PRINTED: 09/22/2023 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPL	EIED
		FCL035034	B. WING		00/1	5/2023
					09/1	3/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	FON ROAD RG, NC 27549			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	0 Initial Comments		C 000			
	The Adult Care Licensure Section conducted an Annual and Follow-Up Survey on 09/14/23-09/15/23 with a telephone exit on 09/15/23.					
C 007	10A NCAC 13G .0200	6 Capacity	C 007			
	homes have a capaci (b) The total number exceed the number s (c) A request for an in adding rooms, remode modifications shall be department of social step the Division of Facility two copies of bluepring showing the existing of rooms and the secundition, remodeling showing the use of exconstruction, plans showing the proposed changes in (d) When licensed had existence of the exacutation capability from the evacuation of the evacuation capability from the	ty of two to six residents. of residents shall not hown on the license. Increase in capacity by eling or without any building a made to the county services and submitted to a Services, accompanied by this or floor plans. One plan building with the current use and plan indicating the for change in use of spaces ach room. If new shall show how the addition disting building and all the structure. In the addition to or sting physical plant, the set all current fire safety The licensee's designee shall facility Services if the overall of the residents changes capability listed on the ne addition of any be residing within the home. The besubmitted through the				

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TTON ROAD JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 007	Continued From page	÷ 1	C 007			
	Division of Facility Se	rvices for review of any t may be required to the				
	reviews, the facility fa Health Service Regularesident's evacuation from the evacuation of facility's license for 4 #2, #3, and #6) who rexit the facility during	ns, interviews, and record iled to notify the Division of				
	01/01/23 revealed the ambulatory residents.					
	revealed 6 residents r	•				
	revealed: -A fire rehearsal form system was activated of the alarm was dood detector, heat detectod description of the situ awake and time to ex -A fire rehearsal form	was dated 03/14/23; the at 6:00am; the origination umented as a smoke or, and pull station, and the ation was everyone was it the house was 4 minutes. was dated 06/30/23; the at 7:45am; the origination				

Division of Health Service Regulation

STATE FORM 6899 6Q8H11 If continuation sheet 2 of 71

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE S COMPLE	
		FCL035034	B. WING		09/1	5/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TON ROAD			
			RG, NC 27549		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 007	Continued From page	e 2	C 007			
	of the alarm was dock detector and the desce everyone was awake house was 2 minutes -A fire rehearsal form system was activated of the alarm was not description of the situ very safely to the loca minutes; it was docur -A fire rehearsal form system was activated of the alarm was dock detector and the desce everyone was awake quickly as they could; documented. Telephone interview was docked to the condition of	umented as a smoke cription of the situation was and the time to exit the . was dated 09/01/23; the lat 7:00am; the origination documented, and the ation was everyone moved ation and exit time was 4 mented verbally informed. was dated 09/05/23; the lat 6:00am; the origination umented as a smoke cription of the situation was and moved outside as there was no exit time with the facility's on 09/14/23 at 6:38pm ucted every three months. use an alarm on the to move out of the facility in ed the facility without conducted a fire drill. a fire drill sometime in late as conducted, she re."				
0.000	-She did not know sh they needed to exit th -She did not need to because the residents	e could not tell the residents ne facility. contact construction s could exit the facility.	0.022			
C 022	10A NCAC 13G .0302 Construction	z (b) Design And	C 022			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL035034	B. WING		09)/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTT	ON RD 1359 SU	ADDRESS, CITY, STATE ITTON ROAD URG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From pag	e 3	C 022			
	(b) Each home shall	2 Design And Construction be planned, constructed, ined to provide the services				
	reviews, the facility farevacuation capabilities the evacuation capabilities the evacuation capabilities the evacuation capabilities for 4 of #2, #3, and #6) including a facility (#1), one result and required physical facility during a fire different diagnosis of dehearing and did not result facility facility during a fire different facility facilit	ns, interviews, and record ailed to ensure the residents' es were in accordance with bility listed on the facility's of 6 sampled residents (#1, ding one resident who had a a and did not respond to the ident who was legally blind assistance to exit the rill (#2), one resident who ementia and was hard of espond to the fire drill (#3) o did not speak English and				
	Review of the facility 01/01/23 revealed the ambulatory residents Review of the facility revealed: -A fire rehearsal form	s current license effective e facility was licensed for 6 : s fire rehearsal schedule was dated 03/14/23; the d at 6:00am, the origination				

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DIVISION	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					1	
		FCL035034	B. WING		09/15/2023	
		FCE033034			09/15/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F DI FOCINCO AT CUTTO	1359 SU	TTON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	LOUISBU	JRG, NC 27549			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DEFICIENCY)		
C 022	Continued From page	e 4	C 022			
	of the alarm was doc	umented as a smoke				
		or, and pull station, and the				
		lation was everyone was				
	•	tit the house was 4 minutes.				
		was dated 06/30/23; the				
		at 7:45am, the origination				
	of the alarm was docu					
		cription of the situation was				
		and the time to exit the				
	house was 2 minutes					
	-A fire rehearsal form	was dated 09/01/23; the				
		at 7:00am, the origination				
	of the alarm was not					
		ation was everyone moved				
		ation and exit time was 4				
		mented verbally informed.				
	-A fire rehearsal form	was dated 09/05/23; the				
	system was activated	at 6:00am, the origination				
	of the alarm was doci					
	detector and the desc	cription of the situation was				
	everyone was awake	and moved outside as				
	quickly as they could;	; there was no exit time				
	documented.					
		pervisor in Charge (SIC) on				
	09/14/23 at 1:58pm re					
	-She performed fire d					
		software package that				
		orm specific tasks from their				
		er) on her telephone that				
	was for fire alarms.	hugu and agreeded the corre				
		lway and sounded the app				
	for the fire alarm.	until abo atatad "Fire drill"				
		intil she stated, "Fire drill."				
		s but two [named] residents				
		o of the residents needed				
	assistance exiting the	е іасіііту.				
	Telephone interview v	with the facility's				
		on 09/14/23 at 6:38pm				
	OWITE!/AUTIIIIISHALUI	on oar 14/20 at 0.30pm	- 1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
711272711	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _			
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUT	TON ROAD			
		LOUISBU	RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
C 022	Continued From page	e 5	C 022			
C 022	revealed: -Fire drills were cond -The process was to telephoneThe residents were to two minutesAll the residents exit assistance when she -She last conducted a 2022When the fire drill wa "screamed fire, fire, fi 1. Review of Resident 11/14/22 revealed: -Diagnoses listed we -The resident's sight Review of Resident # revealed: -There was an admis -There was a handwr legally blind. Review of Resident # plan dated 01/25/23 r -The resident was leg	ucted every three months. use an alarm on the o move out of the facility in ed the facility without conducted a fire drill. a fire drill sometime in late as conducted, she re." It #2's current FL-2 dated re not legible. was limited. E2's Resident Register sion date of 01/25/23. itten note the resident was E2's assessment and care revealed:	0.022			
	-	reminders. d limited assistance from ting, ambulation/locomotion,				
	bathing, dressing, groand transferring.	ooming/personal hygiene, igned by Resident #2's PCP				
	on 06/02/23.					
	(PCP) after visit sumrevealed:	2's Primary Care Provider mary dated 06/02/23 blindness, schizoaffective				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY	
		FCL035034	B. WING		09/	15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SU	TTON ROAD			
		LOUISBI	URG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From page	e 6	C 022			
	disorder, and mild va psychotic disturbance -Current medication i cognition-enhancing dementia).	es.				
	times between 7:30al 4:00pm-6:30pm revel assisted by the SIC v	acility on 09/14/23 at various m-7:45am and aled Resident #2 was when walking from one place e and outside the facility.				
	Observations of the facility on 09/14/23 at 5:12pm and 5:24pm revealed: -The fire alarm was sounded by the SIC at 5:12pm using the app on her telephoneResident #2 was sitting in the living roomResident #2 remained seatedA second fire alarm was sounded by the SIC at 5:24pm by activating the smoke alarm and the resident remained seated in the living room.					
	revealed: -He was considered I see some out of his r -He heard the fire ala -He did not exit the fa usually took him out of	ent #2 on 09/14/23 at 5:27pm egally blind though he could ight eye in "good light.". Imm go off today, 09/14/23. ecility because the SIC of the facility during fire drills. he facility on his own but did or not.				
	5:33pm revealed Resorber residents because Interviews with the Stand 1:58pm revealed -Resident #2 smoked	er resident on 09/14/23 at sident #2 was assisted by use the resident was blind. IC on 09/14/23 at 12:04pm it: I on the front porch of the buld not go down the steps				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B WING			
		FCL035034	B. WING		09/15/2023	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUTT	ON ROAD RG, NC 27549			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 022	Continued From page	e 7	C 022			
	smoking area out bac -Resident #2 needed blind.	ut assistance to go to the ck with the other residents. assistance because he was ot get from his room to the hout assistance.				
	revealed: -She was aware staff #2Resident #2 was not	on 09/14/23 at 6:38pm had to walk with Resident				
	gave it to him, and he asked him what she le	described her when she ooked like.				
	Telephone interview v Adult Day Program or revealed:	vith the Director of a local n 09/15/23 at 8:25am				
	because he had to be day program.	a lot of assistance from staff constantly guided at the				
		safe, the resident would ave the facility during a fire.				
		interview with Resident #2's :18pm was unsuccessful.				
	revealed: -Diagnoses included schizophrenia, and bi -Resident #1 was inteResident #1 wandereCurrent medications Namenda (both are comedications used to to	lateral hearing loss. ermittently disoriented. ed. include Aricept and ognition-enhancing reat dementia).				
	Review of Resident #	1's most current care plan				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
	FCL035034	B. WING		000	15/2023
NAME OF PROVIDER OR SUPPLIER		ADDRESS CITY STATE	ZID CODE	09/	13/2023
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE I TTON ROAD	, ZIP CODE		
HOUSE OF BLESSINGS AT SUTTO	ON RD	URG, NC 27549			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
-Resident #1 needed eating, toileting, and to bathing, dressing, and 1/106/20. Review of Resident #/ summary dated 02/13 -Resident #1 was accreported the resident's worseResident #1 would so in the facility was his resident had a diagno. Observation of the facility resident #1 after-visit summary date resident had a diagno. Observation of the facility resident #1 exited the sound of a fire alarm and -Resident #1 exited the living room, and sat dotol -The fire alarm was autroom area.	netimes disoriented. metimes forgetful and ud voices and sounds. limited assistance with ransferring ambulation, d grooming. gned by the PCP on 1's PCP's after-visit 6/23 revealed: ompanied by the SIC who is memory was getting ometimes forget what room room. 1's emergency department ated 08/09/23 revealed the asis of dementia. cility on 09/14/23 at 1:58pm ephone to activate the at 1:58pm. he bathroom, walked into the own. he bathroom, walked into the own. he didle in the bathroom/living acility on 09/14/23 at 5:12pm for on her telephone. he in the living room. d seated.	C 022			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE S COMPL	
	FCL035034	B. WING		09/1	5/2023
ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
F BLESSINGS AT SUTTO	ON RD				
. 22200007 00110	LOUISBL	JRG, NC 27549			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Continued From page	9	C 022			
resident remained se	ated in the living room.				
revealed: -Resident #1 did not I what month; he thoug -He had not heard a f and he did not recall f alarmIf he heard a smoke look to see where the and he would then tel where it was coming Interviews with the SI and 1:58pm revealed -Resident #1 had den asking the same quee -When she did the fire Resident #1 did not ce	know what year it was or ght it was the spring. Fire alarm today, 09/14/23, the last time he heard a fire detector alarm he would alarm was coming from, il someone else to see from. C on 09/14/23 at 12:04pm: nentia "bad" and would keep stions. e drill in September 2023, ome out of his room, and				
5:33pm revealed: -Resident #1 needed "Alzheimer's diseaseResident #1 got lost -Resident #1 would w to be told to come ba not get hit by a car. Telephone interview w Owner/Administrator revealed: -Resident #1 had mer -She was aware Resi worsenedResident #1 did not reday, 09/14/23, at 1:	help because he had in the facility. valk toward the road and had ck to the facility so he did with the facility's on 09/14/23 at 6:38pm mory problems. dent #1's memory had respond to the first fire drill 58pm because there were				
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page resident remained se. Interview with Reside revealed: -Resident #1 did not I what month; he thoughed a fand he did not recall alarmIf he heard a smoke look to see where the and he would then tell where it was coming. Interviews with the SI and 1:58pm revealedResident #1 had den asking the same quest-When she did the fire Resident #1 did not coshe had to go get him. Interview with anothe 5:33pm revealed: -Resident #1 needed "Alzheimer's diseaseResident #1 got lost -Resident #1 would we to be told to come ba not get hit by a car. Telephone interview wowner/Administrator revealed: -Resident #1 had met she was aware Resident #1 had met she was aware Resident #1 did not it today, 09/14/23, at 1:	FCL035034 ROVIDER OR SUPPLIER FBLESSINGS AT SUTTON RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 resident remained seated in the living room. Interview with Resident #1 on 09/14/23 at 2:10pm revealed: -Resident #1 did not know what year it was or what month; he thought it was the springHe had not heard a fire alarm today, 09/14/23, and he did not recall the last time he heard a fire alarmIf he heard a smoke detector alarm he would look to see where the alarm was coming from, and he would then tell someone else to see where it was coming from. Interviews with the SIC on 09/14/23 at 12:04pm and 1:58pm revealed: -Resident #1 had dementia "bad" and would keep asking the same questionsWhen she did the fire drill in September 2023, Resident #1 did not come out of his room, and she had to go get him because he could not hear. Interview with another resident on 09/14/23 at 5:33pm revealed: -Resident #1 needed help because he had "Alzheimer's disease." -Resident #1 needed help because he had "Alzheimer's disease." -Resident #1 needed help because he had "Alzheimer's disease." -Resident #1 needed help because he had "Alzheimer's disease." -Resident #1 would walk toward the road and had to be told to come back to the facilityResident #1 would walk toward the road and had to be told to come back to the facility's Owner/Administrator on 09/14/23 at 6:38pm revealed: -Resident #1 had memory problemsShe was aware Resident #1's memory had	ROVIDER OR SUPPLIER FELOSSINGS AT SUTTON RD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 resident remained seated in the living room. Interview with Resident #1 on 09/14/23 at 2:10pm revealed: -Resident #4 did not know what year it was or what month; he thought it was the springHe had not heard a fire alarm today, 09/14/23, and he did not recall the last time he heard a fire alarmIf he heard a smoke detector alarm he would look to see where the alarm was coming from, and he would then tell someone else to see where it was coming from. Interviews with the SIC on 09/14/23 at 12:04pm and 1:58pm revealed: -Resident #1 had dementia "bad" and would keep asking the same questionsWhen she did the fire drill in September 2023, Resident #1 had dementia "bad" and would keep asking the same questionsWhen she did the fire drill in September 2023, Resident #1 did not come out of his room, and she had to go get him because he could not hear. Interview with another resident on 09/14/23 at 5:33pm revealed: -Resident #1 got lost in the facilityResident #1 got lost in the facilityResident #1 would walk toward the road and had to be told to come back to the facility's Owner/Administrator on 09/14/23 at 6:38pm revealed: -Resident #1 had memory problemsShe was aware Resident #1's memory had worsenedResident #1 did not respond to the first fire drill today, 09/14/23, at 1:58pm because there were	ROVIDER OR SUPPLIER FCL035034 STREET ADDRESS, CITY, STATE, ZIP CODE 1359 SUTTON ROAD LOUISBURG, NC 27549 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 resident remained seated in the living room. Interview with Resident #1 on 09/14/23 at 2:10pm revealed: -Resident #1 did not know what year it was or what month; he thought it was the springHe had not heard a fire alarm today, 09/14/23, and he did not recall the last time he heard a fire alarmIf he heard a smoke detector alarm he would look to see where the alarm was coming from, and he would then tell someone else to see where it was coming from. Interviews with the SIC on 09/14/23 at 12:04pm and 1:58pm revealed: -Resident #1 did not come out of his room, and she had to go get him because he could not hear. 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STATE FORM 6899 6Q8H11 If continuation sheet 10 of 71

