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
	HAL054067	A. BUILDING: ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	**1935 IDLEWILD DRIVE KINSTON, NC 28504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care licensure Section and the Lenoir County Department of Social Services conducted an annual and follow-up survey and complaint investigation on April 17, 2024 through April 18, 2024. The complaint investigation was initiated by the Lenoir County Department of Social Services on April 17, 2024.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (#2) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #2's FL2 dated 04/04/24 revealed diagnoses included, Type II diabetes long term current with insulin, bipolar II disorder, urinary tract infection, alcoholic cirrhosis, generalized weakness, chronic obstructive	D 234		

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D 234	Continued From page 1 pulmonary disease, and hypertension. Review of Resident's #2's Resident Register revealed, Resident #2 was admitted to the facility on 09/15/22. Review of Resident #2's record revealed there was no documentation of a TB test since Resident's #2 was admitted to the facility 09/15/22. Interview with Resident #2 on 04/18/24 at 11:11am revealed she had taken a TB test at a previous facility. Interview with the Special Care Unit Coordinator (SCUC) on 04/18/24 at 2:57pm revealed: -She could not find Resident #2's TB results but knew there was one from a prior facility. -She was responsible for ensuring residents' TB tests were completed. -She could not remember when the last record audit was completed. Interview with the Administrator on 04/18/24 at 2:36pm revealed: -Resident #2's TB test could not be located. -Resident #2 had transferred from another facility and a TB test was completed there. -The SCUC was responsible for ensuring residents completed TB testing.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	D 270		

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care plan and current symptoms.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2, #3) as evidenced by a supplemental oxygen dependent resident with supervised smoking restrictions found smoking in his room (#3) and a resident who required supervision with ambulation and used a rollator leaving the facility independently and walk to a local store where on one occasion she fainted on the roadside of a busy highway and one another occasion she was hit by a car in the store parking lot (#2).

The findings are:

1. Review of the facility's undated Use of Tobacco Policy revealed:
-The facility was a smoke-free community.
-Residents who smoke will be requested to use designated smoking areas.
-Staff will supervise residents who smoke as needed.
-Residents who are found to be unsafe with smoking materials will not be allowed to keep the materials in their possession.
-The facility reserves the right to confiscate all smoking material and to discharge the resident if the resident fails to abide by the use of Tobacco Policy.
-Any resident seeking living arrangements in the community will not be allowed to smoke within the facility.

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-The designated outside area is on the back porch.

Review of the Tobacco section for the Resident handbook revealed:
-The facility is a smoke free environment, therefore smoking is not permitted in the community.
-The community reserves the right to confiscate all smoking materials if a resident fails to abide by smoking policies to ensure fire safety for themselves and other residents.

Review of Resident #3's current FL2 dated 02/27/24 revealed:
-Diagnoses included unspecified chronic obstructive pulmonary disease (COPD), history of pneumonia, oxygen dependence, nicotine dependence, hypoxemia (hypoxemia is a low level of oxygen in the blood), pulmonary nodule, severe sepsis secondary to left lower lobe pneumonia, muscle weakness, adjustment disorder and history of mental and behavioral disorders.
-He was semi-ambulatory.
-He was intermittently disoriented.
-He was on continuous oxygen at 4 liters per minute per nasal cannula.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 08/25/22.

Review of Resident #3's care plan dated 09/25/23 revealed:
-The resident was non-compliant with his oxygen and smoking.
-He constantly played with his oxygen tank and had to be reminded to wear his oxygen.
-He was ambulatory with the aid of wheelchair.

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Review of Resident #3's progress note by the previous interim Executive Director (ED) dated 01/30/24 at 6:00pm revealed:
-The medication aide (MA) reached out to her regarding how to handle the resident refusing to take his oxygen off when going outside to smoke.
-The resident told the MA, he had the line off and the MA informed him that whether the line was on or off, he could not take his oxygen outside while smoking because it was extremely unsafe for him and other residents.

Review of Resident #3's progress note by the Special Care Unit Coordinator (SCUC) dated 01/30/24 at 11:18pm revealed:
-The MA called and stated that the resident was outside smoking a cigarette with his oxygen on.
-She told the MA to see if the resident was still out there and if he was to put her on speaker so she could speak to him.
-She put her on speaker and he said "what do you want"?
-The SCUC told Resident #3, you have been asked multiple times to not come out and smoke with your oxygen on due to it being a safety issue with the other residents and staff, so please take it off to smoke, he did not say anything, the MA then told the SCUC he turned his oxygen off, but still had the oxygen tubing and machine with him and finished his cigarette.

Review of Resident #3's progress note by the previous interim ED dated 01/31/24 at 1:20pm revealed:
-She and the SCUC spoke with the resident regarding a smoking supervision plan.
-She explained that due to his continuous refusal to comply with removing his oxygen when going outside to smoke and putting himself and other

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residents in danger, that he would need to agree to a smoking supervision plan that would include his cigarettes and lighters be kept on the medication cart and scheduled smoke times starting at 6:30am every 3 hours until 11:30pm and the MA was to ensure the resident did not have his oxygen tank with him and was to light his cigarette for him.
-He tried to deny smoking with his oxygen tank outside and said it would not blow up.
-It was explained to him that it definitely could and was extremely dangerous.
-He then said he knew it could happen because he had seen it before.
-She asked the resident if knew what could happen and was he having any thoughts about wanting to harm himself or others.
-The resident replied "come on, do you have to do this today, I am tired and need to rest, I won't take it outside anymore".
-She let him know his word was appreciated but he has been asked to not do this several times and in order to protect his safety and the safety of others, he would have to sign the smoking supervision plan or they would have to issue a discharge.
-He asked for time to think it over.
-She let the resident know, she would be back in an hour.
-Prior to this conversation, she called his family member and left a message, letting her know about the situation and to call if she had any questions.
-She would revisit the resident at 2:30pm.

Review of Resident #3's progress note by the previous interim ED dated 01/31/24 at 2:20pm revealed:
-His family member returned her call and agreed to the smoking plan.

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-She and the SCUC went back to his room with his family member on the phone and the resident agreed and signed the smoking plan and handed his cigarettes to her and they were put on the medication cart.

