Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` ′  | E CONSTRUCTION               | (X3) DATE SURVEY<br>COMPLETED   |        |                          |
|--|---|--|------------------------------|---|--------|--------------------------|
|  |   | HAL030010  | B. WING                      |   |        | C<br><b>15/2023</b>      |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S              | STATE, ZIP CODE   | •      |                          |
| PS SENI  | OR LIVING OF MOCK   | SVILLE   | STVIEW DRIV<br>(ILLE, NC 27) |   |        |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETE<br>DATE |
| D 000  | Initial Comments  |  | D 000                        |   |        |                          |
|  | County Department<br>a State Involved Co<br>09/18/23. The Com   | ensure Section and the Davie<br>t of Social Services conducted<br>emplaint Investigation on<br>plaint Investigation was<br>ie County Department of<br>08/31/23.  |                              |   |        |                          |
| D 269  | 10A NCAC 13F .09<br>Supervision   | 01(a) Personal Care and  | D 269                        |   |        |                          |
|  | Supervision (a) Adult care hom care to residents ac plans and attend to   | 01 Personal Care and e staff shall provide personal coording to the residents' care any other personal care ay be unable to attend to for  |                              |   |        |                          |
|  | reviews, the facility<br>according to the ca<br>residents (Resident<br>having oily hair and<br>sponge bath or sho | et as evidenced by: ons, interviews and record failed to provide personal care re plan for 1 of 4 sampled t #4) related to the resident no documentation of a wer for 10 of 14 days during since being admitted to the |                              |   |        |                          |
|  | The findings are:   |  |                              |   |        |                          |
|  | 08/04/23 revealed: -Diagnoses include -Resident #4 was ir   | #4's current FL2 dated d dementia and autism. ncontinent of bladder. ed assistance with bathing  |                              |   |        |                          |
|  |   | :#4's Resident Register<br>dmitted to the facility on  |                              |   |        |                          |

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

TITLE (X6) DATE

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE | SURVEY                   |
|--------------------------|---|--|---------------------|--|-----------|--------------------------|
|                          | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUILDING:        |  | COMPLETED |                          |
|                          |   |  |                     |  |           | ;                        |
|                          |   | HAL030010  | B. WING             |  | 1         | 5/2023                   |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| DC CENII                 |   | 191 CRES   | TVIEW DRIN          | /E   |           |                          |
| PS SENI                  | OR LIVING OF MOCK   | MOCKSVI  | LLE, NC 27          | 028  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| D 269                    | Continued From pa   | ge 1   | D 269               |  |           |                          |
|                          | 09/01/23.   |  |                     |  |           |                          |
|                          | Review of Resident #4's record revealed there was no care plan completed as of 09/14/23.  |  |                     |  |           |                          |
|                          | Observation of Resident #4 during the tour of the facility on 09/14/23 at 9:23am revealed: -Resident #4's hair appeared oily and unwashedResident #4's clothes appeared clean and there were no apparent odors. |  |                     |  |           |                          |
|                          | revealed she had no   | dent #4 on 09/14/23 at 9:24am<br>ot had a shower, but she did<br>long it had been since she  |                     |  |           |                          |
|                          | September 2023 re -There was docume receive a shower or Fridays on first shift -Resident #4 require bathing.  | entation Resident #4 was to<br>n Mondays, Wednesdays, and  |                     |  |           |                          |
|                          | 09/03/23, 09/04/23, 09/10/23.   | t shift on 09/01/23, 09/02/23, 09/08/23, 09/09/23, and entation Resident #4 received   |                     |  |           |                          |
|                          | 09/07/23 and 09/08  |  |                     |  |           |                          |
|                          | assistance was pro<br>through 09/14/23 or<br>-There was no docu<br>assistance was pro   | umentation that bathing vided or refused on 09/11/23 in first shift.  umentation that bathing vided or refused on second or 09/01/23 through 09/14/23. |                     |  |           |                          |
|                          | -Resident #4 was a  | #4's progress notes revealed:<br>ssisted with a shower on<br>sing multiple times and on  |                     |  |           |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 2 of 35

Division of Health Service Regulation

| STATEMEN                 | IT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
|                          |  |  |                     |  | С                 |                          |
|                          |  | HAL030010  | B. WING             |  | 09/1              | 5/2023                   |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| DC CENII                 | OR LIVING OF MOCK  | 191 CRES   | TVIEW DRIN          | /E   |                   |                          |
| PS SEINI                 | OR LIVING OF WOCK  | MOCKSVI  | LLE, NC 27          | 028  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 269                    | Continued From pa  | ae 2   | D 269               |  |                   |                          |
|                          | 09/13/23There was no other offering, assistance offering, assistance offering, assistance of the care aide (PCA) on the personal careWhen residents residents residents or shower or sponge the care of the sponge baths or the sponge bath or | er documentation regarding e, or refusals of a shower.  dication aide (MA)/personal 09/14/23 at 3:40pm revealed: first day at the facility not adjust well and refused fused showers or sponge at another PCA in to attempt a path.  able to assist residents with owers on the scheduled shift, at shift sometimes attempted shower.  owers and sponge baths for d during her shift unless he ous shift told her a resident |                     |  |                   |                          |
|                          | revealed: -Some days were by assisting Resident including showers a lf Resident #4 did difficult to get her to lf a resident refuse  | not have snacks, it was  |                     |  |                   |                          |
|                          | shift, staff on secon<br>a shower if they had<br>-If a shower or spor  | ed a shower scheduled on first and shift attempted to assist with d time.  Indeed the street attempted to a street attempted to a street attempted to a street attempted to a street attempte attempts should have   |                     |  |                   |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 3 of 35

Division of Health Service Regulation

| STATEMEN                 | IT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     |  |      | E SURVEY<br>MPLETED      |  |
|--------------------------|---|---|---------------------|--|------|--------------------------|--|
| HAI 020040               |   | 1141,000,40   | B. WING             |  | C    |                          |  |
|                          |   | HAL030010   | D. WING             | · · · · · · · · · · · · · · · · · · ·  | 09/1 | 5/2023                   |  |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |      |                          |  |
| PS SENI                  | OR LIVING OF MOCK   | SVILLE  | TVIEW DRIV          |  |      |                          |  |
| MOCKS                    |   |   | LLE, NC 27          | 028  |      |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |  |
| D 269                    | Continued From pa   | ge 3  | D 269               |  |      |                          |  |
|                          | been documented.  |   |                     |  |      |                          |  |
|                          | revealed: -If Resident #4 refutimes to assist her village inform the Director try to assist her with she has notice Rewithin the two week facilityResident #4's hair have a showerResidents hair was assisted with shower.  | tinued to refuse, PCAs were to and request for second shift to a sponge bath or a shower. sident #4 to have an order as she has been in at the was oily when she did not a washed only when they were |                     |  |      |                          |  |
|                          | Interview with a second PCA on 09/15/23 at 10:00am revealed: -Resident #4 refused showers a lotShe attempted to assist her with a shower this morning, but she refusedResident #4 did not have a shower on 09/14/23, her scheduled shower day, but she did not know if she refused or notShe noticed Resident #4's hair was oily on yesterday and today, but PCAs assisted with washing hair when they assisted with showersIf a resident refused a shower, other staff were to ask 3 or 4 different times and second shift was informed that the resident refused on first shiftShe did not know if residents who refused a shower on first shift were assisted with a shower on second shift. |   |                     |  |      |                          |  |
|                          | revealed:   | Director on 09/15/23 at 2:58pm<br>ed a shower, staff was to try   |                     |  |      |                          |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 4 of 35

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '                          | E CONSTRUCTION  |                                   | SURVEY<br>PLETED         |
|--------------------------|--|---|--------------------------------|---|-----------------------------------|--------------------------|
|                          |  |   | A. BOILDING                    |   |                                   | c                        |
|                          |  | HAL030010   | B. WING                        |   |                                   | 15/2023                  |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET  | ADDRESS, CITY,                 | STATE, ZIP CODE   |                                   |                          |
| PS SENI                  | OR LIVING OF MOCK  | SVILLE  | RESTVIEW DRI'<br>SVILLE, NC 27 |   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| D 269                    | Continued From pa  | nge 4   | D 269                          |   |                                   |                          |
|                          | -Usually, staff did n<br>shower within their<br>-When a shower wa<br>bath should have be<br>-Resident #4 did not<br>but her hair did not<br>-If Resident #4 nee<br>her hair on non-sho<br>used dry shampoo.<br>Telephone interview<br>09/15/23 at 4:23pm<br>-Staff should have a<br>assist Resident #4<br>-Staff should have a<br>#4 with a shower m | ot have a shower on 09/15/23 look oily. Ided assistance with washing ower days, staff should have w with the Administrator on a revealed: made a good faith effort to |                                |   |                                   |                          |
| D 270                    | Supervision  10A NCAC 13F .09  Supervision (b) Staff shall provi   | 01(b) Personal Care and<br>01 Personal Care and<br>ide supervision of residents i<br>ach resident's assessed need<br>ent symptoms.                                    |                                |   |                                   |                          |
|                          | Based on observati interviews, the facil for 2 of 5 sampled a resident who had   | et as evidenced by:  ON  ions, record reviews, and ity failed to provide supervisi residents (#2 and #3) includi aggressive behaviors dent physically and verbally    |                                |   |                                   |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 5 of 35

