STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Pitt County Department of Social Services conducted a follow-up survey and complaint investigation on 08/02/23 through 08/04/23. The Pitt County Department of Social Services initiated the complaint investigation on 07/19/23.	D 000		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 161	Continued From page 1	D 161		

interviews, the facility failed to ensure unlicensed staff were competency validated by a Registered Nurse with return demonstration for 3 of 3 medication aides sampled for a resident who had a Jackson Pratt drain which is a closed suction medical device used to collect bodily fluids from a surgical site.

The findings are:

Review of Resident #4's current FL-2 dated 05/16/23 revealed:
-Diagnoses included end stage renal disease with hemodialysis, seizure, acid reflux, hypertension, avascular necrosis, left non-traumatic intracerebral ventricular hemorrhage, and myositis.
-There was no documentation of a Jackson Pratt (JP) drain (A JP drainage tube is a closed suction medical device used to collect bodily fluids from a surgical site. The device consists of an internal drain connected to a grenade-shaped bulb via a tube).

Review of the facility's progress note dated 11/04/22 revealed Resident #4 was admitted back to the facility on 11/04/22 at 4:50pm from a skilled nursing/rehabilitation facility.

Review of Resident #4's previous FL-2 dated 11/04/22 revealed:
-Diagnoses included acid reflux, left non-traumatic intracerebral ventricular hemorrhage, hypertension, avascular necrosis, seizure disorder, and end state renal disease.
-There was no documentation of a JP drain.

Review of Resident #4's physician order from the skilled nursing/rehabilitation facility dated 11/03/22 revealed instructions for assisted living

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 161	Continued From page 2	D 161		

facility staff to empty the JP drain at 8:00am and 8:00pm daily.

Review of Resident #4's Infectious Disease physician order dated 11/07/22 revealed:
-There was an order to flush the JP drain with 10ml normal saline (NS), measure and record output twice a day and send record with resident to follow-up visit.
-There was an order to notify the physician when drainage output was less than 10ml for 3 consecutive days.

Review of Resident #4's Infectious Disease physician order dated 12/08/22 revealed there were instructions to record the JP drainage output twice a day, flush JP with 10 ml NS twice a day, and keep bulb to suction.

Review of Resident #4's Infectious Disease physician visit consultation report dated 01/17/23 revealed:
-The reason for the for visit was for lower left extremity (LLE) myositis.
-The physician assessment notes revealed LLE with myositis, drain in place, CT (computerized tomography) with persistent fluid collection despite antibiotic treatment and drainage.
-There were instructions to refer resident to surgery regarding fluid collection and future drain evaluation.
-There were orders to flush the JP drain with 10ml of normal saline (NS) twice a day and keep to bulb suction.

Review of Resident #4's hospital discharge summary report dated 01/25/23 revealed:
-Resident #4 was in the hospital from 01/20/23 to 01/25/23 due to an abscess of left lower extremity (LLE) that had pain and swelling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 3	D 161		

-The resident was noted to be septic from the pyomyositis.
-Antibiotic therapy was recommended by Infectious Disease for suppression.
-No surgery was recommended by Orthopaedic at this time due to the risk regarding the hip hardware.
-There was a recommendation to monitor drainage output and once the amount was less than 10ml, refer to VIR (Vascular Interventional Radiology) for removal of drainage tube.

Review of Resident #4's emergency room (ER) discharge summary report dated 05/03/23 revealed:
-Resident #4 went to the ER on 05/03/23 for a wound check.
-The JP drain was clogged and not draining.
-There were instructions to coordinate with interventional radiology to have the drain removed when drain output was less than 15ml/day for 2 consecutive days.

Review of Resident #4's primary care provider (PCP) notes revealed:
-The progress note dated 01/02/23 revealed instructions for staff to monitor sign/symptoms (s/s) of infection and continue wound/drain management per Home Health (HH) skilled nursing.
-The progress note dated 01/28/23 revealed instructions for staff to monitor for s/s of infection and continue wound/drain management per HH skilled nursing.
-The progress note dated 03/02/23 revealed instructions for staff to monitor for s/s of infection and continue wound/drain management per HH skilled nursing.
-The progress note dated 03/28/23 revealed instructions for staff to monitor for s/s of infection

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 161	Continued From page 4	D 161		

and continue wound/drain management per HH skilled nursing.
-The progress note dated 04/18/23 revealed instructions for staff to monitor for s/s of infection and continue wound/drain management per HH skilled nursing.
-The progress note dated 06/05/23 revealed instructions for staff to monitor for s/s of infection and continue wound/drain management per HH skilled nursing.

Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 12/09/22 revealed
-The JP drain was listed and checked off as a LHPS task.
-The JP drain was listed and documented that training on the LHPS task was provided to staff.

Review of Resident #4's LHPS evaluation dated 03/29/23 revealed:
-The JP drain was listed and checked off as a LHPS task.
-The JP drain was listed and documented that training on the LHPS task training provided to staff.

Review of Resident #4's LHPS evaluation dated 06/29/23 revealed:
-There were no LHPS tasks checked.
-There was no documentation of any LHPS task training provided to staff.

Review of a medication aide's (MA) skills/competency evaluation revealed:
-The evaluation was dated 06/23/22 and no task was listed for the care of the JP drain.
-There was no documentation the staff was evaluated for competency on Resident #4's JP drain after it was placed in October 2022.

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 5 Review of a second MA's skills/competency evaluation revealed: -The evaluation was dated 12/09/20 and no task was listed for the care of Resident #4's JP drain. -There was no documentation the staff was evaluated for competency on Resident #4's JP drain after it was placed in October 2022. Review of a third MA's skills/competency evaluation revealed: -The evaluation was dated 05/11/22 and no task was listed for the care of Resident #4's JP tube. -There was no documentation the staff was evaluated for competency on Resident #4's JP drain after it was placed in October 2022. Observation of Resident #4's JP site on 08/03/23 at 4:45pm revealed: -The bulb was closed and compressed flat. -The sutures were loosely tied to the JP drain tubing and were not connected to the skin. -The skin surrounding the site was dry and had a darker pigmentation than other parts of the thigh. -The insertion site of the drainage tube was dry and scaly. Review of Resident #4's home health (HH) visit notes revealed: -The resident was admitted to home health skilled nursing for JP drain management and dressing change on 11/07/22 which included inspecting the insertion site for infection, emptying and recording the amount of drainage, compressing the bulb, flushing the drainage tube, and recording smell and order. -The HH nurse made 35 visits to the facility from 11/07/22 through 06/22/23. -Home Health visits to the facility were made on 11/07/22, 11/10/22, 11/17/22, 11/21/22, 11/29/22,	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 161	Continued From page 6 12/01/22, 12/06/22, 12/15/22, 12/20/22, 12/27/22, 01/02/23, 01/10/23, 01/19/23, 01/31/23, 02/02/23, 02/10/23, 02/17/23, 02/23/23, 02/24/23, 02/25/23, 03/02/23, 03/07/23, 03/14/23, 03/24/23, 03/28/23, 04/04/23, 04/11/23, 05/03/23, 05/10/23, 05/12/23, 05/15/23, 05/16/23, 05/29/23, 06/05/23, and 06/22/23. -On 01/31/23, the HH nurse informed the Resident Care Coordinator (RCC) to contact VIR (Vascular and Interventional Radiology) when the JP drainage was less than 10cc/24hrs. -On 02/02/23, the HH nurse observed drain was not compressed for suction; she re-educated staff to keep bulb always compressed. -On 05/03/23, the HH nursed observed sutures loose and red purulent drainage; the PCP was notified. -On 05/12/23, the HH nurse observed the port flow turned off; she re-educated staff on the port flow to be opened and not closed. -On 05/15/23, the HH nurse observed the sutures to be loose. -On 06/05/23, the HH nurse observed the sutures to be loose; the PCP was notified. -On 06/22/23, the HH nurse observed the sutures to be loose. -There was documentation the JP drain was flushed 35 times by the HH nurse from 11/07/22 through 06/22/23. Interview with Resident #4 on 08/04/23 at 10:20am revealed: -Staff emptied the JP drainage bulb and took care of it for him. -He would like the JP drain to be removed. -He would be more comfortable without the JP drain. Telephone interview with the LHPS nurse on 08/04/23 at 5:20pm revealed:	D 161		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 161	Continued From page 7	D 161		

-She was a Registered Nurse and provided clinical training to the staff at the facility.
-She completed the LHPS review and evaluations on 12/09/22 and 03/29/23.
-She did not observe or assess Resident #4's JP drain on 03/29/23, she might have inspected the JP drain on 12/09/22 but could not recall.
-She did not train unlicensed staff on providing care to Resident #4's JP drainage tube.
-She checked off staff were trained to provide care to Resident #4's JP drain on the evaluation form based on the facility informing her that staff had been trained by the home health nurse.
-She could not remember who informed her that staff had been trained.

Telephone interview with the second LHPS nurse on 8/04/23 at 4:40pm revealed:
-She was a registered nurse who usually provided CPR (Cardio-pulmonary resuscitation) training to staff at the facility.
-She completed the LHPS review and evaluation form on Resident #4 dated 06/29/23.
-She could not recall seeing Resident #4.
-She was not aware Resident #4 had a JP drainage tube in place.
-Had she known Resident #4 had a JP drainage tube, she would have trained staff and checked it off on the LHPS review and evaluation form.

Interview with a medication aide (MA) on 08/03/23 at 3:20pm revealed:
-The MA's provided care to Resident #4's JP drainage tube.
-She had never been trained on how to care for Resident #4's JP drainage tube.
-She was instructed by other MA's on how to care for the JP drainage tube.
-She was instructed to empty the bulb, record the amount of drainage, and compress the bulb; she

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 8	D 161		

did not know why the bulb had to be compressed.
-The MA's did not flush the JP drain, the HH nurse did.
-The care of the JP drainage tube was not listed on the electronic medication administration record (eMAR) or any place else that she was aware of.
-She just knew to provide care for the JP drainage tube by "word of mouth" from other MA's.
-There used to be a composition book on top of the medication cart to record the amount of fluid drained from the JP drainage tube, but she had not seen it for a while.
-She thought a home health nurse came in to clean around the drainage tube, change the bulb when needed and flush the tube.

Telephone interview with the facility's contracted home health case manager on 08/03/23 at 3:20pm revealed:
-The HH agency provided JP drainage tube care to Resident #4 for about 6 to 9 months.
-The HH agency discharged Resident #4 in June 2023 and had not provided JP drainage tube care since that time.
-Services included inspecting the JP drainage tube site for infection, flushing the tube, emptying the bulb, compressing the bulb, and recording the amount of drainage and color.

Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 9:10am revealed:
-She was not a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).
-She was a MA prior to April 2023.
-The home health nurse showed her how to care for Resident #4's JP drain.
-She trained the other MAs on how to provide care to Resident #4's JP drain including emptying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 9	D 161		

the bulb, compressing the bulb, recording the amount of drainage, documenting the color and smell of the drainage, and looking for any signs of infection such as redness, swelling and pain.
-Only the MAs provided care to the JP drainage tube.
-There had been some issues with the JP drainage tube.
-The home health nurse notified her that Resident #4's JP drain tube was clogged and not draining and leaked due to dislocation of the tube, and she sent the resident to the emergency room (ER); she could not recall the timeframe.
-The home health nurse showed her how to unclog the JP drain should it happen again, and she trained the other MAs.
-She did a "walk through" every morning and observed Resident #4's JP drain.
-There were times she had to remind staff to empty, record drainage amount and compress the bulb for Resident #4's JP drain because it had not been done.
-The home health nurse used to come in 2-3 times a week to provide care to the JP drain, including flushing the tube, but their services had been discontinued due to recertification requirements.
-She was trained by the HH nurse on how to flush the JP drain and she flushed the JP drain now that HH was no longer coming to the facility.
-Staff was supposed to empty the JP drain bulb, compress the bulb, and document the amount of drainage in a book on top of the medication cart each shift (three times a day).
-She was not familiar with any orders to provide JP drain care twice a day.
-She went by the information on the Fact Sheet that came with Resident #4 when the JP drain was placed on 10/12/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 10 Interview with the Administrator on 08/02/23 at 5:10pm revealed: -When Resident #4 was admitted to the facility back in November 2022, there was an LPN on staff. -The home health nurse did not train all MAs on the care of Resident #4's JP drainage tube. -The facility contracted with an LHPS nurse to provide clinical training to staff. -She was not aware the JP drainage tube was not listed on the LHPS as a task and staff was not trained. -It should have been listed on the LHPS task review and evaluation and training should have been provided for staff. Telephone Interview with Resident #4's primary care provider (PCP) on 08/03/23 at 4:30pm revealed: -Resident #4 had a JP drainage tube placed in his left thigh in October 2022 to drain an abscess caused by myositis. -She was not aware unlicensed staff were providing care to the JP drainage tube. -It was her understanding the care of the JP drainage tube was to be managed "completely" by home health skilled nursing. -She was not aware home health skilled nursing was discontinued for Resident #4 in June 2023 due to needing to be recertified. -She was aware Resident #4 was sent to the emergency room (ER) in January 2023 due to an infection and in May 2023 due to a clogged and leaking JP drainage tube. -If the JP drainage tube was not being flushed, emptied and compressed, it could possibly cause the JP drain to become clogged that could result in an infection and delay in wound healing. -If the sutures were loose on the JP drain, that could cause the tube to become dislodged.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 11 -She expected unlicensed staff to be trained to provide JP drainage tube care to Resident #4 to ensure the task was being properly performed for the safety of the resident. Telephone interview with an Infectious Disease Physician on 08/04/23 at 3:23pm revealed: -The Infectious Disease physician last saw Resident #4 in May 2023. -Resident #4 had an abscess with a drainage tube placement. -If a JP drain was not properly managed including emptying and flushing the tube, this could cause the tube to become clogged. -A clogged JP drain could cause pain, a delay in healing and removal of the tube, and an infection that could lead to sepsis that could result in organ failure and death. Attempted telephone interview with Resident #4's family member on 08/04/23 at 5:10pm was unsuccessful. _____ The facility failed to ensure unlicensed staff were competency validated by a registered nurse by return demonstration to flush a JP drain and measure and record output twice daily as ordered for a resident, which resulted in unlicensed staff caring for the JP drain without proper skill and knowledge which resulted in the bulb not being compressed for suction, and the port flow being turned off. This failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/04/23.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	Continued From page 12 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 03, 2023.	D 161		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure the routine and acute health care needs of 1 of 5 (#4) sampled residents as evidenced by missed appointments and a referral for a resident diagnosed with a rare autoimmune condition that caused inflammation of the skeletal muscles, who had a closed suction medical device used to collect bodily fluids from a surgical site. The findings are: Review of Resident #4's current FL-2 dated 05/16/23 revealed: -Diagnoses included end stage renal disease with hemodialysis, seizure, acid reflux, hypertension, avascular necrosis, left non-traumatic intracerebral ventricular hemorrhage, and myositis. -There was no documentation of a Jackson Pratt (JP) drain (A JP drainage tube is a closed suction medical device used to collect bodily fluids from a surgical site. The device consists of an internal drain connected to a grenade-shaped bulb via a tube).	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13 Review of Resident #4's previous FL-2 dated 11/04/22 revealed: -Diagnoses included acid reflux, left non-traumatic intracerebral ventricular hemorrhage, hypertension, avascular necrosis, seizure disorder, and end state renal disease. -There was no documentation of a JP drain. Review of the facility's progress note dated 11/04/22 revealed Resident #4 was admitted back to the facility on 11/04/22 at 4:50pm from a skilled nursing/rehabilitation facility. Review of Resident #4's physician order from the skilled nursing/rehabilitation facility dated 11/03/22 revealed instructions for assisted living facility staff to empty the JP drain at 8:00am and 8:00pm daily. Review of the Fact Sheet in Resident #4's record when the JP drain was placed in 10/12/22 revealed: -Proper JP drain care was essential to your physical recovery. -Drains prevented the buildup of blood and fluid from occurring in the surgical site. -When the drain was squeezed, a vacuum is created. -This suction helped to draw out any fluid collections. -The collection bulb should always be collapsed (flat) to maintain continuous suction. -The bulb needed to be emptied when it is filled with fluid or the bulb is no longer on suction. - The JP drain output needed to be properly measured and recorded for your surgeon to determine when it can be safely removed. -There were instructions on how to empty a JP drain.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 14 -There were instructions on how to strip a JP drain if clogged. -The physician may typically remove the drain when drainage output was less than 30ml per day for two consecutive days. Review of Resident #4's Infectious Disease physician order dated 11/07/22 revealed: -There was an order to flush the JP drain with 10ml normal saline (NS), measure and record output twice a day and send record with resident to follow-up visit. -There was an order to notify the physician when drainage output was less than 10ml for 3 consecutive days. Review of Resident #4's Infectious Disease after visit summary report dated 12/08/22 revealed: -There were instructions to record the JP drain output twice a day, flush JP drain with 10 ml NS twice a day and keep bulb to suction. -There was a handwritten note on the report to bring JP drainage output to next appointment. Review of Resident #4's Infectious Disease after visit summary report dated 01/17/23 revealed: -There were notes documenting LLE (lower left extremity) with myositis, drain in place, CT (computerized tomography) with persistent fluid collection despite antibiotic treatment and drainage. -There were instructions to flush the JP drain with 10ml of NS twice a day and keep to bulb suction. Review of Resident #4's drainage output log documented by facility staff revealed there was documentation on 01/20/23 the output was 45 ml, the color was brown, there was a strong odor and the drain site on the leg was swollen.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 15	D 273		

Review of Resident #4's hospital discharge summary report dated 01/25/23 revealed
-Resident #4 was in the hospital from 01/20/23 to 01/25/23 due to an abscess of left lower extremity (LLE) that had pain and swelling.
-The resident was noted to be septic from the pyomyositis.
-Antibiotic therapy was recommended by Infectious Disease for suppression.
-No surgery was recommended by Orthopedic at this time due to the risk regarding the hip hardware.
-There was a recommendation to monitor drainage output and once the amount was less than 10ml, refer to VIR (Vascular Interventional Radiology) for removal of drainage tube.
-There was a follow-up appointment with Surgery for 01/30/23.
-There was an appointment to follow up with Infectious Disease on 02/08/23.

Review of Resident #4's primary care provider's (PCP) progress note dated 01/31/23 revealed:
-The resident complained of left leg pain and observed to be limping by staff.
-She advised staff to send resident to the emergency room (ER).
-The resident was hospitalized for pyomyositis of left thigh abscess in January 2023.
-The resident was to receive long term antibiotics per Infectious Disease.
-The plan was to continue antibiotic therapy, wound/drain management per home health HH skilled nursing, and routine follow-up with Infectious Disease.

Telephone interview with the Surgery Department on 08/04/23 at 12:20pm revealed there was an appointment for Resident #4 on 01/30/23 and he was a no show and no further appointments were

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 16 scheduled. Review of Resident #4's JP drain log for 01/25/23 through 01/31/23 the drainage amount was less than 10ml one time on 01/25/23 at 5:37pm. Review of Resident #4's record revealed there was no indication a referral was made for Vascular Interventional Radiology for a drainage output less than 10ml for drainage tube removal. Review of Resident #4's February 2023 JP drainage output log revealed there was no documentation the drainage output was less than 10ml however there were 53 occasions the drainage output was not recorded. Review of Resident #4's March 2023 JP drainage output log revealed: -On 03/04/23, drainage was 5 ml at 4:25am. -On 03/04/23, drainage was 5 ml at 5:48pm. -On 03/05/23, drainage was 7.5ml. -On 03/05/23, drainage was 7.5ml. -On 03/06/23, drainage was 5ml. -On 03/08/23, drainage was less than 10ml at 9:02pm. -On 03/09/23, drainage was zero at 5:00am. -On 03/11/23, drainage was zero at 10/29/23. -On 03/12/23, drainage was 7.5ml at 4:26am. -On 03/12/23, drainage was 7.5ml at 10:34am -On 03/16/23, drainage was 2.5ml. -On 03/18/23,drainage was 7.5ml -On 03/19/23, drainage was 7.5ml -On 03/23/23, drainage was 7.5ml. -On 03/25/23, drainage was 7.5ml. -On 03/30/23, drainage was 7.5ml. -On 03/30/23, drainage was 7.5ml. -The drainage output was less than 10ml seventeen times.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 17	D 273		

Review of Resident #4's record revealed there was no indication a referral was made for Vascular Interventional Radiology for a drainage output less than 10ml for drainage tube removal.

Review of Resident #4's April 2023 JP drainage output log revealed:
-On 04/16/23, drainage was 7ml.
-On 04/25/23, drainage was 1ml , red in color.
-On 04/26/23, drainage was 5ml , red yellowish in color.
-On 04/27/23, drainage was 5ml, red yellowish in color.
-The drainage output was less than 10ml four times.

Review of Resident #4's record revealed there was no indication a referral was made for Vascular Interventional Radiology for a drainage output less than 10ml for drainage tube removal.

Review of Resident #4's ER after visit report dated 05/03/23 revealed:
-Reason for visit was for wound check.
-The JP drain was clogged and not draining.
-There were instructions that the JP drain may need to be replaced at some point in the future if the drain continues to not drain and fluid accumulates in the thigh.
-There were instructions to coordinate with interventional radiology to have the drain removed when drain output was less than 15ml/day for 2 days consecutively.
-There was an appointment for Adult Specially Care/Infectious Disease on 05/25/23.

