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
	HAL081054	A. BUILDING: ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	**2270 OAKLAND ROAD FOREST CITY, NC 28043**

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D 000	Initial Comments The Adult Care Licensure Section completed a complaint investigation on 11/16/23-11/21/23.	D 000		
D 028	10A NCAC 13F .0301 Application Of Physical Plant Requirements 10A NCAC 13F .0301 Application O f Physical Plant Requirements The physical plant requirements for each adult care home shall be applied as follows: (1) New construction shall comply with the requirements of this Section. (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Facility Services, 701 Barbour Drive, Raleigh, North Carolina, 27603 at no cost; (3) New additions, alterations, modifications and repairs shall meet the technical requirements of this Section; (4) Effective July 1, 1987, resident bedrooms and resident services shall not be permitted on the second floor of any facility licensed for seven or more beds prior to April 1, 1984 and classified as two story wood frame construction by the North Carolina State Building Code; (5) Rules in this Section are minimum requirements and are not intended to prohibit buildings, systems or operational conditions that exceed minimum requirements;	D 028		

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(6) The bed capacity and services provided in a facility shall be in compliance with G.S. 131E, Article 9 regarding Certificate of Need. A facility shall be licensed for no more beds than the number for which required physical space and other required facilities are available;
(7) Equivalency: Alternate methods, procedures, design criteria and functional variations from the physical plant requirements shall be approved by the Division when the facility can effectively demonstrate that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and
(8) Where rules, codes or standards have any conflict, the most stringent requirement shall apply and any conflicting requirement shall not apply.

This Rule is not met as evidenced by:
Based on observation and interviews the facility failed to meet licensure and code requirement standards as evidenced by allowing a staff member to reside in a licensed resident room.

The findings are:

Interview with the Administrator on 11/16/23 at 9:30am revealed a facility census of 28.

Review of the resident room list for the facility revealed Room #4 was empty.

Observation of a resident room on 11/16/23 at 11:36am revealed:
-The room was the next to the last room on the left side.
-In the closet of room #4 were soft drinks, a black duffel bag, a towel hanging on the close rod,

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three pairs of tennis shoes on the closet shelf, a gray scrub top and other clothes hanging in the closet on the right side of the room.
-There was a bed with no linen and a white chair beside the bed.
-There were clothes and nonperishable food items in the dresser and a chest of drawers in the room.

Interview with a resident on 11/16/23 at 10:15am revealed:
-There was a staff member who lived in the facility.
-The staff member was a personal care aide (PCA).

Interview with a second resident on 11/16/23 at 10:15am revealed:
-The PCA who lived in the facility had been living there for several weeks.
-The PCA was in the next to the last room on the left on the second hallway.

Interview with a third resident on 11/16/23 at 2:35pm revealed:
-There was a PCA who resided on the end of the second hall.
-The PCA had been staying in the facility a couple of weeks.
-He voiced his concerns about the PCA's behaviors during her off hours at the facility but stated he had not shared those with anyone.

Interview with the Administrator on 11/17/23 at 3:40pm revealed:
-She was aware there was a staff member living in resident room #4.
-She was also aware the staff member living there was in conflict with the facility license but due to staffing needs and the staff members

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needs the facility was trying to meet the needs of both by allowing the staff member to live in a resident licensed room.
-The PCA was residing at the facility temporarily until she could find a place to live.

Interview with the Resident Care Coordinator (RCC) on 11/20/23 at 1:08pm revealed the PCA had been living at the facility in an empty resident room as the facility was trying to help her.

Attempted interview with the PCA on 11/17/23 at 4:02pm and 11/21/23 at 10:10am was unsuccessful.

D 338 10A NCAC 13F .0909 Resident Rights D 338

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure appropriate care and services were provided related to serving a burnt meal to residents during a noon meal.

The findings are:

Observation on 11/16/2323 at 12:16pm revealed:
-Residents were served 1 fish stick burnt on one side, 4 burnt brussel sprouts, potato salad or coleslaw, and a dinner roll burnt on the bottom.

Interview with a resident on 11/16/23 at 12:16pm revealed:

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-His fish was burnt "to a crisp" on the bottom but he was going to eat the fish anyway because he was hungry and he did not eat breakfast.
-The bottom of his dinner roll was also burnt.
-The food was served burnt occasionally over the last 2 years because the facility staff told him the oven would cook hot and burn the food if it was not carefully watched.