Division of Health Service Regulation

|                                | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                         | E CONSTRUCTION  |                                   | SURVEY<br>PLETED         |  |
|--------------------------------|--|--|-----------------------------|---|-----------------------------------|--------------------------|--|
|                                |  |  | A. BOILDING.                |   |                                   | C                        |  |
|                                |  | HAL030010  | B. WING                     |   |                                   | 15/2023                  |  |
| NAME OF I                      | PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, S              | STATE, ZIP CODE   |                                   |                          |  |
| PS SENIOR LIVING OF MOCKSVILLE |  |  | STVIEW DRI\<br>'ILLE, NC 27 |   |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG       | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| D 270                          | Continued From pa  | nge 5  | D 270                       |   |                                   |                          |  |
|                                |  | sidents (#3) and a resident<br>alls which resulted in injuries   |                             |   |                                   |                          |  |
|                                | The findings are:  |  |                             |   |                                   |                          |  |
|                                | 07/14/23 revealed: -Diagnoses include anxiety, depression -Resident #3 was a behaviors.  Review of Residen revealed: -Resident #3 had n  | ent #3's current FL2 dated and Alzheimer's dementia, an, and hyperlipidemia. constantly confused. ambulatory and had wandering at #3's care plan dated 07/14/23 by problems with ambulation. |                             |   |                                   |                          |  |
|                                | -Resident #3 required supervision with ambulation and transferring.  a. Review of Resident #3's progress notes dated 06/05/23 revealed Resident #3 got aggravated a few times with other residents and staff.  |  |                             |   |                                   |                          |  |
|                                | care aide (PCA) where progress note on 0 and are resident #3 never and sometimes he way elling at other resident at other experies and resident at other res | lked down the hall fussing and dents and staff. tor he needed an as needed ation and behaviors. dent #3 more after behaviors, scheduled increased  |                             |   |                                   |                          |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 6 of 35

Division of Health Service Regulation

|                                | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------------|---|---|---|--|--------------------------------|-------------------------------|--|
|                                |   |   | 7t. Boilebiito.                         |  |                                | c                             |  |
|                                |   | HAL030010   | B. WING                                 |  |                                | 15/2023                       |  |
| NAME OF I                      | PROVIDER OR SUPPLIER  | STREET AI   | DDRESS, CITY,                           | STATE, ZIP CODE  |                                |                               |  |
| PS SENIOR LIVING OF MOCKSVILLE |   |   | STVIEW DRIV<br>/ILLE, NC 27             |  |                                |                               |  |
| (X4) ID<br>PREFIX<br>TAG       | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| D 270                          | b. Review of Reside 06/19/23 at 2:36pm became aggressive while in the sunroor residents to the become at 1.06/19/23 at 2:36pm 3:40pm revealed: Resident #3 yelled when he became at 2.5he usually gave in this attention or took area. She was not aware or safety checks im on 06/19/23.  Review of Resident was no documentate supervision after his concept at 2.29pm behaving aggressive around the facility. | tion of any increased s behaviors on 06/05/23.  ent #3's progress note dated revealed Resident #3 e towards another resident m; staff redirected the droom.  MA/PCA who documented the progress note on 09/14/23 at at residents and staff at times |   |  |                                |                               |  |
|                                | -Resident #3 rando<br>throughout the facil<br>-She was not aware  | e of any increased supervision<br>aplemented after his behaviors  |   |  |                                |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 7 of 35

Division of Health Service Regulation

| STATEMEN                 | IT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE<br>COMP |                          |
|--------------------------|---|---|---------------------|---|-------------------|--------------------------|
| HAI 020040               |   | B. WING   |                     | C<br>09/15/2023   |                   |                          |
|                          |   | HAL030010   | B. WING             |   | 09/1              | 5/2023                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE   |                   |                          |
| PS SENI                  | OR LIVING OF MOCK   | SVILLE  | TVIEW DRI\          |   |                   |                          |
|                          |   |   | LLE, NC 27          |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| D 270                    | Continued From pa   | ge 7  | D 270               |   |                   |                          |
|                          | was no documental supervision after his supervision after his d. Review of Reside 07/29/23 revealed: -Resident #3 got violate. He went up behind him, was shaking hat the other resident Later in the shift, a couch and Resident was screaming and Resident #3 charg throughout the day  | resident was asleep on the t #3 grabbed the resident and l cursing at the resident. ed at other residents and yelled at staff. fer the situation and distract   |                     |   |                   |                          |
|                          | o7/29/23 progress revealed: -When Resident #3 difficult to distract h -When she came ir third shift staff told aggressive moodResident #3 came morning and cursed -After breakfast, Re another resident, pl began shaking him -She was in the din resident came to he happenedAfter lunch betwee same resident was Resident #3 grabbe -Resident #3 got ar | n on the morning of 07/29/23, her Resident #3 was in an to the nurse's station that d staff. esident #3 went up behind aced him in a bear hug, and ing hall when the other er upset and told her what en 1:30pm and 2:00pm, the sitting on the couch and ed his thighs and yelled at him. |                     |   |                   |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 8 of 35

Division of Health Service Regulation

|   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,  |   |  | SURVEY<br>PLETED  |  |
|---|---|--|---|--|---|--|
|   |   |  |   |  | C   |  |
|   | HAL030010   | B. WING  |   |  | 15/2023   |  |
| PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S   | STATE, ZIP CODE   |  |   |  |
| PS SENIOR LIVING OF MOCKSVILLE  |   |  |   |  |   |  |
| (EACH DEFICIENCY  | / MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTURE CROSS-REFERENCED TO   | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETE<br>DATE  |  |
| Continued From pa   | ge 8  | D 270  |   |  |   |  |
| hallway outside the   | Director's office.  |  |   |  |   |  |
| was no documenta  | tion of any increased   |  |   |  |   |  |
| Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:  -The facility notified her Resident #3 had experienced increased aggression.  -Resident #3 became frustrated because he was not able to communicate.  -She expected staff to redirect Resident #3.  -Staff "kept eyeballs" on him because he stayed in the hallways.  -If Resident #3 was not walking in the hallways, she expected staff to know where he was. |   |  |   |  |   |  |
| revealed: -Resident #3 becant trouble communica -When Resident #3 direct his frustration anyone in particular -He usually turned awere a couple times residentsHe was always on hallwaysResident #3 was nor increased supervisions residents who have   | ne upset because he had ting. became upset, he did not nor aggression towards. and walked away, but there is he would yell at other the move up and down the ot on scheduled safety checks vision. y scheduled safety checks or ion implemented for any is had behaviors.   |  |   |  |   |  |
|   | Continued From parthat separated the shallway outside the Heathen got in anoyelling at her.  Review of Resident was no documentar supervision after his Interview with Reside (PCP) on 09/15/23 -The facility notified experienced increatesident #3 becarnot able to communicate the shallways.  If Resident #3 was she expected staff "kept eyeballs in the hallways.  If Resident #3 was she expected staff "Resident #3 was she expected staff unterview with the Experienced increatesident #3 was she expected staff.  Interview with the Expendent #3 was she expected staff.  Interview with the Expendent #3 becarn trouble communicates and the usually turned a were a couple time residents.  He was always on hallways.  -Resident #3 was no increased supervisions and the second supervisions are second supervisions and supervisions and the second supervisions are second supervisions and the second supervisions and the second supervisions are second supervisions and the second supervisions are second supervisions and the second supervisions are second supervisions and the | PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  that separated the front sitting area and the hallway outside the Director's office.  He then got in another resident's face and began yelling at her.  Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 07/29/23.  Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:  -The facility notified her Resident #3 had experienced increased aggression.  -Resident #3 became frustrated because he was not able to communicate.  -She expected staff to redirect Resident #3.  -Staff "kept eyeballs" on him because he stayed in the hallways.  -If Resident #3 was not walking in the hallways, she expected staff to know where he was.  Interview with the Director on 09/15/23 at 2:58pm revealed:  -Resident #3 became upset because he had trouble communicating.  -When Resident #3 became upset, he did not direct his frustration or aggression towards anyone in particular.  -He usually turned and walked away, but there were a couple times he would yell at other residents.  -He was always on the move up and down the | A BUILDING:  HALO30010  B. WING  BROVIDER OR SUPPLIER  STREET ADDRESS, CITY, S. 191 CRESTVIEW DRIM MOCKSVILLE, NC 27  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  that separated the front sitting area and the hallway outside the Director's office.  He then got in another resident's face and began yelling at her.  Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 07/29/23.  Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:  -The facility notified her Resident #3 had experienced increased aggression.  -Resident #3 became frustrated because he was not able to communicate.  -She expected staff to redirect Resident #3.  -Staff "kept eyeballs" on him because he stayed in the hallways.  -If Resident #3 was not walking in the hallways, she expected staff to know where he was.  Interview with the Director on 09/15/23 at 2:58pm revealed:  -Resident #3 became upset because he had trouble communicating.  -When Resident #3 became upset, he did not direct his frustration or aggression towards anyone in particular.  -He usually turned and walked away, but there were a couple times he would yell at other residents.  -He was always on the move up and down the hallways.  -Resident #3 was not on scheduled safety checks or increased supervision.  -There were not any scheduled safety checks or increased supervision implemented for any residents who have had behaviors. | A BUILDING:  HAL030010  BY WING  ROVIDER OR SUPPLIER  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE  MOCKSVILLE, NC 27028  SUMMARY STATEMENT OF DEFICIENCIES  (EACH OFFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  that separated the front sitting area and the hallway outside the Director's office.  He then got in another resident's face and began yelling at her.  Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 07/29/23.  Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:  -The facility notified her Resident #3 had experienced increased aggressionResident #3 became fustrated because he was not able to communicate.  -She expected staff to redirect Resident #3Staff "kept eyeballs" on him because he stayed in the hallwaysIf Resident #3 was not walking in the hallways, she expected staff to know where he was.  Interview with the Director on 09/15/23 at 2:58pm revealed: -Resident #3 became upset because he had trouble communicating.  When Resident #3 became upset, he did not direct his frustration or aggression towards anyone in particularHe usually turned and walked away, but there were a couple times he would yell at other residentsHe was always on the move up and down the hallwaysResident #3 was not on scheduled safety checks or increased supervisionThere were not any scheduled safety checks or increased supervision implemented for any residents who have had behaviors. | A BUILDING:  HAL030010  B. WING  B. WING  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE  MOCKSVILLE, NC 27028  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR IS COENTIFYING INFORMATION)  Continued From page 8  that separated the front sitting area and the hallway outside the Director's office.  He then got in another resident's face and began yelling at her.  Review of Resident #3's record revealed there was no documentation of any increased supervision after his behaviors on 07/29/23.  Interview with Resident #3's primary care provide (PCP) on 09/15/23 at 12:39pm revealed:  -The facility notified her Resident #3 had experienced increased aggression.  -Resident #3 became frustrated because he was not able to communicate.  -She expected staff to redirect Resident #3.  -Staff 'Rept eyebable's on him because he stayed in the hallways.  -If Resident #3 became upset because he had trouble communicating.  -When Resident #3 became upset because he had trouble communicating.  -When Resident #3 became upset, he did not direct his frustration or aggression towards anyone in particular.  -He usually turned and walked away, but there were a couple times he would yell at other residents.  -He was always on the move up and down the hallways.  -Resident #3 was not on scheduled safety checks or increased supervision implemented for any residents who have had behaviors. |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 9 of 35