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUTT	ON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
C 022	would follow what the Telephone interview wand Adult Day Program or revealed: -Resident #1's memo-Resident #1 needed-Resident #1 would hould not know he netacilityResident #1 would needed to do during a life Resident #1 saw of facility, he would folloo Attempted telephone PCP on 09/14/23 at 4 and 3. Review of Resident revealed: -Diagnoses included a schizophreniaThe resident wander-Current medication in cognition-enhancing in dementia). Review of Resident #1 revealed an admission Review of Resident #2 revealed: -The resident was sond-The resident was for remindersThe resident could here	be done when other facility because Resident #1 other residents did. with the Director of a local in 09/15/23 at 8:25am ry had "been off" for a while. constant supervision. ear the fire alarm but he edded to get out of the ot comprehend what he a fire drill. ther residents leave the w what they were doing. interview with Resident #1's ::20pm was unsuccessful. It #3's FL-2 dated 10/10/22 dementia and ed. included Aricept (a medication used to treat 3's Resident Register in date of 12/02/08. 3's care plan dated 11/09/22 metimes disoriented. getful and needed ear loud sounds and voices.	C 022	DEFICIENCY		
		d limited assistance from ting, ambulation/locomotion,				

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STATE FORM 6899 6Q8H11 If continuation sheet 11 of 71

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		no)/15/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	0	1713/2023
HOUSE O	F BLESSINGS AT SUTTO	1359 SUT	TON ROAD			
110031 0	T BEESSINGS AT SUTTO	LOUISBU	IRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From page	e 11	C 022			
	and transferring.	ooming/personal hygiene,				
	and 5:24pm revealed -The fire alarm was s 5:12pm using the app -Resident #3 was sitti -Resident #3 remaine -A second fire alarm v 5:24pm by activating	ounded by the SIC at on her telephone. Ing in the living room. Ind seated. Indicate the seated of th				
	resident remained seated in the living room. Interviews with the SIC on 09/14/23 at 12:04pm and 1:58pm revealed: -When she started working at the facility, she noticed Resident #3 could not hear and she told the Administrator he needed hearing aidsShe had to yell at Resident #3 for him to hearShe had not noticed any problems with Resident #3's memory, and he had not had any issues with wanderingWhen she did the fire drill in September 2023, Resident #3 did not come out of his room, and she had to go get him because he could not hear. Telephone interview with the Owner/Administrator					
	could not hear but whe exiting the facility here. Telephone interview was Adult Day Program or revealed: -Resident #3 could not -Resident #3 seemed	with the Director of a local n 09/15/23 at 8:25am				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. 501251110.			
		FCL035034	B. WING		09	15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTT	ON RD	TON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From page	e 12	C 022			
	-If Resident #3 saw of fire drill he would mo	other residents move during a ve too. was Resident #3 would not				
		ns, interviews, and record mined Resident #3 was not				
	· ·	interview with Resident #3's 4:18pm was unsuccessful.				
	4. Review of Resident #6's current FL-2 dated 01/12/23 revealed:					
	bipolar, and seizures	schizoaffective disease, ermittently disoriented.				
	Review of Resident # revealed: -The resident was so	#6's care plan dated 01/12/23				
	-The resident was for reminders.					
	documented as weak					
	eating, toileting, and bathing, dressing, an					
	-The care plan was s on 01/12/23.	igned by Resident #6's PCP				
	and 5:24pm revealed -The fire alarm was s 5:12pm using the app -Resident #6 was sitt -Resident #6 remains	ounded by the SIC at o on her telephone. ing in the living room.				
	5:24pm by activating	the smoke alarm and the atted in the living room.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL035034	B. WING		09	9/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTT	ON RD	JTTON ROAD SURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 022	Continued From pag	e 13	C 022			
	and 6:27pm revealed -Resident #6 spoke 3 -It was hard to tell if if he did not understa -She thought he cou others could not und -It was like following he went with everyor sounded. Telephone interview on 09/14/23 at 6:38p would leave the facil residents exiting the Telephone interview Adult Day Program or revealed: -Resident #6 spoke 3 communicatingIf Resident #6 saw of fire drill he would mo-She did not know if alarm was and what heard it.	Spanish. Resident #6 was confused or and what he was being told. Id understand others, but erstand him. the leader with Resident #6, he else when the fire alarm with the Owner/Administrator of the revealed Resident #6 ity when he saw other facility. with the Director of a local on 09/15/23 at 8:25am Spanish and had a hard time other residents move during a love too. Resident #6 knew what a fire he needed to do when he				
	Attempted interview at 7:40am was unsu	with Resident #6 on 09/14/23 ccessful.				
		e interview with Resident #6's 4:18pm was unsuccessful.				
	equipped and mainta facility's licensed cap residing in the facility (#1,#3, and #4) and	ensure the building was ained in accordance with the pacity to allow residents a, who had cognitive deficits a resident who was legally the facility independently in				

Division of Health Service Regulation

STATE FORM 6899 6Q8H11 If continuation sheet 14 of 71

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STATE TTON ROAD JRG, NC 27549	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 022	was detrimental to the well-being of the resid B Violation. The facility provided a	y such as a fire. This failure health, safety, and lents and constitutes a Type plan of protection in 131D-34 on 09/14/23 for	C 022		
C 069	30, 2023.	OT EXCEED OCTOBER	C 069		
	Exits (g) In homes with at I determined by a physic to be disoriented or a for resident use shall sounding device that opened. The sound so that it can be heard by of remote sounding do control panel for the sound in a location access by the administrator to the terminal of the period of the per	s activated when the door is shall be of sufficient volume y staff. If a central system evices is provided, the ystem shall be located in erson on call, the office area sible only to staff authorized o operate the control panel.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TON ROAD			
0/0/15	STIMMADA ST	ATEMENT OF DEFICIENCIES	RG, NC 27549	PROVIDER'S PLAN OF CORRECTION	<u>.</u>	0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 069	Continued From page	e 15	C 069			
	facility, the kitchen do back door off the gara working alarm that wa could be heard by sta staff for 6 of 6 resider #6), including two res #3) and three residen disoriented (#4, #5, # always disoriented (# The findings are: Observation of the from 09/14/23 at various the time of the storm door (suffacility was opened the door (full glass door) used the storm door to the exterior wooden sounded when the does demonstrated by the storm of the storm door to the storm door to the exterior wooden sounded when the does demonstrated by the storm of the door (full glass door) to the storm door to the storm door to the storm of the storm of the door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened a soft, I beep sound could be residents were obseficility using the kitcher door exit when opened as oft, I beep sound could be residents were obseficility using the kitcher door exit when opened as oft.	for into the garage, and the age were opened, had a as of sufficient volume that all off when activated to alert all off who wandered (#1, the sum of the were sometimes as of the all off who was 2). The tentrance to the facility on the all off who was 2). The tentrance to the facility on the all off who was 2). The tentrance to the facility on the all off who was closed; the residents of the all off who was closed; the residents of the all off who was opened and closed the supervisor in Charge are going in and out of the and closed. The tentrance to the facility on the was opened and closed the supervisor in Charge are going in and out of the and closed. The tentrance to the facility on the served going in and out of the all off who was heard when they				