Interview with a second resident on 11/16/23 at 12:20pm revealed:
-He was unable to eat the food served to him because he received a piece of burnt fish, burnt brussels sprouts, and a burnt dinner roll.
-He was served coleslaw but did not like coleslaw so he would just eat the pudding cup served for dessert.
-He told a personal care aide (PCA) that his food was burnt, but she did not offer to get him something else to eat.

Interview with a third resident on 11/16/23 at 12:20pm revealed:
-He was eating only the potato salad as everything else was burnt.
-Meals were not always this bad but the cook was new and the stove was bad.
-The stove cooked okay in the front but when food was placed in the back of the stove it always burnt.

Interview with a fourth resident on 11/16/23 at 12:22pm revealed:
-He was not going to eat lunch because it was all burnt food.
-He did not care for potato salad and was unable to eat anything else.
-No one had asked him if he wanted anything else.
-"Everyone" had burnt food.

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Observation of a female residents plate during the noon meal on 11/16/23 at 12:25pm revealed scrambled eggs, burnt brussel sprouts, tomato soup and a roll that was completely burnt on the bottom.

Interview with a fifth resident on 11/16/23 at 12:25pm revealed:
-The staff had not served her what she had asked for.
-She could not eat the dinner roll nor the brussel sprouts as they were burnt.
-The facility frequently served burnt food.

Interview with a sixth resident on 11/16/23 at 12:28pm revealed:
-She was unable to eat the meal served because her fish, brussels sprouts, and dinner roll were burnt.
-She ate the chocolate pudding served for dessert and requested a second pudding to eat because she could not eat her meal.
-The PCA did not ask her if she wanted something different to eat since her food was burnt.

Interview with a seventh resident on 11/16/23 at 12:31pm revealed:
-She took one bite of the fish but could not eat more of it because it was burnt on the bottom.
-She only had a couple of bites of her potato salad because everything else was served burnt.
-Her dinner roll was burnt also.
-The facility sometimes served meals that were burnt, and the facility staff told her it was because the oven cooked too hot.

Interview with a medication aide (MA) in the dining room on 11/16/23 at 12:40pm revealed:

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-The lunch meal did not look appetizing to her.
-Residents were just picking at their food or not eating at all.
-She had asked several residents if they wanted something else.
-A resident had asked for a sandwich and others did not want anything else, some just got up and left the dining room.
-Meals were not usually this bad.

Observation of food left on resident plates in the main dining room on 11/16/23 at 12:50pm revealed:
-There were 11 out of 16 residents who did not not eat the fish stick and only ate some of the dinner roll, everything else remained on the plates.
-Residents mainly ate the potato salad.
-There were 2 residents who ate peanut butter and jelly sandwiches.

Observation of food left on resident plates in the small dining room on 11/16/23 at 12:55pm revealed:
-There were 7 out of 10 residents who did not eat the fish or the brussel sprouts and only ate the top half of the roll that was not burnt.
-One resident ate 2 peanut butter and jelly sandwiches and 2 chocolate puddings.

Interview with the cook on 11/16/23 at 2:50pm revealed:
-He worked for the facility for approximately 2 weeks.
-Another cook trained him when he was hired.
-The oven did not cook the food appropriately and would burn the bottom of the food unless the food was flipped and watched carefully.
-He knew the fish, brussel sprouts, and dinner rolls were burnt that he prepared for the lunch

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D 338	Continued From page 7 meal service, but he did not have time to prepare another meal and served the meal to the residents anyways. Interview with the Administrator on 11/16/23 at 4:09pm revealed: -The Cook was new and he was scheduled for training. -The stove was old and cooked the food too hot. -She was not aware he had served the food burnt until after he had already finished the meal service. -She had already spoken to him about serving food that was burnt.	D 338		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed 1 of 1 resident (Resident #1) take medications administered, resulting in medications left setting on the resident's bedside table in her room. The findings are:	D 366		

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Review of the facility's undated policies and procedures for medication administration revealed:
-Medications will be administered in accordance with the prescribing practitioner's orders.
-Staff will provide documentation on the medication administration record after observing the residents taking the medications and before administration to another resident.
-In the event of medication errors, the facility staff will notify the physician, notify the immediate supervisor, document any orders received by the physician and actions taken to comply with the orders, and chart any documentation of the errors.