Review of the Supervised Smoking Agreement dated 01/31/24 revealed:
-The facility was a smoke-free environment, therefore smoking was not permitted inside the building.
-Smoking was permitted in designated smoking areas only.
-The facility reserved the right to confiscate all smoking materials if a resident failed to abide by smoking policies to ensure fire safety for themselves and other residents.
-If a resident was unsafe with smoking, supervised smoking will be permitted in 3-hour intervals.
-Smoking times start at 6:30am and end at 11:30pm for 15-minute increments.
-The facility staff supervised the resident during smoking times and maintained all smoking materials.
-The resident was given one cigarette at a time and it should be lit by the staff member.
-I understand the supervised smoking is for my safety and I will abide by this plan.
-I understand violation of this plan can lead to discharge.
-The agreement was signed by Resident #3 and the interim Executive Director (ED) on 01/31/24.

Review of Resident #3's progress note by the MA dated 02/15/24 for the 3pm to 11pm shift revealed:
-The resident was outside smoking alone.
-He did not have his oxygen on.
-No cigarette was given to the resident by the MA.

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Review of Resident #3's progress note by the MA dated 02/16/24 for the 3pm to 11pm shift revealed:
-The resident "cussed out" staff for a cigarette although he just smoked.
-He would not get out of bed to eat but went out alone to smoke without staff.

Review of Resident #3's progress note by the MA dated 02/22/24 at 9:00pm revealed:
-He went outside to the smoking area, while others were smoking and smoked his cigarette.
-The cigarette was not given to him by staff and another resident lit his cigarette.

Review of Resident #3's progress note by the SCUC dated 02/23/24 with revealed:
-She received a call from the MA at 5:52pm that the resident was outside smoking with his oxygen on.
-She came to the building and told him that the agreement he signed stated that he could not be outside smoking by himself and with his oxygen on, someone had to be out there with him.
-He said that no one told him that.
-The SCUC explained to him that they did, both the ED and she were in there with him and explained everything when he signed the agreement.

Review of Resident #3's progress note by the current interim ED dated 02/23/24 with no time noted revealed:
-Notice of discharge was issued to resident due to him not following the smoking plan.
-The ED spoke with the resident's family member and made her aware of immediate discharge and informed her the resident would be moved once they had found placement.

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-The county DSS was contacted and a message left on voicemail.
-His primary care physician (PCP) was notfied of the discharge plan.

Review of Resident #3's progress note by the MA dated 02/24/24 at 3:25pm revealed:
-The resident was outside smoking.
-He got a lighter from another resident.
-He did not have his oxygen outside.

Review of Resident #3's progress note by the MA dated 02/24/24 at 5:35pm revealed:
-He came into the hallway to to speak to another resident, then proceeded to sit in the hallway trying to hold a conversation with passers by, claiming he was on his way outside to smoke.
-She believed another resident slipped him a lighter.
-The resident sat outside around a bunch of other residents in close proximity in the smoking area for a long time.

Review of Resident #3's progress note by the MA dated 02/25/24 and labeled "1st shift" revealed the resident went outside to smoke, but went out without a personal care aide (PCA) or MA.

Review of a second progress note by the MA for Resident #3 dated 02/25/24 and labeled "1st shift" revealed the resident went out less than 30 minutes from smoking to smoke again without a PCA or MA.

Review of Resident #3's progress note by the MA dated 04/09/24 at 7:30pm revealed:
-The fire alarm went off in the building.
-Staff smelled smoke near the resident's room.
-A co-worker opened the door to the resident's room and the floor was burnt and soot was on his

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hands and face.
-Emergency medical services (EMS) were called and the resident was pulled out of the room.
-They notified hospice and his family member.
-The ED was notified.

Review of Resident #3's Incident/Accident (I/A) report revealed dated 04/09/24 revealed:
-The time of the event was 7:30pm.
-The type of event was smoke inhalation and fire.
-The location of injury was face, left and right arm, and left and right hand.
-The nature of injury was burn.
-The resident refused vital signs.
-The location of the incident was the resident's room.
-The incident involved first aid.
-Medical attention was necessary.
-The physician was called.
-EMS was called.
-Interventions implemented were, the resident was removed from his room and reassured the fire did not spread, residents were evacuated until the fire department (FD) cleared the building.
-EMS took the resident to the hospital to treat superficial burns.
-The resident was admitted to the hospital.
-The hospice physician was notified, and the resident was sent to the hospital for evaluation, hospice recommended admission to in-patient hospice facility due to agitation in the hospital.
-Description of follow-up orders were the resident was treated for burns, the resident had end of life (EOL) agitation and was awaiting transfer to hospice house unrelated to this incident, the resident was near EOL prior to this incident.
-A family member was notified at 7:45pm on 04/09/24.
-The county Department of Social Services (DSS) was notified on 04/10/24 at 1:44pm.

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-The I/A report was signed by the Interim ED on 04/11/24.

Review of Resident #3's progress note by the traveling interim ED dated 04/10/24 at 12:06pm revealed:
-She spoke with the Fire Marshall regarding the small fire that occurred on 04/09/24 at 7:30pm.
-He was on the volunteer service that night and the chief of fire investigation was on duty and assessed the scene of the fire.
-He said the ends of the resident's nasal cannula were burned and there was a cigarette butt, ashes, and a lighter on the floor indicating the resident was smoking in his room with his oxygen on and that sparked the fire.
-There were burns on the floor where the resident took the oxygen tubing off and dropped it onto the power strip, causing it to catch fire.

Review of the fire marshal report dated 04/09/24 revealed:
-The alarm time was 7:39pm.
-The arrival time was 7:43pm.
-911 received notification of an alarm at the assisted living facility, smoke detector front northeast zone.
-A call from on site was then received advising of a fire in a tenant's room.
-The incident was dispatched as a structure fire.
-They arrived to nothing visible from outside of the facility, but upon further investigation there was visible smoke inside.
-On site staff were in the process of evacuating the facility.
-They found a small fire had occurred in the room and it appeared to be out upon arrival.
-The rooms occupant (Resident #3) was found to have sustained smoke inhalation and soot deposits to his lower face and nostrils.

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-Personnel removed the occupant (Resident #3) from the area to assess and monitor him until the arrival of medics.
-The fire was confirmed to be extinguished with no extension beyond the tenant's room floor, power cords, a relocatable power strip and oxygen tubing.
-Under the ignition section of the report, bedroom was listed as the area of fire origin and cigarette was listed as the heat source, pipe, duct, conduit, hose was listed as item first ignited and plastic was listed as type of material first ignited.