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Observation of the garage area on 09/14/23 at

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	1 09/15/2023	
		1359 SUTT	, ,	, E, ZII 600E		
HOUSE O	F BLESSINGS AT SUTTO	ON RD LOUISBUR	G, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 069	Continued From page	e 16	C 069			
C 069	various times betwee -Inside the garage, the the outside that had a corner of the doorNo sound was heard. Observation of the factor revealed the Owner of the garage and sound could be heard. 1. Review of Resident revealed: -Diagnoses included a schizophrenia, and bito-Resident #1 was integreed.	n 7:30am-6:40am revealed: ere was a door that exited to an alarm attached to the top when the door was opened. cility on 09/14/23 at 7:50pm eplaced the battery in the ad a long, loud beeping I throughout the facility. t #1's FL-2 dated 10/10/22 neurocognitive, lateral hearing loss. ermittently disoriented. ed. 1's Primary Care Provider's	C 009			
	reported the resident' worse.	companied by the SIC who s memory was getting cometimes forget what room				
	in the facility was his					
	Review of Resident # revealed: -The resident was soreThe resident had a sore and had to be directeThere was handwritte. Resident #1's dement worsening and Resident supervision.	1's care plan dated 08/26/19 metimes disoriented. ignificant loss of memory d. en documentation that				
	Review of Resident #	1's care plan dated 11/06/20				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL035034	B. WING		09/15	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TON ROAD			
			RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 069	Continued From page	e 17	C 069			
	needed remindersResident #1's care p on 11/06/20.	metimes forgetful and lan was signed by the PCP				
	times between 8:00an -At 8:00am, Resident no alarm soundedThe SIC was in the r 8:08am, at which poir -At 8:42am, Resident no alarm soundedThe SIC was in the r went to check on Res	#1 went out the front door; medication room until nt she went outside. #1 went out the front door; medication room and never sident #1's whereabouts. #1 came back inside the				
	revealed: -The residents helped #1 when they were of -Resident #1 had tried and the staff had to b couple of years agoResident #1 went too	ent on 09/14/23 at 5:33pm d keep an eye on Resident utside. d to walk to the store before ring him back, it was a wards the road every day, m he needed to come back.				
	revealed: -Resident #1 did not I what month; he thoug -He had not heard an outside of the facility. Interview with the SIC and 1:58pm revealed	y door alarms when he went C on 09/14/23 at 12:04pm				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ()	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	FCL035034	B. WING		09/15/2023	
NAME OF PROVIDER OR SUPPLIER HOUSE OF BLESSINGS AT SUTTON	1359 SUT	DRESS, CITY, STA TON ROAD RG, NC 27549	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
that she was aware of. Telephone interview wit Adult Day Program on Orevealed: -Resident #1's memory-Resident #1 talked about she positioned her swhere the staff could alway. Resident #1 needed condition at the positioned her swhere the staff could alway. Resident #1 needed condition at the property of the property of the property. Refer to the interviews wat 12:31pm and 5:14pm. Refer to the telephone in Administrator on 09/14/2. Refer to the telephone in Administrator on 09/14/2. Refer to the telephone in Administrator on 09/15/2. Review of Resident #11/14/22 revealed diagral legible. Review of Resident #2's dated 06/02/23 revealed blindness, schizoaffective vascular dementia with Review of Resident #2's plan dated 01/25/23 revealed of the property of Resident #2's plan dated 01/25/23 revealed the plan date	cons. randered from the facility th the Director of a local 09/15/23 at 8:25am Thad "been off" for a while. rout leaving the program staff and the resident ways see where he was. ronstant supervision. Iterview with Resident #1's 20pm was unsuccessful. with the SIC on 09/14/23 n. interview with the /23 at 6:38pm. interview with the /23 at 9:46am. #2's current FL-2 dated noses listed were not s PCP after-visit summary d diagnoses included we disorder, and mild psychotic disturbances. s assessment and care vealed: rys disoriented and was	C 069			

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on 06/02/23.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		FCL035034	B. WING		09	/15/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
HOUSE O	F BLESSINGS AT SUTT	ON RD	TTON ROAD URG, NC 27549				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 069	Continued From pag	e 19	C 069				
		ent #2 on 09/14/23 at 5:27pm lear door alarms when he ke.					
	times between 7:30a -Resident #2 was acc facility by the SIC.	cility on 09/14/23 at various m-6:40pm revealed: companied in and out of the sit on the front porch to					
		pted telephone interview with Resident #2's on 09/14/23 at 4:18pm was unsuccessful.					
	Refer to the interview at 12:31pm and 5:14	vs with the SIC on 09/14/23 pm.					
	Refer to the telephon Administrator on 09/						
	Refer to the telephon Administrator on 09/						
	Review of Resider revealed: -Diagnoses included schizophrenia. -The resident wande						
	Review of Resident # revealed: -The resident was so -The resident was for reminders.	#3's care plan dated 11/09/22					
	Observation of the fa times between 7:30a	cility on 09/14/23 at various m-6:40pm revealed					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL035034	B. WING		09	0/15/2023
	PROVIDER OR SUPPLIER OF BLESSINGS AT SUTTO	1359 SU	ADDRESS, CITY, STATE TTON ROAD URG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 069	Resident #3 would go there were no alarms went outside. Interviews with the SI and 1:58pm revealed problems with Reside not had any issues w Attempted telephone PCP on 09/14/23 at 4 Based on observation reviews, Resident #3 Refer to the interview at 12:31pm and 5:14ph Refer to the telephon Administrator on 09/1 Refer to the telephon Administrator on 09/1 4. Review of Resident 10/20/22 revealed dia an autoimmune diseated Review of Resident #1 10/25/22 revealed: -Resident #4 was administrator #4 was adm	coin and out of the facility; heard when the resident C on 09/14/23 at 12:04pm she had not noticed any ent #3's memory, and he had ith wandering. interview with Resident #3's e:18pm was unsuccessful. Ins, interviews, and record was not interviewable. Is with the SIC on 09/14/23 om. The interview with the 4/23 at 6:38pm. The interview with the 5/23 at 9:46am. It #4's current FL-2 dated agnoses included bipolar and ise. A's Resident Register dated mitted to the facility on orgetful and needed A's care plan dated 10/25/22 metimes disoriented.	C 069			

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1	_	
		FCL035034	B. WING		09/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		1359 SUT	TON ROAD		
HOUSE O	F BLESSINGS AT SUTTO	ON RD LOUISBU	IRG, NC 27549		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 069	Continued From page	e 21	C 069		
	-The care plan was signed by the PCP on 11/09/22.				
	Observation of the fac	cility on 09/14/23 at various			
	times between 7:30ar				
		o in and out of the facility;			
		heard when the resident			
	went outside.				
	Interview with the SIC on 09/14/23 at 5:08pm				
		's memory was "in and out."			
		interview with Resident #2's			
	_	er on 09/14/23 at 4:18pm			
	was unsuccessful.				
		s with the SIC on 09/14/23			
	at 12:31pm and 5:14p	om.			
	Refer to the telephone	e interview with the			
	Administrator on 09/1				
	Refer to the telephone				
	Administrator on 09/1	5/23 at 9:46am			
	5 Review of Residen	t #5's current FL-2 dated			
		agnoses included stage III			
		se, diabetes, depression,			
	and anxiety.	,,			
	-				
		5's Resident Register dated			
	05/01/22 revealed:	mitted to the facility are			
	-Resident #5 was adr 05/01/22.	mitted to the facility on			
	-Resident #5's was fo	orgetful and needed			
	reminders.	goar and noodod			
	Review of Resident # revealed:	5's care plan dated 05/01/22			

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-The resident was sometimes disoriented.

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	or Berlaith Service Negu	I	0.00	CONTRICTION	1000	115/15/
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLE	
VIAD LEWIN C	7 CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLE	-1-0
		FCL035034	B. WING		09/1	5/2023
NAME OF DE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
NAME OF FE	CONDEN ON OUR FEILIN		TON ROAD	, 2.1 0002		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	RG, NC 27549			
			KG, NC 27549	I		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 069	Continued From page	22	C 069			
	-The resident was for	getful and needed				
	reminders.					
	- The PCP signed the	care plan on 10/10/22.				
	Interview with Reside	nt #5 on 09/14/23 at 5:43pm				
	revealed:	//o on oo/ 1 //20 at o. 10pm				
		I the door alarms when he				
	went outside, but not	every time.				
		e door alarms could be				
	turned on and off, but	he did not hear the alarm				
	every time he went ou	utside.				
	Observation of the fac	cility on 09/14/23 at various				
	times between 7:30ar					
	Resident #5 would go	in and out of the facility;				
	there were no alarms	heard when the resident				
	went outside.					
	A.(
		interview with Resident #5's er on 09/14/23 at 4:18pm				
	was unsuccessful.	er on 09/14/23 at 4. ropin				
	พลจ นกจนปปีจจินก.					
	Refer to the interview	s with the SIC on 09/14/23				
	at 12:31pm and 5:14p					
	· '					
	Refer to the telephone					
	Administrator on 09/1	4/23 at 6:38pm.				
	Defends the televil	- into mileith th				
	Refer to the telephone					
	Administrator on 09/1	JIZJ at 9.40am.				
	6. Review of Residen	t #6's current FL-2 dated				
	01/12/23 revealed:	ind a damana in L. L. datod				
		schizoaffective disease,				
	bipolar, and seizures.					
	-	ermittently disoriented.				
		•				
		6's care plan dated 01/12/23				
	revealed:		I			

