STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 conducted an annual and follow up survey and complaint investigation on May 14 - 17, 2024. The complaint investigation was initiated by the Moore County Department of Social Services on April 16, 2024.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure safety and security on the Special Care Unit (SCU) related to the ease of opening 5 windows in resident rooms on the SCU. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 60 beds; 32 assisted living (AL) beds and 28 Special Care Unit (SCU) beds. Review of the facility's census report dated 05/14/24 revealed there were 20 residents residing on the AL side and 16 residents residing in the SCU. Observation during the tour of the SCU on 05/14/24 at 10:04am revealed: -There were two windows side by side,	D 105		

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D 105	Continued From page 1	D 105		

approximately 2½ feet from the floor in resident room 111 on the wall opposite the entrance to the room.
-The lower windowpane of both windows was raised approximately 3 inches from the top.
-There was a screen in place at both open windows.
-The windows in resident room 111 opened to an unsecured area at the side and middle of the facility.
-The unsecured area included the end of the main driveway with access for deliveries and to the dumpsters.

Observation on the SCU on 05/14/24 at 1:24pm revealed:
-There were older windows that were heavy, stuck, and difficult to open in resident rooms 103, 104, 105, 107, 112, 113, 114, 115, and 116.
-There were newer windows that were easily unlocked and opened in resident rooms 102, 106, 108, 109, 110, and 111.
-There was a latch on the inner side of the upper pane that prevented the lower pane from opening more than approximately 4 inches when it was extended.
-The Maintenance Manager and Memory Care Manager (MCM) were going room to room extending latches on windows.
-The latch was accessible to press down and allow the bottom pane to fully open.

Review of a window installation receipt dated 07/07/23 revealed:
-29 new windows were installed in the facility (locations not specified).
-The new windows were made with a double pane tilt for easy cleaning and nighttime security latches.

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D 105	Continued From page 2	D 105		

Interview with a personal care aide (PCA) on 05/14/24 at 10:18am revealed:
-She did not know the windows in resident room 111 were open.
-The resident in that room must have opened the windows.
-Staff tried to keep windows locked.
-Staff completed walk throughs during their shift to check for safety concerns such as open windows.

Interview with the MCM on 05/14/24 at 10:30am revealed:
-Windows on the SCU were supposed to have a stop in place to prevent them from opening more than 4 inches.
-She did not know the windows in resident room 111 were fully open.
-She did not know who opened the windows in resident room 111 or why.

Second interview with the MCM on 05/14/24 at 1:30pm revealed:
-She just learned (on 05/14/24) from the Maintenance Manager there were latches that prevented the newer windows from opening more than 4 inches.
-She and the Maintenance Manager went around and extended the latches on all the newer windows in the SCU that day (05/14/24).
-The latch was accessible to anyone, including residents on the SCU, to press down and allow the window to be fully opened.
-She did not know of any resident attempting to get out of the windows in the SCU.

Interview with the Maintenance Manager on 05/17/24 at 1:25pm revealed he did not think there was any issue with the windows in the SCU because he knew the new windows had latches.

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

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SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 105	Continued From page 3 Interview with the Administrator on 05/14/24 at 2:09pm revealed: -The facility had an environmental inspection resulting in the replacement of some windows in the SCU. -She thought the windows were replaced a few months ago or around the fall of 2023. -Window openings were supposed to be restricted in the SCU for safety. -She did not know there were any issues with the windows in the SCU until now. -She did not know the latch on the new windows could easily be pressed down which allowed unrestricted opening of the windows. -All staff were responsible for conducting environmental rounds which included checking for any safety concerns such as fully open windows. -PCAs and medication aides (MAs) rounded every 2 hours. -The MCM rounded 3 times per working day and her office was located on the SCU for presence and awareness. -She did not know of any resident attempts to get out through the windows in SCU. Based on observations, interviews and record reviews, it was determined the residents who resided in room 111 were not interviewable. _____ The facility failed to ensure the safety of residents on the secured Special Care Unit (SCU) related to windows installed on 07/07/24 in 5 resident rooms on the SCU with latches that could be pressed down which allowed the windows to be fully opened and were not monitored by SCU staff. The facility's failure resulted in increased opportunities for elopement without staff awareness which was detrimental to the safety of	D 105		

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D 105	Continued From page 4 residents on the SCU and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2024.	D 105		
D 126	10A NCAC 13F .0403(b) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 4 sampled staff (Staff A, B, C, and D) who administered medications had completed the six required hours of diabetic training and 1 of 4 sampled staff (Staff B) had not had her medication aide testing verified until 05/17/24. The findings are:	D 126		