Review of Resident #3's county EMS patient care record dated 04/09/24 revealed:
-The assessment time was 7:56pm.
-The chief complaint was burns to the face.
-The resident's level of distress was moderate.
-Signs and symptoms were listed as first and second degree burns to the head and face.
-Upon arrival, the fire department directed them to a male patient (Resident #3) sitting in a wheelchair.
-The resident had been burned.
-The resident had first and second degree burns around his mouth, nose, eyes, and forehead.
-The tip of his tongue was also burned.
-His nose had back soot with burned hair in both nostrils.
-His vitals were assessed and were within normal limits, lung sounds were clear and equal.
-When asked what happened, he stated he dropped his lighter and it exploded.
-Fire department on the scene advised that the fire might have been caused by the resident smoking while on oxygen.
-He was transported to the local emergency room (ER) at 8:12pm and arrived at the ER at 8:24pm.

Observation of Resident #3's room on 04/17/24 at

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9:04am revealed:
-There were 4 black burn marks on the floor in the middle of the room.
-There was white power strip that was partially covered in black soot.
-There was oxygen tubing, power cords and what appeared to be a phone charger tangled with the power strip.

Review of an email from the facility's interim ED to the county DSS dated 04/11/24 and time stamped 5:25pm revealed:
-On 04/09/24, the fire alarm sounded in the building and staff ran to the emergency panel to see where the fire was located.
-The staff smelled smoke coming from Resident #3's room while going to the panel.
-They tested the doorknob, and it was cool to the touch, so they opened the door.
-Resident #3 was observed holding a power strip in his hand and it was on fire at the top of it, he was holding the bottom.
-Staff told him to put the power strip down and he refused, and they told him again and he put it down on the floor.
-The resident had superficial burns to his face, arms and hands.
-The staff rolled him out of his room and the fire had put itself out.
-Staff evacuated the other residents and they came back in once the FD cleared them to do so.
-Resident #3 was taken to the hospital for evaluation and told the facility staff that he "did it on purpose", but did not clarify what it was that he did on purpose.
-She spoke with the fire marshal, who stated the chief fire investigator was on the scene and concluded that the fire was started due to Resident #3 trying to smoke based on the observations of a cigarette butt, ashes and a

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lighter and the end of the nasal cannula for his oxygen tubing was burned.
-The fire marshal felt like the resident threw the oxygen tubing to the ground where it sparked fire, which melted into the power strip, causing it to catch on fire.
-The hospice nurse called on 04/10/24 and said that Resident #3 was being treated for superficial burns and that he had end of life agitation and was trying to kick the nurses on staff at the hospital.
-Hospice noted Resident #3 was nearing end of life prior to the incident and that he would benefit from going to the local hospice house because with his level of agitation they did not feel they could meet his needs.
-They were planning to leave him in the hospital until a bed opened for him at the hospice house.
-Resident #3 passed away at 10:51am on 04/11/24 at the hospital.
-Resident #3's family member was contacted.

Review of Resident #3's hospital records dated 04/09/24 to 04/11/24 revealed:
-Chief complaint, on 04/09/24 at 11:06pm by the medical doctor (MD) patient presented with burn-major, patient presents via EMS with complaints of first degree burn to face, around eyes and mouth, his airway was intact, he was noted to have black soot to his tongue, he had a non-rebreather mask in place, with a do not resuscitate/do not intubate order and the oxygen level was 99%.
-History of present illness on 04/09/24 at 11:06pm by the MD, he had a do not resuscitate and do not intubate order secondary to end stage COPD, he presented to the ER with a major burn to his face, he was noted with that to have laxity to his tongue and nostrils, he had first-degree burns to his face at this point in time, he presented with a

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non-rebreather mask in place, his hospice nurse was in route, he had no complaints and initially refused to come to the hospital for evaluation.
-Physical Exam on 04/09/24 at 11:06pm included Head: Patient had first-degree burns to the areas surrounding his nose, most notably on the right but also slightly on the left.
-Social history on 04/09/24 at 11:06pm by the MD, he reported that he has been smoking cigarettes and e-cigarettes.
-Medical Decision making on 04/09/24 at 11:06pm by the MD, he presented to the ED with a burn to his face, he reportedly had a power strip in his hand that was on fire and did not set it down for a little bit.
-Consultation with a physicians assistant with the burn center on 04/09/24 at 11:06pm, the patient had his face cleaned along with x rays, he had his tetanus updated, he was treated for pain as well.
-ER progress note dated 04/10/24 at 10:50am by the MD, patient was re-evaluated, he was scheduled for discharge back to the assisted living facility, he was presently on hospice and presented with a facial burn, he however was noted to have decreased oxygen saturation and dropped down to the low 90s on 6 liters of oxygen via nasal cannula, he was subsequently placed on a non-rebreather mask with improvement of oxygenation to the low 90s, his mentation was slightly altered, he was able to respond more sluggishly, his symptoms were consistent with inhalation injury from facial burn, he had a do not resuscitate, do not intubate order, therefore there was no intubation, given his deterioration in clinical status, he would benefit from inpatient hospice.
-ER progress noted dated 04/11/24 at 11:01am by the MD, the patient had expired, "I went to check on the patient, the patient's pupils were dilated, there was no heartbeat, no breath sounds, patient

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had no neurological signs, patient was pronounced dead at 10:51am".

Telephone interview with hospice Clinical Care Manager (CCM) on 04/18/24 at 8:44am revealed:
-Resident #3 was admitted to hospice on 02/14/24 with a diagnosis of COPD.
-Hospice provided palliative care for Resident #3.
-Resident #3 continued to smoke.
-She was not aware that Resident #3 smoked in his room.