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-The resident was sometimes disoriented.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION I		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		FCL035034	B. WING		09/1	5/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUT	TON ROAD			
110001	- BEEGGINGG AT GOTTE	LOUISBU	RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 069	Continued From page	e 23	C 069			
	-The resident was for remindersThe care plan was si on 01/12/23.	rgetful and needed igned by Resident #6's PCP				
	times between 7:30ai Resident #6 would go	cility on 09/14/23 at various m-6:40pm revealed o in and out of the facility; heard when the resident				
		ns, interviews, and record was not interviewable				
		interview with Resident #6's 4:18pm was unsuccessful.				
	Refer to the interview at 12:31pm and 5:14p	rs with the SIC on 09/14/23 pm.				
	Refer to the telephon Administrator on 09/1					
	Refer to the telephon Administrator on 09/1					
	and 5:14pm revealed -The residents usually to the Adult Day Prog -One of the residents smoke.	y exited the front door to go gram. went out the front door to at door when she got up in				
	-The storm door was the door (wooden) wa -She closed the front residents smoked, ard -The front door to the	closed during the day but as open. door every night after the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09	/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STATE TTON ROAD JRG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 069	door off of the kitcher and out to the back so The exit door going i off when the door was She did not know who could not be heard to She thought the door the outside where the alarm that sounded. She had heard the athe last time she heard She kept the door opshe knew all the resident go outside or to use to Telephone interview on 09/14/23 at 6:38pr. The exit doors at the The front door had at the main door was There was no reason storm door. The door in the kitch garage had an alarm when the residents welf the alarm on the kit must be because it no The exit door off the have an alarm, but the resident was exiting the door alarm went off. No one had ever was The facility was a far residents had the right whenever they wanted.	moked out back used the a that went into the garage moking area. Into the garage usually went is opened. By the alarm off the kitchen day, 09/14/23. It leading from the garage to be residents smoked had an a larm before but did not recall red the alarm. Been to her private room until dents were in their rooms as got up during the night to the bathroom. With the Owner/Administrator in revealed: If acility had alarms. In alarm but the storm door not alarmed. In to have an alarm on the so the staff would know ent into the garage. Itchen door did not sound, it eeded a battery. It back of the garage did not e staff would know a the facility when the kitchen andered away. In it o "come and go"	C 069			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	·
I HOUSE OF BLESSINGS AT SUTTON RD			ON ROAD G, NC 27549		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 069	69 Continued From page 25		C 069		
C 100	on 09/15/23 at 9:46ar way to install an alarr SIC was informed to closed at all times. The facility failed to a equipped with workin the exit doors were of #3) who were assess sometimes disoriented assessed as always of residents (#4, #5, #6) sometimes disoriented detrimental to the saft residents and constituted A plan of protection waccordance with G.S. CORRECTION DATE VIOLATION SHALL Madditional States of the plan of Disaster Plan	ety and welfare of the utes a Type B Violation. vas requested on 09/20/23 in 131D-34 for this violation. FOR THE TYPE B NOT EXCEED OCTOBER 6 (e) Fire Safety And	C 100		
	10A NCAC 13G .0316 Fire Safety And Disaster Plan				
	fire evacuation plan e rehearsals shall be m furnished to the coun services annually. The date and time of the r	least four rehearsals of the each year. Records of leaintained and copies ty department of social ne records shall include the rehearsals, staff members description of what the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 50.25			
		FCL035034	B. WING		09	/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
1101105.0	F DI FOOINOO AT CUTTO	1359 SUT	TON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	LOUISBL	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 100	Continued From page	26	C 100			
	reviews, the facility fa evacuated the facility resulting in 5 of 6 resi #6) who did not respo The findings are:	is, interviews, and record iled to ensure the residents without verbal prompting dents (#1, #2, #3, #5, and and to the fire drill.				
	revealed: -A fire rehearsal form system was activated of the alarm was door detector, heat detector description of the situ awake and time to ex -A fire rehearsal form system was activated of the alarm was door detector and the description was awake house was 2 minutes -A fire rehearsal form system was activated of the alarm was not of description of the situ very safely to the local minutes; it was document of the rehearsal form.	or, and pull station, and the ation was everyone was it the house was 4 minutes. was dated 06/30/23; the at 7:45am; the origination umented as a smoke cription of the situation was and the time to exit the was dated 09/01/23; the at 7:00am; the origination				

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FCL035034 B. WING 09/15/2	/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HOUSE OF BLESSINGS AT SUTTON RD 1359 SUTTON ROAD LOUISBURG, NC 27549	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
detector and the description of the situation was everyone was awake and moved outside as quickly as they could; there was no exit time documented. Interviews with the Supervisor in Charge (SIC) on 09/14/23 at 1:58pm and 5:14pm revealed: -She performed fire drills at the facilityShe used an app (a software package that allowed users to perform specific tasks from their telephone or computer) on her telephone that was for fire alarmsWhen she did a fire drill, she stood in the hallway and sounded the app for the fire alarmNo one responded until she stated, "fire drill." Then, all the residents but two [named] residents exited the facility: two of the residents needed assistance exiting the facilityShe did not know she could not tell the residents it was a fire drill. Telephone interview with the facility's Owner/Administrator on 09/14/23 at 6:38pm revealed: -Fire drills were conducted every three monthsThe process was to use an alarm on the telephoneThe residents were to move out of the facility in two minutesAll the residents exited the facility without assistance when she conducted a fire drillShe last conducted a fire drill sometime in late 2022When the fire drill was conducted, she "screamed fire, fire, fire." -She did not know she could not scream fire. 1. Review of Resident #2's current FL-2 dated	

