Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CHAMPIONS ASSISTED LIVING** | **1007 PORTERS NECK ROAD WILMINGTON, NC 28411** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted an annual and follow up survey and complaint investigation on 11/01/23, 11/02/23, 11/03/23, and 11/06/23. The complaint investigations were initiated by the New Hanover County Department of Social Services on 10/05/23 and 10/26/23. | D 000 | | |
| D 105 | 10A NCAC 13F .0311(a) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure that a call bell system was in working order for assisted living residents who resided in the facility.<br><br>The findings are:<br><br>Review of the facility license on 11/01/23 revealed the facility was licensed for a capacity of 122 residents.<br><br>Review of the facility's census on 11/01/23 revealed 79 residents resided in the assisted living section.<br><br>Interview with a resident on 11/01/23 at 11:05am revealed:<br>-The call bell system did not work. | D 105 | | |

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|---|---|---|---|---|
| D 105 | Continued From page 1 | D 105 | | |

Continued From page 1

-The call bell system had not worked for "months".
-The facility provided the resident with a whistle to blow when assistance was needed.

Interview with a second resident on 11/01/23 at 3:15pm revealed:
-The call bell system did not work.
-The resident had a whistle to blow when the resident needed assistance.
-The resident had used the whistle to call for staff assistance.
-The resident thought it took staff a long time to provide the assistance - "about one hour".

Interview with the family member on 11/01/23 at 3:19pm who was present with the resident revealed:
-The call bell system in the resident's room was not working.
-She could not tell how long the resident waited for staff assistance - "it could be longer or shorter" than one hour.

Confidential interview with a staff revealed:
-The call bell system at the facility had not been working for over a year.
-Personal care staff were supposed to conduct resident checks every 30 minutes.

Interview with a facility Maintenance Technician on 11/03/23 at 12:33pm revealed:
-He was not sure what was going on with the call bell system.
-He thought the call bell system was being worked on.
-He was not sure how long the call bell system had not been working.
-He was not sure how long he had known about the call bell system not working

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|---|---|---|---|---|
| D 105 | Continued From page 2 | D 105 | | |

Interview with a third resident on 11/02/23 at 10:50am revealed:
-She had a fall and had difficulty blowing her whistle loudly due to her chronic obstructive pulmonary disease (COPD).
-She blew her whistle and staff did not come.
-Her neighbor heard her whistle and went to get staff to assist her.

Interview with a fourth resident on 11/03/23 at 3:43pm revealed:
-He was supposed to have a whistle to call for assistance when needed.
-He did not know where the whistle he was supposed to have was located.
-The call bell system did not work.

Interview with a fifth resident on 11/06/23 at 3:40pm revealed:
-She had lived at the facility for several years.
-She could not remember when the call bells were last functional.
-She never received a whistle to use in place of the call bell.
-She was independent but if she needed assistance, she guessed she would call out to someone.

Interview with a sixth resident on 11/06/23 at 3:42pm revealed:
-He moved to the facility in April 2023.
-The call bell system had not functioned since he moved in.
-A paper sign was placed over the call bell in his room by his bed to "use whistle".
-He had a whistle on a lanyard hanging on a rack by his hall door.
-He was able to blow his whistle.
-He had never had to use his whistle but felt the

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|---|---|---|---|---|
| D 105 | Continued From page 3 | D 105 | | |

Continued From page 3

facility should address the call bell system.

Interview with a Personal Care Aide (PCA) on 11/02/23 at 3:10pm revealed:
-She conducted hourly checks on the residents.
-The residents had whistles to blow when assistance was needed.
-She could hear a blowing whistle from anywhere on the hall.

Interview with a second PCA on 11/03/23 at 3:35pm revealed:
-It was hard to hear a blowing whistle.
-She conducted every 30-minute checks on the residents.
-She documented what she did in her personal notebook.

Interview with a third PCA on 11/03/23 at 3:38pm revealed:
-The call bell system had not been working for over a year.
-When a resident blew their whistle staff had to check multiple rooms to determine which resident needed assistance.

Observations on the 300 hall on 11/03/23 from 3:35pm to 4:05pm revealed:
-At 3:35pm the PCA exited a resident room.
-At 3:39pm, the surveyor pulled the call bell in a resident bathroom. There was no audible sound heard. The call bell did not light up.
-At 3:43pm a resident in another room was unable to locate his whistle.
-At 3:46pm, the surveyor rang a hand bell located close to the door in the residents' room.
-At 3:55pm, the PCA was standing in the hall close to the dining room. The PCA started walking toward the resident room where the hand bell was activated. The PCA greeted the resident

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|---|---|---|---|---|
| D 105 | Continued From page 4 | D 105 | | |

and asked the resident if laundry service was needed. The PCA did not ask the resident if assistance was needed as a result of the hand bell ring.
-At 3:59pm, the surveyor invited the PCA in the bathroom where the call bell was activated at 3:39pm.