Division of Health Service Regulation

|                   | of Health Service Re   |  | 1             |   | 1         |                  |
|-------------------|--|--|---------------|---|-----------|------------------|
|                   | IT OF DEFICIENCIES OF CORRECTION                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:             |               | E CONSTRUCTION  | (X3) DATE | SURVEY<br>LETED  |
| AND LEAN          | O. COMMEDITION   | BERTH IOATION NOWIBER.   | A. BUILDING:  |   | CONF      | :-0              |
|                   |  |  |               |   | 0         | ;                |
|                   |  | HAL030010  | B. WING       |   | 09/1      | 5/2023           |
| NAME OF           | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS CITY S | STATE, ZIP CODE   |           |                  |
|                   |  |  | STVIEW DRIV   | ,   |           |                  |
| PS SENI           | OR LIVING OF MOCK  | SVILLE   | ILLE, NC 27   |   |           |                  |
| 0(4) ID           | CUMMA DV CTA   |  |               |   | )NI       | ()(5)            |
| (X4) ID<br>PREFIX | _  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL             | ID<br>PREFIX  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL |           | (X5)<br>COMPLETE |
| TAG               | REGULATORY OR L  | SC IDENTIFYING INFORMATION)                                    | TAG           | CROSS-REFERENCED TO THE APPROI                              | PRIATE    | DATE             |
|                   |  |  |               | DEFICIENCY)   |           |                  |
| D 270             | Continued From pa  | age 9  | D 270         |   |           |                  |
|                   | .09/05/23 at 4⋅23nm  | revealed he expected staff to                                  |               |   |           |                  |
|                   |  | supervision when residents                                     |               |   |           |                  |
|                   |  | naviors and to consult with the                                |               |   |           |                  |
|                   |  | nental health provider.  |               |   |           |                  |
|                   | 2. Review of Reside  | ent #2's current FL-2 dated                                    |               |   |           |                  |
|                   | 06/09/23 revealed:   |  |               |   |           |                  |
|                   | -Diagnoses included Type II diabetes mellitus,                       |  |               |   |           |                  |
|                   | acute kidney failure, primary hypertension,                          |  |               |   |           |                  |
|                   | hypomagnesemia, hyperlipidemia, coronary                             |  |               |   |           |                  |
|                   | arteriosclerosis and dementiaResident #2 was constantly disoriented. |  |               |   |           |                  |
|                   | -Resident #2 was a   |  |               |   |           |                  |
|                   |  | ncontinent of bowel and  |               |   |           |                  |
|                   |  | d assistance with bathing and                                  |               |   |           |                  |
|                   | dressing.  | J  |               |   |           |                  |
|                   | Paview of Residnet   | t #2's care plan dated 07/14/23                                |               |   |           |                  |
|                   | revealed:  | t #2 5 care plan dated 07/14/20                                | <b>'</b>      |   |           |                  |
|                   |  | ervision with eating, ambulation                               |               |   |           |                  |
|                   | and transferring.  | C.   |               |   |           |                  |
|                   | •  | nsive assistance with toileting,                               |               |   |           |                  |
|                   | bathing, and groom   | ning.  |               |   |           |                  |
|                   | Review of Resident   | t #2's Incident and Accident                                   |               |   |           |                  |
|                   | reports revealed:  |  |               |   |           |                  |
|                   | -On 07/19/23, Resid  | dent #2 was found on the floor                                 |               |   |           |                  |
|                   |  | were no injuries found and no                                  |               |   |           |                  |
|                   | complaints of pain.  |  |               |   |           |                  |
|                   |  | t #2 was standing at the desk<br>. Resident #2 had a skin tear |               |   |           |                  |
|                   |  | first aid was administered.                                    |               |   |           |                  |
|                   |  | dent and Accident report                                       |               |   |           |                  |
|                   |  | of the 08/01/23 falls.   |               |   |           |                  |
|                   | -There was no Incid  | dent and Accident report                                       |               |   |           |                  |
|                   | available for review   | for the 08/06/23 fall  |               |   |           |                  |
|                   | Review of Resident   | t #2's progress note dated                                     |               |   |           |                  |
|                   |  | Resident #2 had a fall and her                                 |               |   |           |                  |
|                   |  | ne to the facility and took the                                |               |   |           |                  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 10 of 35

Division of Health Service Regulation

| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP   |               | Of Fleatth Service IN  |   | T              |  | <del></del> |                          |
|--|---------------|--|---|----------------|--|-------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028  [X4] ID PREFIX TAG  [ACA   DEPROVIDER OR SUMMARY STATEMENT OF DEFICIENCIES TAG  [ACA   DEPROVIDER OR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  D 270  Continued From page 10  resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2's skin assessment dated 07/30/23 revealed Resident #2's had a skin tear on her left leg and arm, a knot on her head, bruising  |               |  |   | ` '            |  |             |                          |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 10 resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising   | 7.11D 1 L/11V |  | BENTH 15 WIGHT HOMBER.  | A. BUILDING:   |  |             |                          |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 10  resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimeters.  -There were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, brusing  |               |  |   | R WING         |  |             |                          |
| PS SENIOR LIVING OF MOCKSVILLE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  D 270  Continued From page 10 resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed:Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising  |               |  | HAL030010   | D. WING        |  | 09/1        | 5/2023                   |
| CAMPAIR   CAMP | NAME OF       | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S | STATE, ZIP CODE  |             |                          |
| (X4) ID PREFIX TAG  (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 10  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising  | PS SFNI       | IOR LIVING OF MOCK   | SVILLE  |                |  |             |                          |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 270  Continued From page 10  resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising   | 1002.11       |  | MOCKSV  | ILLE, NC 27    | 028  |             |                          |
| resident to the hospital.  Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising  | PRÉFIX        | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL  | PREFIX         | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE       | (X5)<br>COMPLETE<br>DATE |
| Review of Resident #2's hospital emergency department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising   | D 270         | Continued From pa  | age 10  | D 270          |  |             |                          |
| department (ED) report dated 07/29/23 revealed: -Resident #2 was admitted to the ED on 07/29/23 and released on 07/30/23Resident #2's ED visit diagnoses included fall and skin tear of the right forearmThe skin tear to the right forearm was 2 to 3 centimetersThere were multiple subcentimeter lesions to the anterior skin, honey crusted with mild erythemiaThere was an x-ray of Resident #2's left hip with no findingsThere were no other injuries documented.  Review of Resident #2's skin assessment dated 07/30/23 revealed Resident #2 had a skin tear on her left leg and arm, a knot on her head, bruising  |               | resident to the hosp   | pital.  |                |  |             |                          |
| Review of Resident #2's progress note dated 08/01/23 revealed Resident #2 had 2 falls today and her family member picked her up at the facility and took her to the hospital.  Review of Resident #2's progress note dated 08/06/23 revealed: -At 5:13 am, staff was taking the resident to the bathroom and the resident slipped and hit her leg on her walkerFirst aid was applied.  Review of Resident #2's record revealed there was no documentation of interventions or increased supervision after the documented falls on 07/19/23, 07/26/23, 2 falls on 08/01/23, and 08/06/23.  Review of Resident #2's Emergency Medical  |               | Review of Resident department (ED) re-Resident #2 was a and released on 07-Resident #2's ED wand skin tear of the The skin tear to the centimeters.  There were multiplicanterior skin, honey. There was an x-rano findings.  There were no oth Review of Resident 07/30/23 revealed her left leg and arm on her left hip and a Review of Resident 08/01/23 revealed and her family men facility and took her Review of Resident 08/06/23 revealed:  At 5:13 am, staff whether was no documental increased supervision 07/19/23, 07/26/08/06/23. | t #2's hospital emergency eport dated 07/29/23 revealed: admitted to the ED on 07/29/23 r/30/23. visit diagnoses included fall eright forearm. e right forearm was 2 to 3 le subcentimeter lesions to the y crusted with mild erythemia. y of Resident #2's left hip with her injuries documented. It #2's skin assessment dated Resident #2 had a skin tear on a knot on her head, bruising a black eye.  It #2's progress note dated Resident #2 had 2 falls today on her picked her up at the resident #2 had 2 falls today on her picked her up at the resident slipped and hit her legued.  It #2's progress note dated was taking the resident to the resident slipped and hit her legued.  It #2's record revealed there tion of interventions or ion after the documented falls /23, 2 falls on 08/01/23, and |                |  |             |                          |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 11 of 35

