsy, hepatic encephalopathy, osteopenia, alcoholic hepatitis, alcoholic cirrhosis, severe malnutrition, and alcohol use disorder. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 04/27/23. a. Review of Resident #3's primary care provider (PCP) order dated 05/03/23 revealed an order for Triple Antibiotic Ointment apply a small amount to callus on right big toe until healed externally once a day for 14 days. (Triple Antibiotic Ointment is an over-the-counter topical medication used to treat and reduce the risk of infections for minor skin injuries.) Review of Resident #3's podiatry provider's progress note dated 05/06/23 revealed: -The resident had a wound on the right great toe measuring 1.5cm x 1.0cm with pinpoint bleeding, no purulent drainage, no pain, and no erythema (redness) noted. -The resident had peripheral neuropathy. -There was an order to contact home health to evaluate and treat wound on right great toe. -Until home health could be available, there was an order to apply Bactroban ointment and bandaid to right great toe every day for 7 days. (Bactroban is a prescription antibiotic ointment used to treat infections.)	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 56 Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Triple Antibiotic Ointment, apply a small amount to callus on right big toe and cover with bandaid daily until healed scheduled for 8:00am. -Triple Antibiotic Ointment was documented as administered from 05/05/23 - 05/25/23 except for 05/10/23 and 05/11/23 when the resident was documented as being out of the facility. -There was no entry for Bactroban ointment as ordered on 05/06/23 and none was documented as administered. Observation of Resident #3's medications on hand on 05/25/23 at 7:09pm revealed: -There was an over-the-counter tube of Triple Antibiotic Ointment. -There was no Bactroban ointment available to administer. Interview with the medication aide (MA) on 05/25/23 at 7:23pm revealed: -He used Triple Antibiotic Ointment for Resident #3's toe wound. -The resident's toe wound had an open area and was red and bleeding. -The resident had not complained of pain with the toe wound. -He was not aware of an order for Bactroban ointment. Telephone interview with Resident #3's family member on 05/26/23 at 4:14pm revealed: -When he was admitted to this facility, they noticed the wound on his toe. -Resident #3 was seen by a podiatrist and the podiatrist trimmed some more of the heavy	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 57	C 330		

calluses off.
-She saw the resident's toe wound on Monday, 05/22/23, and it "did not look so good".
-The toe wound was getting worse, and she thought it might be infected because the resident was picking at it.
-The wound had a very light watery, bloody drainage with a tint of faint yellow color.
-She let the facility staff know on Monday, 05/22/23.
-She thought the facility staff was going to clean up the toe wound and bandage it.

Observation of Resident #3 on 05/25/23 at 2:02pm revealed:
-There was a white bandage with tape on the resident's right great toe.
-There was a dime-sized light brown stain saturated to the top of the bandage on the left side of the great toe.

Interview with Resident #3 on 05/25/23 at 2:02pm revealed:
-He had been dealing with calluses on his feet for years.
-He "sands" off the calluses at times.
-There was blood on the wound that morning, 05/25/23, so he put a bandage on it.
-The podiatrist had been to the facility to check his feet but he could not recall when.
-His toe wound was bleeding and it hurt when touched.
-He was not sure what kind of medication was being put on the wound or when it was applied.

Interview with the Administrator on 05/25/23 at 6:48pm revealed:
-The Resident Care Coordinator (RCC) was responsible for implementing and sending new medication orders to the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 58	C 330		

-The pharmacy staff usually put the new orders into the eMAR system.
-He was not aware of the Bactroban ointment order for Resident #3.
-He relied on the RCC to ensure medications were administered as ordered.

Telephone interview with the RCC on 05/26/23 at 9:00am revealed:
-She was not working when Resident #3 was seen by the podiatrist.
-The MA on duty at the time an order was received was responsible for faxing the order to the pharmacy.
-She was not aware of the order for Resident #3's Bactroban ointment because the order was filed in the resident's record.
-She had not seen the order in the resident's record.
-The order was overlooked by staff but should have been implemented.
-She was unable to indicate a system to check medication orders.

Telephone interview with the lead pharmacy technician at the facility's contracted pharmacy provider on 05/26/23 at 2:55pm revealed:
-They did not receive Resident #3's order for Bactroban ointment until today, 05/26/23.
-The Bactroban ointment order was dated 05/06/23.

Attempted telephone interview with Resident #2's podiatry provider on 05/26/23 at 1:59pm was unsuccessful.

b. Review of Resident #3's current FL-2 dated 05/03/23 revealed an order for Symbicort 160-4.5mcg inhale twice daily, rinse after. (Symbicort is used for maintenance treatment of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 59 chronic obstructive pulmonary disease.) Review of Resident #3's previous FL-2 dated 04/25/23 revealed an order for Symbicort 160-4.5mcg inhale 2 puffs twice a day. Review of Resident #3's hospital emergency department discharge instructions dated 05/22/23 revealed: -The resident was seen and diagnosed with shortness of breath and neck pain. -The resident was to use two inhalers (Albuterol and Spiriva) for breathing problems and take an oral medication for inflammation. Observation of Resident #3's medications on hand on 05/25/23 at 7:09pm revealed: -Resident #3's medications were stored together in a plastic container. -There was a Symbicort 80-4.5mcg inhaler in the manufacturer's box with an area of the box label missing where it appeared a prescription label had been pulled off. -The area where the label was pulled off had "8A & 8P" handwritten in blue marker. -The dose counter on top of the Symbicort 80-4.5mcg inhaler indicated there were 48 doses (inhalations) of 120 inhalations remaining. -There was a Symbicort 160-4.5mcg inhaler with no box and no prescription label. -The dose counter on top of the Symbicort 160-4.5mcg inhaler indicated there were 21 inhalations of 60 inhalations remaining. Review of Resident #3's medication orders revealed no order for Symbicort 80-4.5mcg inhaler. Review of Resident #3's April 2023 electronic medication administration record (eMAR)	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 60	C 330		

revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs twice daily, rinse mouth after use scheduled for 8:00am and 8:00pm.
-Symbicort 160-4.5mcg inhaler was documented as administered from 04/28/23 - 04/30/23.
-There was no entry for Symbicort 80-4.5mcg inhaler.