Observations on the 300 hall on 11/03/23 from 3:36pm to 3:38pm revealed:
-At 3:36pm, a resident blew her whistle for assistance.
-At 3:38pm, a PCA came to the room and asked the resident if she blew her whistle.

Interview with the PCA on 11/03/23 at 3:59pm revealed:
-The call bell should make a noise when pulled down to activate.
-The noise would sound loud enough to be heard on the other end of the hall.
-She did not hear any call bell sound when she was standing by the dining room.

Interview with a resident on the 200 Hall on 11/01/23 at 9:42am revealed:
-The call bell system had not worked in months.
-She was provided a whistle to use due to the call bell system being inoperable.
-She felt staff could not hear the whistles if they were blown when in a resident's room with the door closed or if staff were not in the hall.
-Staff often worked on other halls besides the hall they were assigned to.
-She could not remember the date but she and another resident had blown their whistles a few days prior to 11/01/23 for 5 minutes while they were in the elevator, as a resident's wheelchair had gotten stuck in the elevator.
-She and the other resident were able to get the

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|---|---|---|---|---|
| D 105 | Continued From page 5 | D 105 | | |

resident's wheelchair free after no staff came when they blew their whistles.

Observation of a resident's room on the 200 Hall on 11/01/23 at 9:55am revealed the call bell near the entrance door to the room was covered by a piece of paper that displayed a stop sign.

Interview with a second resident on the 200 Hall 11/01/23 at 10:15am revealed:
-The call bell system had not worked for several months.
-He did have a whistle but had not had to use it.
-He was concerned that staff would not be able to hear whistles when blown due to the size of the building or if staff were not on the hall, as they worked on multiple halls.

Interview with a third resident on the 300 Hall 11/01/23 at 10:53am revealed:
-The call bell system was not operable.
-She had a whistle to use due to the call system not being operable.
-She had chronic obstructive pulmonary disease (COPD) and felt that she could not blow the whistle loud if she needed help.
-Due to having COPD, she would use personal cell phone to call family in the event of an emergency.

Observation of a resident's bathroom on the 300 Hall 11/02/23 at 4:20pm revealed:
-The call bell in the bathroom behind the toilet was covered by a piece of paper that displayed a stop sign.
-There was a whistle attached to a lanyard that hung from the call bell system.

Interview with a fourth resident on the 300 Hall on 11/02/23 at 4:20pm revealed:

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|---|---|---|---|---|
| D 105 | Continued From page 6 | D 105 | | |

-She had a fall recently in her bathroom but could not remember the date of the fall.
-She pulled the string to the call bell system in the bathroom after the fall with no response from staff.
-She managed to get up and go to the door of the room to verbally call for staff for assistance.
-The resident was not aware of the whistle, that hung from the call bell system in bathroom.

Interview with a PCA on 11/02/23 at 4:08pm revealed:
-She worked throughout the building, but she primarily worked in memory care (MC).
-The MC residents did not have whistles, as staff kept the residents in common areas where they could be supervised.
-She was aware that the assisted living (AL) residents had a whistle due to the call bell system not working.
-She had not heard a resident in AL blow a whistle.
-If an AL resident blew a whistle, it would depend on staff's location in the building whether the whistle would be heard.
-One PCA was usually assigned 2 halls and may not always be on one of the halls assigned if a resident needed assistance.

Observation of a resident on the 300 Hall on 11/03/23 at 3:38pm-3:56pm revealed:
-The resident blew her whistle at 3:38pm and 3:56pm.
-Staff did not respond to the resident after she blew her whistle at 3:38pm and 3:56pm.

Interview with a fifth resident on the 300 Hall on 11/03/23 at 3:38pm revealed:
-The call bell system had not worked for several months.

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|---|---|---|---|---|
| D 105 | Continued From page 7 | D 105 | | |

-She had a whistle to use due to the call bell system being inoperable.
-When the resident blew the whistles, staff did not know what resident blew the whistle and had to check every room on the hall to determine who blew the whistle.
-Staff also could not hear blown whistles if they were in a resident's room with the room door closed.
-The whistles were not always heard by staff as they may not be on the floor due to working multiple floors.