Division of Health Service Regulation

|                          | NT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPF IDENTIFICATION   |   | , ,                    | E CONSTRUCTION   |                                   | SURVEY<br>PLETED         |
|--------------------------|--|---|---|------------------------|--|-----------------------------------|--------------------------|
|                          |  |   |   | A. BUILDING:           |  |                                   |                          |
| HAL030010                |  | B. WING   |   |                        | C<br>1 <b>5/2023</b>   |                                   |                          |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | STREET AD   | DRESS, CITY, S         | STATE, ZIP CODE  |                                   |                          |
| PS SENI                  | PS SENIOR LIVING OF MOCKSVILLE   |   |   | STVIEW DRINILLE, NC 27 |  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCY<br>Y MUST BE PRECEDED<br>SC IDENTIFYING INFOR   | BY FULL   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
|                          | Services (EMS) rep-EMS arrived to me Resident #2 had be-EMS assessed Reher face above the and the top and ba falls.  Review of Residen dated 08/08/23 rev-Resident #2 was a from the ED on 08/-The paramedic pre-  | eet facility staff who<br>een tired for the las<br>esident #2 to have<br>left eye, across the<br>ck of her head from<br>t #2's hospital sum<br>ealed:<br>idmitted to and dis-<br>08/23.<br>esented Resident #   | o advised st week. bruising on e forehead, n previous mary report charged #2's history  |                        |  |                                   |                          |
|                          | and reported Reside ago and was seen -Resident #2 had define the fore of the some greenish/grasuggested an older of the was a small forearm.  -Resident #2 present for evaluation of left and worsening menually and worsening menually ago and worsening menually seed and worsening seed and w | at a different hospi<br>iscolored bruising<br>head and left eye.<br>e left side of the for<br>yish discoloration ver<br>timeframe of injural<br>skin tear noted to<br>nted from the facility<br>thargy, generalized<br>ntal status.                           | ital. noted to the rehead had which y. the right ity via EMS weakness,  |                        |  |                                   |                          |
|                          | -This had gradually days and it was not any chronic medical were changed recerving the compared to a creater reference range is indication of acute (normal reference range is any change of the compared to a creater range is indication of acute (normal reference range)   | t clear if Resident # ation or if any medi- ation or if any medi- ation administrat with her. ad work was review at no significant le blood cell count). aurrent creatinine le atinine level of 1.23 0.6-1.1 mg/dl) in 20 kidney injury. evel was low at a le | #2 was on cations ion records wed and she ukocytosis evel of 1.26 ion (normal) ion |                        |  |                                   |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 12 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |  |                     | (X3) DATE SURVEY<br>COMPLETED   |           |                          |  |
|---|---|--|--|---------------------|---|-----------|--------------------------|--|
|   |   |  |  | A. BUILDING:        |   |           | С                        |  |
|   |   | HAL0   | 30010  | B. WING             | ·····   |           | 15/2023                  |  |
| NAME OF I   | PROVIDER OR SUPPLIER  |  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |           |                          |  |
| PS SENI   | OR LIVING OF MOCK   | SVILLE   |  | TVIEW DRIN          |   |           |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |  |
| D 270   | -Chest X-rays show or intracranial hemo and a head comput not show evidence -Resident #2's only weakness and fatig stable.  Review of Resident summary dated 08/-Resident #2 was a 08/25/23The chief complain hyperglycemiaResident #2 presetype 2 diabetes, hy from EMS that Resagitated and confuse-EMS had an eleval documented as rear-Resident #2 was in agitation and sever hyperglycemic state kidney injury (AKI) -Resident #2's AKI fluids were discontilinitially, with Resid were held including | wed no evide orrhage and ted tomogra of acute strosymptom where and here the theory of | or acute stroke, phy (CT) scan did oke. ras generalized vital signs were all discharge aled: the hospital on the hospital of the hospital of the hospital of hospital on the hospital of hospital on the hospital of hospital of hospital on the hospital of h | D 270               |   |           |                          |  |
|   | -Resident #2 was no blood pressuresOn 08/28/23, Resinormal level of 150 stableResolved hospital superimposed on codiabetes mellitus whyperglycemic state hypernatremia.   | dent #2's blo<br>and her vita<br>problems in<br>hronic kidne<br>ith hyperosn   | ood sugar was at a al signs were cluded AKI by disease, Type 2 nolar   |                     |   |           |                          |  |
|   | Telephone interview   | Telephone interview with Resident #2's family  |  |                     |   |           |                          |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 13 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′    | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED |  |         |                          |
|---|---|--------|----------------|-------------------------------|--|---------|--------------------------|
|   |   |        |                |                               |  |         | С                        |
|   |   | HAL030 | 0010           | B. WING                       |  | 09/     | 15/2023                  |
| NAME OF I   | PROVIDER OR SUPPLIER  |        |                |                               | STATE, ZIP CODE  |         |                          |
| PS SENI   | OR LIVING OF MOCK   | SVILLE |                | TVIEW DRIN                    |  |         |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |        |                | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE |
| D 270   | Continued From pa   | ge 13  |                | D 270                         |  |         |                          |
|   | member on 08/31/23 at 2:17pm revealed Resident #2 was declining and a hospice provider was called in to provide comfort care.  Telephone interview with Resident #2's family member on 09/05/23 at 9:46am revealed Resident #2 passed away on 09/04/23 at a hospice facility.  Interview with a personal care aide (PCA) on 09/15/2023 at 10:00 am revealed: -She was aware Resident # 2 had falls but was unsure of datesShe was present for one fall (07/26/23) when the resident slipped out of her chair at the front desk and had a skin tear on her armStaff were supposed to do 30-minute checks after a resident fellResident #2 had a black eye, bruising over her eye and swelling to her face on 07/30/23 when Resident #2 returned from the hospital and she notified the Director. |        |                |                               |  |         |                          |
|   |   |        |                |                               |  |         |                          |
|   |   |        |                |                               |  |         |                          |
|   | Interview with a second PCA on 09/15/2023 at 9:30 am revealed: -She was aware Resident #2 had been falling but was not sure of datesShe had not witnessed any of Resident #2's fallsStaff were supposed to do 30-minute checks after a resident fell.   |        |                |                               |  |         |                          |
|   |   |        |                |                               |  |         |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 14 of 35