Review of Resident #4's May 2023 JP drainage output log revealed:
-On 05/12/23, drainage was zero.
-On 05/12/23, drainage was 5ml.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 18 -On 05/13/23, drainage was less than 5ml. -On 05/13/23, drainage was less than 5ml. -On 05/16/23, drainage was 7.5ml. -On 05/16/23, drainage was 5ml. -On 05/17/23, drainage was zero. -On 05/17/23, drainage was 10ml. -On 05/27/23, drainage was 5ml. -On 05/28/23, drainage was 5ml. -On 05/29/23, drainage was 2.5ml. -On 05/29/23, drainage was 5ml. -On 05/30/23, drainage was 2.5ml. -On 05/30/23, drainage was 2.5ml. -The drainage output was less than 15ml four times. Review of Resident #4's home health (HH) visit notes revealed on 05/03/23, the HH nursed observed sutures loose and red purulent drainage; the PCP was notified. Review of Resident #4's Vascular Access Clinic after visited report dated 05/18/23 revealed the next step was an appointment with Adult Speciality Care/Infectious Disease on 07/05/23. Review of Resident #4's June 2023 JP drainage output log revealed: -On 06/01/23, drainage was 2.5ml. -On 06/02/23, drainage was less than 5ml. -On 06/03/23, drainage was less than 5ml. -On 06/05/23, drainage was less than 5ml. -The drainage output was less than 15ml two times. Review of Resident #4's July 2023 JP drainage output log revealed: -On 7/31/23, drainage was zero. -The drainage output was not recorded 60 times.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 19	D 273		

Review of Resident #4's August 2023 JP drainage output log revealed:
-On 08/02/23, drainage was 5ml.
-On 08/02/23, drainage was zero.
-On 08/02/23, drainage was zero.
-On 08/03/23, drainage was 10ml.
-On 08/03/23, drainage was zero.
-The drainage output was less than 15ml one time.

Telephone interview with a receptionist at the Adult Specialty/Infectious Disease Clinic on 08/04/23 at 3:05pm revealed:
-Resident #4 was last seen by an Infectious Disease physician on 03/02/23.
-Resident #4 had an appointment on 02/08/23 (Wednesday) that was canceled by the facility and re-scheduled for 03/02/23.
-Resident #4 had an appointment on 05/25/23 (Thursday) that was canceled by the facility and rescheduled for 06/22/23.
-Resident #4 had an appointment on 06/22/23 (Thursday) that was canceled by the provider due to the provider not being there and was rescheduled for 07/05/23.
-Resident #4 had an appointment on 07/05/23 (Wednesday) that was a no show.

Interview with Resident #4 on 08/04/23 at 10:20am revealed:
-Staff emptied the JP drainage bulb and took care of it for him.
-He would like the JP drain to be removed.
-He would be more comfortable without the JP drain.

Interview with the Resident Care Coordinator (RCC) on 08/04/23 at 2:20pm revealed:
-She was a medication aide (MA) prior to April 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 20 -She was not familiar with Resident #4's appointments before that time. -The Assistant RCC was responsible for making residents' appointments and providing transportation to those appointments. Interview with the Assistant RCC on 08/04/23 at 5:00pm revealed: -She was responsible for scheduling all residents' appointments and providing the transportation to their appointments. -Resident #4's appointments were missed sometimes because of the resident having dialysis on Monday, Wednesday, and Friday and he would leave the facility around 12:00pm. -The last appointment she took Resident #4 to, the physician said that once the amount of drainage was less than 10ml, they may be able to remove the JP drain. -She usually reviewed the physician and hospital visit summary reports and placed the appointments on the calendar. -Sometimes the physician office may call and leave a message with another staff person regarding the resident's appointment, and she may not know that the appointment was on his dialysis day until the appointment was near. -She would have to call the physician's office to try to reschedule. -She did not know why Resident #4's appointment to follow-up with Surgery on 01/30/23 was missed. -She did not make an appointment with VIR to see if Resident #4's JP drain could be removed. Interview with the Administrator on 08/04/23 at 5:15pm revealed: -The Assistant RCC was responsible for scheduling appointments and providing transportation for the residents to their	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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

appointments.
-Resident #4 missed some of his doctor's appointments due to the resident going to dialysis on Monday, Wednesday, and Friday.
-She was not aware the appointments on 01/30/23 and 05/25/23 were missed.
-She was aware the appointment on 07/05/23 was missed due to dialysis.
-She did not know why he missed his appointments on non-dialysis days.
-She was concerned about Resident #4 missing his appointments because they were important to ensure he was getting the care he needed.
-She expected Resident #4 to make his appointments when scheduled.

Telephone interview with Resident #4's primary care provider (PCP) on 08/04/23 at 4:45pm revealed:
-Resident #4 had a drainage tube placement due to an abscess in the left thigh caused by myositis.
-The care of the JP drain was being managed by home health skilled nursing.
-The myositis was being managed by Infectious Disease.
-She was aware the resident was sent to the emergency room (ER) in January 2023 due to an infection of the JP drain.
-She was aware the resident was sent to the ER in May 2023 due to a clogged and leaking JP drainage tube due to the dislocation of the tube.
-She was not aware of the missed appointments for Surgery, Infectious Disease and the referral to VIR for possible drain removal.
-The facility was aware of Resident #4's dialysis schedule and should be able to make appointments around that schedule.
-She expected routine appointments with the Infectious Disease physician for management of the JP drain to be kept because they were critical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 22 for his care. -Resident #4's JP tube could have been discontinued had he made his appointments with the Infectious Disease physician. -She expected to be notified when Resident #4 did not make all of his appointments, especially Infectious Disease. Telephone interview with an Infectious Disease Physician on 08/04/23 at 3:23pm revealed: -The Infectious Disease physician last saw Resident #4 on 03/02/23. -Resident #4 had an abscess with a drainage tube placement. -A clogged JP drain could cause pain, a delay in healing and removal of the tube, and an infection that could lead to sepsis resulting in organ failure and death. Attempted telephone interview with Resident #4's family member on 08/03/23 at 5:10pm was unsuccessful. _____ The facility failed to meet the routine and acute health care needs of a resident who was diagnosed with a rare autoimmune inflammation of the skeletal muscles with a fluid-filled abscess in the left thigh with a temporary closed suction medical device (Jackson-Pratt Drain) who missed an appointment with Surgery 01/30/23, which was not rescheduled and appointments with Infectious Disease (02/08/23, 05/25/23 and 07/05/23). The resident also had orders to schedule appointments if the drainage from JP drain was less than a specified amount with Vascular Interventional Radiology for possible JP drain removal. The drainage was less than the specified amount on at least 38 occasions. The missed appointments resulted in a resident having a temporary JP drain from October 2022	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23 through August 2023. This failure resulted in serious neglect of Resident #4 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/04/23. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 03, 2023.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of an order to flush a Jackson Pratt drain and document the amount of drainage from a closed suction medical device used to collect bodily fluids from a surgical site for 1 of 5 sampled residents (#4) as ordered. The findings are: Review of Resident #4's current FL-2 dated 05/16/23 revealed: -Diagnoses included end stage renal disease with	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 24	D 276		

hemodialysis, seizure, acid reflux, hypertension, avascular necrosis, left non-traumatic intracerebral ventricular hemorrhage, and myositis.
-There was no documentation of a Jackson Pratt (JP) drain (A JP drainage tube is a closed suction medical device used to collect bodily fluids from a surgical site. The device consists of an internal drain connected to a grenade-shaped bulb via a tube).

Review of Resident #4's previous FL-2 dated 11/04/22 revealed:
-Diagnoses included acid reflux, left non-traumatic intracerebral ventricular hemorrhage, hypertension, avascular necrosis, seizure disorder, and end state renal disease.
-There was no documentation of a JP drain.

Review of a facility progress note dated 11/04/22 revealed resident #4 was admitted back to the facility on 11/04/22 at 4:50pm from a skilled nursing/rehabilitation facility.

Review of Resident #4's physician order from the skilled nursing/rehabilitation facility dated 11/03/22 revealed instructions for assisted living facility staff to empty the JP drain at 8:00am and 8:00pm daily.

Review of the Fact Sheet in Resident #4's record when the JP drain was placed in 10/12/22 revealed:
-Proper JP drain care was essential to your physical recovery.
-Drains prevented the buildup of blood and fluid from occurring in the surgical site.
-When the drain was squeezed, a vacuum is created.
-This suction helped to draw out any fluid

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 25	D 276		

collections.
-The collection bulb should always be collapsed (flat) to maintain continuous suction.
-The bulb needed to be emptied when it is filled with fluid or the bulb is no longer on suction.
- The JP drain output needed to be properly measured and recorded for your surgeon to determine when it can be safely removed.
-There were instructions on how to empty a JP drain.
-There were instructions on how to strip a JP drain if clogged.
-The physician may typically remove the drain when drainage output was less than 30ml per day for two consecutive days.

Review of Resident #4's JP drainage log from 11/04/22 through 11/06/22 revealed:
-On 11/04/22, drainage was 20 ml at 8:00pm
-On 11/05/22, drainage was 50cc at 1:45pm by Home Health (HH) nurse.
-On 11/05/22, drainage was very little at 9:30pm.
-On 11/06/22, drainage was very little.

Review of Resident #4's Infectious Disease physician order dated 11/07/22 revealed:
-There was an order to flush the JP drain with 10ml normal saline (NS), measure and record output twice a day and send record with resident to follow-up visit.
-There was an order to notify the physician when drainage output was less than 10ml for 3 consecutive days.

Review of Resident #4's JP drainage output from 11/07/22 through 12/06/22 revealed:
-On 11/07/22, drainage was 50 ml at 9:00am.
-On 11/07/22, drainage was 25ml.
-On 11/08/22, drainage was less than 5 ml.
-On 11/08/22, drainage was 15ml.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 26 -On 11/08/22, drainage was less than 5 ml. -On 11/09/22, drainage was very little. -On 11/09/22, drainage was 20ml. -On 11/09/22, drainage was 15ml. -On 11/12/22, drainage less than 25ml. -On 11/13/22, drainage was 10ml. -On 11/13/22, drainage was 25ml.. -On 11/17/22, drainage was 25ml. -On 11/17/22, drainage was 25ml. -On 11/17/22, drainage was less than 15ml. -On 11/17/22, drainage was 20ml by HH nurse. -On 11/18/22, drainage was 25ml. -On 11/19/22, drainage was 25ml. -On 11/21/22, drainage was 10ml by HH nurse. -On 11/25/22, drainage was 25ml. -On 11/25/22, drainage was 25ml. -On 11/26/22, drainage was less than 5ml. -On 11/26/22, drainage was less than 25ml. -On 11/27/22, drainage was less than 25ml. -On 11/28/22, drainage was less than 25ml. -On 11/28/22, drainage was less than 5ml. -On 11/29/22, drainage was less than 25ml. -On 11/29/22, drainage was 18ml by HH nurse. -On 11/30/22, drainage was 25ml. -On 12/01/22, drainage was less than 25ml. -On 12/01/22, drainage was less than 25ml. -On 12/01/22, drainage was less than 20ml by HH nurse. -On 12/02/22, drainage was 20ml. -On 12/03/22, drainage was 25ml. -On 12/05/22, drainage was less than 25cc. -On 12/06/22, drainage was 15ml by HH nurse -The drainage output was not recorded 30 times from 11/07/22 through 12/06/22. Review of Resident #4's Infectious Disease physician order dated 12/08/22 revealed: -There were instructions to record JP drain output twice a day, flush JP drain with 10 ml NS twice a day, and keep bulb to suction, bring drain output	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 27	D 276		

record to follow-up visits.
-There was an order to notify the physician when drainage output was less than 10ml for 3 consecutive days.