Interview with a Medication Aide (MA) on 11/06/23 at 9:41am revealed:
-The call bell system had not worked for several months and residents were given whistles.
-The whistles were not effective.
-Staff did their best to respond when the whistles were blown but the whistles could not always be heard especially if they were in a resident's room with the door closed.
-When a resident blew the whistle, staff had no way to know which resident blew whistle without checking each room on the hall.
-The management staff were aware the whistles were not effective and told staff they were in the process of trying to get the call bell system fixed.

Interview with a representative from the facility's communications provider on 11/06/23 at 5:51pm revealed:
-She recently inherited the account for the facility.
-She was contacted by the facility on Wednesday 11/01/23 and Friday 11/03/23.
-Her company provided the facility with a paging system only.
-The paging system transmitted a signal to operate.
-She did not know if the facility used the current

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|---|---|---|---|---|
| D 105 | Continued From page 8 | D 105 | | |

paging system as their call bell signaling system.
-The current signal density was not strong enough and the WiFi needed to be expanded.
-She was helping to transition the facility to a new smart based wireless system that was not up and running yet.
-The facility tested a smart based wireless mobile application on Friday 11/03/23 but it was not fully operational.
-They were working to expand the facility's current pager signal.
-There was currently enough signal to transmit to one pager only.

Interview with the Administrator on 11/03/23 at 4:33pm revealed:
-The call bell system was "fixed to an extent".
-There was a transmitter on the first floor of the three-story facility.
-A signal from a call bell activated would pick up on a pager located 20 - 30 feet from the transmitter.
-A staff member had to be by the transmitter with a pager.
-The room number where the call bell was activated would show on the pager.
-Whoever had the pager had to call the floor where the call bell was activated letting staff know assistance was needed by the resident activating the call bell system.

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The facility failed to provide a functioning call bell system for several months that was accessible to all the residents and resulted in delays in or no assistance from staff when residents required assistance. The lack of a properly functioning call bell system was detrimental to the health and safety of all residents and constitutes a Type B Violation.

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|---|---|---|---|---|

D 105 Continued From page 9

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The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/03/23 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 21, 2023.

D 209 10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing

10A NCAC 13F .0604 Personal Care Other Staffing

The following describes the nature of the aide's duties, including allowances and limitations

(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure personal care aides in the memory care unit were not assigned food service duties.

The findings are:

Confidential interview with a staff revealed:
-The lunch meals in the memory care unit were plated by personal care staff.
-Kitchen staff prepared the mechanical soft,

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|---|---|---|---|---|
| D 209 | Continued From page 10 | D 209 | | |

chopped meats, or diets with consistency changes.
-The personal care aides plated the food for regular diets when there was not a kitchen staff to plate the food.
-The memory care personal care aides placed the silverware on the tables and served the memory care residents' drinks.

Confidential interview with a second memory care staff revealed:
-Dietary staff delivered the food to memory care and placed it in the steam well.
-Sometimes dietary staff served the food.
-Sometimes the memory care staff served the food when there was not enough dietary staff.

Observations of memory care staff on 11/02/23 from 12:11pm to 12:20pm revealed:
-At 12:11pm, the memory care manager retrieved serving bowls from the food cart.
-A second memory care staff gloved, plated the salad in the serving bowls, and served the salad to the residents in the memory care dining room.

Interview with the staff who plated the salads on 11/02/23 at 12:15pm revealed:
-She was a personal care aide.
-She was working on the memory care unit.

Observations of memory care kitchen on 11/03/23 at 8:15am revealed:
-Kitchen staff brought food to special care unit and placed it on steam table.
-Personal care aide (PCA) plated food, poured beverages, and served food to residents.
-Special Care Unit Coordinator (SCUC) was assisting residents with feeding.

Interview with a second shift medication aide

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|---|---|---|---|---|
| D 209 | Continued From page 11 | D 209 | | |

(MA) in the special care unit (SCU) on 11/02/23 at 3:19pm revealed:
-The kitchen staff brought food for the SCU residents' meals to the preparation area of the SCU dining room to be served to the SCU residents.
-The personal care aides (PCAs) and the MA's on the SCU were responsible for plating the meals for the SCU residents and serving the meals to the SCU residents.