Division of Health Service Regulation

| AND PLAN OF CORRECTION IDENTIFICATION NOMBER.  A. BUILDING:  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|-------------------------------|--|
| HAL030010 B. WING 09/15  | ;<br>5/2023                   |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028  |                               |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5)<br>COMPLETE<br>DATE      |  |
| D 270 Continued From page 14 -She was aware of Resident #2's black eye and bruising to Resident #2's faceThe bruise looked like Resident #2's face was pressed against a bedrail like what was on a hospital bed.  Interview with the Director on 09/15/23 at 3:20pm revealed: -She was aware Resident #2 had a few falls, but she was not aware Resident #2 had a total of 5 fallsStaff were supposed to do 30-minute checks after a fall and if falls continued, staff were supposed to do 15-minute checksThe PCP should be notified of all injuriesResident #2 had a black eye, bruising over her eye and swelling to her face when she returned from the hospital on 07/30/2023She notified the PCP about the black eye, bruising over her eye and swelling to her face when she returned from the hospital on 07/30/2023.  Interview with the Administrator on 09/15/23 at 4:25pm revealed: -She was not aware Resident #2 had 5 fallsShe expected the staff to document all falls, notify the ED and notify the PCP if there were multiple falls for any resident and keep a closer eye on the resident after falls.  The facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) resulting in a resident physically and verbally assaulting other residents by placing a resident in a bear hug, shaking, and grabbing the resident's legs, and yelling at other residents (#3) and a resident having falls resulting in a skin tear on her left leg and arm, a knot on her head, bruising on her left |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 15 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ′   | E CONSTRUCTION                               | (X3) DATE SURVEY<br>COMPLETED  |  |  |  |
|---|---|---|--|--|--|--|--|
|   |   | HAL030010   | B. WING                                      | C<br>09/15/20  |  |  |  |
|   | PROVIDER OR SUPPLIER  OR LIVING OF MOCK   | SVILLE 191 CRES   | DRESS, CITY, S<br>STVIEW DRIV<br>ILLE, NC 27 |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | N SHOULD BE COMPLETE<br>E APPROPRIATE DATE |  |  |
| D 270   | The facility provided accordance with G. this violation   | aced the residents at risk for<br>rm and neglect which  | D 270  |  |  |  |  |
| D 273   | to meet the routine of residents.  This Rule is not me TYPE A2 VIOLATION  Based on observation reviews, the facility care provider (PCP (#1 and #2) related available for adminion weight loss over a 3 refusals of medications over a 3 month. The findings are:  1. Review of Reside 06/09/23 revealed of Type II diabetes me | O2 Health Care I assure referral and follow-up and acute health care needs et as evidenced by: ON ons, interviews and record failed to notify the primary ) for 2 of 5 sampled residents to medications not being stration and a 21 pound B month period (#1), and ons and an 18.5 pound weight | D 273  |  |  |  |  |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 16 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | , ,  | E CONSTRUCTION  |                               | (X3) DATE SURVEY<br>COMPLETED  |                                |                          |  |
|--|--|--|---|-------------------------------|--|--------------------------------|--------------------------|--|
|  |  | HAL0300  | 110   | B. WING                       |  | I                              | C<br>09/15/2023          |  |
|  |  | HALUSUU  |   |                               | 2747F 7ID 00DF   | 09/                            | 15/2023                  |  |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |   | DRESS, CITY, S<br>STVIEW DRIV | STATE, ZIP CODE  |                                |                          |  |
| PS SENIC   | OR LIVING OF MOCK  | SVILLE   |   | ILLE, NC 27                   |  |                                |                          |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L   |  | DED BY FULL   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| D 273  | Continued From para. Review of Resided dated 05/24/23 reve Memantine 5mg (us 8:00am twice daily Review of Resident 05/31/23) eMAR re-There was an entradaily at 8:00am and There was documented (refused).  Review of Resident revealed: There was an entradaily at 8:00am and There was an entradaily at 8:00am and There was documented (refused).  Review of Resident revealed: There was an entradaily at 8:00am and There was documented administration time anytime between 7: resident was awaked Review of Resident revealed: There was an entradaily at 8:00am and There was an entradaily at 8:00am and There was no entratine of morning med 7:00am-3:00pm who There was documented of 31 opportunity 07/17-07/22/24, 07/17-07/22/2 | ent #2's physicialed medications dead to treat medications dead to treat medications dead to treat medications dead to treat medication Memanus (27/23 at 8:00a dead to a physicially at #2's June 202 of for Memantin (28:00pm.)  Entation Memanus (29/2)  If a fine provided to the composition of the c | on orders for emory loss) at utine.  3 (05/25/23 to be 5mg twice on tine was not am with the unable to take of the emory loss on 06/04/23, 23 at 8:00am.  It's order dated on the emory loss on 06/04/23, 23 at 8:00am.  It's order dated on the emory loss on 06/04/23, 23 at 8:00am.  It's order dated on the emory loss on 06/04/23, 23 at 8:00am.  It's order dated on the emory loss on 06/04/23, 23 at 8:00am.  It's order dated on the emory loss of | D 273                         |  |                                |                          |  |

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 17 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |   |                     | (X3) DATE SURVEY<br>COMPLETED  |             |                          |
|---|--|--|---|---------------------|--|-------------|--------------------------|
|   |  |  |   | A. BOILDING.        |  |             | c                        |
|   |  | HAL03  | 0010  | B. WING             |  |             | 15/2023                  |
| NAME OF   | PROVIDER OR SUPPLIER   |  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |             |                          |
| PS SENI   | OR LIVING OF MOCK  | SVILLE   |   | TVIEW DRIN          |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG  | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| D 273   | Continued From pa  | ge 17  |   | D 273               |  |             |                          |
|   | Review of Resident #2's record and eMARs revealed there was no documentation the PCP was notified of the resident refusing Memantine.  |  |   |                     |  |             |                          |
|   | b. Review of Resident #2's physician's order dated 05/24/23 revealed medication orders for Metformin 500mg (used to treat elevated blood sugar levels) twice daily at 8:00am and 8:00pm.   |  |   |                     |  |             |                          |
|   | Review of Resident #2's May 2023 (05/25/23 to 05/31/23) electronic medication administration record (eMAR) revealed: -There was an entry for Metformin 500mg twice daily at 8:00am and 8:00pmThere was documentation metformin was refused or physically unable to take for 2 out of 7 opportunities on 05/25/23 and on 05/27/23 at 8:00am.  |  |   |                     |  |             |                          |
|   | Review of Resident #2's physician's orders dated 06/09/23 revealed an order for fingerstick blood sugars (FSBS) once daily if FSBS less than 80 or greater than 450 call the PCP; if FSBS less than 60 give 8 ounces of orange juice or glucose gel and recheck FSBS in 15 minutes.  |  |   |                     |  |             |                          |
|   | Review of Resident revealed: -There was an entry daily and 8:00am at There was docume refused for 4 out of 06/06/23, 06/28/23 -There was an entry am, if FSBS less that PCP; if FSBS less that the PCP less that t | y for Metform<br>nd 8:00pm.<br>entation Metf<br>30 opportun<br>and on 06/29<br>y for FSBS o<br>an 80 or greass than 60 g<br>cose gel and | formin was ities on 06/04/23, 2/23 at 8:00am. nce daily at 6:30 ater than 450 call live 8 ounces of recheck FSBS in |                     |  |             |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 18 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---------------------|---|-------------------------------|--------------------------|
|  |   | HAL030010   | B. WING             |   |                               | C<br><b>15/2023</b>      |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | TATE, ZIP CODE  |                               |                          |
| DC CENI  | OD LIVING OF MOCK   | 191 CRES  | STVIEW DRIV         | 'E  |                               |                          |
| PS SENI  | OR LIVING OF MOCK   | MOCKSV  | ILLE, NC 27         | 028   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE                      | (X5)<br>COMPLETE<br>DATE |
| D 273  | Continued From page 18 refused or the resident would not wake up for 14                       |   |                     |   |                               |                          |
|  | out of 22 opportunit<br>-There was no docu  | ies from 06/17/23 to 06/30/23. umentation of FSBS checks rom 06/09/23 to 0/16/23.   |                     |   |                               |                          |
|  | 07/14/23 revealed a administration time   | #2's physician's order dated an order to change the of morning medications to   |                     |   |                               |                          |
|  | anytime between 7:00am-3:00pm while the resident was awake and to change FSBS to once weekly. |   |                     |   |                               |                          |
|  | revealed:   | #2's July 2023 eMAR   |                     |   |                               |                          |
|  | daily at 8:00am and   |   |                     |   |                               |                          |
|  |   | y to change administration of<br>ns to 7:00am-3:00pm daily<br>vas awake.  |                     |   |                               |                          |
|  | refused or the resid  | entation Metformin was<br>lent would not wake up for 9  |                     |   |                               |                          |
|  | 07/08/23-07/09/23,<br>07/28/23, 07/30/23  | ies on 07/03/23, from<br>07/11/23, 07/22/23, 07/24/23,<br>and on 07/31/23 at 8:00am.<br>entation Metformin was                |                     |   |                               |                          |
|  | refused or the resid<br>out of 31 opportunit<br>07/29/23 at 8:00pm                            | ent would not wake up for 2<br>ies on 07/28/23, and on  |                     |   |                               |                          |
|  | am, if FSBS less th<br>the PCP; if FSBS le  | for FSBS once daily at 6:30<br>an 80 or greater than 450 call<br>ass than 60 give 8 ounces of<br>cose gel and recheck FSBS in |                     |   |                               |                          |
|  | 15 minutesThere was docume  | entation FSBS checks were lent would not wake up for 12   |                     |   |                               |                          |
|  | out of 15 opportunit<br>-07/04/23, on 07/06   | ies from 07/01/23<br>6/23, and from   |                     |   |                               |                          |
|  |   | at 6:30 am.<br>entation FSBS was not<br>nk space on 07/05/23 at 6:30  |                     |   |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 19 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--|--------------------------------|-------------------------------|--|
|  |   |   |  |                                | c                             |  |
|  | HAL030010   | B. WING                                 |  |                                | 15/2023                       |  |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S                          | STATE, ZIP CODE  |                                |                               |  |
| PS SENIOR LIVING OF MOCKSV   | III F   | TVIEW DRIV                              |  |                                |                               |  |
| PREFIX (EACH DEFICIENCY MU   | MENT OF DEFICIENCIES<br>JST BE PRECEDED BY FULL<br>IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| between 7:00am to 3:0 07/14/23.  -There was no docume obtained from 07/15/23.  Review of Resident #2 revealed: -There was an entry for daily at 8:00am and | atation as obtained on result documented. o check FSBS once weekly 00pm with a start date of entation FSBS checks were 3 to 07/31/23.  2's August 2023 eMAR  or Metformin 500mg twice 00pm. ation Metformin was m and 8:00 pm 08/01/23 to 0 check FSBS once weekly 00pm with a start date of ation FSBS checks were nd 8/18/23. ation of 2 FSBS checks on result of 105 and on result of 142. ation the resident was out 25/23 to 08/31/23.  2's record and eMARs o documentation the PCP ident refusing Metformin  #2's physician's order ed medication orders for ed to treat high blood laily for morning routine. | D 273                                   |  |                                |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 20 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (I   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X |  |            | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|--|------------|-------------------------------|--|
|  |  | 7. Bolizino.                                |  |            | С                             |  |
|  | HAL030010  | B. WING                                     |  | 09/15/2023 |                               |  |
| NAME OF PROVIDER OR SUPPLIER   | STREET AL  | DRESS, CITY, S                              | STATE, ZIP CODE  |            |                               |  |
| PS SENIOR LIVING OF MOCKS  | VILLE  | STVIEW DRIV<br>ILLE, NC 27                  |  |            |                               |  |
| PREFIX (EACH DEFICIENCY M  | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE    | (X5)<br>COMPLETE<br>DATE      |  |
| refused or the medicator 2 of 7 opportunities 05/30/23 at 6:00am.  -There was document refused for 2 of 7 oppon 05/30/23 at 2:00ppon 05 | ntation Hydralazine was ation was not in the facility as on 05/25/23 and on a station Hydralazine was portunities on 05/29/23 and m.  #2's June 2023 eMAR  for Hydralazine 25mg every 1:00pm and 10:00pm. Intation Hydralazine was 30 opportunities from 1:00mm of 05/23-06/08/23, 1:06/13 | D 273                                       | BEI IOIENOT)   |            |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 21 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |            |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|------------|--|-------------------------------|--------------------------|
|   |  | HAL030010   | B. WING    |  | C<br><b>09/15/2023</b>        |                          |
|   |  |   | l          |  | 09/1                          | 5/2023                   |
| NAME OF I   | PROVIDER OR SUPPLIER   |   | TVIEW DRIV | STATE, ZIP CODE  |                               |                          |
| PS SENI   | OR LIVING OF MOCK  | SVILLE  | LLE, NC 27 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   |            | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 273   | Continued From pa  | ge 21   | D 273      |  |                               |                          |
|   | -There was documerefused for 8 out of 07/14/23, 07/15/23, 07/28/23-07/31/23 -There was documerefused for 1 out of at 10:00pmThere was documereading of 124/76 or   | entation Hydralazine was 31 opportunities on 07/08/23, 07/19/23, and from at 2:00pm. entation Hydralazine was 31 opportunities on 07/28/23 entation of of a blood pressure in the eMAR.   |            |  |                               |                          |
|   | to 08/24/23) eMAR -There was an entry 8 hours at 2:00am, -There was no entry morning medication while the resident w -There was docume refused or the resident out of 24 opportunit 08/10/23, 08/12/23, 08/20/23, 08/21/23, 6:00amThere was docume refused for 2 out of and 08/23/23 at 2:0 -There was docume refused for 1 out of at 10:00pm -There was no docume administration on 0 10:00pmThere was docume reading of 112/75 or Review of Resident | y for Hydralazine 25mg every 2:00pm and 10:00pm. y to change administration of its to 7:00am-3:00pm daily was awake. entation Hydralazine was lent would not wake up for 17 ties from 08/01/23 - 08/08/23, 08/14/23, 08/15/23, 08/12/23, and 08/24/23 at entation Hydralazine was 24 opportunities on 08/19/23 0pm. entation Hydralazine was 24 opportunities on 08/05/23 umentation (a blank space) of 8/02/23 and 08/07/23 at entation of of a blood pressure |            |  |                               |                          |
|   | the resident refusin   | g Hydralazine in August 2023. ent #2's physician's order  |            |  |                               |                          |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 22 of 35