legible.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL035034	B. WING		09	0/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	1359 SU	TTON ROAD			
110001	- BEEGGINGG AT GOTT	LOUISBL	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 100	Continued From page	e 28	C 100			
	Observations of the fand 5:24pm revealed -The fire alarm was s -Resident #2 was sitt -Resident #2 remaine	ounded by the SIC. ing in the living room.				
	Interview with Resident #2 on 09/14/23 at 5:27pm revealed: -He was considered legally blind though he could see some out of his right eye in "good light."He heard the fire alarm go off today, 09/14/23He did not exit the facility because the SIC usually walked him out of the facility during fire drillsHe could try to exit the facility on his own but did not know if he could or not.					
	revealed she or anoth	C on 09/14/23 at 1:58pm ner resident assisted ng him out of the facility				
	revealed: -She was aware staff #2Resident #2 was not because she saw him	on 09/14/23 at 6:38pm had to walk with Resident blind and could see n count his money when she described her when she				
	revealed: -Diagnoses included schizophrenia, and bi -Resident #1 was inte					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
		FCL035034	B. WING		09	/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STATE TTON ROAD JRG, NC 27549	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 100	sound of a fire alarmResident #1 exited the living room, and sat of the fire alarm was a room area. Observations of the fire alarm was a room area. Observations of the fire alarm was substituted a fire alarm was substituted and the side revealed: -Resident #1 remained and he did not recall alarmIf he heard a smoke look to see where the and he would then the where it was coming and 1:58pm revealed september 2023, Resident #1 did not hear. Telephone interview with the SIC and 1:58pm revealed september 2023, Resident #1 did not hear. Telephone interview with the SIC and fire room, and she he could not hear. Telephone interview with the side september 2023, Resident #1 did not hear. Telephone interview with the side september and she he could not hear. Telephone interview with the side september 2023, Resident #1 did not hear. Telephone interview with the side september and she he could not hear.	dephone to activate the me bathroom, walked into the lown. udible in the bathroom/living decility on 09/14/23 at 5:12pm is counded by the SIC. Ing in the living room. In the living room. In the living room what year it was or good what year it was or good to the serious detector alarm he would alarm was coming from, all someone else to see from. If on 09/14/23 at 12:04pm when she did the fire drill in sident #1 did not come out had to go get him because with the facility's on 09/14/23 at 6:38pm respond to the first fire drill 58pm because there were the facility.	C 100			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 100	revealed diagnoses in schizophrenia. Observations of the fa and 5:24pm revealed -The fire alarm was scresident #3 was sitti-Resident #3 remained Interview with the SIC and 1:58pm revealed September 2023, Resof his room, and she he could not hear. Telephone interview won 09/14/23 at 6:38pm could not hear but whe exiting the facility he was assed on observation reviews, Resident #3 4. Review of Residen 01/12/23 revealed diagrams.	other residents did. It #3's FL-2 dated 10/10/22 Included dementia and Ideality on 09/14/23 at 5:12pm Ideality on 09/14/23 at 5:12pm Ideality on one out of the second of the living room. Ideality on one out of the second of the living room. Ideality on one out of the second of the living room. Ideality on one out of the living room. In one out of the living room out of the living room. In one of the living room. In	C 100	DEFICIENCY)		
	and 5:24pm revealed -The fire alarm was so -Resident #6 was sitti -Resident #6 remaine	ounded by the SIC. ng in the living room. d seated. C on 09/14/23 at 7:36am				
	-Resident #6 spoke S					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL035034	B. WING		09/1	5/2023
	ROVIDER OR SUPPLIER BLESSINGS AT SUTTO	ON RD 1359 SUTT	RESS, CITY, STA ON ROAD G, NC 27549	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 100	sounded. Telephone interview won 09/14/23 at 6:38pr would leave the facilit residents exiting the fire drill program or revealed: -If Resident #6 saw of fire drill he would move-she did not know if Falarm was and what heard it. Based on observation reviews, Resident #6 5. Review of Resident 04/18/23 revealed dia chronic kidney diseas and anxiety. Observations of the faland 5:24pm revealed the fire alarm was starthe telephoneResident #5 was starthe telephoneResident #5 did not exited the facility so heard 19/14/23 at 6:38pr	with the Owner/Administrator in revealed Resident #6 by when he saw other acility. with the Director of a local in 09/15/23 at 8:25am ther residents move during a re too. Resident #6 knew what a fire the needed to do when he as, interviews, and record was not interviewable. It #5's current FL-2 dated agnoses included stage III e, diabetes, depression, acility on 09/14/23 at 5:12pm bunded by the SIC. Inding in the dining room on exit the facility. In #5 on 09/14/23 at 5:43pm be fire alarm but not one else e did not either. With the Owner/Administrator in revealed Resident #5	C 100			
	knew to exit the facilit	y during a fire drill.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FOL 005004	B WING		00/4	5/0000
		FCL035034	D. WING		09/1	5/2023
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
HOUSE OF BLESSINGS AT SUTTON RD			ON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 145	Continued From page 32		C 145			
C 145	15 10A NCAC 13G .0406(a)(5) Other Staff Qualifications		C 145			
	(a) Each staff person shall:(5) have no findings	6 Other Staff Qualifications of a family care home listed on the North Carolina el Registry according to G.S.				
	This Rule is not met a	as evidenced by:				
	facility failed to ensure	ews and interviews, the e 2 of 3 sampled staff (A, B) findings listed on the North Personnel Registry.				
	The findings are:					
	1. Review of Staff A's there was no personn	personnel record revealed el record to review.				
	revealed:	on 09/14/23 at 2:15pm				
	-She started working at the facility in mid-July 2023.					
	-one worked at other	facilities prior to this one.				
	9:33am revealed:	vith Staff A on 09/15/23 at				
	-She was the Supervisor in Charge (SIC)She did not know what the HCPR was or if hers had been checked.					
	Refer to the telephone Administrator on 09/1					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	DN RD	DRESS, CITY, STA TON ROAD RG, NC 27549	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
C 145	Attempted telephone 09/15/23 at 9:36am w Refer to the telephone Administrator on 09/1 Telephone interview v 09/15/23 at 9:49am re-Personnel records w were in her officeShe did not have tim records today, 09/15/25 The facility failed to enot have substantiate	personnel record revealed pel record to review. interview with Staff B on ras unsuccessful. e interview with the 5/23 at 9:49am with the Administrator on evealed: ere not at the facility; they e to fax the personnel 23. Insure Staff A and Staff B did d findings listed on the	C 145		
C 147	Health Care Personne working at the facility. resulted in it being un substantiated findings detrimental to the hea the resident and cons A plan of protection wa accordance with G.S.	el Registry (HCPR) prior to The facility's failure known if staff had s on the HCPR, which was alth, welfare, and safety of titutes a Type B Violation. as requested on 09/20/23 in 131D-34 for this violation. FOR THE TYPE B IOT EXCEED OCTOBER	C 147		
		Other Staff Qualifications of a family care home			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL035034	B. WING		09	9/15/2023
	PROVIDER OR SUPPLIER OF BLESSINGS AT SUTTO	1359 SU	ADDRESS, CITY, STATE TTON ROAD URG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 147	(7) have a criminal basin accordance with Gavailable in the staff parallel in the staff	ackground check completed .S. 131D-40 and results berson's personnel file; as evidenced by: ews and interviews, the e 2 of 3 sampled staff (A, B) round check completed upon on the personnel record revealed hel record to review. on 09/14/23 at 2:15pm at the facility in the staff A on 09/15/23 at disor in Charge (SIC). If her application, she signed ackground check had ackground check had be interview with the 5/23 at 9:49am. Is personnel record revealed hel record to review. Interview with Staff B on was unsuccessful.	C 147			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.11.2 7.27.11		152.111.157.116.1116.11	A. BUILDING: _			
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TTON ROAD JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 147	Continued From page	e 35	C 147			
C 148	09/15/23 at 9:49am re-Personnel records were in her officeShe did not have time records today, 09/15/ The facility failed to ecriminal background hire. The facility's fail unknown if Staff A an history which was dewelfare of the resider violation. A plan of protection waccordance with G.S. CORRECTION DATE VIOLATION SHALL National Staff Augualifications 10A NCAC 13G .040 Qualifications 10A NCAC 13G .040 Qualifications 10A NCAC 13G .040 Qualifications 10A NCAC 13G .040 Qualifications	rere not at the facility; they he to fax the personnel 23. Insure 2 of 2 staff had a check completed prior to ure resulted in it being d Staff B had a criminal trimental to the safety and hts and constitutes a Type B Vas requested on 09/20/23 in 131D-34 for this violation. E FOR THE TYPE B NOT EXCEED OCTOBER	C 148			
	This Rule is not met	as evidenced by:				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TTON ROAD URG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 148	Continued From page	e 36	C 148			
	facility failed to ensure had an examination a	ews and interviews, the e 2 of 3 sampled staff (A, B) and screening for the d substances completed				
	The findings are:					
	Review of Staff A's personnel record revealed there was no personnel record to review. Interview with Staff A on 09/14/23 at 2:15pm revealed she had started working at the facility in mid-July 2023.					
	9:33am revealed: -She was the Supervi -She had a drug screeurgent careShe was not given the	with Staff A on 09/15/23 at isor in Charge (SIC). ening completed at a local ne results; the results would be Administrator by the staff				
	Refer to the telephon Administrator on 09/1					
	Review of Staff B's there was no personn	personnel record revealed nel record to review.				
	Attempted telephone 09/15/23 at 9:36am w	interview with Staff B on as unsuccessful.				
	Refer to the telephone Administrator on 09/1					
	09/15/23 at 9:49am re	with the Administrator on everaled: evealed: ere not at the facility: they				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING	B. WING		5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	ON ROAD			
	T	LOUISBUF	RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 148	Continued From page 37		C 148			
	were in her officeShe did not have time to fax the personnel records today, 09/15/23.					
	screening for the pres substances was perfo staff (B and C) hired a was detrimental to the	nsure an examination and sence of controlled ormed for 2 of 3 sampled after 10/01/13. This failure health, safety, and welfare onstitutes a Type B Violation.				
	A plan of protection was requested on 09/20/23 in accordance with G.S. 131D-34 for this violation.					
	CORRECTION DATE VIOLATION SHALL N 30, 2023.	FOR THE TYPE B OT EXCEED OCTOBER				
C 231	10A NCAC 13G .0801	1(b) Resident Assessment	C 231			
	(b) The facility shall a each resident is comp following admission a thereafter using an as established by the Deparcontaining at least the required on the established assessment to be confollowing admission a be a functional assess resident's level of functional functioning in Activities of daily living personal hygiene, am transferring, toileting a	and at least annually assessment instrument artment or an instrument artment based on it assame information as lished instrument. The appleted within 30 days and annually thereafter shall asment to determine a actioning to include and, cognitive status and an activities of daily living. It is a compared to the compar				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	N RD	TON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 231	mental health, develor substance abuse services. This Rule is not metal Based on interviews a facility failed to ensure annually for 1 of 3 sand The findings are: Review of Resident # revealed: -Diagnoses included a schizophrenia, and biresident #1 was interviewed for the resident #1 wandered Review of Resident #1 wandered Review of Resident #1 was interviewed for the resident was soned for the resident #1 heard lowed for t	t's physician or other professional, a provider of pmental disabilities or vices or a community as evidenced by: and record reviews, the er a care plan was completed impled residents (#1). 1's FL-2 dated 10/10/22 Ineurocognitive, lateral hearing loss. In writtently disoriented. It is Resident Register in date of 06/30/15. 1's most current care plan led: Inetimes disoriented. Inetimes forgetful and ud voices and sounds. Ilimited assistance with ransferring ambulation,	C 231			
	Telephone interview v	vith the Supervisor in				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		FCL035034	B. WING		09	/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STAT FTON ROAD JRG, NC 27549	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 231	Telephone interview v 09/15/23 at 9:46am re- She was responsible	care plans or FL-2's and she s responsible. with the Administrator on evealed:	C 231			
C 249	following in the reside (3) written procedure a physician or other li and (4) implementation or	2 Health Care assure documentation of the	C 249			
	reviews, the facility fa orders were implement residents (#1 and #2)	ns, interviews, and record iled to ensure physicians' nted for 2 of 3 sampled related to fingerstick blood blood pressure checks (#1)				
	revealed diagnoses ir schizophrenia, and bi a. Review of Residen orders dated 10/10/22	t #1's FL-2 dated 10/10/22 included neurocognitive, lateral hearing loss. t #1's signed physician's revealed an order for ar (FSBS) checks twice				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			7.1. 20.23.110.			
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	1359 SU	TTON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	LOUISBI	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	e 40	C 249			
	revealed: -There was an entry f with all the dates man Monday/Tuesday and weekThere was no docum FSBS was checked fi there were no except Review of Resident # revealed: -There was an entry f with all the dates man Monday/Tuesday and weekThere was documen was checked on 08/0 08/14/23, 08/17/23; tt -There was no docum FSBS was checked on	for FSBS check twice weekly ked out except for a Thursday/Friday for each mentation Resident #1's rom 07/01/23-07/31/23; ions documented. This August 2023 MAR For FSBS check twice weekly ked out except for a Thursday/Friday for each tation Resident #1's FSBS 3/23, 08/07/23, 08/10/23, ne range was 100-112. nentation Resident #1's sin 08/21/23 or 08/29/31; there				
	from 09/01/23-09/14/3 -There was an entry f with all the dates mar	or FSBS check twice weekly				
	-There was documen was checked on 09/0 09/07/23 with a result -There was no docum FSBS was checked of Telephone interview was	nentation Resident #1's n 09/11/23 or 09/12/23.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D. CO			
		FCL035034	B. WING		09)/15/2 02 3
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	·	
HOUSE O	F BLESSINGS AT SUTTO	1359 SU	TTON ROAD			
		LOUISBU	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	e 41	C 249			
	were dispensed on 05 check FSBS twice we -The entry for Reside would have been enter the order to check the weeklyIf expired FSBS testi FSBS readings might Telephone interview with Resident #1's current 09/14/23 at 3:53pm reorder dated 07/06/23 no glucometer supplies	test strips (100 test strips) 5/20/23 with the directions to bekly. Int #1's FSBS twice weekly bered into the MAR based on the resident's FSBS twice Ing strips were used, the the not be accurate. With a Pharmacist at the contracted pharmacy on bevealed Resident #1 had an for FSBS twice weekly but the shad been dispensed.				
	hand on 09/14/23 at 9 -There were 2 boxes dispensed date of 09/ openedThere was a containing glucometer; the manumas 05/31/23There were 6 of 50 to containerThere was a second strips in a second glu expiration date was 0 -There were 31 of 50 container. Observation of both g 9:14am compared to	of 50 test strips each with a /09/22 that had not been er of FSBS test strips in a ufacturer's expiration date est strips remaining in the container of FSBS test cometer; the manufacturer's 5/31/23. test strips remaining in the				
	#1's name.	vas labeled with Resident displayed did not match the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (DENTI TOATION NOWIDER.		A. BUILDING: _		COMPLETED
		FCL035034	B. WING		09/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HOUSE O	E DI ESSINCS AT SUTTO	1359 SUTT	ON ROAD		
HOUSE O	F BLESSINGS AT SUTTO	LOUISBUF	RG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 249	Continued From page	e 42	C 249		
C 249	-Twenty-seven FSBS 01/01/23-09/14/23Sixteen of the most rone glucometer were readings matched any readings in Resident 01/01/23-09/14/23The second glucometer FSBS displayed and matched any of the drin Resident #1's MAR Interview with Resider revealed the Supervishis FSBS twice a more linterview with the SIC revealed: -She checked Reside because that was whomatically with the officient MARIf the glucometer reashe documented in Resident was whomatically must be well-she did not know Refises twice a weekShe did not know whomatically with middle of FSBS were missing the sixteen of the middle of FSBS were missing the most of the middle of the mi	were documented from recent FSBS displayed in observed; only 3 of the 16 y of the documented FSBS #1's MARs from eter only had a total of 18 only 3 of the readings ocumented FSBS readings res from 01/01/23-09/14/23. Int #1 on 09/14/23 at 2:10pm for in Charge (SIC) checked onth. C on 09/14/23 at 2:15pm ent #1's FSBS once a month at was on the MAR. Resident #1's FSBS, she he and wrote the results on redings did not match what resident #1's MAR, then rong with the glucometer. resident #1's order was for resident #1's FSBS was hecked in July 2023; she	C 249		
	09/15/23 at 9:46am re	with the Administrator on evealed the SIC was ing FSBS according to the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUT	TON ROAD			
110002 0	I BEEGGINGO AI GOTTO	LOUISBL	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	e 43	C 249			
	Attempted telephone	interview with Resident #1's E:20pm was unsuccessful.				
	Resident #1's current 09/14/23 at 3:53pm re	w with a Pharmacist at contracted pharmacy on evealed Resident #1 had an for blood pressure (BP)				
	revealed: -There was an entry f -There was documen was checked on 07/1 106/71 and on 07/24/	for BP checks once weekly. Itation that Resident #1's BP 5/23 with a reading of 23 with a reading of 117/77; So when Resident #1's BP				
	revealed: -There was an entry f -There was documen was checked two time	for BP checks once weekly. tation that Resident #1's BP es from 08/01/23-08/31/23; s when Resident #1's BP as checked.				
		ent #1 on 09/14/23 at 2:10pm cked his BP once a week.				
	revealed: -She thought Resider once a monthShe was not sure whe checked as ordered a she thought it was on					
	Telephone interview v 09/15/23 at 9:46am re	with the Administrator on evealed the SIC was				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		FCL035034	B. WING		09	9/15/2023
	ROVIDER OR SUPPLIER	1359 SU	DDRESS, CITY, STATE, TTON ROAD JRG, NC 27549	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 249	responsible for check FL-2 and MAR. Attempted telephone PCP on 09/14/23 at 4 2. Review of Residen 11/14/22 revealed dialegible. Review of Resident # (PCP) after-visit summer revealed a diagnosis Review of Resident # orders dated 07/02/23 -There was an order to pressure (BP) once a -Parameters for Resident # 100 pressure (BP	ing BP according to the interview with Resident #1's 220pm was unsuccessful. It #2's current FL-2 dated Ignosis listed were not 2's Primary Care Provider Mary dated 06/02/23 of high blood pressure. 2's signed physician's 3 revealed: Ito check Resident #2's blood Month and heart rate (HR). Ident #2's HR were if the HR Ireater than 130 notify the	C 249			
	administration record revealed: -There was an entry f once a month and no was less than 60 or g -There was no docum	for checking BP and HR tifying the PCP if the HR reater than 130. nentation that Resident #1's n 07/01/23-07/31/23; there				
	revealed: -There was an entry fonce a month and no was less than 60 or g-There was no docum	nentation that Resident #1's n 08/01/23-08/31/23; there				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SUT	DDRESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 249	Continued From page	45	C 249		
	from 09/01/23-09/14/2 -There was an entry fonce a month and now was less than 60 or g -There was no docum HR was checked from were no exceptions d Interview with Reside revealed the Supervishis BP once a month; was checked when his	or checking BP and HR tifying the PCP if the HR reater than 130. sentation that Resident #1's n 09/01/23-09/14/23; there ocumented. Int #2 on 09/14/23 at 5:57pm for in Charge (SIC) checked he did not know if his HR			
	-She only checked Re -She did not know the Resident #2's HR.	nt #2's BP once a month. esident #2's BP, not his HR. ere was an order to check sed Resident #2's HR.			
	Telephone interview v 09/15/23 at 9:46am re responsible for check according to the FL-2	ing Resident #2's HR			
	•	interview with Resident #2's :18pm was unsuccessful.			
C 259	10A NCAC 13G .0904 Service	4(a)(3) Nutrition and Food	C 259		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	ON RD	ORESS, CITY, STA	TE, ZIP CODE	
		LOUISBUI	RG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
C 259	menus established in for both regular and the purpose of this Rule " is likely to spoil or dec 40 degrees Fahrenheit of food" is food that can temperature and is not within seven days.	n the facility based on the Paragraph (c) of this Rule, nerapeutic diets. For the perishable food" is food that cay if not kept refrigerated at it or below, or frozen at zero r below and "non-perishable be stored at room ot likely to spoil or decay	C 259		
	failed to have a 5-day foods based on the ce	s and interviews the facility supply of non-perishable ensus and the menus in the the food pantry having			
	The findings are:				
	Observations of the for facility on 09/14/23 2: -There were 6 cans or of 3.5 one-half cup serving of 3.5 per one-there were no other canned fruit available -There was a bag of oserving of 5 one-half of serving of 5 one-ha	f green beans with a serving rivings per can. If pork and beans with a servings per can. If cup servings per can. If canned vegetables or to be served. If it is a beans with a cups per bag. If it is a serving of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
	- D000.00 A- 0	1359 SUT	TON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	LOUISBU	RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 259	Continued From page 47		C 259			
	Observation of the refrigerator on 09/14/23 at 7:43am revealed one jar of applesauce with approximately 1 cup of applesauce remaining in the jar.					
	week revealed:	s breakfast menu for one of peaches was to be				
	-On Wednesday, 1/2 served.	cup of pineapple was to be				
	-On Saturday, yogurt -On Sunday, yogurt v	f pears was to be served. was to be served with fruit. was to be served with fruit. e juice was to be served				
	revealed: -On Monday, 1 cup o served and ½ cup of	s lunch menu for one week f garden salad was to be applesauce was to be				
	cup of mixed fruit wei	cup of carrots and ½ cup of				
	of fruit were to be ser	garden salad and 1/2 cup of				
	-On Saturday, 2 slice ½ cup of apple sauce -On Sunday, 1/2 cup cup of pineapple were -A total of 3.5 cups of	s of lettuce and tomato and were to be served. of mixed vegetables and ½ et o be served. I vegetables and 3.5 cups of oe served for each resident				
	Review of the facility	s dinner menu for the week				