Interview with a PCA on 11/03/23 at 8:30am revealed:
-There was no kitchen staff in the SCU.
-Kitchen staff brought the food to the SCU.
-PCA's and MA's were responsible for plating and serving the food to the residents in the SCU.
-PCA's and MA's plated and served food in the SCU for breakfast, lunch, and dinner.

Interview with a first shift MA on 11/03/23 at 8:40am revealed:
-For breakfast the kitchen staff brought food and placed it on the steam table.
-The PCA's plated and served the food to the SCU residents.

Interview with a Special Care Unit Coordinator (SCUC) on 11/03/23 at 8:55am revealed:
-PCA's were responsible for plating and serving food and beverages to the residents for breakfast only.
-Kitchen staff plated food for lunch and dinner in the SCU.

Interview with the Administrator on 11/06/23 at 11:45am revealed:
-Kitchen staff were expected to be in the SCU to plate the food and the PCA's were expected to serve the food to residents.

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|---|---|---|---|---|
| D 209 | Continued From page 12<br>-PCA's were not supposed to plate the food for the residents.<br>-PCA's were plating the food because the facility had a shortage of kitchen staff.<br>-The facility did not have enough kitchen staff to plate the food in the SCU. | D 209 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 11 sampled residents (#8 and #11) who wandered to an unsupervised floor and was found after a fall with injury (#8), and a resident that sustained 9 falls within a period of 3 months (#11).<br><br>The findings are:<br>The facility had no written fall prevention or supervision policy prior to 10/04/23.<br>1. Review of Resident #8's current FL-2 dated 08/18/23 revealed:<br>-Diagnoses included urinary tract infection, other chronic pain, generalized anxiety disorder, hypertension, acute respiratory disease, other ill-defined heart diseases, and chronic kidney | D 270 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 13 | D 270 | | |

disease.
-He was constantly disoriented.
-He was semi-ambulatory.
-He was assisted living level of care.

Review of Resident #8's care plan dated 10/26/22 revealed:
-He used a rollator for ambulation.
-He was forgetful and needed reminders.
-He was independent with activities of daily living (ADLs) except for needing supervision with bathing.

Review of Resident #8's Resident Care Assessment dated 07/20/23 revealed:
-This was a 6-month review for level of care.
-Concerns were a decrease in resident's ADL's, vision, hearing, and frequent falls.
-He required intermittent assistance with eating including verbal encouragement or guidance, and/or assistance to/from the dining room.
-He ambulated with the assistance of a rollator.
-He was dependent on staff for the entire dressing activity and bathing.
-Moderate assistance including constant cueing and prompting was required for the resident's grooming/personal hygiene.
-He required one person to provide constant guidance, steadiness, or physical assistance with transfers.
-He required constant supervision and/or physical assistance with major or all parts of toileting,
-The resident had 5+ falls in the last quarter.
-He had moderate confusion or forgetfulness with some predictable behavior but was able to be redirected most of the time.
-He roamed throughout the building or unit and might enter other residential areas and/or pilfer through items.
-He was constantly disoriented with no history of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **CHAMPIONS ASSISTED LIVING** | **1007 PORTERS NECK ROAD WILMINGTON, NC 28411** |

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|---|---|---|---|---|
| D 270 | Continued From page 14 | D 270 | | |

wandering.
-The resident's care was assessed as level 3, extensive assistance-heavy care.

Reveal of Resident #8's hospice patient admission and certification report date 07/24/23 revealed:
-The resident was enrolled in hospice on 07/24/23 with a primary diagnosis of protein-calorie malnutrition.
-Comorbidities and secondary diagnoses included cognitive dysfunction, debility, falls, senility, and failure to thrive.
-The hospice medical provider documented the resident had an accelerating functional, cognitive, and physical decline over the last six months.
-The resident's mental status was forgetful and disoriented with poor memory of safety precautions.
-He had cognitive dysfunction consistent with senility with periods of confusion and hallucinations.
-He had increased daytime sleep and spent most of his time in bed.
-He needed assistance with all ADLs.
-He used a walker for ambulation, had an unsteady and unsafe gait, and needed the assistance of others for ambulation and transfers.
-Resident #8 had a fall risk score of 10.
-A score of 4 or more was considered at risk of falling.