| DIVISION                 | of Health Service Re  | guiation       |                 | ı                          |  |                               |                          |
|--------------------------|---|----------------|-----------------|----------------------------|--|-------------------------------|--------------------------|
|                          | IT OF DEFICIENCIES  |                | R/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY<br>COMPLETED |                          |
| AND PLAN                 | OF CORRECTION   | IDENTIFIC      | CATION NUMBER:  | A. BUILDING:               |  | COMP                          | LETEU                    |
|                          |   |                |                 |                            |  | С                             |                          |
|                          |   | HAL03          | 80010           | B. WING                    |  |                               | 5/2023                   |
| NAME OF                  |   |                | OTDEET 45       |                            | CTATE ZID CODE   |                               | -                        |
| NAME OF I                | PROVIDER OR SUPPLIER  |                |                 |                            | STATE, ZIP CODE  |                               |                          |
| PS SENI                  | OR LIVING OF MOCK   | SVILLE         | -               | TVIEW DRIN                 |  |                               |                          |
|                          |   |                | MOCKSVI         | LLE, NC 27                 | 028  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |                |                 | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From pa   | ge 22          |                 | D 273                      |  |                               |                          |
|                          | dated 05/24/23 reve<br>Losartan 50mg (use<br>pressure) at 8:00an  | ed to treat hi |                 |                            |  |                               |                          |
|                          | Review of Resident #2's June 2023 eMAR revealed: -There was an entry for Losartan 50mg daily at 8:00amThere was documentation Losartan was refused or the resident would not wake up for 4 out of 30 opportunities on 06/04/23, 06/06/23, 06/28/23 and on 06/29/23.  Review of Resident #2's physician's order dated 07/14/23 revealed an order to change the administration time of morning medications to anytime between 7:00am-3:00pm while the resident was awake. |                |                 |                            |  |                               |                          |
|                          |   |                |                 |                            |  |                               |                          |
|                          |   |                |                 |                            |  |                               |                          |
|                          | Telephone interview member on 09/14/2   |                |                 |                            |  |                               |                          |

6899

-A medication aide (MA) gave her eMARs

Division of Health Service Regulation STATE FORM

If continuation sheet 23 of 35 08H311

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |  |                        | (X3) DATE SURVEY<br>COMPLETED   |                                   |                          |  |
|---|--|---|--|------------------------|---|-----------------------------------|--------------------------|--|
|   |  |   |  | ·                      |   |                                   | С                        |  |
|   |  | HAL030010   |  | B. WING                |   | 09/1                              | 15/2023                  |  |
| NAME OF   | PROVIDER OR SUPPLIER   |   |  |                        | STATE, ZIP CODE   |                                   |                          |  |
| PS SENI   | OR LIVING OF MOCK  | SVILLE  |  | STVIEW DRINILLE, NC 27 |   |                                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |   |  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |  |
| D 273   | Continued From parshowing where ResmedicationsResident #2 had not like they should have she thought Resid due to not taking here. Interview with a MA revealed: -She was aware of on 07/14/23 to char administration of mot 8:00am to between she was aware Reswake up and refuse she notified the Dicontinued to not was medicationsThe Director was roand other staff were PCP.  Interview with a second saware of dated 07/14/23 to condinistration of mot 8:00am to between she was aware of dated 07/14/23 to condinistration of mot 8:00am to between she was aware Reswake up and refuse she was aware she was awar | ot been given her we been given. ent #2 had decline er medications.  I on 09/14/23 at 3:  the new order from the Resident #2's continued morning medication 7:00am-3:00pm. esident #2 continued morning medicate exponsible to notific not allowed to not exponsible to notific exponsible to notify the Direct exponsible to notify the Petent #2's PCP on the exponsible | medications ed in health  42pm  In the PCP  from ed to not ations. Resident #2  If the PCP  otify the  723 at  In the PCP 2's s from ed to not ations. Ins for 3 days, ector and the PCP.  09/15/23 at  essing | D 273                  |   |                                   |                          |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 24 of 35

Division of Health Service Regulation

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                    | E CONSTRUCTION  | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|--|---|------------------------|---|-------------------|--------------------------|
|                          |  |   | A. BUILDING.           |   |                   |                          |
|                          |  | HAL030010   | B. WING                | <del></del>   |                   | 5<br> 5/2023             |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S         | STATE, ZIP CODE   |                   |                          |
| PS SENI                  | OR LIVING OF MOCK  | SVILLE  | STVIEW DRINILLE, NC 27 |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE            | (X5)<br>COMPLETE<br>DATE |
| D 273                    | -The order dated 0 morning medication 7:00am-3:00pmShe had not been continued refusing administered medically administered medically administered medically administered medically administration of medication of medications administration of medications and medications are she was notified by the not wake up and medications are she notified the Potential of the medication of medications are she notified the potential of the medication of medications are she notified the potential of the medication of medications are she notified the potential of the medication of the medication of the medication of the medication of the morning and weight to the 12th of the morning medically and weight to the 12th of the morning medical of | 7/14/23 was written for its to be administered between informed Resident #2 medications and was not cations after 07/14/23. anted to be informed of cals of medications.  Director on 09/15/23 at 3:07pm the new order from the PCP change Resident #2's corning medications from 17:00am-3:00pm.  By staff Resident #2 continued refused her morning  CP that Resident #2 was ake up and refused day, but it was not aware of Resident tions and would advise staff to lid take to be in compliance ders.  Bent #2's physician's order realed an order for monthly vital to be checked and recorded on onth.  It #2's hospital discharge /24/23 revealed Resident #2's | D 273                  |   |                   |                          |
|                          |  | vealed there was no entry for   |                        |   |                   |                          |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 25 of 35