Telephone interview with a hospice nurse on 04/18/24 at 9:06am revealed:
-She was the on-call hospice nurse for the evening and overnight shift.
-Resident #3's day hospice nurse was on leave currently and not available for interview.
-She was contacted by the facility in the evening around 7:30pm on 04/09/24 that a power strip had caught fire in Resident #3's room.
-She advised if Resident #3 had shortness of breath or burns, he should be sent to the ER.
-She was told Resident #3 did not want to be sent to the ER.
-She went to the facility and when she arrived, EMS was there already, she did not go into the facility but followed EMS to the hospital.
-She was allowed to stay at Resident #3's bedside at the ER, when she saw him, he had soot on his face and right hand, superficial burns to the right side of his face and forehead and possibly his right hand.
-Resident #3 was alert and oriented and seemed at his baseline.
-He was pleasant with her and when she asked him why he was holding the burning power strip, he joked with her that maybe he was trying to light a cigarette with it.
-She was told there were cigarettes in Resident

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#3's room but was not told he was smoking.
-Photographs of Resident #3's burns were sent to the burn center, and it was felt the burns were superficial.
-Resident #3 wanted to return to the facility and she contacted his family member, and the decision was made to send him back to the facility the next morning.
-She left Resident #3 after a few hours and called the following morning on 04/10/24 around 7:00am or 7:30am to check on him as she ended her shift and was told Resident #3 had an uneventful night with one episode of agitation.

Second telephone interview with the hospice CCM on 04/18/24 at 9:33am revealed:
-She was contacted by the hospital on 04/10/24 around 7:36am that they were trying to wean Resident #3's oxygen prior to sending him back to the facility.
-She was later contacted around 11:00am on 04/10/24 that Resident #3 had a sudden change in condition, his oxygen saturation had dropped, and he became agitated, hitting and kicking at staff, trying to get off of the stretcher and removing the electrocardiogram (EKG) leads and his oxygen mask.
-Resident #3 required a one-on-one aide and required sedation for agitation.
-It was decided that Resident #3 would not be able to return to the facility and should go to a hospice house bed.
-She contacted Resident #3's family member to start the paperwork and consent for Resident #3 to go to the hospice house.
-On the morning of 04/11/24, she notified the hospital, the paperwork for Resident #3 to go to the hospice house was complete and they would arrange transport.
-She received a phone call on 04/11/24 from the

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hospital at 11:00am and was notified that Resident #3 had expired at 10:51am that morning.

Interview with a medication aide (MA) on 04/17/24 at 3:27 revealed:
-The residents were checked every 2 hours by the PCAs and MAs.
-The residents' lighters and cigarettes were to be kept on the medication cart.
-The residents were not to have cigarettes or lighters on them or in their rooms.
-The residents came to the medication cart when they wanted to smoke and were given 3 or four cigarettes, and a staff member went outside with them and lit their cigarettes for them.
-Some residents had their own lighters but were not supposed to.

Interview with a PCA on 04/17/24 at 3:35pm revealed:
-The residents were checked every two hours by the PCAs and the MAs.
-The residents were not supposed to have cigarettes or lighters in their room.
-The residents' cigarettes and lighters were kept on the medication cart.
-If a resident wanted to smoke, they had to get cigarettes from the MA and staff were to go out and light the cigarettes for them.
-Resident #3 had to be supervised by staff while smoking because he had gone out and smoked while wearing his oxygen.
-Staff took Resident #3 out every 2 to 3 hours to smoke.
-One of the housekeepers had reported that she smelled smoke in Resident #3's room in the past and had seen ashes in the sink in the past.
-He worked 2nd shift on 04/09/24 and about 7:00pm for 7:30pm, he and two MAs were out

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front smoking with 2 other residents.
-There was one other PCA on the assisted living (AL) hall and she was assisting another resident with a shower.
-They heard the fire alarm and went back inside the building.
-At Resident #3's door, it smelled like "burning metal".
-Resident #3 was sitting in his wheelchair and there was smoke in the room.
-Resident #3 was combative when they tried to get him out of his room and he said, "I did it on purpose".
-Resident #3 had burns on his arms and appeared to have wax on his face he thought possibly from his oxygen tubing.
-The fire department came, and EMS were called as well.

Interview with a second PCA on 04/17/24 at 4:04pm revealed:
-The residents on the AL unit were checked every 2 hours by the PCAs or the MAs.
-The residents were not to have cigarettes or lighters in their rooms.
-The residents' cigarettes and lighters were kept in the medication cart.
-Most of the AL residents could smoke unsupervised but some of the residents had to be supervised by staff while smoking.
-The residents asked the MA for cigarettes and a lighter when they wanted to smoke.
-The MA gave the residents their cigarettes and a lighter and the residents returned the lighter after they finished smoking.

Interview with a housekeeper on 04/18/24 at 7:32am revealed:
-She worked at the facility as a housekeeper for about 2 years.

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-Her duties included sweeping and mopping the residents' rooms and cleaning their bathroom.
-She had not seen Resident #3 smoking in his room but had smelled cigarette smoke in Resident #3's room and saw ashes in his bathroom sink about one month ago.
-She reported it to the MA in charge immediately and said the MA took care of it that same day by talking with the resident about the dangers of smoking in his room especially with oxygen.
-The residents were not to smoke in their rooms and Resident #3 had oxygen and smoking in his room with oxygen put him, the other residents, and the staff at risk for harm.
-She thought Resident #3 had tried to smoke in his room several months ago but could not remember for certain and was not witnessed by her.

Interview with the MA in charge on 04/18/24 at 10:37am revealed:
-The residents were checked on by the PCAs or MAs every 2 hours.
-The residents were not to have cigarettes or lighters in their rooms, these were kept on the medication cart.
-If residents had lighters, the lighters were taken away and locked on the medication cart.
-Resident #3 required supervised smoking because he would go out and smoke while wearing his oxygen.
-She was close with Resident #3 and had removed a lighter from his room about 2 weeks ago, when she saw it sliding out of his pocket while he was asleep.
-A group of staff were outside watching the eclipse on 04/08/24, she was not sure exactly who all was out there, and a housekeeper was talking to a group of staff and casually mentioned that she had recently smelled cigarette smoke