Review of Resident #8's progress notes dated 07/01/23 through 10/04/23 revealed:
-On 07/01/23 at 4:25am, staff documented the resident started getting up and coming out into the halls in the early morning for breakfast several times a week, which was a fairly new behavior. He was usually up and doing something in his room if awake. He expressed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 15 | D 270 | | |

understanding that it was not time for breakfast yet and was easily redirected if he remembered what staff said.
-On 07/23/23 at 6:15am, staff documented the resident was up three times that night looking for breakfast or dinner. He was easy to redirect if he could hear the staff. The nurse took him to the dining room to see it was empty, and he came back to his room with the nurse and went to bed.
-On 07/31/23 at 6:41am, staff documented the resident was up one time ready for dinner, easily redirected back to bed.
-On 08/11/23 at 10:52am, staff documented the resident was becoming more forgetful and sometimes felt confused.
-On 08/28/23 at 3:55pm, staff documented the resident was ambulating using a rollator down the hall from the elevator. He was redirected to his room. He wandered at times due to increased confusion. He appeared agitated and asked if there was an event on the 3rd floor.
-On 10/04/23 at 6:30am, staff documented the nurse was informed by the housekeeper that the resident was upstairs laying on the floor. The resident was lying on the floor in front of the elevator on his right side with his glasses and rollator turned over against the wall. He was awake and moaning. The top of his head had a quarter size laceration with several other lacerations and bleeding. His right eye was swollen and bruised. The resident was taken to hospital via Emergency Medical Services (EMS).
-On 10/04/23 at 3:30pm, staff documented the resident's RP said the resident would be transferred to a hospice nursing life care center. The resident was not responding verbally and appeared to be very agitated.
Review of Resident #8's incident/accident report dated 10/04/23 revealed:
-At 5:45am the resident was observed laying in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | | D 270 | | |

Continued From page 16

front of the elevator on the third floor North (3 N) hall.
-There were several lacerations on the top of his head, a swollen and bruised right eye, and left arm pain.
-The resident was transported to the emergency room (ER) at 6:40am.
-The resident's primary care provider and responsible party were notified.

Review of Resident #8's emergency room encounter report dated 10/04/23 revealed:
-The resident was seen after an unwitnessed ground level fall at the facility.
-He was last seen by staff at 4:00am and found at 6:00am.
-He had a hematoma and bruising to the left eye, swelling to the left forehead, laceration and dried blood to top of his head, and wrist pain.
-The resident was diagnosed with intracranial and subarachnoid hemorrhage (bleeding in the brain).
-The resident was already enrolled with hospice and was do not resuscitate (DNR) status.
-He was discharged to the hospice care facility.

Review of Resident #8's hospice medical doctor notes dated 10/05/23 revealed:
-The resident was moved to the hospice care center due to severe pain and restlessness after his fall at the facility.
-He had significant facial and forehead trauma.
-He was bedbound and mostly unresponsive with nonverbal signs of pain, especially with care and turning.
-He required 24-hour nursing care.

Interview with a nurse supervisor on 10/05/23 at 10:20am revealed:
-Resident #8 was found on the third floor of the facility that was closed for renovations.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | Continued From page 17 | D 270 | | |

-All residents had been moved from the third floor but there was nothing in place to prevent them from accessing the floor until after Resident #8's fall on 10/04/23, and staff was not required to check the floor.
-On 10/05/23, tape was placed over the elevator button for the third floor and a sign was placed outside the third floor North (3 N) hall elevator warning of construction.
-The resident was found by a housekeeper who notified a medication aide (MA) and personal care aide (PCA) for assistance.
-The PCA gave the resident a snack around 3:00am on 10/04/23 but had to cover the entire second North (2 N) floor and two rooms on the first floor.
-Before the third-floor renovations started a week earlier, the resident ate meals in the third floor dining room.
-The resident's room was on the second floor and he could have easily accessed the third floor using the elevator.
-Assisted living residents were checked every 2 hours during third shift unless there was a specific need for increased supervision.
-Resident #8 was a high fall risk based on his age and was hard of hearing.
-Staff had to check on him "a lot", which meant every 2 hours.
-He constantly walked looking for something to eat.

Interview with a housekeeper on 10/05/23 at 2:00pm revealed:
-She arrived at work early on 10/04/23 and only went to the third floor to observe the completed renovations.
-As soon as the elevator doors opened, she saw Resident #8 on the floor.
-He was wearing khaki pants, a flannel shirt, belt,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | Continued From page 18 | D 270 | | |

and shoes and did not have his hearing aid.
-He was wet with urine from his waist to knees on his right side.
-His face was bloody, head was swollen and had bruising that was turning dark.
-His rollator was turned over against the wall facing the elevator, along with his glasses.
-She observed blood on the wall and a blood trail on the floor.
-The blood appeared dry and dark in color.
-He was conscious but was only moaning.
-She immediately sought help from the PCA on the second floor and the MA on the first floor who responded to assist the resident.