Review of Resident #4's JP drainage output log from 12/08/22 through 12/31/22 revealed:
-On 12/08/22, drainage was less than 25ml.
-On 12/09/22, drainage was less than 15ml.
-On 12/09/22, drainage was 25ml.
-On 12/10/22, drainage was less than 25 ml.
-On 12/10/22, drainage was less than 15ml.
-On 12/12/23, drainage was 15ml.
-On 12/15/23, drainage was 10ml by HH nurse.
-On 12/16/22, drainage was 50ml.
-On 12/31/22, drainage was 30ml from 6:00am to 2:00pm.
-On 12/31/22, drainage was less than 15ml at 5:30pm.
-The drainage output was not recorded from 12/08/22 through 12/31/22 38 times.

Review of Resident #4's Infectious Disease physician visit consultation report dated 01/17/23 revealed:
-The reason for the for visit was for lower left extremity (LLE) myositis.
-The physician assessment notes revealed LLE with myositis, drain in place, CT (computerized tomography) with persistent fluid collection despite antibiotic treatment and drainage.
-There were instructions to refer resident to surgery regarding fluid collection and future drain evaluation.
-There were orders to flush the JP drain with 10ml of normal saline (NS) twice a day and keep to bulb suction.

Review of Resident #4's JP drainage output log from 01/01/23 through 01/24/23 revealed:.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 28 -On 01/01/23, drainage was 20ml from 6:00am to 2:00pm. -On 01/01/23, drainage was 25ml from 2:00pm to 10:00pm. -On 01/02/23, drainage was less than 8ml at 2:00pm to 10:00pm. -On 01/03/23, drainage was 30 ml by HH nurse. -On 01/04/23, drainage was 25ml from 2:00pm to 10:00pm -On 01/05/23, drainage was 7.5ml from 6:00am to 2:00pm. -On 01/05/23, drainage was less than 10ml from 2:00pm to 10:00pm. -On 01/06/23, drainage was 10ml at 9:42am. -On 01/06/23, drainage was 16ml from 2:00pm too 10:00pm. -On 01/10/23, drainage was zero. -On 01/10/23, drainage was 20ml by HH nurse. -On 01/11/23, drainage was less than 10ml at 6:00am. -On 01/11/23, drainage was less than 5ml at from 2:00pm to 10:00pm. -On 01/12/23, drainage was zero from 6:00am to 2:00pm. -On 01/12/23, drainage was less than 3ml at 2:00pm to 10:00pm. -On 01/17/23, drainage was zero at 2:00pm to 10:00pm. -On 01/18/23, drainage was zero at 2:00pm to 10:00pm. -On 01/18/23, drainage was 45 ml, the odor was very strong and leg appeared to be swollen. -On 01/20/23, drainage was 45ml at 6:00am to 10:00pm , drainage color was brown with a strong odor, and insertion site was swollen. -Resident #4 was in the hospital from 01/20/23 through 01/25/23. -The drainage output was not documented 21 times from 01/01/23 through 01/20/23.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 29	D 276		

Review of Resident #4's hospital discharge summary dated 01/25/23 revealed:
-Resident #4 was in the hospital from 01/20/23 to 01/25/23 due to an abscess of left lower extremity (LLE) that had pain and swelling.
-The resident was noted to be septic on this visit from the pyomyositis.
-Antibiotic therapy was recommended by Infectious Disease for suppression.
-No surgery was recommended by Orthopaedic at this time due to the risk regarding the hip hardware.
-There was a recommendation to monitor drainage output and once the amount was less than 10ml, refer to VIR (Vascular Interventional Radiology) for removal of drainage tube.

Review of Resident #4's JP drain log for 01/25/23 through 01/31/23.
-On 01/25/23, drainage was zero at 5:37am.
-On 01/25/23, drainage was 20ml at 2:00pm to 10:00pm
-The drainage output was not documented 12 times from 01/25/23 through 01/31/23.

Review of Resident #4's February 2023 JP drainage output log revealed:
-On 02/02/23, drainage was 40ml recorded by HH nurse.
-On 02/10/23, drainage was 10ml recorded by HH nurse.
-On 02/25/23, drainage was 20ml recorded by HH nurse.
-The drainage output was not documented 53 times during February 2023.

Review of Resident #4's March 2023 JP drainage output log revealed:
-On 03/03/23, drainage was 25ml at 5:20am
-On 03/04/23, drainage was 5 ml at 4:25am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 276	Continued From page 30 -On 03/04/23, drainage was 5 ml at 5:48pm. -On 03/05/23, drainage was 7.5ml. -On 03/05/23, drainage was 7.5ml. -On 03/06/23, drainage was 5ml. -On 03/07/23, drainage was 10ml at 4:43am. -On 03/07/23, drainage was 15ml at 9:29pm. -On 03/07/23, drainage was 10ml recorded by HH nurse. -On 03/08/23, drainage was less than 10ml at 9:02pm. -On 03/09/23, drainage was zero at 5:00am. -On 03/11/23, drainage was zero at 10/29/23. -On 03/12/23, drainage was 7.5ml at 4:26am. -On 03/12/23, drainage was 7.5ml at 10:34am -On 03/14/23, drainage was 30ml. -On 03/14/23, drainage was 20ml recorded by HH nurse. -On 03/15/23, drainage was 15ml. -On 03/16/23, drainage was 2.5ml. -On 03/18/23, drainage was 15ml. -On 03//18/23, drainage was 7.5ml -On 03/19/23, drainage was 7.5ml -On 03/20/23, drainage was 15ml -On 03/21/23, drainage was 25ml. -On 03/23/23, drainage was 7.5ml. -On 03/24/23, drainage was 10ml recorded by HH nurse. -On 03/25/23, drainage was 7.5ml. -On 03/28/23, drainage was 10ml. -On 03/28/23, drainage was 25ml. -On 03/28/23, drainage was 10ml recorded by HH nurse. -On 03/30/23, drainage was 7.5ml. -On 03/30/23, drainage was 7.5ml. -The drainage put was not recorded 32 times for the March 2023. Review of Resident #4's April 2023 JP drainage output log revealed: -On 04/01/23, drainage was 15ml.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 31 -On 04/04/23, drainage was 10ml recorded by HH nurse. -On 04/07/23, drainage was 25ml. -On 04/14/23, drainage was 15ml. -On 04/15/23, drainage was 15ml. -On 04/16/23, drainage was 7ml. -On 04/17/23 drainage was 30ml. -On 04/18/23, drainage was 50ml, dark red color. -On 04/20/23, drainage was 5ml, dark red color. -On 04/21/23, drainage was 30ml , dark red color. -On 04/22/23, drainage was 15ml, red in color. -On 04/24/23, drainage was 10ml , red in color. -On 04/24/23, drainage was 10ml, red in color. -On 04/25/23, drainage was 1ml , red in color. -On 04/26/23, drainage was 5ml , red yellowish in color. -On 04/26/23, drainage was 15ml , red yellowish in color. -On 04/27/23, drainage was 5ml, red yellowish in color. -Drainage output was not recorded 31 times in April 2023. Review of Resident #4's ER discharge summary report dated 05/03/23 revealed: -Resident #4 went to the ER on 05/03/23 for a wound check. -The JP drain was clogged and not draining. -There were instructions to coordinate with interventional radiology to have the drain removed when drain output was less than 15ml/day for 2 consecutive days. Review of Resident #4's May 2023 JP drainage output log revealed: -On 05/02/23, drainage was 20ml. -On 05/10/23, drainage was 15ml. -On 05/10/23, drainage was 10ml by HH nurse. -On 05/11/23, drainage was 15ml. -On 05/11/23, drainage was less than 25ml.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 32	D 276		

-On 05/12/23, drainage was zero.
-On 05/12/23, drainage was 5ml.
-On 05/13/23, drainage was less than 5ml.
-On 05/13/23, drainage was less than 5ml.
-On 05/14/23, drainage was 5ml.
-On 05/15/23, drainage was 10ml.
-On 05/15/23, drainage was 20 ml
-On 05/16/23, drainage was 7.5ml.
-On 05/16/23, drainage was 5ml.
-On 05/17/23, drainage was zero.
-On 05/17/23, drainage was 10ml.
-On 05/18/23, drainage was 10ml.
-On 05/18/23, drainage was 7.5 ml.
-On 05/20/23, drainage was 10ml.
-On 05/21/23, drainage was 10 ml.
-On 05/21/23, drainage was 5ml.
-On 05/22/23, drainage was zero.
-On 05/23/23, drainage amount was unreadable.
-On 05/25/23, drainage was 5ml.
-On 05/26/23, drainage was 20ml recorded by HH nurse.
-On 05/27/23, drainage was 5ml..
-On 05/28/23, drainage was 5ml.
-On 05/29/23, drainage was 2.5.
-On 05/29/23, drainage was 5ml.
-On 05/30/23, drainage was 2.5ml.
-On 05/30/23, drainage was 2.5ml. -On 05/31/23, drainage was 2.5.
-The drainage output was not recorded 29 times during May 2023.