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revealed:

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PUBLICATION OF CORRECTION (X3) DATE SURVE COMPLETED					
74101244	or contraction	BERTIN IS WISH THOMBER	A. BUILDING: _			22.25
		FCL035034	B. WING		09	/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1359 SUT	TON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	DN RD LOUISBU	RG, NC 27549			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
C 259	Continued From page	e 48	C 259			
	pears were to be serv-On Tuesday, ½ cup apricots were to be served. On Wednesday, 1 cup apricots were to be served. On Thursday, ½ cup of peaches were to be on Friday, ½ cup of apricots were served. On Saturday, ½ cup cup of pineapple were on Sunday, 1 cup of mandarin oranges were on the served. On Sunday, 1 cup of mandarin oranges were on the served.	of green peas and ½ cup of erved. up of spinach and ½ cup of erved. of green beans and ½ cup es served. carrots and ½ cup of . of carrot/celery sticks and ½ et obe served. f collard greens and ½ cup of ere to be served. egetables and 3.5 cups of one served for each resident				
	-They were served gr -They would love to h vegetablesThey did not get fruit -If they had fruit, it was Interview with the Sur 09/14/23 at 2:51pm re -The residents ate lur weekends and two da Friday) she sent lunc their day program and and Thursday the day -She used the menus what foods were need -The Administrator br usually on the 2nd or	etables to eat very often. reen beans mostly. rave collards or other green to eat every day. results usually applesauce. pervisor in Charge (SIC) on revealed: rech at the facility on the residents to don Tuesday, Wednesday, or program provided lunch. rest to tell the Administrator ded for the month. reen beans mostly.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION (X3) DATE S COMPL		E SURVEY PLETED
		FCL035034	B. WING		09	/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTT	ON RD 1359 SU	ADDRESS, CITY, STATE ITTON ROAD URG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 259	facility. -There were no other other than what had -She substituted whe something that was I Telephone interview 09/15/23 at 9:46am r -The SIC looked at the needed, and sh -She took food every -There was food for the facility. 10A NCAC 13G .090 Service	r canned foods at the facility been shown. en she did not have isted on the menu. with the Administrator on revealed: ne menu and told her what e took it to the facility. I two weeks. the residents to eat at the	C 259			
	Menus in Family Car (7) The facility shall I diet menu for any restherapeutic diet for g This Rule is not met Based on observatio reviews, the facility fatherapeutic diet men sampled residents w sodium diet (#2). The findings are:	nave a matching therapeutic sident's physician-ordered uidance of food service staff.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL035034	B. WING		09/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HOUSE O	E DI ECCINICO AT CUTTO	1359 SUT	ON ROAD		
HOUSE O	F BLESSINGS AT SUTTO	LOUISBUF	RG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 270	Continued From page	e 50	C 270		
	-The diagnoses listed were not legibleThere was no diet listed.				
	(PCP) after-visit sumr revealed:	•			
	-Resident #2 had high vitamin D deficiency. -Resident #2 was ord	n blood pressure and a ered a low-salt diet.			
	Review of the diet list revealed Resident #2	posted on the kitchen wall was not listed.			
	Review of the therapeutic menus posted on the kitchen wall on 09/14/23 at 10:00am revealed there were three separate menus posted on the kitchen wall, a regular menu, a diabetic menu chopped, and a regular menu chopped; there was				
	no low salt menu posted. Observation of the dinner meal on 09/14/23 at 6:15pm revealed Resident #2 was served ½ cup of sloppy joe on a bun, ½ cup of green beans, and a cup of rice.				
	facility on 09/14/23 2: -A can of sloppy joe s sodium per ½ cupA can of green beans sodium per ½ cupThe rice was not in the	bood pantry/cabinets in the 56pm revealed: sauce contained 300mg of s contained 300mg of the original container and the bot available to be reviewed.			
	mg of sodium per day	vealed no more than 2,300 vand an ideal limit of less y for most adults, especially			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023	
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	ON RD 1359 SUTT	ORESS, CITY, STATE ON ROAD RG, NC 27549	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 270	revealed he did not us know if he was supported interviews with the St 09/14/23 at 8:00am, 2 revealed: -All the residents were-There were no diabet and no other diets; all -She did not know Rerecommended a low-s-She did not use salt of the salt o	nt #2 on 09/14/23 at 5:57pm se much salt; he did not sed to be on a low-salt diet. upervisor in Charge (SIC) on 2:51pm, and 6:29pm e on regular diets. tic diets, no chopped diets, were on regular diets. sident #2's PCP had salt diet. when she cooked. with the Administrator on evealed: on the wall in the kitchen.	C 270			
C 273	Service 10A NCAC 13G .0904 (d) Food Requirement (3) Daily menus for reson the U.S. Department Guidelines for Americal hereby incorporated but subsequent amendment guidelines can be four https://dietaryguidelines.	A Nutrition and Food Service ats in Family Care Homes: agular diets shall be based ent of Agriculture Dietary ans 2020-2025, which are by reference, including ents and editions. These and at es.gov/sites/default/files/202 les_for_Americans-2020-20	C 273			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL035034	B. WING		09	0/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HOUSE	E DI ESSINCS AT SUTTO	1359 SU	TTON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	LOUISB	URG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 273	Continued From page	e 52	C 273			
	interviews, the facility residents were served daily as recommende Department of Agricu Americans 2020-2029	ns, record reviews, and I failed to ensure the Id one and a half cups of fruit I based on the U.S. Iture Dietary Guidelines for				
	The findings are:					
	Dietary Guidelines for revealed: -Adults aged 19-59 and minimum of 1 1/2 cup 1600-calorie diet and caloric diets The fruit food group 100% fruit juiceWhole fruits included dried formsWhole fruits could be such as cut, sliced, died as cut, sliced, died form whole fruits could be such as cut, sliced, died form whole fruits could be such as cut, sliced, died form whole fruits could be such as cut, sliced, died form whole fruits could be such as cut, sliced, died form whole from whole from whole from whole from whole from whole from the food for the food for the food for the food for the food form whole from whole from the food for the food for the food form whole for the food food food food food food food foo	up to 2 cups for higher included whole fruits and d fresh, canned, frozen, and e eaten in various forms, iced, or cubed. commended amount of fruit hole fruit, rather than 100% onsumed, they should be lys pasteurized or 100% juice				
	kitchen wall on 09/14	vas to be served every				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLETED
					
		FCL035034	B. WING		09/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
HOUSE	F BLESSINGS AT SUTTO	1359 SUT	TON ROAD		
HOUSE O	r blessings at sorte	LOUISBU	RG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 273	Continued From page	e 53	C 273		
	lunch meal and dinne such as pineapple, ar oranges, pears, apric	it was to be served at the remail including options oplesauce, mixed fruit, ots and peaches.			
	8:00am and 2:56pm revealed: -There was no fresh fruit or frozen fruit in the facility.				
	-There were no fruit ju	uices in the facility.			
	-There was one jar of	applesauce in the			
	refrigerator with appro	* · · · · · · · · · · · · · · · · · · ·			
	applesauce remaining	g in the jar.			
	Interview with a residence revealed:	ent on 09/14/23 at 5:27pm			
	-They very seldom ha	ad juices to drink at the			
	1	uit to eat at the facility.			
	-The day program gar about 3-weeks ago.	ve him an orange to eat			
	5:33pm revealed:	r resident on 09/14/23 at ange juice, or any other kind			
	of juice in 3-4 months				
	-They had apples, ora Christmas, but not at	anges, and bananas at other times.			
	5:43pm revealed: -They had not been s juice in a long time.	resident on 09/14/23 at erved orange juice or apple d fruit, but he wished they d fruit.			
	Telephone interview v Charge on 09/15/23 a -She served applesau -The residents brough	at 9:33am revealed:			