Interview with a PCA on 10/12/23 at 12:30pm revealed:
-On 10/04/23 Resident #8 got up a little after 3:00am and thought he missed breakfast and lunch.
-The PCA gave him some cookies and soda and he returned to his room.
-At 4:20am, she went to the first floor to provide care to two other assigned residents.
-This took her off the second floor North (2 N) hall, where she was the only assigned PCA, for approximately one hour and 15 minutes.
-She had to leave the 2 N hall every night for a period of time during third shift to work on another floor.
-As the only PCA, this left no one to redirect Resident #8 when he wandered, which supervisors were aware of.
-It concerned her that there was not a second PCA to cover the hall when she was off the floor, but due to staffing that was what happened.
-Resident #8 was typically confused and wandered frequently including at night.
-He was used to eating meals in the 3 N floor dining room.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | Continued From page 19 | D 270 | | |

-Prior to renovations, he was confused about time and went to the third floor if he thought he missed a meal.
-There were no barriers to prevent residents from accessing the third floor and no requirement for staff to check that floor.
-The construction crew usually arrived by 7:00am.
-She tried to do 1-hour checks for all 2 N hall residents, except for two who did not want to be disturbed.
-Resident #8 was on one-hour checks.
-Resident #8 got to the third floor while she was attending to the residents on the 2 N hall.
-The resident was discovered before she got to start her 6:00am room checks on 10/04/23.

Interview with a MA on 11/06/23 at 2:55pm revealed:
-She was the only MA for the building on 10/04/23 and was on the first floor doing a medication pass when a housekeeper yelled for her to respond to Resident #8.
-When the MA reached the 3 N hall, she saw the resident on the floor outside the elevator on his stomach.
-While other staff stayed with the resident, she went to get paperwork, contact the responsible party (RP) and consult with hospice.
-Hospice advised the resident had to be sent to the hospital because of the blood pouring from his face.
-The PCA last saw Resident #8 at 3:00am when he was looking for breakfast and she gave him a snack and drink and walked him back to his room.
-While the PCA was on the first floor assisting other residents, there was no PCA on the second floor to prevent Resident #8 from getting on the elevator to the third floor.
-The resident could have pushed the button on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______<br>B. WING ______ | R<br>11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD<br>WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | Continued From page 20 | D 270 | | |

the elevator as there were no other barriers to prevent him from accessing the 3 N hall.
-Resident #8 had dementia, wandered, and was confused.
-He came out of his room at night, never tried to leave the building and was easily redirected by staff if they were present.

Interview with the Clinical Nurse Supervisor on 11/6/23 at 10:23am revealed Resident #8 wandered within the building trying to go to breakfast and had to be redirected.

Interview with the Administrator on 10/05/23 at 1:41pm revealed:
-Prior to Resident #8's fall on the 3 N hall, the only issue was his hearing aid due to cognitive decline.
-A care plan meeting was held on 07/24/23 with the RP.
-The resident was assisted living level of care but was becoming more confused.
-The facility recommended hospice care and discussed increased level of care to skilled nursing facility.
-After Resident #8 was found on the 3 N hall, facility put up signs and covered the button for the third-floor elevator.
-Prior to the resident's fall, there was nothing in place to prevent resident from going to the third floor.
-The floor was not blocked off because staff needed to access the floor for medical records and supplies.

Interview with the Administrator on 11/01/23 at 3:55pm revealed:
-The facility had no written fall prevention or supervision policy prior to 10/04/23.
-The facility instituted a fall precautions policy

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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|---|---|---|---|---|
| D 270 | Continued From page 21 | D 270 | | |

dated 10/05/23, after Resident #8's fall.

2. Review of Resident #11's current FL-2 dated 01/25/23 revealed:
-Diagnoses included Parkinson's disease, type 2 diabetes mellitus without complications, acute respiratory disease, hypothyroidism, and reported falls.
-He was intermittently disoriented, ambulatory, and continent.

Review of Resident #11's quarterly resident assessment dated 10/30/23 revealed:
-He was ambulatory, required no supervision and used a wheelchair and rollator for mobility.
-He required staff assistance with transfers, toileting, bathing, and dressing.
-He was a fall risk and had 5+ falls in the last quarter.

Review of Resident #11's fall risk worksheet dated 10/09/23 revealed:
-Cane or walker was used for gait.
-Level of consciousness was alert.
-Diagnosis of Parkinson's disease
-History of previous falls in the past year.
-Resident was a fall risk.