Division of Health Service Regulation

|                          | Of Fleatth Service IN   |  | T                   |  | T                             |                          |
|--------------------------|---|--|---------------------|--|-------------------------------|--------------------------|
|                          | IT OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|                          |   |  | A. BUILDING:        |  |                               |                          |
|                          |   | 1141 020040  | B WING              |  | 00/4                          |                          |
|                          |   | HAL030010  |                     |  | 09/1                          | 5/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                               |                          |
| PS SENI                  | OR LIVING OF MOCK   | SVILLE   | STVIEW DRIN         |  |                               |                          |
|                          |   | MOCKSV   | ILLE, NC 27         | 028  |                               | 1                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| D 273                    | Continued From pa   | ige 25   | D 273               |  |                               |                          |
|                          | monthly vital signs   | or weights.  |                     |  |                               |                          |
|                          | revealed:<br>-There was no entr   | t #2's June 2023 eMAR y for monthly vital signs which  |                     |  |                               |                          |
|                          | pressure and weigh  | re, pulse, respirations, blood   |                     |  |                               |                          |
|                          | , .   | ght documented for 06/12/23.   |                     |  |                               |                          |
|                          | revealed: -There was an entrincluded temperatu pressure and weight-The weight docum 07/12/23. | ented was 152 lbs on   |                     |  |                               |                          |
|                          | (08/01/23-08/24/23<br>-There was an entrincluded temperatu<br>pressure and weigh              | y for monthly vital signs which re, pulse, respirations, blood   |                     |  |                               |                          |
|                          |   | t #2's weights documented on<br>d Resident #2 had a weight<br>months.                                    |                     |  |                               |                          |
|                          | was no documenta  | t #2's record revealed there<br>tion the primary care provider<br>of the resident's weight loss of<br>s. |                     |  |                               |                          |
|                          | 09/14/23 at 3:42 re<br>-The eMARs includ<br>12th of each month<br>-There was a histor         | ed an entry for weight on the  |                     |  |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 26 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | ` ′   | E CONSTRUCTION      | (X3) DATE<br>COMF  | SURVEY<br>PLETED               |                          |
|--|--|---|---|---------------------|--|--------------------------------|--------------------------|
|  |  |   |   | A. BUILDING:        |  |                                | C                        |
|  |  | HAL030010   |   | B. WING             |  |                                | 15/2023                  |
| NAME OF  | PROVIDER OR SUPPLIER   |   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                                |                          |
| PS SENI  | OR LIVING OF MOCK  | SVILLE  |   | TVIEW DRIN          |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENC<br>Y MUST BE PRECEDED<br>SC IDENTIFYING INFOR  | BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| D 273  | Continued From pa  | age 26  |   | D 273               |  |                                |                          |
|  | -She was not awar weight documented -She notified the D losing weightThe Director was a communicated with if the weight loss had #2's PCP.   | e Resident #2 did r<br>d for June 2023.<br>irector that Resider<br>the only staff who<br>n the PCP, so she o                    | nt #2 was   |                     |  |                                |                          |
|  | Interview with a see 9:34am revealed: -There was an entr be obtained on the Resident #2There was a histor documentation of tild she was not awar weight documented -She was not awar.                                    | ry on the eMARs fo<br>12th of each mont<br>ry section on the el<br>he previous month<br>e Resident #2 did r<br>d for June 2023. | r weights to<br>h for<br>MAR with<br>'s weight.<br>not have   |                     |  |                                |                          |
|  | Interview with Resi 12:30pm revealed: -She was not inform weightShe would have weight was a 10-pour monthsShe normally place supplements if their resident was not ear -She could have pl supplements because her meals. | med Resident #2 wanted to be notified and weight loss with ed residents on nurve was weight loss ating meals.                   | ras losing d when nin 2 to 3 tritional or if a on nutritional |                     |  |                                |                          |
|  | Interview with the Description -She was aware of -She was notified by having weight loss.  | Resident #2's weigns staff that Reside  | ght loss  |                     |  |                                |                          |
|  | Telephone interviev  | w with Resident #2'   | 's family   |                     |  |                                |                          |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 27 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---|---|-----------------------------------|-------------------------------|--|
|   |  |  | A. BOILDING                             |   |                                   | c                             |  |
|   |  | HAL030010  | B. WING                                 |   |                                   | 15/2023                       |  |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY,                           | STATE, ZIP CODE   |                                   |                               |  |
| PS SENI   | OR LIVING OF MOCK  | SVILLE   | STVIEW DRI                              |   |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| D 273   | -Resident #2 weigh admitted to the facil-She felt like facility Resident #2 and she thereShe walked in the occasions and Reshad not eaten any control of the facility of the facility of the facility of the facility.  Interview with the Advictor of the facility of the facility of the facility.  Review of Resident facility of the facility of the facilityThere was an entrol of the facilityThere was no door provider (PCP) was being available for of the facility of the facility of the facility of the facility.  Interview with a me one of the facility of the facility of the facility of the facility.  There was no door provider (PCP) was being available for of the facility of | 23 at 6:58pm revealed: ned 180 pounds when she was ility. y staff was not feeding ne lost weight during her stay dining hall on multiple sident #2 was sitting alone and of her food. Administrator on 09/15/23 at e was not aware of Resident d would advise staff to inform ight loss. dent #1's FL2 dated ed diagnoses of schizophrenia, anxiety and insomnia.  ent #1's physician's order ealed an order for Lorazepam at anxiety) twice daily.  It #1's June 2023 electronic estration record (eMAR)  Ty for Lorazepam 0.5mg twice d 8:00pm. entation Lorazepam was not is 13/23, 06/14/23, 06/15/23 the reason documented as not umentation the primary care is notified of Lorazepam not radministration. edication aide (MA) on in revealed: |   |   |                                   |                               |  |
|   | <ul> <li>She was aware Lo<br/>administered becau</li> </ul>  | orazepam was not<br>use the medication was not in  |   |   |                                   |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 28 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |  |   | (X3) DATE SURVEY<br>COMPLETED  |                          |
|--|--|--|--|---|--------------------------------|--------------------------|
|  |  | HAL030010  | B. WING                                      |   | <b>I</b>                       | C<br>I <b>5/2023</b>     |
|  | PROVIDER OR SUPPLIER OR LIVING OF MOCK   | SVILLE 191 CRES  | DRESS, CITY, S<br>STVIEW DRIV<br>ILLE, NC 27 |   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>(EACH CORRECTIVE ACTION<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EACH)<br>(EA | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| D 273  | o6/16/23She notified the Director was to medications.  Interview with a second administered bein the facility on 06/06/16/23There were probled getting medications.  Interview with a second administered bein the facility on 06/06/16/23There were probled getting medications and needed to be resident #1's medications, but she medications effective 2023.  Interview with Residual and needed to be resident with the facility on 06/06/16/23.  Interview with Residual and needed to be resident with the facility on 06/06/16/23.  Interview with Residual and needed to be resident with the facility of the PCP was not a sadministered medications effective 2023.  Interview with Residual and the properties of the PCP was away getting medications since switching to a she should have been the resident did not hissing five doses given for anxiety) with the properties of the | /23, 06/14/23, 06/15/23 and rector (unsure of the date) that repam was not in the facility, ered and documented in the he only staff that ordered and MA on 09/15/23 at esident #1's Lorazepam was recause the medication was not 13/23, 06/14/23, 06/15/23 and ans with the pharmacy not to the facility on time. The facility on the facility erector (unsure of the date) that cation was not in the facility erector (unsure of the date) that cation was not in the facility erector (unsure of the date) that cation was not in the facility erector (unsure of the date) that cation was not in the facility erector (unsure of the date) that cation was not in the facility erector (unsure of the date) that cation due to the medication dility.  The facility of the date of the date of the medication dility.  The facility of the date of the date of the date of the medication dility.  The facility of the date of the date of the date of the date of the medication dility.  The facility of the date of t |  |   |                                |                          |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 29 of 35

Division of Health Service Regulation

| DIVISION                 | of Health Service Re  | eguiation  |                     |   |                               |
|--------------------------|---|--|---------------------|---|-------------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|                          |   | HAL030010  | B. WING             |   | C<br><b>09/15/2023</b>        |
| NAME OF I                |   |  |                     | OTATE ZID CODE  | 1 00:10:2020                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  |                     | STATE, ZIP CODE   |                               |
| PS SENI                  | OR LIVING OF MOCK   | SVILLE   | STVIEW DRIV         |   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE                |
| D 273                    | Continued From pa   | ge 29  | D 273               |   |                               |
|                          | dated 04/10/23 reve<br>50mg (used to treat  | ent #1's physician's order<br>ealed an order for Losartan<br>t high blood pressure) take<br>m for morning routine.   |                     |   |                               |
|                          | Review of Resident eMAR revealed:   | #1's June 2023 electronic  |                     |   |                               |
|                          | at 8:00am.  | y for Losartan 50mg one daily  |                     |   |                               |
|                          | administered on 06<br>06/15/23 and 06/16<br>documented as not   | /23 with the reason in the facility.   |                     |   |                               |
|                          |   | umentation the PCP was not being available for   |                     |   |                               |
|                          | revealed:   | on 09/15/23 at 9:25am  |                     |   |                               |
|                          | because the medica<br>06/13/23, 06/14/23,<br>-She notified the Di<br>Resident #1's Losa<br>needed to be reord | sartan was not administered ation was not in the facility on 06/15/23 and 06/16/23. rector on 06/13/23 that rtan was not in the facility, ered and documented in the |                     |   |                               |
|                          | notes on the eMAR -The Director was t medications.  | he only staff that ordered   |                     |   |                               |
|                          | 10:00am revealed:   | cond MA on 09/15/23 at   |                     |   |                               |
|                          | administered becauthe facility on 06/13 06/16/23.   | esident #1's Losartan was not use the medication was not in /23, 06/14/23, 06/15/23 and  |                     |   |                               |
|                          | getting medications -She notified the Di  | ms with the pharmacy not to the facility on time. rector (unsure of the date) tha cation was not in the facility   | t                   |   |                               |

Division of Health Service Regulation

and needed to be reordered.