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			(X3) DATE SURVEY COMPLETED		
		FCL035034	B. WING		09/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STATI TTON ROAD JRG, NC 27549	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
C 273	to the residents. -Two weeks ago, she residents. -The residents ate the Administrator brought. -The residents were at the Administrator brought. -She took groceries to weeks. -She took orange juict she bought groceries. -She usually took 2-3 time, and it was the firest also took a gallot facility when she took.	st week and she served that served bananas to the e fresh fruit as soon as the t it in. also served canned fruits. with the Administrator on evealed: to the facility every two the to the facility every time gallons of orange juice at a rest thing to go. on of apple juice to the t groceries. I her there was no juice or	C 273		
C 284	Service 10A NCAC 13G .0904 Service (e) Therapeutic Diets (4) All therapeutic die supplements and thic served as ordered by This Rule is not met Based on observatior interviews, the facility diets were served as	4(e)(4) Nutrition and Food 4 Nutrition and Food 5 in Family Care Homes: ets, including nutritional kened liquids, shall be the resident's physician. as evidenced by: ns, record reviews, and failed to ensure therapeutic ordered for 2 of 3 sampled ders for chopped meats (#1,	C 284		

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DIVISION	of Fleatili Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLE	ETED
			, DOILDING			
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		1359 SUT	TON ROAD			
HOUSE O	F BLESSINGS AT SUTTO	ON RD LOUISBUI	RG, NC 27549			
	0.0000000000000000000000000000000000000		1	DD0//DDD0 D/ AM 05 00DD50T/01		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
IAG		,	1/40	DEFICIENCY)		
C 284	Continued From page	e 55	C 284			
	The findings are:					
	Review of the daily m	enu for a regular chopped				
	diet on 09/14/23 revea	aled:				
	-The breakfast meal in	ncluded eggs, grits, and				
	chopped toast.					
	-The lunch meal inclu	ded a chopped peanut				
		vich, 8 ounces of cheese				
		en salad, and minced fruit.				
		cluded chopped chicken and				
	_					
		otatoes, green beans,				
		d a chopped dinner roll.				
		r another day included				
	potato chips and on the	<u>•</u>				
	chopped diet potato c	chips were substituted with				
	cooked carrots.					
	Interview with the Sur	pervisor in Charge (SIC) on				
	09/14/23 at 8:00am re					
	-All the residents were					
		tic diets, no chopped diets,				
		• • • • • • • • • • • • • • • • • • • •				
	and no other diets; all	l were on regular diets.				
		t #1's FL-2 dated 10/10/22				
	revealed:					
	-Diagnoses included i					
	schizophrenia, and bi	lateral hearing loss.				
	-There was an order f	for a chopped diet.				
	Review of the therape	eutic diet list posted in the				
	kitchen on 09/14/23 a	-				
		e served a chopped diet.				
	1 CONCONTRACT WAS TO DE	o oo, voa a onoppea aiet.				
	Observation of the bar	eakfast meal service on				
	•					
	09/14/23 at 7:28am re					
		ved 2 pancakes with syrup				
	and grits; the pancake					
	-Resident #1 was usir	ng a spoon to cut the				
	pancakes into large b	ite-size pieces.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
NAME OF D			ADDESS SITV STA	TF 7/D 00DF	1 03/13/2023
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TON ROAD RG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 284	Continued From page	e 56	C 284		
C 284	Observation of the lur 09/14/23 at 12:02pm -Resident #1 was ser meat and cheese and sandwich was not cheThere were no carroibe used as a substitu. Observation of the dir 09/14/23 at 6:15pm reserved ½ cup of slopp green beans, a cup obun and the cookies with the cookies with the side revealed: -He had some problement of the did not have back at the ate whatever the linterview with the SIC revealed: -She did not know RedietResident #1 ate fine him have any problem. Attempted telephone Primary Care Provided 4:20pm was unsucce. Refer to the telephone Administrator on 09/1 2. Review of Residen revealed: -Diagnoses included of the cookies with the side of the cookies wit	nch meal service on revealed: ved a sandwich with delided 1 cup of potato chips; the opped. Its observed in the facility to tee for the potato chips. Inner meal service on evealed Resident #1 was by joe on a bun, ½ cup of frice, and 2 cookies; the were not chopped. Int #1 on 09/14/23 at 5:50pm Ins with chewing because teeth. SIC gave him to eat. It on 09/14/23 at 6:29pm Insident #1 had a chopped Insident #1's er (PCP) on 09/14/23 at seful. Interview with Resident #1's er (PCP) on 09/14/23 at seful. Interview with the 5/23 at 9:46am. It #3's FL-2 dated 10/10/22	C 204		
	schizophreniaThere was an order f				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
		FCL035034	B. WING		09	/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TTON ROAD			
		LOUISBI	URG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 284	Continued From page	e 57	C 284			
	kitchen on 09/14/23 a	eutic diet list posted in the at 10:00am revealed e served a chopped diet.				
	09/14/23 at 7:28am re -Resident #3 was ser	ved 2 pancakes with syrup es were not chopped. ng a spoon to cut the				
	Observation of the lu 09/14/23 at 12:02pm the adult day progran	revealed Resident #3 was at				
	served 1/2 cup of slop	evealed Resident #3 was py joe on a bun, ½ cup of f rice, and 2 cookies; the				
	Interview with the SIC revealed:	C on 09/14/23 at 6:29pm				
	-She did not know Red	esident #3 had a chopped				
	were hard for him to	have teeth so some foods eat. et her know if there was				
	something he could n	ot eat.				
		ns, interviews, and record was not interviewable.				
		interview with Resident #3's 1:18pm was unsuccessful.				
	Refer to the telephon Administrator on 09/1					
	Telephone interview v	 with the Administrator on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09)/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	TTON ROAD JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 284	09/15/23 at 9:46am r -There was a menu for the kitchen. -She expected reside	evealed: or chopped diets posted in ents who were on chopped od chopped before it was	C 284			
C 330	(a) A family care hor preparation and adm prescription and non-by staff are in accord (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met Based on observation reviews, the facility fawere administered as residents (#2, #3) reliand an eye drop (#2) The findings are: 1. Review of Resident #1/14/22 revealed dialegible. Review of Resident # (PCP) after visit summerevealed diagnoses in	4 Medication Administration me shall assure that the inistration of medications, prescription and treatments ance with: led prescribing practitioner of in the resident's record; and on and the facility's policies as evidenced by: led prescribing practitioner of in the resident's record; and on and the facility's policies as evidenced by: led prescribing practitioner of in the resident's record; and on and the facility's policies as evidenced by: led prescribing practitioner of in the resident's record; and record alled to ensure medications or ordered for 2 of 3 sampled ated to an inhaler (#2, #3) at #2's current FL-2 dated agnoses listed were not #2's Primary Care Provider mary dated 06/02/23 included blindness, der, high blood pressure, and	C 330			