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and found ashes in the bathroom sink of Resident #3's room.
-She told the housekeeper, if this happened again, to take pictures of the ashes and to come and get her or whoever was in charge immediately.
-She confronted Resident #3 the same day about smoking in his room and he responded, "now you know I wouldn't do anything like that".
-She discussed the dangers of smoking with his oxygen with Resident #3.
-A resident smoking with oxygen posed a safety risk to the resident, other residents, and staff.
-No additional monitoring measures were put in place for Resident #3.
-She did not document the housekeeper's mention of Resident #3 possibly smoking in his room in a progress note because she, herself had not witnessed it and the housekeeper was just talking not necessarily "reporting it".
-She did not report this to management until after Resident #3 died because she was not the one who witnessed the smell of cigarette smoke or ashes in the bathroom sink.
-She worked the night of the fire in Resident #3's room.
-She took Resident #3 outside for a cigarette and brought him back in and gave him a breathing treatment and left his door open.
-She went outside with another MA, PCA and two other residents to smoke and while out there, they heard the fire alarm.
-They immediately came back inside and found Resident #3's door closed, she did not smell smoke at Resident #3's room and passed his room to go to the control panel to see where the alarm was triggered.
-The other MA that was out smoking with her previously, smelled something like rubber burning, opened Resident #3's door, and he was

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in his wheelchair holding a smoldering power strip.
-The other MA was trying to get Resident #3 out of his room and was on the phone with EMS.
-She said there was no active fire at this time.
-She was looking for fresh tubing for the resident's portable oxygen and saw a cigarette butt and lighter by the closet door.
-She moved the lighter to Resident #3's dresser.
-The fire department arrived and then EMS.

Interview with another MA on 04/18/24 on 4:31pm revealed:
-She worked at the facility for a couple of years.
-There were several reports that Resident #3 smoked in his room.
-The most recent she thought was about a month and a half ago, a housekeeper reported smelling cigarette smoke, found a cigarette butt and ashes in Resident #3's sink.
-She reported this to the SCUC and she thought the SCUC inspected Resident #3's room.
-She worked the night of the fire in Resident #3's room.
-The MA in charge took Resident #3 out to smoke around 7:00pm and brought him back to his room and gave him a breathing treatment and put his oxygen back on.
-She, the MA in charge, a PCA and 2 other residents went out to smoke and heard the fire alarm.
-They came back inside after hearing the fire alarm and she smelled "something funny" at Resident #3's room door and opened the door and he was holding the smoking power strip.
-She told Resident #3 to drop the power strip and called EMS and got him out of his room.

Interview with a resident on 04/17/24 at 3:15pm revealed:

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-His cigarettes were kept on the medication cart.
-The MA gave him 3 or 4 cigarettes at a time.
-If he did not have a lighter, he borrowed one from another resident.
-He had borrowed a lighter from another resident and showed this surveyor a green cigarette lighter.

Interview with a second resident on 04/17/24 at 3:21pm revealed:
-The MA kept her cigarettes on the medication cart.
-The MA gave her 3 or 4 cigarettes at a time.
-She had her own cigarette lighter and showed this surveyor a white cigarette lighter.
-She heard that Resident #3 smoked in his room last month and she thought he had tried to smoke in his room before.
-Resident #3 used oxygen and she knew he was not to smoke with his oxygen on due to the risk of fire.

Interview with a third resident on 04/17/24 in the designated smoking area at 3:54pm revealed:
-The MAs kept his cigarettes on the cart and gave him a couple at a time when asked for them.
-He kept his own lighter and showed this surveyor a white cigarette lighter.

Interview with a fourth resident on 04/17/24 in the designated smoking area at 3:55pm revealed:
-The MAs kept his cigarettes and gave him 3 or 4 at a time when he asked for them.
-He kept his own lighter and showed this surveyor a black cigarette lighter.

Interview with a fifth resident on 04/17/24 at 4:00pm revealed:
-Her cigarettes were kept on the medication cart.

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-The MA gave her 2 or 3 cigarettes at a time.
-She would borrow a lighter from other residents or would ask the MA for a lighter.
-The MA gave her a lighter and after she went out and smoked, she returned the lighter to the MA.
-There were one or two residents that the MA would not give a lighter to due to confusion.

Observation on 04/17/24 at 4:35pm on the AL unit, the MA gave a cigarette lighter to a resident who was sitting in her wheelchair and the resident rolled herself outside to the designated smoking area and she lit her cigarette herself.

Interview with the SCUC on 04/17/24 at 4:07pm revealed:
-She covered both the Assisted Living (AL) unit and the Special Care Unit SCU).
-All the residents in the SCU required smoking supervision.
-The AL unit was more lenient and just a few of the residents required smoking supervision because of medical conditions such as seizures.
-There was not a list of residents that required smoking supervision, staff just got to know them.
-She thought the residents on the AL unit could have cigarettes but were not to have lighters.
-Staff were to light the residents' cigarettes for them and keep the lighters.
-If a resident was found to have a lighter, it was taken away from them.
-There was no process to monitor the residents for possession of lighters.
-Resident #3 had been on supervised smoking for couple months due to going outside to smoke with his oxygen.
-Resident #3 was allowed to go to the designated smoking area with a staff member every 3 hours between 6:30am and 11:30pm to smoke.
-There had been no reports to her of residents

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smoking in their rooms since 2017.
-She denied staff notifying her of anyone including Resident #3 smoking in his room.
-She thought Resident #3 probably got a lighter from another resident prior to the fire in his room on 04/09/24.

Interview with Resident #3's family member on 04/18/24 on at 9:04am revealed:
-She lived out of state and could not visit Resident #3 often.
-She last visited Resident #3 about 2 to 3 weeks ago and knew he was not doing well because he could hardly breathe.
-She and other family members sent him money and he used the money to buy cigarettes.
-He would go out and smoke with his oxygen.
-She stopped sending Resident #3 money, hoping he would not be able to buy cigarettes.
-He had been caught smoking in his room twice that she was made aware of.
-She was notified by the previous interim ED a few months ago regarding Resident #3 smoking in his room and was told that he was being discharged.
-She could not remember the first time she was notified about Resident #3 smoking in his room.

Interview with the previous interim ED on 04/18/24 at 4:05pm revealed:
-Resident #3 was asked to sign a supervised smoking agreement earlier this year.
-Resident #3 had been asked to sign the supervised smoking agreement due to going outside to smoke with his oxygen.
-Resident #3 had been issued a discharge from the facility due to him going outside to smoke with his oxygen.
-She was not aware of any instances of Resident #3 smoking in his room.

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-There had been maybe 2 reports of cigarette smoke in Resident #3's room and ashes in his bathroom sink but this could be explained as Resident #3 was a heavy smoker and always smelled of cigarette smoke and the cigarette ashes in the sink could have fallen from his clothing.
-There were never any cigarette butts found in his room that she was aware of.
-He had been recently issued a discharge due to continued non-compliance with the supervised smoking agreement, but no other supervision interventions had been put in place for Resident #3.