Review of Resident #3's May 2023 eMAR revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs twice daily, rinse mouth after use scheduled for 8:00am and 8:00pm.
-Symbicort 160-4.5mcg inhaler was documented as administered from 05/01/23 - 05/25/23 (8:00am).
-There was no entry for Symbicort 80-4.5mcg inhaler.

Telephone interview with the lead pharmacy technician at the facility's contracted pharmacy provider on 05/26/23 at 2:55pm revealed:
-They did not have any orders for Symbicort 80-4.5mcg inhaler for Resident #3 and none had been dispensed.
-They had dispensed Symbicort 160-4.5mcg inhaler on 04/27/23.

Telephone interview with Resident #3's family member on 05/26/23 at 4:14pm revealed:
-Resident #3 had a breathing condition, tracheobronchomalacia, (leads to cough, wheezing, shortness of breath).
-Resident #3 also had asthma since he was a child.
-Resident #3 recently went to the hospital emergency room for shortness of breath.

Observation on 05/25/23 at 7:13pm revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 61	C 330		

medication aide (MA) administered Symbicort 80-4.5mcg inhaler to Resident #3 instead of Symbicort 160-4.5mcg inhaler as ordered.

Interview with the MA on 05/25/23 at 7:13pm revealed:
-He usually administered the inhaler labeled as Symbicort 80-4.5mcg to Resident #3.
-He had not noticed there was a second Symbicort inhaler that was 160-4.5mcg.
-He had not noticed Symbicort 160-4.5mcg was listed on the eMAR as the inhaler to be administered to the resident.
-He was unsure when or where the Symbicort 80-4.5mcg inhaler was dispensed since there was no prescription label on the box or the inhaler.

Interview with Resident #3 on 05/25/23 at 7:19pm revealed:
-He felt like he was wheezing and having shortness of breath.
-He just used an inhaler and it was helping with his symptoms.

Interview with the Resident Care Coordinator (RCC) on 05/25/23 at 7:21pm revealed:
-Resident #3's Symbicort inhaler should be administered as ordered.
-She was unsure why Resident #3 had two different Symbicort inhalers on hand.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 05/25/23 at 2:44pm was unsuccessful.

c. Review of Resident #3's hospital emergency department discharge instructions dated 05/22/23 revealed:
-The resident was seen and diagnosed with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 62	C 330		

shortness of breath and neck pain.
-The resident's neck exam revealed no fracture or indication for imaging.
-The resident was to take Ibuprofen for any pain. (Ibuprofen is for pain and inflammation.)
-The resident was to start using two inhalers (for breathing problems).
-The resident was to take Prednisone 20mg 2 tablets once daily for 5 days. (Prednisone reduces inflammation in the airways to help relieve breathing problems.)

Review of Resident #3's physician's order dated 05/23/23 revealed an order for Prednisone 20mg take 2 tablets (40mg total) daily for 5 days.

Observation of Resident #3's medications on hand on 05/25/23 at 7:09pm revealed:
-There was a supply of Prednisone 20mg tablets dispensed on 05/23/23 with a quantity of 10 tablets.
-The instructions on the Prednisone label were to take 2 tablets (40mg) daily for 5 days.
-There were 5 of 10 Prednisone 20mg tablets remaining.

Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Prednisone 20mg take 2 tablets (40mg) once daily for 5 days scheduled for 8:00am.
-No Prednisone was documented as administered on 05/23/23.
-Prednisone was documented as administered on 05/24/23 and 05/25/23, for a total of 2 doses (4 tablets).

Interview with the medication aide (MA) on 05/25/23 at 7:23pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 63 -He had not administered any Prednisone to Resident #3 because he did not usually work on first shift. -He was not sure why there was an odd number of tablets remaining since 2 tablets should be administered each time. Interview with Resident #3 on 05/25/23 at 7:19pm revealed: -He felt like he was wheezing and having shortness of breath. -He was not sure what oral medications he was receiving. Interview with the Resident Care Coordinator (RCC) on 05/25/23 at 7:21pm revealed: -She was unsure why there was an odd number of Prednisone tablets remaining in the supply. -Resident #3 should be receiving 2 tablets of Prednisone as ordered. Attempted telephone interview with Resident #3's primary care provider (PCP) on 05/25/23 at 2:44pm was unsuccessful. _____ The facility failed to administer medications as ordered to 2 of 3 residents sampled. Resident #2's order for an antibiotic ointment for treatment of a foot wound was not implemented resulting in the wound becoming infected and requiring treatment with an oral antibiotic for infection. Resident #2's Trazodone was unavailable for administration for at least 4 days in May 2023 resulting in the resident continuing to have trouble sleeping. Resident #3's order for an antibiotic ointment for treatment of a toe wound was not implemented resulting in the wound worsening with bleeding and pain. Resident #3, who had symptoms of wheezing and shortness of breath, with a recent emergency room visit for shortness	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092295	A. BUILDING: _____ B. WING _____	R-C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENDELLE ASSISTED LIVING ON LAZY RIVER	2268 LAZY RIVER DRIVE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 64 of breath, was administered an inhaler that was a lower strength than ordered and had not received an oral medication for inflammation as ordered. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/26/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 25, 2023.	C 330		