Review of monthly assignment form fir Resident #11 dated 10/01/23 through 10/31/23 revealed:
-Fall risk of 10/10.
-Needed set up and stand-by assist with bathing.
-Needed assistance with toileting.
-Needed verbal encouragement to complete dressing and moderate assistance required.
-Needed intermittent supervision with transferring due to fall risk.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 22<br><br>Review of Resident #11's incident reports dated 07/06/23 through 10/30/23 revealed:<br>-On 07/06/23, the resident had an unwitnessed fall in bedroom, no injuries were reported and was not sent to emergency room.<br>- On 07/07/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br>- On 08/20/23, the resident had an unwitnessed fall in bedroom, redness was noted and was not sent to emergency room.<br>- On 08/23/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br>- On 09/13/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br>- On 10/17/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br>-On 10/19/23, the resident had an unwitnessed fall in bedroom, abrasion on right knee was noted and was not sent to emergency room.<br>- On 10/30/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br>- On 10/30/23, the resident had an unwitnessed fall in bedroom, no injuries were noted and was not sent to emergency room.<br><br>Interview with a personal care aide (PCA) on 11/06/23 at 9:30am revealed:<br>-Facility installed a mini bedrail in October 2023 to assist the resident when getting out of bed.<br>-The resident attempted to dress himself with the assistance of family member, he wanted to be as independent as possible.<br>-The resident had been told to wait for staff assistance with transferring, toileting, and dressing. | D 270 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ____ B. WING ____ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 23 | D 270 | | |

Continued From page 23

-She believed he needed a higher level of care than what has been provided.
-When the resident fell, she called for a medication aide to assess him, if there were no injuries they help resident up into wheelchair or bed.
-After each fall the fall prevention program was initiated, the resident was checked by staff hourly for 24 hours then every 2 hours for 72 hours.

Interview with Resident #11 on 11/06/23 at 10:20am revealed:
-He had difficulty getting out of bed and would fall to the ground between the bed and his rollator.
-He had tripped over his carpet in his bedroom multiple times.
-The facility installed a small handrail to assist him with getting out of bed.
-Staff told him to wait for assistance when getting out of bed so that he would not have more falls.
-He did not feel like he needed more assistance from the staff.
-He liked to be as independent as possible.
-When he had a fall staff would check on him regularly to make sure he was not injured.

Interview with the Resident Care Coordinator (RCC) on 11/06/23 at 11:00am revealed:
-Facility staff had weekly meetings to discuss fall risk residents.
-Staff members provided assistance to all residents to attempt to prevent falls.
-There have been small paper leaves placed on the name plates outside the doors of all residents who are fall risks.
-Staff had encouraged Resident #11 to wait for assistance from staff when transferring and getting dressed.
-Every hour or two the personal care aide's should have checked on the residents who were

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|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 24 | D 270 | | |

fall risks to see if they need assistance.
-Resident #11 and his family were informed he may need to be moved to a skilled nursing facility for his safety, they did not want to move him.

Interview with the Administrator on 11/06/23 at 11:45pm revealed:
- After each fall the fall prevention program was initiated, the resident was checked by staff hourly for 24 hours then every 2 hours for 72 hours.
-Resident #11 had ignored fall prevention measures that were put in place to prevent falls, he refused to wait for personal care aides to assist him.
-Resident #11 wanted to be independent and refused to wait for PCA's to assist him with transfers.
-He refused to get a hospital bed, physical therapy, and occupational therapy because he did not want to be responsible for the copay.
-The resident would benefit from moving to a skilled nursing facility.

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The facility failed to provide adequate supervision for 2 of 11 sampled residents (#8 and #11). The facility's failure to supervise Resident #8, who had an identified supervision need for a history of falls and wandering behavior resulted in the resident being found after a fall with injury in a construction area of the facility, and Resident #11, who was identified as a fall risk, resulted in 9 falls over a 3-month period. The facility's failure resulted in substantial risk of serious injury and death and constitutes a Type A2 Violation.