Interview with current interim ED on 04/17/24 at 5:00pm revealed:
-She was not aware of any concerns of the AL residents having lighters.
-The MAs kept the residents' cigarettes on the medication cart and allotted 3 or 4 at a time so they would not quickly smoke the whole pack.
-She was not concerned that four residents were found to have lighters in their possession.
-She was not aware of any safety issues with the AL residents having lighters.
-She was not aware that the AL residents were not to have lighters.

Second interview with the SCUC on 04/17/24 at 5:05pm revealed:
-She came into the current interim ED's office and told her that the AL residents were not to have lighters.
-She was not aware that at least 4 residents residing in the AL unit had lighters in their possession.
-If residents were found to have lighters they were confiscated and placed on the medication cart.
-Staff were supposed to light cigarettes for the

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residents.
-There was no process in place to ensure the residents did not have lighters.

Third interview with the SCUC on 04/18/24 at 4:58pm revealed:
-She had never received reports of Resident #3 or any resident smoking in their room for several years.
-The safety of the residents and staff was very important especially if a smoker used oxygen while smoking.
-If smoking in a resident's room had been reported to her, she would immediately report it to the ED.
-The only intervention for a resident caught smoking in their room that she was aware of would be the issuance of a discharge from the facility.

Second interview with the current interim ED on 04/18/24 at 5:17pm revealed:
-She had just received a phone call from the previous interim ED that she now remembered there was a time in either October or November of 2023, that smoking was reported in Resident #3's room.
-Concerns about Resident #3 smoking in his room were reported to the acting ED at that time and she reported it to the previous ED, who reported it to the corporate nurse then to the CEO.
-A discussion was had with Resident #3 and his family member about the dangers of smoking with oxygen and smoking in his room and that it was against facility policy to smoke inside the facility.
-A discharge was issued to Resident #3 for smoking in his room and for refusal of care around October or November of 2023.

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-Resident #3's family appealed the discharge and won the appeal.
-Resident #3 was asked and agreed to sign the supervised smoking agreement on 01/31/24.
-A second discharge was issued for Resident #3 in February 2024 after he continued to violate the supervised smoking agreement by going out by himself to smoke.
-There were no other supervision interventions put in place other than the supervised smoking agreement and discharge from the facility for Resident #3 for violating smoking policy.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 04/18/24 at 5:56pm was unsuccessful.

2. Review of Resident #2's FL2 dated 04/04/24 revealed:
-Diagnosis included urinary tract infection, alcoholic cirrhosis, generalized weakness, bipolar II disease, Type II diabetes long term current with insulin, chronic obstructive pulmonary disease, and hypertension.
-Resident #2 was ambulatory with the use of a rollator.

Review of Resident #2's care plan dated 09/26/23 revealed:
-Resident #2 required supervision with ambulation.
-Resident #2 used a rollator as an assistive device.
-Resident #2 required supervision with transfer.

Review of Resident #2's emergency room discharge summary dated 10/12/23 at 4:30pm revealed:
-Resident #2 was treated for a fall due to weakness.

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-Resident #2 was to follow up with her Primary Care Physian (PCP) as soon as possible.

Review of Resident #2's incident accident (I/A) report dated 10/12/23 revealed:
-Resident #2 had a fall off site.
-The fall was due to loss of consciousness.
-The injuries were abrasions and pain in wrist.
-Resident #2 was transported to the ER.
-The PCP was contacted and recommended increased supervision for every 2 hours for 6 hours and to give insulin if below sugar was below 200.

Review of Resident #2's ER discharge summary dated 02/29/24 revealed:
-Resident #2 was diagnosed with a contusion of right thigh.
-Resident #2 was injured in a nontraffic accident involving a motor vehicle.
-Resident #2 was treated with Ketorolac (a medication to treat pain).

Review of Resident #2's record on 04/17/24 revealed there was not an I/A completed for 02/29/24.

Review of the global positioning system (GPS) on 04/18/24 revealed the local store is ½ miles away in travel distance.

Observation of the highway where the facility was located on 04/18/24 at 7:36am revealed:
-The speed limit was posted at 55 miles.
-The highway did not have pedestrian signs noted along the highway.
-There highway did not contain pedestrian walkways.

Interview with Resident #2 on 04/17/24 at 5:05pm

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revealed:
-She always walked to the local store alone at least two to three times a day just to get out of the facility.
-She had a fall a few months ago (did not give the date).
-She had left the store and felt dizzy when she got to the highway and fainted.
-She knew her blood sugar was low because she was depressed about the death of a friend.
-She was told an off-duty Fire Fighter noticed her faint and called 911 and the facility.
-She was hit by a pickup truck in February 2024 while leaving the store.
-She was struck on her right hip.
-She did not fall to the ground and was able to walk with her rollator.
-The Store Manager called 911.
-The Special Care Unit Coordinator (SCUC) and another staff had come to the store to shop and noticed her and called the facility to let the staff know she was being transported to the hospital.
-She did sign in/out when she left the facility but did not always inform staff when she was leaving.
-She walked along side of the pavement within the white lines on the highway and did not walk in the grass.

Second interview with Resident #2 on 04/18/24 at 8:56am revealed she was going to walk to the store.

Observation of Resident #2 on 04/18/24 at 8:56am revealed:
-Resident #2 exited the facility without signing out.
-Resident #2 did not inform staff that she was leaving the facility.
-Resident #2 left the facility with her rollator.
-Resident #2 was walking alongside the highway.

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Telephone interview with Resident #2's family member on 04/18/24 at 9:26am revealed:
-She knew Resident #2 walked to the local store often.
-She was informed Resident #2 had passed out alongside of the highway as she walked to the local store back in October 2023 and was taken to the hospital.
-She was informed of the 02/29/24 incident where Resident #2 was hit by a car but was not informed about the extent of Resident #2's injuries.
-She had some concerns about Resident #2 walking to the store without staff supervision but felt Resident #2 was comfortable walking alone to the store.

Interview with a personal care aide (PCA) on 04/18/24 at 4:03pm revealed:
-Staff were to monitor signing in and out of the facility because she left daily to walk to the local store.
-She had not accompanied Resident #2 on her walks to the local store.
-Staff were not required to go to the store with Resident #2.
-Resident #2 was to inform staff when Resident #2 left the facility.
-All residents were to sign in/out when they left and returned to the facility.