Review of Resident #4's June 2023 JP drainage output log revealed:
-On 06/01/23, drainage was 2.5ml.
-On 06/02/23, drainage was less than 5ml.
-On 06/03/23, drainage was less than 5ml.
-On 06/05/23, drainage was less than 5ml.
-On 06/16/23, drainage was less than 2.5ml, drainage was dark and slight odor.
-The drainage output was not recorded 55 times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 33 during June 2023. Review of Resident #4's July 2023 JP drainage output log revealed: -On 07/31/23, drainage was zero. -On 07/31/23, drainage was zero. -The drainage output was not recorded 60 times during July 2023. Review of Resident #4's August 2023 JP drainage output log revealed: -On 08/01/23, drainage was 10ml . -On 08/01/23, drainage was 10ml. -On 08/02/23, drainage was 5ml. -On 08/02/23, drainage was zero. -On 08/02/23, drainage was zero. -On 08/03/23, drainage was 10ml. -On 08/03/23, drainage was zero. Review of Resident #4's home health (HH) visit notes revealed: -The resident was admitted to home health skilled nursing for JP drain management and dressing change on 11/07/22 which included inspecting the insertion site for infection, emptying and recording the amount of drainage, compressing the bulb, flushing the drainage tube, and recording smell and order. -The HH nurse made 35 visits to the facility from 11/07/22 through 06/22/23. -Home Health visits to the facility were made on 11/07/22, 11/10/22, 11/17/22, 11/21/22, 11/29/22, 12/01/22, 12/06/22, 12/15/22, 12/20/22, 12/27/22, 01/02/23, 01/10/23, 01/19/23, 01/31/23, 02/02/23, 02/10/23, 02/17/23, 02/23/23, 02/24/23, 02/25/23, 03/02/23, 03/07/23, 03/14/23, 03/24/23, 03/28/23, 04/04/23, 04/11/23, 05/03/23, 05/10/23, 05/12/23, 05/15/23, 05/16/23, 05/29/23, 06/05/23, and 06/22/23. -On 01/31/23, the HH nurse informed the	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 34 Resident Care Coordinator (RCC) to contact VIR (Vascular and Interventional Radiology) when the JP drainage was less than 10cc/24hrs. -On 02/02/23, the HH nurse observed drain was not compressed for suction; she re-educated staff to keep bulb always compressed. -On 05/03/23, the HH nursed observed sutures loose and red purulent drainage; the PCP was notified. -On 05/12/23, the HH nurse observed the port flow turned off; she re-educated staff on the port flow to be opened and not closed. -On 05/15/23, the HH nurse observed the sutures to be loose. -On 06/05/23, the HH nurse observed the sutures to be loose; the PCP was notified. -On 06/22/23, the HH nurse observed the sutures to be loose. -The JP drain was documented as flushed 35 times by the HH nurse from 11/07/22 through 06/22/23. Interview with a former employee on 08/02/23 at 3:37pm revealed: -Resident #4's JP drainage bulb was not consistently emptied and the amount recorded. -There was no place to record the drainage amount that she was aware of. -He had gone to the emergency room (ER) for a possible infection of the JP drain. Interview with a medication aide (MA) on 08/03/23 at 3:20pm revealed: -The MA's provided care to Resident #4's JP drainage tube, to be done on each shift. -She was instructed by other MA's on how to care for the JP drain. -She was instructed to empty the bulb, record the amount of drainage, and compress the bulb; she did not know why the bulb had to be compressed.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 276	Continued From page 35 -The care of the JP drainage tube was not listed on the electronic medication administration record (eMAR) or any place else that she was aware of. -She just knew to provide care for the JP drainage tube by "word of mouth" from other MA's. -There used to be a composition book on top of the medication cart to record the amount of drainage from the JP drain, but she had not seen it for a while. -She thought a home health nurse came in to clean around the insertion site, change the bulb when needed and provide other care. Telephone interview with the facility's contracted home health case manager on 08/03/23 at 3:20pm revealed: -The HH agency provided JP drainage tube care to Resident #4 for about 6 to 9 months. -The HH agency discharged Resident #4 in June 2023 and have not provided JP drain care since that time. -Services included inspecting the JP drain site for infection, flushing the tube, emptying the bulb, compressing the bulb, and recording the amount of drainage and color. Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 9:10am revealed: -She was not a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). -She was a MA prior to April 2023. -The home health nurse showed her how to care for Resident #4's JP drain. -She trained the other MAs on how to provide care to Resident #4's JP drain including emptying the bulb, compressing the bulb, recording the amount of drainage, documenting the color and smell of the drainage, and looking for any signs of	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 36	D 276		

infection such as redness, swelling and pain.
-Only the MAs provided care to the JP drainage tube.
-There had been some issues with the JP drainage tube.
-The home health nurse notified her that Resident #4's JP drain tube was clogged and not draining and leaked due to dislocation of the tube, and she sent the resident to the emergency room (ER); she could not recall the timeframe.
-The home health nurse showed her how to unclog the JP drain should it happen again, and she trained the other MAs.
-She did a "walk through" every morning and observed Resident #4's JP drain.
-There were times she had to remind staff to empty, record drainage amount and compress the bulb for Resident #4's JP drain because it had not been done.
-The home health nurse used to come in 2-3 times a week to provide care to the JP drain, including flushing the tube, but their services had been discontinued due to recertification requirements.
-She was trained by the HH nurse on how to flush the JP drain and she flushed the JP drain now that HH was no longer coming to the facility.
-Staff was supposed to empty the JP drain bulb, compress the bulb, and document the amount of drainage in a book on top of the medication cart each shift (three times a day).
-She was not familiar with any orders to provide JP drain care twice a day.
-She went by the information on the Fact Sheet that came with Resident #4 when the JP drain was placed on 10/12/22.

Interview with the Administrator on 08/02/23 at 5:10pm revealed:
-When Resident #4 was admitted to the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 37 back in November 2022, there was an LPN on staff. -The JP drainage amount should be documented per physician order. -The facility will have their contracted pharmacy to place the JP drainage order on the eMAR to ensure documentation. Telephone Interview with Resident #4's PCP on 08/03/23 at 4:30pm revealed: -Resident #4 had a JP drain placed in his left thigh in October 2022 to drain an abscess caused by myositis. -She was not aware unlicensed staff were providing care to the JP drain. -It was her understanding the care of the JP drain was to be managed "completely" by home health skilled nursing. -She was not aware there was an order to document drainage output from the JP drain and to notify the physician when less than a specified amount over a period of time. -Had she known there was an order to document drainage output, she would have reviewed the drainage output log during her routine visits to the facility every Tuesday. -The order should have been followed as ordered for the health care needs of the resident. -If the JP drainage tube was not being flushed, emptied and compressed, it could possibly cause the JP drainage tube to become clogged that could result in an infection and delay in wound healing. Telephone interview an Infectious Disease Physician on 08/04/23 at 3:23pm revealed: -The Infectious Disease physician last saw Resident #4 in May 2023. -Resident #4 had an abscess with a drainage tube placement.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 276	Continued From page 38 -If a JP drainage tube was not properly managed including emptying and flushing the tube, this could cause the tube to become clogged. -A clogged JP drainage tube could cause pain, a delay in healing and removal of the tube, and an infection that could lead to sepsis that could result in organ failure and death. Attempted telephone interview with Resident #4's family member on 08/04/23 at 5:10pm was unsuccessful. _____ The facility failed to implement physician orders to flush, drain and record drainage output twice daily as ordered for a resident who had a Jackson Pratt drain which resulted in a hospitalization for an abscess and sepsis and a emergency room visit for a clogged drain. This failure resulted in physical harm and neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/04/23. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 03, 2023.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph	D 280		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 280	Continued From page 39 (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an on-site review and evaluation was conducted by a licensed professional to include a physical assessment of the resident and the care to be provided for 1 of 5 (#4) sampled resident who had a closed suction medical device used to collect bodily fluids from a surgical site. The findings are: Review of Resident #4's current FL-2 dated 05/06/23 revealed diagnoses included end stage renal disease with hemodialysis, seizure, acid reflux, hypertension, avascular necrosis, left non-traumatic intracerebral ventricular hemorrhage, and myositis.	D 280		

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D 280	Continued From page 40 Review of Resident #4's Resident Register revealed an admission date of 06/25/20. Review of Resident #4's emergency room (ER) discharge summary report dated 01/25/23 revealed: -Resident #4 was in the hospital from 01/20/23 to 01/25/23 due to an abscess of left lower extremity (LLE) that had pain and swelling. -A JP drain was placed in the outer upper aspect of the resident's left thigh due to an abscess on 10/12/22 during a prior hospitalization). (A JP drain is a closed suction medical device used to collect bodily fluids from a surgical site. The device consisted of an internal drain connected to a grenade-shaped bulb via a tube). Review of the facility's progress note dated 11/04/22 revealed: -Resident #4 was admitted back to the facility on 11/04/22 at 4:50pm from a nursing/rehabilitation facility. -JP drainage was 20ml on 11/04/22 at 8:00pm. Observation of Resident #4's JP drain site on 08/04/23 at 4:30pm revealed: -The bulb was closed and compressed flat. -The sutures were attached to the tubing but no longer attached to the skin. -The skin surrounding the site was dry and had a darker pigmentation than other parts of the thigh. -The hole where the white plastic tube came out of had dry scaly skin around the hole. Review of Resident #4's physician order from the nursing/rehabilitation facility dated 11/03/22 revealed instructions for assisted living facility staff to empty the JP drain at 8:00am and 8:00pm daily.	D 280		

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D 280	Continued From page 41	D 280		

Review of Resident #4's Infectious Disease physician order dated 11/07/22 revealed:
-There was an order to flush the JP drain with 10ml normal saline (NS), measure and record output twice a day and send record with resident to follow-up visit.
-There was an order to notify the physician when drainage output was less than 10ml for 3 consecutive days.

Review of Resident #4's Infectious Disease physician order dated 12/08/22 revealed there were instructions to record the JP drain output twice a day, flush JP with 10ml with normal saline (NS) twice a day and keep bulb to suction.

Review of Resident #4's Infectious Disease physician order dated 01/07/23 revealed to flush JP drain with 10ml of NS twice a day and keep to bulb suction.

Review of Resident #4's Licensed Health Professional Support (LHPS) review and evaluation form dated 12/09/22 revealed:
-The JP drain was listed and checked off as a LHPS task.
-The JP drain was listed on the LHPS personal care task documenting that training was provided to staff.
-There was documentation resident was alert and oriented with confusion, ambulates with assistance of walker, on hemodialysis three times a week, no complaints voice, JP drain intact post surgery.

Review of Resident #4's LHPS review and evaluation form dated 03/29/23 revealed:
-The JP drain was listed and checked off as a LHPS task.
-The JP drain was listed on the LHPS task

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 280	Continued From page 42	D 280		

documenting that training was provided to staff.
Review of Resident #4's LHPS review and evaluation form dated 06/29/23 revealed:
-There were no LHPS task checked off related to the JP drain.
-There was no documentation that LHPS task training was provided to staff.
-There was documentation resident was alert and orientation with confusion, ambulatory with assistance of walker, on hemodialysis three times a week, JP drain still in place, resident on antibiotics and no complaints of pain.

Review of a medication aide's (MA) skills/competency evaluation revealed:
-The evaluation was dated 06/23/22 and no task was listed for care of the JP drain.
-There was no competency evaluation completed for the MA after the JP drain was placed in October 2022.
-There was documentation Resident #4 was alert and oriented, blood pressure (BP)was stable, weight was stable, and the resident had completed a 90 day course of Ciprofloxacin on 06/05/23.

Review of a second MA's skills/competency evaluation revealed:
-The evaluation was dated 12/09/20 and no task was listed for the care of Resident #4's JP drain.
-There was no competency evaluation completed for the MA after the JP drain was placed in October 2022.