Review of Resident #1's current FL2 dated 06/23/23 revealed:
-Diagnoses included seizures, hypertension, bipolar disorder, dementia, major depressive disorder, anxiety, and chronic obstructive pulmonary disease.
-There was no order for Resident #1 to self-administer medications.
-There was a medication order for Effexor (used to treat depression) 150mg take 1 tablet daily.
-There was a medication order for Buspar (used to treat anxiety) 15mg take 1 tablet twice daily.
-There was a medication order for lorazepam (used to treat anxiety) 0.5mg take 1/2 tablet twice daily as needed for anxiety.
-There was a medication order for Risperdal (used to treat bipolar disorder) 1mg take 1 tablet daily.
-There was a medication order for memantine (used to treat dementia) 5mg take 1 tablet twice daily.
-There was a medication order for hydroxyzine (used to treat anxiety) 25mg take 1/2 tablet twice daily.

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Review of Resident #1's physician's orders dated 10/23/23 revealed there was an order to increase Buspar 15mg from twice daily to three times daily.

Observation of Resident #1's room during the initial tour of the facility on 11/16/23 at 11:16am revealed:
-Resident #1 was lying on the bed with her eyes open.
-There was a paper cup setting on Resident #1's bedside table with a plastic medication cup floating in water inside the paper cup.
-The plastic medication cup contained a small, oblong orange tablet and a small, round white tablet.

Interview with Resident #1 on 11/16/23 at 11:16am revealed:
-The 2 tablets in the medication cup were part of her morning medications and she forgot to take the medication.
-The MA handed her the medication cup this morning, told her to take the medication, and walked out of the room.
-She took some of her morning medications but forgot to take the last 2 tablets.
-The MA did not usually leave her medications with her to self-administer but did this morning.

Observation of Resident #1 on 11/16/23 at 11:18am revealed she picked up the medication cup, poured the 2 tablets in her mouth and took a drink of water and swallowed the pills before she could be stopped from swallowing the medication.

Review of Resident #1's 11/01/23-11/16/23 electronic medication administration record (eMAR) revealed:
-There was an entry for Buspar 15mg take 1

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tablet three times daily, scheduled at 8:00am, 2:00pm, and 8:00pm.
-Buspar 15mg was documented as administered on 11/16/23 at 8:00am.
-There was an entry for Effexor 150mg take 1 capsule daily scheduled at 8:00am daily.
-Effexor 150mg was documented as administered on 11/16/23 at 8:00am.
-There was an entry for lorazepam 0.5mg take ½ tablet twice daily scheduled at 8:00am and 8:00pm.
-Lorazepam 0.5mg was documented as administered on 11/16/23 at 8:00am.
-There was an entry for Risperdal 1mg take 1 tablet daily scheduled at 8:00am.
-Risperdal 1mg was documented as administered on 11/16/23 at 8:00am.
-There was an entry for memantine 5mg take 1 tablet twice daily was scheduled at 8:00am and 8:00pm.
-Memantine 5mg was documented as administered on 11/16/23 at 8:00am.
-There was an entry for hydroxyzine 25mg take ½ tablet twice daily scheduled at 8:00am and 8:00pm.
-Hydroxyzine 12.5mg was documented as administered on 11/16/23 at 8:00am.

Interview with a MA on 11/16/23 at 11:19am revealed:
-She did not administer Resident #1's medications this morning (11/16/23).
-The facility's policy for medication administration included watching residents swallow their medications and to never leave medications with a resident to self-administer unless the resident had an order to self-administer.

Interview with a second MA on 11/16/23 at 2:55pm revealed:

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-She administered Resident #1's 8:00am medications on 11/16/23 and watched Resident #1 swallow all the medications.
-She did not know where the 2 unidentified tablets in a medication cup in Resident #1's room that Resident #1 self-administered on 11/16/23 at 11:18am were from.
-She knew she was supposed to make sure Resident #1 swallowed her medications administered before administering medications to another resident.
-Resident #1 did not have an order to self-administer medications.

Interview with the primary care provider (PCP) on 11/20/23 at 3:38pm revealed:
-Resident #1 had dementia and was not capable of self-administering medications.
-The orange tablet was most likely memantine and if a double dose was taken by Resident #1 it could cause grogginess and increase the risk of falls.
-The white tablet in the cup could be a "problem" because it was unknown what the medication was or how the medication could affect Resident #1 if the medication did not belong to Resident #1 or was administered as a double dose.
-She expected the MAs to make sure Resident #1 swallowed her medications upon administration.

Interview with the Administrator on 11/16/23 at 3:30pm revealed:
-She did not know what the medications were, but she thought the MA did not watch Resident #1 swallow all the medications administered on the morning medication pass on 11/16/23.
-The MAs were not supposed to leave medications with residents unless the resident had a self-administer order.