Interview with a second PCA on 04/18/24 at 4:07pm revealed:
-Resident #2 would walk to the store alone at least twice daily.
-Resident #2 would inform staff when she was leaving the facility to walk to the store.
-Staff were required to know when Resident #2 left the facility but were not required to

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accompany Resident #2 to the store.
-PCAs were not allowed to transport residents.

Interview with a medication aide (MA) on 04/18/24 at 4:15pm revealed:
-Resident #2 had passed out alongside of the highway on 10/12/23 because her blood sugar had dropped.
-Resident #2 was hit by a truck on 02/29/24 while at the store.
-Resident #2 would inform staff whenever she left the facility.
-She was not sure how long Resident #2 would be out of the facility during her trips to the store.
-Staff was not required to supervise Resident #2 when she left to go to the store.

Interview with Resident #2's mental health provider on 04/18/24 at 2:24pm revealed:
-Resident #2 was last seen on 03/19/24 for medication management.
-Resident #2 mental health diagnosis included bipolar affective disorder, insomnia and anxiety.
-There was no documentation of the 10/12/23 and 02/29/24 incidents.
-There were more so safety concerns of Resident #2 walking to the store alone than mental health concerns.

Interview with Resident #2's PCP on 04/18/24 on 10:03pm revealed:
-There were concerns of Resident #2 blood sugar level due to hypoglycemic episodes.
-Resident #2's insulin was adjusted to interact with her blood sugar.
-Resident #2 was able to sign in/out of the facility without supervision and was capable of walking to the store alone.
-She had safety concerns of Resident #2 walking to the store alone because the highway was not

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pedestrian friendly.

Interview with the SCUC on 04/18/24 at 4:15pm revealed:
-Resident #2 had not been placed on increased supervision due to her daily walks to the store.
-If Resident #2 could sign in/out of the facility staff were not required to monitor her walks to the store.
-Resident #2 fainted while at the store on 10/12/23.
-There was a Fire Fighter who was familiar with Resident #2 who called 911 and the facility to report the incident.
-Resident #2 was hit by a pickup truck on 02/29/24 while leaving the store.
-She had just arrived at the store to learn of the incident and contacted the facility to report Resident #2 would be transported to the ER for treatment.
-The back of the pickup truck struck Resident #2 on her leg.
-Resident #2 was able to walk and complained of pain.
-Resident #2 was able to walk to the store without staff assistance.
-Staff were to manage the residents' sign in/out logs daily.
-Residents who had issues with signing in/out of the facility, would be addressed with the family and Ombudsman.

Interview with the Interim Executive Director on 04/18/24 at 4:35pm revealed:
-Staff were to monitor residents' sign in/out log so they would know when residents were not in the facility.
-Residents who were able to sign themselves in/out did not require supervision.
-There was not a destination column on the sign

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D 270	Continued From page 33 in/out log because it was a violation of residents' rights. ______________________________ The facility failed to provide supervision for a resident with a past history of smoking with his oxygen on and smoking in his room, who was placed on a supervised smoking plan which required staff to confiscate all smoking material and to supervise the resident while smoking (#3). This failure resulted in Resident #3 having smoking materials in his possession and starting a fire in his room and sustaining facial burns and smoke inhalation injury requiring hospitalization. This failure resulted in serious physical harm and constitutes a Type A1 Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/17/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 18, 2024.	D 270		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 358		

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reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#4) including a medication to treat diabetes.

The findings are:

Review of Resident #4's current FL-2 dated 02/26/24 revealed diagnoses included diabetes, hypertension, anemia, respiratory failure, stage 4 chronic kidney disease, congestive heart failure, and coronary artery disease.

Review of the physician's order sheet for Resident #4 dated 04/05/24 revealed an order for Lantus 100 units/ml inject 18 units everyday at 12:00pm (Lantus is used to control blood sugar and is a long-acting insulin that works up to 24 hours to help control blood sugar between meals).

Review of Resident #4's February 2024 medication administration record (MAR) revealed:
-There was an entry for Lantus 100 units/ml inject 18 units every day at 12:00pm.
-Lantus 18 units was documented as administered at 12:00pm on 02/01/24-02/16/24, 02/18/24-02/19/24, 02/21/24-02/24/24, and 02/27/24-02/29/24.
-Lantus 18 units was not documented as ordered on the MAR on 02/17/24, 02/20/24, and 02/25/24-02/26/24.
-There was not a reason documented on the back of the MAR why Lantus 18 units was not administered.

Review of Resident #4's March 2024 MAR revealed:
-There was an entry for Lantus 100 units/ml inject 18 units every day at 12:00pm.

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-Lantus 18 units was documented as administered at 12:00pm on 03/01/24-03/06/24, 03/08/24-03/10/24, 03/12/24-03/16/24, 03/18/24-03/28/24, and 03/30/24-03/31/24.
-Lantus 18 units was not documented as ordered on the MAR on 03/07/24, 03/11/24, and 03/29/24.
-There was not a reason documented on the back of the MAR why Lantus 18 units was not administered.

Observation of Resident #4's medications on hand on 04/17/24 at 3:40pm revealed:
-There was one Lantus 100/ml pen on the medication cart dated as opened on 04/15/24.
-There was one Lantus 100/ml pen located in the refrigerator dispensed on 04/16/24.

Interview with Resident #4 on 04/18/24 at 2:30pm revealed:
-She had never refused to take her insulin.
-Sometimes her insulin was administered after she ate lunch.
-She had not remembered missing any of her insulin shots.

Interview with a medication aide (MA) on 04/17/24 at 3:55pm revealed:
-When the MAR was left blank the medication was not given.
-The reason was documented on the back of the MARs.
-She had been trained on how to complete the MARs.

Interview with a second MA on 04/18/24 at 7:20am revealed:
-When the MAR was left blank the MA did not sign that the medication was given.
-She had been educated on how to complete the MARs.