Review of a third MA's skills/competency evaluation revealed:
-The evaluation was dated 05/11/22 and no task was listed for the care of Resident #4's JP drain.
-There was no competency evaluation completed for the MA after the JP drain was placed in

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 280	Continued From page 43 October 2022. Interview with the HH case manager on 08/03/23 at 3:20pm revealed: -Home health skilled nursing provided JP drain care to Resident #4 for about 6-9 months which included flushing and inspecting the drain for signs and symptoms (s/s) of infection, recording the amount of drainage, and emptying and compressing the bulb. -Home Health saw the resident 1-2 times a week. -There were a couple of times the bulb would not be compressed when they visited, and the HH nurse had to re-educate staff on compressing the bulb to maintain suction. -On one of the visits, when the HH nurse tried to flush the drain, it leaked from the insertion site. -She notified the MA and the primary care provider (PCP) and the resident was sent to the ER and the drain was replaced. -Home health discontinued services to Resident #4 in June 2023 due to needing to be re-certified. -The PCP was notified. Telephone interview with the LHPS Nurse on 08/04/23 at 5:20pm revealed: -She was a registered nurse and provided clinical training to staff at the facility. -She completed the LHPS review and evaluations on 12/09/22 and 03/29/23. -She did not observe or assessed Resident #4's JP drain on 03/29/23, she might have inspected the JP drain on 12/09/22 but could not recall. -She did not train unlicensed staff on providing care to Resident #4's JP drain. -She marked that staff were competent with caring for Resident #4's JP drain based on the facility informing her that staff had been trained by the home health nurse. -She could not recall who informed her that staff	D 280		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 280	Continued From page 44 had been trained. Telephone interview with the second LHPS Nurse on 8/04/23 at 4:40pm revealed: -She was a registered nurse who usually provided CPR (Cardio-pulmonary resuscitation) training to staff at the facility. -She completed the LHPS review and evaluation form on Resident #4 dated 06/29/23. -She could not recall seeing Resident #4. -She was not aware Resident #4 had a JP drain in place. -Had she known Resident #4 had a JP drain, she would have trained staff and checked it off on the LHPS review and evaluation form. Interview with a medication aide (MA) on 08/03/23 at 3:20pm revealed: -The MAs provided care to Resident #4's JP drain. -She had never been trained on how to care for Resident #4's JP drain. -She was instructed by other MAs on how to care for the JP drain. -She was instructed to empty the bulb, record the amount of drainage, and compress the bulb; she did not know why the bulb had to be compressed. -The care of the JP drain was not listed on the electronic medication administration record (eMAR) or any place else that she was aware of. -She just knew to provide care for the JP drain by "word of mouth" from other MAs. -There used to be a composition book on top of the medication cart to record the amount of fluid drained from the JP drain, but she had not seen it for a while. -She thought a home health nurse came in to clean around the drain, change the bulb when needed and provide other care.	D 280		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 280	Continued From page 45 Interview with the Resident Care Coordinator (RCC) on 08/03/23 at 9:10am revealed: -She was not a registered nurse (RN) or a licensed practical nurse (LPN). -The home health nurse trained her on how to provide care to Resident #4's JP drain. -She trained the other MAs on how to provide care to Resident #4's JP drain including emptying the bulb, compressing the bulb, recording the amount of drainage, documenting the color and smell of the drainage, and looking for any signs of infection such as redness, swelling and pain. -Only the MAs provided care to the JP drain. -There had been some issues with the JP drain. -The JP drain was clogged and not draining and she sent the resident to the emergency room (ER); she could not recall the timeframe. -The home health nurse showed her how to unclog the JP drain and she trained the other MAs. -There was another time when the JP drain was dislodged and fluid was leaking from the insertion site; the resident was sent to the ER and the drain was replaced. -She did a "walk through" every morning and observed Resident #4's JP drain. -There were times she had to remind staff to empty and compress Resident #4's JP drain because it had not been done. -The home health nurse used to come in 2-3 times a week to provide care to the JP drain but they had discontinued their services in June 2023. Interview with the Administrator on 08/02/23 at 5:10pm revealed: -When Resident #4 was admitted to the facility back in November 2022, there was an LPN on staff. -The home health nurse did not train all MAs on	D 280		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 46	D 280		

the care of Resident #4's JP drain.
-The facility contracted with an LHPS nurse to provide clinical training to staff.
-She was not aware the JP drain was not listed on the LHPS review and evaluation form as a task and staff was not trained.
-It should have been listed on the LHPS task review and evaluation and training should have been provided for staff.

Telephone interview with Resident #4's primary care provider (PCP) on 08/03/23 at 4:30pm revealed:
-Resident #4 had a JP drain placed in his left thigh in October 2022 to drain an abscess because of an infection in the muscle.
-She was not aware unlicensed staff were providing care to the JP drain.
-It was her understanding the care of the JP drain was to be managed "completely" by home health skilled nursing.
-She was not aware home health skilled nursing was discontinued for Resident #4 in June 2023 due to needing to be recertified.
-She was aware Resident #4 was sent to the emergency room (ER) in May 2023 due to a clogged and leaking JP drain.
-If the JP drain was not draining and the bulb not emptied and compressed, it could possibly cause the JP drain to become clogged that could result in an infection and delay in wound healing.
-She expected unlicensed staff to be trained to provide JP drain care to Resident #4 to ensure the task was being properly performed for the safety of the resident.

Telephone interview with an Infectious Disease Physician on 08/04/23 at 3:23pm revealed:
-The Infectious Disease Clinic last saw Resident #4 on 03/02/23.

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 280	Continued From page 47 -Resident #4 had an abscess with a drainage tube placement. -If a JP drain was not property managed including emptying and compressing the bulb, and flushing the tube, this could cause the tube to become clogged. -A clogged JP drain could cause pain, a delay in healing and removal of the tube, and an infection that could lead to sepsis resulting in organ failure and death.	D 280		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to administer medications as ordered for 2 of 6 sampled residents (#3, #5) including a medication used to treat high blood sugars, blood pressure medication, a supplement, an inhaler (#3) and a cholesterol medication (#5). The findings are: 1. Review of Resident #3's current FL-2 dated 11/22/22 revealed diagnoses included type 2 diabetes, hypertension, and chronic obstructive pulmonary disease (COPD).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 48 a. Review of Resident #3's physician order sheet dated 03/02/23 revealed: -There was an order to check fingerstick blood sugar (FSBS) three times a day. -There was an order for Novolog (used to treat high blood sugars) 6 units twice daily hold if FSBS less than 150. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times a day scheduled at 7:00am, 11:00am, and 5:00pm. -There was an entry for Novolog inject 6 units twice daily hold if FSBS less than 150 scheduled for administration at 11:00am and 5:00pm. -FSBS was documented as 126 at 5:00pm on 06/15/23. -Novolog 6 units was documented as administered at 5:00pm on 06/15/23 when it should have been held. -FSBS was documented as 150 at 11:00am on 06/17/23. -Novolog 6 units was documented as "withheld per doctors orders" at 11:00am on 06/17/23 when it should have been administered. Review of Resident #3's July 2023 eMAR revealed: -There was an entry to check FSBS three times a day scheduled at 7:00am, 11:00am, and 5:00pm. -There was an entry for Novolog inject 6 units twice daily hold if FSBS less than 150 scheduled for administration at 11:00am and 5:00pm. -FSBS was documented as 129 at 5:00pm on 07/04/23. -Novolog 6 units was documented as administered at 5:00pm on 07/04/23 when it should have been held.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 49 -FSBS was documented as 125 at 5:00pm on 07/25/23. -Novolog 6 units was documented as administered at 5:00pm on 07/25/23 when it should have been held. Interview with Resident #3 on 08/02/23 at 3:21pm revealed she was not aware of ever receiving insulin when she did not need it or not getting insulin when she was supposed to receive it. Telephone interview with a medication aide (MA) on 08/03/23 at 12:23pm revealed: -She knew she was supposed to administer Resident #3's Novolog if her FSBS was 150 or greater. -Sometimes Resident #3 refused her insulin and that might be what happened on 06/17/23. -If Resident #3 refused insulin on 06/17/23 she would have documented it as refused. Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -MAs should not administer insulin to Resident #3 if her FSBS was less than 150. -If Resident #3's FSBS was 150 or greater she expected MAs to administer insulin as ordered. -It was important that MAs follow primary care provider (PCP) orders regarding administering insulin to Resident #3 because if insulin was administered when it should not be it could cause the resident's FSBS to become too low. Interview with the Administrator on 08/03/23 at 5:09pm revealed she expected MAs to administer insulin per PCP orders. Telephone interview with Resident #3's PCP on 08/04/23 at 2:21pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 50 -Novolog should not have been administered to Resident #3 for a FSBS below 150 because it could have caused her FSBS to drop which could cause the resident to experience fatigue, become cold and clammy, and could cause her to become nonresponsive if her FSBS dropped too low. -She expected MAs to administer Novolog to Resident #3 if her FSBS was 150 or greater. -Not administering Novolog to Resident #3 for a FSBS 150 or greater could cause the resident to have high FSBSs which could cause the resident to become tired, thirsty, or have increased urination. Attempted telephone interview with a second MA on 08/03/23 at 10:52am was unsuccessful. b. Review of Resident #3's current FL-2 dated 11/22/22 revealed: -There was an order for check blood pressure (BP) monthly. -There was an order for amlodipine (used to treat high BP) 5mg 2 tablets once a day. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 5 mg take 2 tablets once a day scheduled for administration at 7:00am. -Amlodipine 5mg 2 tablets was documented as administered 06/01/23 to 06/30/23 except on 06/03/23 and 06/04/23 where it was documented that the resident was out of the facility. -There was an entry for BP check, check and record blood pressure monthly. -BP was documented as 172/83 on 06/21/23. Review of Resident #3's July 2023 eMAR revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 51 -There was an entry for amlodipine 5mg take 2 tablets once a day scheduled for administration at 7:00am. -Amlodipine 5 mg 2 tablets was documented as administered 07/01/23 to 07/31/23 except on 07/02/23, 07/06/23, 07/07/23, 07/15/23, and 07/16/23 were it was documented as "waiting on RX" (RX is an abbreviation for prescription). -There was an entry for BP check, check and record blood pressure monthly. -BP was documented as 154/96 on 07/19/23. Observation of Resident #3's medications on hand on 08/02/23 at 2:14pm revealed there was a medication card containing 16 tablets of amlodipine 5mg that was dispensed on 07/19/23. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -Sixty tablets of amlodipine 5mg was dispensed for Resident #3 on 05/28/23, a 30 day supply. -Sixty tablets of amlodipine 5mg was dispensed for Resident #3 on 07/19/23, a 30 day supply. -There were no tablets of amlodipine 5mg dispensed to Resident #3 in June 2023. -There were no requests in the pharmacy's system to refill Resident #3's amlodipine 5mg in June 2023. -The contracted pharmacy only refilled prescriptions when it was requested by the facility. -The facility could request a refill on prescriptions by submitting it electronically on the eMAR system or by faxing a request to the pharmacy. -Once the facility requested a refill, they received the medication either that same day or the next day. -Based on dispensing records Resident #3 would not have had amlodipine available for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52 administration for 15 consecutive days in July 2023. Interview with Resident #3 on 08/03/23 at 1:47pm revealed she did not know if she was on a blood pressure medication or not. Interview with a medication aide (MA) on 08/02/23 at 3:06pm revealed: -It was a MA's responsibility to reorder medications for residents. -When a resident's medication got down to the blue area on the medication card a MA should reorder the medication. -There were 6 to 7 pills left when a medication card got down to the blue area. -When she reordered a medication for a resident, she pulled the label off the medication card and placed it on a medication reorder sheet and faxed it to the facility's contracted pharmacy. -She would then call the facility's contracted pharmacy to make them aware she had faxed a refill request. -If the requested medication was not in the facility by the next day, she would call the pharmacy to see why it was not sent. -Sometimes the pharmacy said they sent medication and they had not sent it. -If that happened, she would make the pharmacy aware the facility had not received the medication. -MAs did not document communication with pharmacy staff. Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -It was the MAs responsibility to reorder resident's medications. -A MA should reorder medications when they got	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 53	D 358		

down to the blue area on the medication card.
-A MA could reorder medications by requesting them from the pharmacy through the eMAR system or they could fax a refill request to the pharmacy.
-She was not sure why Resident #3's amlodipine had not been ordered before Resident #3 ran out of it.
-She was the RCC for the female resident's hall.
-She ran a report daily to make sure what medications were needed from the pharmacy.
-She also reviewed eMARs daily and if she saw "waiting on RX" on the eMAR she was supposed to follow up to see why the resident did not have the medication.
-She should also check with the MA to see if they had called the pharmacy about the medication.
-A resident should never go over one day without a medication.
-She was supposed to perform cart audits once a week but sometimes she got busy and was unable to do them.
-When she did perform a cart audit, she would pull the resident's eMAR and compare the medications on the eMAR to what was on the medication cart.
-If a resident's medication was not in the cart, she would call the pharmacy.