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The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/03/23 for this violation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 270 | Continued From page 25<br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 06, 2023. | D 270 | | |
| D 397 | 10A NCAC 13F .1008 (f) Controlled Substance<br><br>10A NCAC 13F .1008 Controlled Substance<br>(f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of.<br><br>This Rule is not met as evidenced by:<br>The facility failed to remove and properly store an expired controlled substance for 1 of 5 residents (Resident #7) resulting in the resident receiving two doses of an expired medication used for anxiety.<br><br>The findings are:<br><br>-Review of Resident #7's current FL-2 dated 10/18/23 revealed:<br>-Diagnoses included depression and anxiety disorder.<br>-There was an order for Alprazolam 0.25mg, take a half tablet once daily as needed (Alprazolam is used to treat anxiety and anxiety caused by depression).<br><br>Review of Resident #7's signed physicians order sheet dated 07/27/23 revealed an order for Alprazolam 0.25mg, take a half tablet for anxiety disorder once daily as needed. | D 397 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 397 | Continued From page 26 | D 397 | | |

Review of Resident #7's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Alprazolam 0.25mg administer one half tablet once a day as needed for anxiety disorder.
-Alprazolam 0.25mg was documented as administered on 10/10/23 at 6:55pm for anxiety and agitation and was documented as "E" for effective per the information key for as needed results on the eMAR.
-Alprazolam 0.25mg was documented as administered on 10/24/23 at 7:10pm for anxiety and agitation and was documented as "NE" for not effective per the information key for as needed results on the eMAR.

Observation of Resident #7's medications on hand on 11/02/23 at 3:19pm revealed:
-There was a bubble pack for Alprazolam 0.25mg tablets, take a half tablet by mouth once a day as needed, #15 tablets dispensed on 10/07/22 for a 30-day supply.
-There were 25 half tablets of Alprazolam 0.25mg remaining in the bubble pack.
-There was an expiration date of 10/07/23 on the Alprazolam 0.25mg label.
-There were no additional Alprazolam tablets available for Resident #7.

Interview with the medication aide (MA) on 11/02/23 at 4:25pm revealed:
-She had been an MA for about one and a half years.
-She thought the night shift MA performed medication cart audits but was not sure how often.
-The cart audit included cleaning the medication cart and making sure medications were available for the residents.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ______ B. WING ______ | R 11/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 397 | Continued From page 27<br>-She had not noticed the Alprazolam for Resident #7 was expired.<br>-Resident #7 should not have received expired medication.<br><br>Interview with Memory Care Coordinator (MCC) on 11/02/23 at 4:30pm revealed:<br>-The third shift MAs did medication cart audits monthly.<br>-The medication cart audits consisted of the medication carts being cleaned, making sure medications were available and removal of expired medications.<br>-She was not sure when the last medication cart audit was completed.<br>-There was no calendar or schedule for the medication cart audit.<br>-Expired medications were to be removed from the medication cart.<br>-The residents should not receive expired medications.<br><br>Interview with the Administrator on 11/02/23 at 4:35pm revealed:<br>-The facility's contracted pharmacy came out to the facility and did medication cart audits monthly.<br>-The third shift MA did medication cart audits weekly.<br>-The nursing staff did medication cart audits on occasion.<br>-The weekly medication cart audits consisted of removing expired medications, making sure medications were available and re-ordered, and cleaning the medication cart.<br>-She expected expired medications to be removed from the medication cart.<br>-She knew there could be potential side effects from expired medications depending on the medication. | D 397 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL065020 | A. BUILDING: ____ B. WING ____ | R 11/06/2023 |

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| CHAMPIONS ASSISTED LIVING | 1007 PORTERS NECK ROAD WILMINGTON, NC 28411 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 397 | Continued From page 28 | D 397 | | |

Interview with a pharmacist from the facility's contracted pharmacy on 11/06/23 at 8:21am revealed:
-Alprazolam 0.25mg was last dispensed for Resident #7 on 10/07/22, a quantity of 15 tablets to take one half tablet once a day as needed.
-A 30-day supply was dispensed.
-There was not a new or recent order for Alprazolam for Resident #7.
-She would be concerned about decreased efficacy of expired Alprazolam.
-She did not have record of the last medication cart audit performed by the pharmacy.

Interview with another pharmacist from the facility's contracted pharmacy on 11/06/23 at 5:34pm revealed:
-The last medication cart audit performed by the pharmacy at the facility was 10/05/23.
-The medication cart audit included removal of expired or discontinued medications and ensuring proper storage of medications.
-The Alprazolam for Resident #7 would not have been removed on 10/05/23 since it would not have been out of date until 10/07/23.

Attempted interview with Resident #7 on 11/02/23 at 4:05pm was unsuccessful, the resident did not wish to be interviewed.

Attempted interview with Resident #7's primary care provider (PCP) on 11/06/23 at 11:50am was unsuccessful.