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D 366	Continued From page 12 -Resident #1 did not have an order to self-administer medications. -The facility policy for medication administration included watching the residents swallow their medications and documenting the administration of medication on the eMAR before administering medications to another resident. -She expected the MAs to watch Resident #1 swallow her medication and not leave medications with Resident #1 to self-administer.	D 366		
D 422	10A NCAC 13F .1104 (d) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to assure 2 of 4 sampled residents' personal funds were not commingled with facility funds (Resident #6 and Resident #2). The findings are: a. Review of Resident #6's current FL2 dated 07/12/23 revealed diagnoses included multiple sclerosis, encepathalopathy, hepatic failure. Interview with Resident #6 on 11/16/23 at 10:15 am revealed:	D 422		

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-He paid privately for his stay at the facility.
-He had asked several times about about his funds and stated he was told by the Administrator he had no money available.
-The facility had declined to give him the difference in what his social security check was and what the facility was charging him for his care.
-He was aware his social security check was more than what the amount of his stay was and he wanted his money.
-He had made the facility representative payee for his check when he was admitted.
-Approximately 2 weeks ago he terminated the facility as his representative payee and his social security check would come directly to him in December of 2023.
-He had asked the previous Administrator at the beginning of November 2023 and was told he had no money.

Review of the Resident Register for Resident #6 revealed an admission date of 11/04/21.

Review of the financial contract for Resident #6 signed by Resident #6 upon his admission revealed he would be charged privately $1182.00 for his care at the facility.

Review of Resident #6's Resident Refund Report revealed there were no Resident Refund Reports for Resident #6.

Review of Resident #6's personal financial record balance sheet revealed:
-There was documentation $1600 had been deposited from the Social Security Administration into the company account for Resident #6 since April of 2023.
-There was no documentation Resident #6 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 422	Continued From page 14	D 422		

any refund placed in a resident fund account.
-There was no documentation of any activity for November 2023.

Interview with the Administrator on 11/17/23 at 3:40pm revealed:
-The residents did not have individual accounts.
-All residents checks were deposited into one company account.
-There was no cash on hand for Resident #6.
-Resident #6 was supposed to be paying $1,182.00.
-Resident #6's had $1,600.00 deposited each month.
-She was aware the facility was no longer his representative payee.

b. Review of Resident #2's current FL2 dated 07/12/23 revealed:
-Diagnoses included cerebral aneurysm and cerebral infarction.
-There was documentation Resident #2 was disoriented intermittently.

Interview with Resident #2 on 10/16/23 at 10:15am revealed she had not received her $90.00 for October 2023 and November 2023.

Review of the Resident Register for Resident #2 revealed an admission date of 11/04/21.

Review of the financial contract for Resident #2 signed by Resident #2 upon her admission revealed she would be charged $1182.00 for her care at the facility.

Review of the October 2023 Resident Fund Records for Resident #2 revealed there was no documentation Resident #2 had signed for her $90.00 in October 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: ______ B. WING ______	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 422	Continued From page 15 -There was documentation Resident #2 had received her $90.00 with a note from the but had signed for it in November of 2023. Review of the November 2023 Resident Refund Report for Resident #2 revealed: -It was dated 11/06/23. -There was a handwritten entry on the report documenting Resident #2 did not want to sign but said she trusted the RCC. -The Resident Refund Report was signed by the Resident Care Coordinator (RCC) by the witness #1 signature line. Review of Resident #2's personal financial record balance sheet revealed: -Resident #2 received special assistance (SA) payment of $90.00 with balance of $194 to the facility in October 2023. -There was no documentation of any activity for November 2023. -Interview with the RCC on 11/20/23 at 10:45am revealed: -She could not find the Resident Refund Report for Resident #2 for October 2023. -Resident #2 had told the RCC to sign the receipt for her as she trusted the RCC to sign it for her. -She was given $90.00 in cash. Interview with the Administrator on 11/17/23 at 3:40pm revealed: -The residents did not have individual accounts. -All residents checks were deposited into one company account. -There was no cash on hand for Resident #2. -Resident #2 was supposed to be paying $1,182.00 but it would be increasing in January 2024 due to the new medicaid rate of 1,355.00. -The previous Administrator would bring Resident	D 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081054	A. BUILDING: ______ B. WING ______	C **11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING	**2270 OAKLAND ROAD FOREST CITY, NC 28043**

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D 422	Continued From page 16 #2 $90.00 in cash by the 5th of each month. -Resident #2 always received her money. -She was unsure as to why they could not find the Resident Refund Report for Resident #2 for October 2023.	D 422		