Interview with the Administrator on 08/03/23 at 5:09pm revealed:
-RCCs performed cart audits every Monday.
-A cart audit consisted of the RCC going through the medication cart to make sure all ordered medications were on the cart.
-If an ordered medication was not on the cart the RCC would order the medication from the pharmacy.
-It was important for residents to receive all ordered medications because not receiving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 54	D 358		

ordered medications could put their life in jeopardy.

Telephone interview with Resident #3's primary care provider (PCP) on 08/03/23 at 2:21pm revealed:
-She expected the facility to reorder resident's medications before they were due so the resident would not miss any doses of their medications.
-Resident #3 was ordered amlodipine for high blood pressure.
-Resident #3 not receiving amlodipine for several days in a row could cause her blood pressure to spike.

c. Review of Resident #3's physician order sheet dated 03/02/23 revealed there was an order for Trelegy (used to treat COPD) inhale 1 puff once daily.

Review of Resident #3's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Trelegy inhale 1 puff once daily scheduled for administration at 7:00am.
-Trelegy was documented as administered 07/01/23 to 07/31/23 except on 07/24/23, 07/29/23, and 07/30/23 where it was documented as "waiting on RX" (RX is an abbreviation for prescription).

Review of Resident #3's August 2023 eMAR revealed:
-There was an entry for Trelegy inhale 1 puff once daily scheduled for administration at 7:00am.
-Trelegy was documented as administered on 08/01/23 and 08/02/23.

Observation of Resident #3's medications on hand on 08/02/23 at 2:14pm revealed there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 55 no Trelegy on the medication cart. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -One inhaler of Trelegy was dispensed for Resident #3 on 06/18/23. -One inhaler of Trelegy contained 30 puffs of the medication which equaled a one-month supply. -One inhaler of Trelegy was dispensed for Resident #3 on 08/02/23. -Trelegy was not dispensed for Resident #3 in July 2023. -There were no requests in the pharmacy's system to refill Resident #3's Trelegy in July 2023. -The contracted pharmacy only refilled prescriptions when it was requested by the facility. -The facility could request a refill on prescriptions by submitting it electronically on the eMAR system or by faxing a request to the pharmacy. -Once the facility requested a refill, they received the medication either that same day or the next day. -Based on dispensing records Resident #3 would not have had Trelegy available for administration for 6 consecutive days in July 2023 and 2 consecutive days in August 2023 for a total of 8 consecutive days. Interview with Resident #3 on 08/03/23 at 1:47pm revealed: -She was currently out of her Trelegy inhaler. -She thought she had been out of her Trelegy inhaler a couple of days. -She took her Trelegy inhaler to help with her breathing. -She had not been short of breath in the past 2 to 3 months.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 56 Interview with a medication aide (MA) on 08/02/23 at 3:06pm revealed: -It was a MA's responsibility to reorder medications for residents. -There was a dose counter on Resident #3's Trelegy inhaler. -A MA should reorder Resident #3's Trelegy inhaler once the dose counter got down to 6 or 7. -When she reordered a medication for a resident, she pulled the label off the medication card and placed it on a medication reorder sheet and faxed it to the facility's contracted pharmacy. -She would then call the facility's contracted pharmacy to make them aware she had faxed a refill request. -If the requested medication was not in the facility by the next day, she would call the pharmacy to see why it was not sent. -Sometimes the pharmacy said they sent medication and they had not sent it. -If that happened, she would make the pharmacy aware the facility had not received the medication. -MAs did not document communication with pharmacy staff. Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -It was the MAs responsibility to reorder resident's medications. -She was not sure why Resident #3 ran out of her Trelegy inhaler. -She was the RCC for the female resident's hall. -She ran a report daily to make sure what medications were needed from the pharmacy. -She also reviewed eMARs daily and if she saw "waiting on RX" on the eMAR she was supposed to follow up to see why the resident did not have	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 57	D 358		

the medication.
-She should also check with the MA to see if they had called the pharmacy about the medication.
-A resident should never go over one day without a medication.
-She was supposed to perform cart audits once a week but sometimes she got busy and was unable to do them.
-When she did perform a cart audit, she would pull the resident's eMAR and compare the medications on the eMAR to what was on the medication cart.
-If a resident's medication was not in the cart, she would call the pharmacy.

Interview with the Administrator on 08/03/23 at 5:09pm revealed:
-RCCs performed cart audits every Monday.
-A cart audit consisted of the RCC going through the medication cart to make sure all ordered medications were on the cart.
-If an ordered medication was not on the cart the RCC would order the medication.
-It was important for residents to receive all ordered medications because not receiving ordered medications could put their life in jeopardy.

Telephone interview with Resident #3's primary care provider (PCP) on 08/03/23 at 2:21pm revealed:
-She expected the facility to reorder resident's medications before they were due so the resident would not miss any doses of their medications.
-Resident #3 was ordered Trelegy for COPD.
-Resident #3 not receiving her Trelegy several days in a row could cause her to have a COPD exacerbation.
-A COPD exacerbation could cause Resident #3 to have shortness of breath, wheezing, cough, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 58 low oxygen saturation levels. d. Review of Resident #3's physician order sheet dated 03/02/23 revealed there was an order for potassium chloride (a supplement) 20meq 2 tablets daily. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20meq 2 tablets daily scheduled for administration at 7:00am. -Potassium chloride 20meq 2 tablets was documented 06/01/23 to 06/30/23 except on 06/03/23 and 06/04/23 where it was documented the resident was out of the facility and on 06/12/23 and 06/16/23 where it was documented as "waiting on RX" (RX is an abbreviation for prescription). Observation of Resident #3's medications on hand on 08/02/23 at 2:14pm revealed: -There was a medication card containing 1 tablet of potassium chloride 20meq dispensed on 07/17/23. -There was a second medication card containing 30 tablets of potassium chloride 20meq dispensed on 07/17/23. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -Sixty tablets of potassium chloride 20meq was dispensed for Resident #3 on 05/08/23, a 30 day supply. -Sixty tablets of potassium chloride 20meq was dispensed for Resident #3 on 06/16/23, a 30 day supply. -Sixty tablets of potassium chloride 20meq was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 59 dispensed for Resident #3 on 07/17/23, a 30 day supply. -The contracted pharmacy only refilled prescriptions when it was requested by the facility. -The facility could request a refill on prescriptions by submitting it electronically on the eMAR system or by faxing a request to the pharmacy. -Once the facility requested a refill, they received the medication either that same day or the next day. -Based on dispensing records Resident #3 would not have had potassium chloride available for administration for 5 consecutive days in June 2023. Interview with a medication aide (MA) on 08/02/23 at 3:06pm revealed: -It was a MA's responsibility to reorder medications for residents. -When a resident's medication got down to the blue area on the medication card a MA should reorder the medication. -There were 6 to 7 pills left when a medication card got down to the blue area. -When she reordered a medication for a resident, she pulled the label off the medication card and placed it on a medication reorder sheet and faxed it to the facility's contracted pharmacy. -She would then call the facility's contracted pharmacy to make them aware she had faxed a refill request. -If the requested medication was not in the facility by the next day, she would call the pharmacy to see why it was not sent. -Sometimes the pharmacy said they sent medication and they had not sent it. -If that happened, she would make the pharmacy aware the facility had not received the medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 60 -MAs did not document communication with pharmacy staff. Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -It was the MAs responsibility to reorder resident's medications. -A MA should reorder medications when they got down to the blue area on the medication card. -A MA could reorder medications by requesting them from the pharmacy through the eMAR system or they could fax a refill request to the pharmacy. -She was not sure why Resident #3's potassium chloride had not been ordered before Resident #3 ran out of it. -She was the RCC for the female resident's hall. -She ran a report daily to make sure what medications were needed from the pharmacy. -She also reviewed eMARs daily and if she saw "waiting on RX" on the eMAR she was supposed to follow up to see why the resident did not have the medication. -She should also check with the MA to see if they had called the pharmacy about the medication. -A resident should never go over one day without a medication. -She was supposed to perform cart audits once a week but sometimes she got busy and was unable to do them. -When she did perform a cart audit, she would pull the resident's eMAR and compare the medications on the eMAR to what was on the medication cart. -If a resident's medication was not in the cart, she would call the pharmacy. Interview with the Administrator on 08/03/23 at 5:09pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 61	D 358		

-RCCs performed cart audits every Monday.
-A cart audit consisted of the RCC going through the medication cart to make sure all ordered medications were on the cart.
-If an ordered medication was not on the cart the RCC would order the medication.
-It was important for residents to receive all ordered medications because not receiving ordered medications could put their life in jeopardy.

Telephone interview with Resident #3's primary care provider (PCP) on 08/03/23 at 2:21pm revealed:
-She expected the facility to reorder resident's medications before they were due so the resident would not miss any doses of their medications.
-Resident #3 was ordered potassium chloride for a low potassium level.
-Resident #3 not received potassium chloride for several days in a row could cause her potassium to become lower.
-She had recently checked Resident #3's potassium level and it was not too low.

2. Review of Resident #5's current FL-2 dated 07/25/23 revealed:
-Diagnoses included visual disturbance and stage 3 chronic kidney disease.
-There was an order for atorvastatin (used to treat high cholesterol) 20mg at bedtime.

Review of Resident #5's July 2023 electronic medication administration record (eMAR) revealed:
-There was an order for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm.
-Atorvastatin 20mg was documented as administered 07/01/23 to 07/31/23 except on 07/25/23 where it was documented as "waiting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62	D 358		

RX" (RX is an abbreviation for prescription) and on 07/27/23 where there was no documentation.

Review of Resident #5's August 2023 eMAR revealed:
-There was an order for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm.
-Atorvastatin was documented as "waiting on RX" on 08/01/23.

Observation of Resident #5's medications on hand on 08/02/23 at 2:25pm revealed there was no atorvastatin on the medication cart.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed:
-Thirty tablets of atorvastatin were dispensed for Resident #5 on 05/08/23, a 30 day supply.
-Thirty tablets of atorvastatin were dispensed for Resident #5 on 06/08/23, a 30 day supply.
-There was no atorvastatin dispensed for Resident #5 in July 2023 or August 2023.
-The contracted pharmacy only refilled prescriptions when it was requested by the facility.
-The facility could request a refill on prescriptions by submitting it electronically on the eMAR system or by faxing a request to the pharmacy.
-Once the facility requested a refill, they received the medication either that same day or the next day.