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D 358	Continued From page 36 Interview with the Special Care Unit Coordinator (SCUC) on 04/18/24 at 7:33am revealed: -Blanks on the MAR meant the MA did not sign that the medication had been given. -The MAs were to document on the back of the MAR the reason the MAR was left blank. -The MAs had been educated on how to complete the MARs. Interview with the Administrator on 04/18/24 at 12:10pm revealed: -When there was a blank on the MAR the medication was not administered. -The MAs should document on the back of the MAR the reason why the medication was not administered. -MAs had been educated on how to complete the MARs. Interview with the facility's contracted pharmacist on 04/18/24 at 9:05am revealed: -Lantus was dispensed to the facility on 02/19/24 one pen (3ml) for 15 days. -Lantus was dispensed to the facility on 03/14/24 one pen(3ml) for 15 days. -Lantus was dispensed to the facility on 04/16/24 one pen(3ml) for 15 days. Attempted telephone interviews with the facility's contracted primary care provider (PCP) on 04/18/24 at 9:40am and 12:30pm was unsuccessful.	D 358		
D 388	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled	D 388		

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medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure an expired medication was destroyed at the facility or returned to the pharmacy within 90 days of the expiration date for 1 of 5 sampled residents (#1).

The findings are:

Review of Resident #1's current FL2 dated 02/16/24 revealed:
-Diagnoses included dementia and hypertension.
-There was an order for acetaminophen 325mg, take two tablets every six hours as needed for pain (acetaminophen is used to treat mild to moderate pain and fever).
-Her level of care was Special Care Unit (SCU).

Review of Resident #1's physician's orders dated 03/05/24 revealed there was an order for acetaminophen 325mg, take 2 tablets every 6 hours as needed for mild pain or fever.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/18/24 revealed:
-There was an entry for acetaminophen 325mg, take 2 tablets every 6 hours as needed for pain.
-There was no documentation that acetaminophen was administered.

Observation of Resident #1's medications on hand on 04/18/24 at 2:50pm revealed:
-There was a bubble pack of acetaminophen

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325mg, take 2 tablets every 6 hours as needed dispensed on 06/17/22 for a quantity of 60 tablets and 26 tablets were remaining.
-The expiration date listed on the bubble pack of acetaminophen 325mg tablets dispensed on 06/17/22 was listed as 06/17/23.

Interview with the facility's contracted pharmacy provider on 04/18/24 at 4:00pm revealed:
-Acetaminophen 325mg tablets were last dispensed on 03/27/24 for a quantity of #20 to take 2 tablets every 6 hours for pain for 72 hours, may hold middle of night dose if sleeping.
-Acetaminophen 325mg tablets were previously dispensed on 06/17/22, to take 2 tablets every 6 hours as needed for pain for a quantity of 60 tablets.

Interview with a medication aide (MA) on the SCU on 04/18/24 at 2:58pm revealed:
-She performed medication cart audits daily.
-During the medication cart audit she looked for loose pills, expiration dates, medications that needed to be re-ordered for the residents, and cleanliness of the medication cart.
-She had not noticed the expiration date on Resident #1's bubble package of acetaminophen.
-She was not sure when acetaminophen had last been administered to Resident #1 from the bubble package.
-There should not be expired medications on the medication cart.

Interview with the Special Care Unit Coordinator (SCUC) on 04/18/24 at 4:44pm revealed:
-The MAs ordered medications for the residents.
-Medications were to be ordered when there was about a one week supply remaining.
-Medication cart audits were done monthly by the MAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 388	Continued From page 39 -Medication cart audits included checking for expired medications. -The bubble pack of acetaminophen for Resident #1 dispensed on 06/17/22 should have been removed from the cart and returned to the pharmacy. -The facility did have floor stock of acetaminophen 325mg for Resident #1 if needed. -There should not be expired medications on the medication cart. Interview with the interim Executive Director (ED) on 04/18/24 at 4:53pm revealed: -The MAs were responsible for making sure the residents' medications were on the cart. -She thought the MAs performed medication cart audits weekly. -The medication cart audits included making sure the medication cart was clean and organized, making sure medications were available for the residents, and checking for expired medications. -There should not be expired medications on the medication cart. -The residents should not receive expired medications as they may not be as effective. -The facility did have acetaminophen 325mg tablets as floor stock. Attempted telephone interview with Resident #1's primary care provider on 04/18/24 at 5:56pm was unsuccessful.	D 388		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in	D 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: ______ B. WING ______	04/18/2024

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D 466	Continued From page 40	D 466		

the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs.

The findings are:

Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 63 beds including 37 beds for Assisted Living (AL) and 26 beds for the Special Care Unit.

Review of the facility's resident census list provided on 04/17/24 revealed:
-10 residents resided on the 200 hall of the SCU.
-12 residents resided on the 300 hall of the SCU.
-25 residents resided on the AL unit.

Observation of the SCU on 04/17/24 from 9:15am to 10:20am revealed:
-There were 2 separate halls designated as SCU (200 hall and 300 hall) that were located at opposite ends of a hallway.
-Each SCU hall was secured, and a coded keypad was used by staff for secure entrance.
-The Special Care Unit Coordinator (SCUC) office was located just inside the locked door on the 200 hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: ______ B. WING ______	04/18/2024

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THE VILLAGE OF KINSTON	**1935 IDLEWILD DRIVE KINSTON, NC 28504**

(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 466	Continued From page 41	D 466		

Interview with the Special Care Unit Coordinator (SCUC) on 04/17/24 at 9:11am revealed:
-She had worked at the facility since 2017.
-Her title was SCUC, but she was considered the Resident Care Coordinator (RCC) for the AL unit as well.
-She had always covered both the AL and the SCU.

Second interview with the SCUC on 04/18/24 at 4:58 revealed:
-She worked 40 hours per week, sometimes more.
-Her title was the SCUC, but she also covered the AL unit as well.
-She had always covered both the SCU and the AL unit.
-There was no designated RCC for the AL unit.
-She and the medication aides (MAs) covered the AL unit.
-She could not say how many hours were spent coordinating care for AL versus SCU, but the majority of her hours were spent on the SCU.
-Her office was located in the SCU, but she would bring charts from the AL unit and work on them in her office as well.

Interview with the Administrator on 04/18/24 at 4:53pm revealed:
-The SCUC covered both the SCU and the AL unit.
-The SCUC worked 40 hours per week, sometimes more.
-The MAs assisted the SCUC with AL unit duties.
-She could not say how many hours the SCUC dedicated to the SCU and to the AL unit but was sure the majority of her hours were dedicated to the SCU.
-There was no RCC for the facility.