STATE FORM 6899 08H311 If continuation sheet 30 of 35

Division of Health Service Regulation

| STATEMEN      | IT OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: |   | (X3) DATE<br>COMP | SURVEY<br>LETED  |
|---------------|--|---|---|---|-------------------|------------------|
|               |  | HAI 020040  | B. WING                                     |   | 00/4              |                  |
|               |  | HAL030010   | <u> </u>                                    |   | 09/1              | 5/2023           |
| NAME OF F     | PROVIDER OR SUPPLIER   |   | , ,   | STATE, ZIP CODE   |                   |                  |
| PS SENI       | OR LIVING OF MOCK  | SVILLE  | STVIEW DRIN<br>LLE, NC 27                   |   |                   |                  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID  | PROVIDER'S PLAN OF CORRECTI   | ON                | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENCY   | YMUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                               | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | COMPLETE<br>DATE |
| D 273         | Continued From pa  | ge 30   | D 273                                       |   |                   |                  |
|               | medications, but sh  | he only staff that ordered<br>ne could now order<br>ve this month September   |   |   |                   |                  |
|               | 12:39pm revealed: -The PCP was not administered medication in the facilityThe PCP was awa getting medications since switching to a -She should have be Resident #1 did not -Missing five doses to treat high blood p | dent #1's PCP on 09/15/23 at aware Resident #1 was not cation due to the medication are there were problems a delivered from the pharmacy a new pharmacy. Deen notified by the Director if a receive medications.  of Losartan (which was given pressure) would not be life ald possibly cause a slight |   |   |                   |                  |
|               | -She was not aware medications for 06/06/15/23 and 06/16 the facilityShe should have bresident had 8 remarks could place an -There were proble getting medications.  | s/23, due to medications not in<br>seen notified by staff when a<br>aining doses of medication so<br>order for the medication.<br>ms with the new pharmacy not<br>is to the facility on time.   |   |   |                   |                  |
|               | 4:25pm revealed: -He was not aware medications for fou -His expectations w notify the PCP and override to ensure the medications on time   | ould be for the Director to call the pharmacy for an the resident got their   |   |   |                   |                  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 31 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                     |   | SURVEY<br>PLETED |                          |
|---|---|--|--|---------------------|---|------------------|--------------------------|
|   |   |  |  | 71. BOILDING.       |   |                  | С                        |
|   |   | HAL0:  | 30010                                    | B. WING             |   |                  | 15/2023                  |
| NAME OF   | PROVIDER OR SUPPLIER  |  | STREET AD                                | DRESS, CITY, S      | STATE, ZIP CODE   |                  |                          |
| PS SENI   | OR LIVING OF MOCK   | SVILLE   |  | TVIEW DRIN          |   |                  |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STA<br>(EACH DEFICIENC)<br>REGULATORY OR L  |  | CEDED BY FULL                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE        | (X5)<br>COMPLETE<br>DATE |
| D 273   | Continued From pa   | ıge 31   |  | D 273               |   |                  |                          |
|   | was to have a conv<br>management.   | ersation witl  | h someone in                             |                     |   |                  |                          |
|   | c. Review of Reside<br>dated 04/04/23 revisigns and weight to<br>the 12th of the mor  | ealed an ord<br>be checked                           | ler for monthly vital                    |                     |   |                  |                          |
|   | Review of Resident<br>revealed:<br>-There was an entr<br>included temperatu<br>pressure and weigh<br>-The weight docum<br>180.5 pounds (lbs). | y for monthly<br>re, pulse, re<br>nt.<br>ented on 06 | y vital signs which<br>spirations, blood |                     |   |                  |                          |
|   | Review of Resident<br>revealed: - There was an ent<br>included temperatu<br>pressure and weigh<br>-The weight docum<br>172.5 lbs.             | ry for month<br>re, pulse, re<br>nt.                 | ly vital signs which spirations, blood   |                     |   |                  |                          |
|   | Review of Resident<br>revealed there was<br>vital signs which increspirations, blood  | no docume<br>cluded temp                             | ntation for monthly erature, pulse,      |                     |   |                  |                          |
|   | Review of Resident<br>revealed: - There was an ent<br>included temperatu<br>pressure and weigh<br>-The weight docum<br>lbs.                   | ry for month<br>re, pulse, re<br>nt.                 | ly vital signs which<br>spiration, blood |                     |   |                  |                          |
|   | Based on review of eMARs revealed R   |  |  |                     |   |                  |                          |

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---|---|-----------------------------------|-------------------------------|--|
|  | HAL030010  | B. WING                                 |   |                                   | C<br><b>15/2023</b>           |  |
| NAME OF PROVIDER OR SUPPLIER   |  |   | STATE, ZIP CODE   | 09/                               | 15/2023                       |  |
| PS SENIOR LIVING OF MOCKS  | SVILLE 191 CRE   | STVIEW DRIN                             | /E  |                                   |                               |  |
| PREFIX (EACH DEFICIENCY N  | EMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | ΓΙΟΝ SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| revealed: -The eMAR generate weights on the 12th or She was aware Rewas unsure of the arrive of previous eMAR system, which she was not aware documented weight of 10:00am revealed: -She was aware Reswas unsure of the arrive of the weight changed, she was not aware documented weight of 11:40pm revealed of 12:40pm revealed of 12:40pm revealed of 15:40pm revealed of 16:40pm revealed of 16:4 | ed a record of Resident #1's or 13th of each month. Issident #1 had lost weight but mount of weight. Initor weight was to look at us month weights on the hashe did not do.  Resident #1 did not have a for July 2023.  Ind MA on 09/15/23 at Issident #1 had lost weight but mount of weight. In the check the history of previous he eMAR system to know if which she did not do.  Resident #1 did not have a for July 2023.  Indexident #1 did not have a for July 2023.  Indexident #1 did not have a for July 2023.  Indexident #1's PCP on 09/15/23 dicented Resident #1 had lost the en notified if a resident lost thin 2 to 3 months. If if it is provided in the condense of the con |   | DEFICIENC   |                                   |                               |  |

Division of Health Service Regulation

STATE FORM 6899 08H311 If continuation sheet 33 of 35

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                        | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|--|--|---|------------------------|--|-----------------|--------------------------|
|  |  | HAL030010   | B. WING                |  | 09/1            | 5/2023                   |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S         | STATE, ZIP CODE  |                 |                          |
| PS SENI  | OR LIVING OF MOCK  | SVILLE  | STVIEW DRINILLE, NC 27 |  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| D 273  | by the MAs.  Interview with the A 4:25pm revealed: -He was not aware loss and the Director -He expected MAs a monthly and notify to "drastic" weight gainty and resident and refuse the staff, the would like to see between the staff, the facility failed to of medication refuserefused multiple methospitalization which placed the resymptoms, refusing which placed the resumment of the resident had an months; and Resident had an months; and Resident withdrawal symptom headaches, and the weight loss in 3 monthe result of underly placed the resident harm and neglect witolation. | dministrator on 09/15/23 at of any resident having weight or or PCP not being notified. to monitor residents' weights the Director if there was a n or loss. the better communication the Director and the PCP.  The ensure physician notification als for Resident #2 who redications and had a th could have resulted in the the health, refusing Lorazepam sident at risk for withdrawal the Losartan and Hydralazine sident at risk for headaches pressure, refusing Memantine sident at risk for increased refusing Metformin which at risk for hyperglycemia, and the resident at risk for the resident had a 21 pound the which could have been the plant the same at the same at the risk for serious physical which constitutes a Type A2 | D 273                  |  |                 |                          |
|  |  | d a plan of protection in<br>S. 131D-34 on 09/15/23 for   |                        |  |                 |                          |

6899

Division of Health Service Regulation STATE FORM

08H311 If continuation sheet 34 of 35

Division of Health Service Regulation

|   | NT OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             |                     | E CONSTRUCTION   | (X3) DATE<br>COMF              | SURVEY                   |
|---|-------------------------------------|--|---------------------|--|--------------------------------|--------------------------|
|   |                                     | HAL030010  | B. WING             |  |                                | C<br>1 <b>5/2023</b>     |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028 |                                     |  |                     |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)                    | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| D 273   | CORRECTION DA                       | ge 34 TE FOR THE TYPE A2 NOT EXCEED OCTOBER                                    | D 273               |  |                                |                          |

6899

Division of Health Service Regulation STATE FORM