Interview with a medication aide (MA) on 08/02/23 at 3:06pm revealed:
-It was a MA's responsibility to reorder medications for residents.
-When a resident's medication got down to the blue area on the medication card a MA should reorder the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 358	Continued From page 63 -There were 6 to 7 pills left when a medication card got down to the blue area. -When she reordered a medication for a resident, she pulled the label off the medication card and placed it on a medication reorder sheet and faxed it to the facility's contracted pharmacy. -She would then call the facility's contracted pharmacy to make them aware she had faxed a refill request. -If the requested medication was not in the facility by the next day, she would call the pharmacy to see why it was not sent. -Sometimes the pharmacy said they sent medication and they had not sent it. -If that happened, she would make the pharmacy aware the facility had not received the medication. -MAs did not document communication with pharmacy staff. Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -It was the MAs responsibility to reorder resident's medications. -A MA should reorder medications when they got down to the blue area on the medication card. -A MA could reorder medications by requesting them from the pharmacy through the eMAR system or they could fax a refill request to the pharmacy. -She was the RCC for the female resident's hall. -She ran a report daily to make sure what medications were needed from the pharmacy. -She also reviewed eMARs daily and if she saw "waiting on RX" on the eMAR she was supposed to follow up to see why the resident did not have the medication. -She should also check with the MA to see if they had called the pharmacy about the medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 358	Continued From page 64 -A resident should never go over one day without a medication. -She was supposed to perform cart audits once a week but sometimes she got busy and was unable to do them. -When she did perform a cart audit, she would pull the resident's eMAR and compare the medications on the eMAR to what was on the medication cart. -If a resident's medication was not in the cart, she would call the pharmacy. Interview with the RCC on 08/03/23 at 2:56pm revealed: -She was the RCC for the male resident's hall. -It was the MAs responsibility to reorder a resident's medication whenever it was getting low so they did not run out of it. -She performed weekly cart audits to check to make sure that residents had all their medications on the medication cart. -If they did not have all their medications on the medication cart she would reorder the medication for them. -She did not know why Resident #5's atorvastatin did not get reordered before he ran out of the medication. Interview with the Administrator on 08/03/23 at 5:09pm revealed: -RCCs performed cart audits every Monday. -A cart audit consisted of the RCC going through the medication cart to make sure all ordered medications were on the cart. -If an ordered medication was not on the cart the RCC would order the medication. -It was important for residents to receive all ordered medications because not receiving ordered medications could put their life in jeopardy.	D 358		

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	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 358	Continued From page 65 Telephone interview with Resident #3's primary care provider (PCP) on 08/03/23 at 2:21pm revealed: -She expected the facility to reorder resident's medications before they were due so the resident would not miss any doses of their medications. -Resident #5 was ordered atorvastatin to treat high cholesterol. -Resident #5 not receiving atorvastatin several days in a row would probably not have any negative affect on him.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 367	Continued From page 66 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 6 sampled residents (#3, #5) including inaccurate documentation of a blood pressure medication, inhaler (#3), a cholesterol medication (#5), and a supplement (#3, #5). The findings are: 1. Review of Resident #3's current FL-2 dated 11/22/22 revealed diagnoses included type 2 diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). a. Review of Resident #3's current FL-2 dated 11/22/22 revealed there was an order for amlodipine (used to treat high BP) 5mg 2 tablets once a day. Review of Resident #3's July 2023 eMAR revealed: -There was an entry for amlodipine 5mg take 2 tablets once a day scheduled for administration at 7:00am. -Amlodipine 5 mg 2 tablets was documented as administered 07/01/23 to 07/31 23 except on 07/02/23, 07/06/23, 07/07/23, 07/15/23, and 07/16/23 were it was documented as "waiting on RX" (RX is an abbreviation for prescription). Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -Sixty tablets of amlodipine 5mg was dispensed for Resident #3 on 05/28/23. -Sixty tablets of amlodipine 5mg was dispensed for Resident #3 on 07/19/23. -There were no tablets of amlodipine 5mg	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 367	Continued From page 67	D 367		

dispensed to Resident #3 in June 2023.
-There were no requests in the pharmacy's system to refill Resident #3's amlodipine 5mg in June 2023.

Telephone interview with a medication aide (MA) on 08/03/23 at 12:23pm revealed:
-If a resident did not have a medication, it should be marked on the eMAR as waiting for prescription.
-It must have been a mistake when she documented that Resident #3 received medication that the facility did not have.

Refer to interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm.

Refer to interview with the Administrator on 08/03/23 at 5:09pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm.

b. Review of Resident #3's physician order sheet dated 03/02/23 revealed there was an order for Trelegy (used to treat COPD) inhale 1 puff once daily.

Review of Resident #3's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Trelegy inhale 1 puff once daily scheduled for administration at 7:00am.
-Trelegy was documented as administered 07/01/23 to 07/31/23 except on 07/24/23, 07/29/23, and 07/30/23 where it was documented as "waiting on RX" (RX is an abbreviation for prescription).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 68 Review of Resident #3's August 2023 eMAR revealed: -There was an entry for Trelegy inhale 1 puff once daily scheduled for administration at 7:00am. -Trelegy was documented as administered on 08/01/23 and 08/02/23. Observation of Resident #3's medications on hand on 08/02/23 at 2:14pm revealed there was no Trelegy on the medication cart. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -One inhaler of Trelegy was dispensed for Resident #3 on 06/18/23. -One inhaler of Trelegy contained 30 puffs of the medication which equaled a one-month supply. -One inhaler of Trelegy was dispensed for Resident #3 on 08/02/23. -Trelegy was not dispensed for Resident #3 in July 2023. -There were no requests in the pharmacy's system to refill Resident #3's Trelegy in July 2023. Interview with Resident #3 on 08/03/23 at 1:47pm revealed: -She was currently out of her Trelegy inhaler. -She thought she had been out of her Trelegy inhaler a couple of days. Telephone interview with a medication aide (MA) on 08/03/23 at 12:23pm revealed if f a resident did not have a medication, it should be marked on the eMAR as waiting for prescription. Refer to interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 69 Refer to interview with the Administrator on 08/03/23 at 5:09pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm. c. Review of Resident #3's physician order sheet dated 03/02/23 revealed there was an order for potassium chloride (a supplement) 20meq 2 tablets daily. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20meq 2 tablets daily scheduled for administration at 7:00am. -Potassium chloride 20meq 2 tablets was documented 06/01/23 to 06/30/23 except on 06/03/23 and 06/04/23 where it was documented the resident was out of the facility and on 06/12/23 and 06/16/23 where it was documented as "waiting on RX" (RX is an abbreviation for prescription). Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -Sixty tablets of potassium chloride 20meq was dispensed for Resident #3 on 05/08/23. -Sixty tablets of potassium chloride 20meq was dispensed for Resident #3 on 06/16/23. -Sixty tablets of potassium chloride 20meq was dispensed for Resident #3 on 07/17/23. Telephone interview with a medication aide (MA) on 08/03/23 at 12:23pm revealed if f a resident did not have a medication, it should be marked on the eMAR as waiting for prescription.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 367	Continued From page 70 Refer to interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm. Refer to interview with the Administrator on 08/03/23 at 5:09pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm. 2. Review of Resident #5's current FL-2 dated 07/25/23 revealed diagnoses included visual disturbance and stage 3 chronic kidney disease. a. Review of Resident #5's current FL-2 dated 07/25/23 revealed there was an order for calcitriol (a supplement) 0.25mcg once daily. Observation of the morning medication pass on 08/02/23 revealed: -Resident #5 refused calcitriol 0.25mcg. -Five pills were administered to Resident #5 at 8:29am on 08/02/23. -Resident #5 was not administered calcitriol 0.25mcg. Review of Resident #5's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for calcitriol 0.25mcg once daily scheduled for administration at 8:00am. -Calcitriol 0.25mcg was documented as administered at 8:00am on 08/02/23. Interview with the medication aide (MA) on 08/03/23 at 10:31am revealed: -Resident #5 refused his calcitriol during the morning medication pass on 08/02/23. -She should have documented Resident #5's	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 367	Continued From page 71	D 367		

calcitriol as refused on the eMAR.
-She made a mistake and documented that she administered calcitriol to Resident #5 because she was nervous.

Refer to interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm.

Refer to interview with the Administrator on 08/03/23 at 5:09pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm.

b. Review of Resident #5's current FL-2 dated 07/25/23 revealed there was an order for atorvastatin (used to treat high cholesterol) 20mg at bedtime.

Review of Resident #5's July 2023 electronic medication administration record (eMAR) revealed:
-There was an order for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm.
-Atorvastatin 20mg was documented as administered 07/01/23 to 07/31/23 except on 07/25/23 where it was documented as "waiting on RX" (RX is an abbreviation for prescription) and on 07/27/23 where there was no documentation.

Review of Resident #5's August 2023 eMAR revealed:
-There was an order for atorvastatin 20mg at bedtime scheduled for administration at 8:00pm.
-Atorvastatin was documented as "waiting on RX" on 08/01/23.

Observation of Resident #5's medications on hand on 08/02/23 at 2:25pm revealed there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074046	A. BUILDING: _____ B. WING _____	R-C 08/04/2023

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D 367	Continued From page 72 no atorvastatin. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/03/23 at 9:09am revealed: -Thirty tablets of atorvastatin were dispensed for Resident #5 on 05/08/23. -Thirty tablets of atorvastatin were dispensed for Resident #5 on 06/08/23. -There was no atorvastatin dispensed for Resident #5 in July 2023 or August 2023. Telephone interview with a medication aide (MA) on 08/03/23 at 12:23pm revealed if f a resident did not have a medication, it should be marked on the eMAR as waiting for prescription. Refer to interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm. Refer to interview with the Administrator on 08/03/23 at 5:09pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm. _____ Interview with the assistant Resident Care Coordinator (RCC) on 08/03/23 at 2:45pm revealed: -Medication aides (MA) should not document a medication that was not administered to a resident. -If a resident did not have a medication on the medication cart the MA should document that they were waiting for a prescription. -She ran a report daily to make sure what medications were needed from the pharmacy. -She also reviewed eMARs daily and if she saw "waiting on RX" on the eMAR she was supposed	D 367		

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
ALPHA CARE ONE ASSISTED LIVING	2060 WEST FIFTH STREET GREENVILLE, NC 27835

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D 367	Continued From page 73 to follow up to see why the resident did not have the medication. -If a MA was not documenting that a prescription was needed for a resident, she could not tell by looking at the eMAR that the resident was out of a medication. Interview with the Administrator on 08/03/23 at 5:09pm revealed she expected MAs to document accurately on a resident's eMAR because that is what the rules said to do. Telephone interview with the facility's contracted primary care provider (PCP) on 08/03/23 at 2:21pm revealed she expected MAs to document on eMARs accurately so if she looked at the eMAR she could see that a resident had not been receiving a medication.	D 367		