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE (X3) DATE SURVE (X4) MULTIPLE CONSTRUCTION (X3) DATE SURVE (X4) MULTIPLE CONSTRUCTION (X5) DATE SURVE (X6) DATE SURVE (X6) DATE SURVE (X7) DATE SURVE (X7) DATE SURVE (X8) DATE SU					
			A. BUILDING: _			
		FCL035034	B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	ON ROAD			
	OUR MARK OT		RG, NC 27549	220//2520 21 44 25 22225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 330	Continued From page	e 59	C 330			
	revealed there was all inhaler (used to treat people with lung dise Review of Resident #	t #2's FL-2 dated 11/14/22 n order for an Albuterol or prevent bronchospasm in ases) two puffs twice daily. 2's medication s (MAR) for July 2023				
	revealed: -There was an entry f	or an Albuterol inhaler to he lungs twice daily for				
	shortness of breath w administration time of -There was documen administered twice da	7:00am and 9:00pm. tation Albuterol was				
	administered twice daily from 07/01/23-07/31/23. Review of Resident #2s August 2023 MAR revealed: -There was an entry for an Albuterol inhaler to inhale two puffs into the lungs twice daily for shortness of breath with a scheduled administration time of 7:00am and 9:00pm. -There was documentation Albuterol was administered twice daily from 08/01/23-08/31/23.					
	from 09/01/23-09/14/2 -There was an entry f inhale two puffs into t shortness of breath w administration time of -There was documen	or an Albuterol inhaler to he lungs twice daily for vith a scheduled f 7:00am and 9:00pm.				
	on 09/14/23 at 10:36a -There was a box lab 90mcg inhale 2 puffs	ent #2's medication on hand am revealed: eled for the Albuterol inhaler into lungs twice daily with a /01/23; it contained 200				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	AND I EAR OF CONNECTION		A. BUILDING: _		COMIL	LILD
	FCL035034		B. WING		09/1	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	ON ROAD			
	- BEEGGINGO AI GOTTO	LOUISBUI	RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
C 330	Continued From page	e 60	C 330			
	-There was a handwritten date of 07/20/23 on the inhaler boxThere were 123 inhalations remaining in the inhaler. Interview with the Supervisor in Charge (SIC) on 09/14/23 at 2:33pm revealed: -The handwritten date on the medication was the date she opened the package and started using the medicationResident #2 was administered one puff of Albuterol in the mornings and one puff at nightShe had not seen Resident #2 have any shortness of breathShe thought Resident #2 was supposed to get one puff twice a dayShe did not know Resident #2 was supposed to get two puffs twice a day.					
	-"I have shorted him his Albuterol." Telephone interview with the Pharmacist at the facility's previous contracted pharmacy on 09/14/23 at 1:39pm revealed: -Resident #2's current order was for Albuterol two puffs twice daily for a total of four puffs dailyBased on the current order the Albuterol dispensed had 200 inhalations and would last 50 daysResident #2's Albuterol was dispensed on 06/22/23, 05/01/23 and 03/21/23 each for a 50-day supplyAlbuterol was usually prescribed to help with breathingIf Resident #2's Albuterol was not administered as ordered the resident could have difficulty breathing and experience shortness of breath.					
	revealed:	nt #2 on 09/14/23 at 5:57pm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		FCL035034	B. WING		09/1	5/2023
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE OF	BLESSINGS AT SUTTO	ON RD	TON ROAD RG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 330	what they were. -He did not know how when he used the inh Attempted telephone PCP on 09/14/23 at 4 Refer to the telephone Administrator on 09/1 b. Review of Residen revealed there was at (used to control symp pulmonary disease [Conce daily. Review of Resident # administration records revealed: -There was an entry f two puffs into the lung scheduled administra -There was documen administered daily from Review of Resident # revealed: -There was an entry f two puffs into the lung scheduled administra -There was an entry f two puffs into the lung scheduled administra -There was documen was administered dail Review of Resident # from 09/01/23-09/14/2	t inhalers but did not know many puffs he received aler. interview with Resident #2's ::18pm was unsuccessful. e interview with the 5/23 at 9:46am. t #2's FL-2 dated 11/14/22 n order for Stiloto Respimat stoms of chronic obstructive COPD]) to inhale 2 puffs 2's medication s (MAR) for July 2023 for Stiloto Respimat to inhale gs once daily with a tion time of 8:00am. tation Stiloto Respimat was m 07/01/23-07/31/23. 2s August 2023 MAR for Stiloto Respimat to inhale gs once daily with a tion time of 8:00am. tation that Stiloto Respimat by from 08/01/23-08/31/23. 2's September 2023 MAR 23 revealed: for Stiloto Respimat to inhale gs once daily with a	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING: _			
	FCL035034	B. WING		09/	15/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HOUSE OF BLESSINGS AT SUTTON I	RD	FON ROAD RG, NC 27549			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
was administered daily for the control of Resident on 09/14/23 at 10:36am. There was a box labeled inhaler with the direction lungs once daily with a do 05/01/23; it contained 60. There was a handwritte. The meter was in the redoses remaining and appinhalations were remaining linterview with the Super 09/14/23 at 2:33pm reverong 14/23 at 2:33pm reverong 14/24 was adminsticated at the medication. Resident #2 was adminsticated the medication. Resident #2 was adminsticated the more puff daily. She thought Resident # one puff daily. She did not know Residing two puffs when the madministered. Telephone interview with facility's previous contraction of 14/23 at 1:39pm reverong 12/25 current or 14/25 current or 14/	ion that Stiloto Respimat from 09/01/23-09/14/23. #2's medication on hand revealed: d for the Stiolto Respimat is to inhale 2 puffs into dispensed date of 0 metered inhalations. In date of 07/20/23. In date of 07/20/23. In date of 07/20/23. In the medication was the ckage and started using distered one puff of the raings. In the medication was the ckage and started using distered one puff of the raings. In the Have any I was supposed to get the first was supposed to medication was In the Pharmacist at the cted pharmacy on saled: I rain was for a Stiolto fis once daily. I rain the Stiolto dispensed	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		FCL035034	B. WING		09	0/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		1359 SU	TTON ROAD			
HOUSE O	F BLESSINGS AT SUTT	LOUISBU	JRG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From pag	e 63	C 330			
	the lungs	decrease mucous and fluid in Ito was not administered as could have difficulty				
	revealed: -He did not need an iuse it every dayHe used two differer what they were.	ent #2 on 09/14/23 at 5:57pm inhaler, but the MA made him nt inhalers but did not know w many puffs he received naler.				
		interview with Resident #2's 4:18pm was unsuccessful.				
	Administrator on 09/					
	revealed there was a	nt #2's FL-2 dated 11/14/22 in order for Latanoprost eye to treat glaucoma) place s at bedtime.				
	revealed: -There was an entry	ls (MAR) for July 2023 for Latanoprost eye drops				
	scheduled administra -There was documer	ch eye at bedtime with a attention time of 8:00pm. Intation Latanoprost was om 07/01/23-07/31/23.				
	revealed: -There was an entry	#2's August 2023 MAR for Latanoprost eye drops ch eye at bedtime with a ation time of 8:00pm.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FCL035034		B. WING		09/15/2023		
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIR CODE	1 09/13/2023	
NAME OF FI	NOVIDER OR SUFFLIER	1359 SUTT	, ,	TE, ZIF CODE		
HOUSE O	F BLESSINGS AT SUTTO	ON RD	G, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	e 64	C 330			
		tation Latanoprost was m 08/01/23-08/31/23.				
		2's September 2023 MAR 23 revealed:				
	from 09/01/23-09/14/23 revealed: -There was an entry for Latanoprost eye drops place one drop in each eye at bedtime with a scheduled administration time of 8:00pm. -There was documentation Latanoprost was administered daily from 09/01/23-09/14/23. Observation of Resident #2's medication on hand on 09/14/23 at 10:36am revealed: -There was a prescription bottle with a dispensed date of 07/26/23 that contained a bottle of Latanoprost eye drops. -There was medication remaining in the bottle.					
	facility's previous con 09/14/23 at 1:39pm re-Resident #2's curren 0.005% one drop in e-A bottle of Latanopro 03/23/23, 05/25/23, a-Based on the current would last 25-28 days -If Resident #2's Lata administered as order increased intraocular	evealed: t order was for Latanoprost ach eye at bedtime. est was dispensed on nd 06/28/23. t order the Latanoprost s.				
	Telephone interview v facility's current pharr revealed: -Resident #2's Latano dispensed on 07/26/2	with the Pharmacist at the macy on 09/14/23 at 3:37pm oppost eye drops were 13. ulk order and would need to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HOUSE O	F BLESSINGS AT SUTTO	ON RD 1359 SUTT			
	CLIMMADY CT		RG, NC 27549	DROVIDEDIC DI ANI OF CODDECTION	u
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 330	Continued From page	e 65	C 330		
	-There had been no r Resident #2's Latano				
	revealed:	C on 09/14/23 at 2:33pm			
	every night.	esident #2's Latanoprost ny there was medication			
	remaining from the 07				
	and 5:57pm revealed				
	see some out of his ri	egally blind though he could ight eye in "good light.".			
		ps in his eyes every day. at the eye drops were or how m.			
		interview with Resident #2's ::18pm was unsuccessful.			
	Refer to the telephon Administrator on 09/1				
	2. Review of Resider revealed:-Diagnoses included	nt #3's FL-2 dated 10/10/22			
	pulmonary disease (C				
	(used to prevent sym				
	Review of Resident #3's medication administration records (MAR) for July 2023 revealed:				
	-	or Advair 250-50 diskus 12 hours with a scheduled 18:00am and 8:00am			

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-There was documentation Advair was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL035034	B. WING		09	0/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE	•	
		1359 SU	TTON ROAD	,		
HOUSE O	F BLESSINGS AT SUTTO	ON RD LOUISB	URG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	e 66	C 330			
		8:00am and 8:00pm from				
	Review of Resident # revealed:	[‡] 3's August 2023 MAR				
	inhale one puff every administration time of -There was documen	for Advair 250-50 diskus 12 hours with a scheduled f 8:00am and 8:00pm. station Advair was 8:00am and 8:00pm from				
	Review of Resident #3's September 2023 MAR from 09/01/23-09/14/23 revealed: -There was an entry for Advair 250-50 diskus inhale one puff every 12 hours with a scheduled administration time of 8:00am and 8:00pmThere was documentation Advair was administered daily at 8:00am and 8:00pm 09/01/23-09/14/23.					
	on 09/14/23 at 10:36a -There was an Advair medication cart with I medicationsThe Advair was not I box available to revie	r diskus loose in the				
	facility's previous con 09/14/23 at 1:39pm re- Resident #3's currer inhale one puff every -An Advair diskus cor	evealed: nt order was for Advair to 12 hours. ntained 60 inhalations and 3's order the diskus would				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL035034	B. WING		09/15/2023	
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	DN RD	DRESS, CITY, STATON ROAD	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 330	ordered the resident of symptoms of COPD in and coughing. Telephone interview of facility's current pharman revealed: -Resident #3's Advair for a one-month supposed and an analysis and sulk or requested to refillThere had been no receive to resident #3's Advair. Interview with the SIC revealed: -She administered Remorning and every nigosed and severy nigosed and seve	air was not administered as could have increased including shortness of breath with the Pharmacist at the macy on 09/14/23 at 3:37pm was dispensed on 07/26/23 ly. der and would need to be equest for refills for con 09/14/23 at 3:12pm esident #3's Advair every ght. by there was medication con on the wealed the Sic at 9:46am. The interview with the 5/23 at 9:46am. With the Administrator on evealed the Sic was er medications correctly	C 330			
C 335	10A NCAC 13G .1004 Administration	4 (f) (1-4) Medication	C 335			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: C		
		FCL035034	B. WING		09/15/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	E, ZIP CODE	•
HOUSE	F BLESSINGS AT SUTTO	1359 SUT	TON ROAD		
H003E 0	F BLESSINGS AT SUTTO	LOUISBU	IRG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C 335	Continued From page	e 68	C 335		
	10A NCAC 13G .1004	4 Medication Administration			
		prepared for administration			
		ring procedures shall be the drugs identified up to			
	the point of administration and sp	ation and protect them from			
	(1) Medications are	dispensed in a sealed			
	·	dose and multi-paks that is of each medication and			
	strength in the sealed	l package. The labeled			
	package of medicatio and kept enclosed in	ns is to remain unopened a capped or sealed			
		ed with the resident's name,			
		are administered to the			
		pak is also labeled with the es not have to be enclosed			
	in a capped or sealed	l container;			
		dispensed in a sealed and			
		pecified in Subparagraph (1) kept enclosed in a sealed			
		es the name and strength of			
		ared and the resident's			
	name; (3) A separate conta	iner is used for each			
		inned administration of the			
	medications and labe				
		(2) of this Paragraph; and e placed together on a			
		device that is labeled with			
		administration and stored in			
		s only accessible to staff as			
	specified in Rule .100	o(u) or this Section.			
	This Rule is not met				
	Based on observation failed to ensure media	ns and interviews, the facility cations prepared for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL035034	B. WING		09	/15/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	1359 SU	DDRESS, CITY, STATE TTON ROAD URG, NC 27549	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 335	container that identifice ach medication prepoint of administration contamination for six. The findings are: Observation of the fa 7:30am-7:38am reversible. When the doorbell we Charge (SIC) was seen of the kitchen area. There were 5 residentable. The dining room table from the room off the room off the room off the sident's place setting multiple tablets/capsurable tables. The cups were not be a made or the medicational residents ook their medications, the SIC was not in the residents took their medications; the SIC linterview with a residence of the residence of the residence of the sidents with a siden	ance were kept in a sealed ed the name and strength of bared, identified up to the n, and protected from residents. cility between aled: ras rung, the Supervisor in en coming out of a room off at sitting at the dining room the could not be observed kitchen area. clastic cups at each ng; each cup contained ules. abeled with the resident's on in the cup. We tops to protect them from tion. The count of the plastic cups and the dining room when the nedications. The could not be observed with the resident's on in the cup. The tops to protect them from tion. The count of the plastic cups and the dining room when the nedications. The count of the plastic cups and the dining room when the nedications. The count of the plastic cups and the dining room when the nedications.	C 335	DEFICIENCY		
	the table when the [n -The [named] SIC alv and did not watch the	amed] SIC was working. vays went back to her room em take their medications. vorked, they went to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL035034	B. WING		09/1	5/2023
	ROVIDER OR SUPPLIER F BLESSINGS AT SUTTO	ON RD	ORESS, CITY, STA TON ROAD RG, NC 27549	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
C 335	5:43pm revealed: -He was always admithe tableSometimes the staff medications. Interview with the SIC revealed: -She pulled the reside morning, put the medication and sat the cups on technical states of the pulled the residence of the pulled the pulled to the pulled to the pulled the pulled to the pulled the pulled to the pulled to the pulled the pulled to the pulled the pulled to the pulled to the pulled the pulled to the pulled	nistered his medications at watched them take their and on 09/14/23 at 2:51pm and on the cup, on of the medication cart. The cup with the residents' ations in the cup, on a put each resident's ir place setting. In the place of the medication cup on a period of the did not leave the residents' and put each resident and on the cup on the did not leave the residents' and proom, but she knew her dents would not take cation. With the Administrator on everaled: In SIC had placed cups of ing room table and left the sidents to take. In the did not resident	C 335			

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