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D 126	Continued From page 5 1. Review of Staff A's personnel record revealed: -Staff A was hired on 03/08/23 as a medication aid (MA) and supervisor in charge (SIC). -There was no documentation Staff A had successfully completed the 6 hours required diabetic training. Review of residents' electronic medication administration records (eMARs) for March, April, and May 2024 revealed Staff A documented administration of medications which included insulin, for 12 of 31 days in March 2024; for 17 of 30 days in April 2024; and for 7 of 15 days from 05/01/24 through 05/16/24. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/03/23 as a medication aid (MA). -There was no documentation Staff B had successfully completed the 6 hours required diabetic training. -Staff B had not had her medication aide testing verified upon or prior to hire date. -Staff B's medication aide testing was verified on 05/17/24. Review of residents' electronic medication administration records (eMARs) for March, April, and May 2024 revealed Staff B documented administration of medications which included insulin, for 15 of 31 days in March 2024; for 11 of 30 days in April 2024; and for 9 of 15 days from 05/01/24 through 05/15/24. 3. Review of Staff B's personnel record revealed: -Staff C was hired on 06/09/23 as a medication aid (MA). -There was no documentation Staff C had successfully completed the 6 hours required diabetic training.	D 126		

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D 126	Continued From page 6 Review of residents' electronic medication administration records (eMARs) for March, April, and May 2024 revealed Staff C documented administration of medications which included insulin, for 15 of 31 days in March 2024; for 11 of 30 days in April 2024; and for 9 of 15 days from 05/01/24 through 05/16/24. 4. Review of Staff D's personnel record revealed: -Staff D was hired on 06/09/23 as a medication aid (MA). -There was no documentation Staff D had successfully completed the 6 hours required diabetic training. Review of residents' electronic medication administration records (eMARs) for March, April, and May 2024 revealed Staff D documented administration of medications which included insulin, for 11 of 31 days in March 2024; for 14 of 30 days in April 2024; and for 6 of 15 days from 05/01/24 through 05/15/24. Interview with the Administrator on 05/17/24 at 6:00pm revealed: -She and the business office manager (BOM) were responsible to ensure that MAs had all hire packets included all the required documentation in the files which included any training certificates and the registry listing on the medication aide registry. -Staff B had been hired originally in 2021 but was not sure where that information was located. -The BOM had only been at the facility for about a year and was still receiving training for the information required in all the staff folders. -She was not aware that the diabetic training certificate (1 hour) in the staff personnel file was not for the required 6 hours of training .	D 126		

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SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 126	Continued From page 7 -The diabetic training was done online through the corporate office. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]	D 126		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident	D 189		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 189	Continued From page 8 calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (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 that personal care aides were tasked primarily with direct personal care and supervision of residents and not routinely assigned other duties such as housekeeping and laundry during the hours of 7:00am to 9:00pm daily. The findings are: Observation of the facility from 05/14/24 to 05/17/24 revealed the current census was 34 residents in the facility, with 16 residents in the Special Care Unit (SCU) and 18 residents on the assisted living (AL) hall. Observation of the AL hall on 05/17/24 at 2:01pm revealed there was a personal care assistant (PCA) putting away laundry in residents' rooms.	D 189		

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 189	Continued From page 9 Observation of the AL hall on 05/15/24 at 11:30am revealed the PCA told a resident she would wash an item for him as soon as the current load finished while she folded laundry in the hall. Observation of the AL hall on 05/15/24 at 1:30pm revealed the PCA told a second resident she would wash his laundry as soon as the current load finished while she folded laundry in the hall. Interview with the PCA on 05/17/24 at 4:27pm revealed: -She worked the day shift and was scheduled for 12 hours from 7:00am to 7:00pm. -She was assigned to work as a PCA for the AL hall. -She was responsible for assisting residents with activities of daily living (ADL) such as bathing, dressing, grooming, eating, and providing supervision. -She was responsible for charting the ADL care she provided to the residents. -She was responsible for doing residents' laundry and estimated she spent about 2 hours doing laundry each shift. -She was responsible for cleaning residents' bathrooms and removing trash from their room and estimated she spent about 1 hour of her shift doing housekeeping duties. -She was responsible for escorting residents to the dining room and sometimes assisted dietary staff with serving meal trays and estimated she spent about 10-15 minutes at each meal serving meal trays. -There were 3 meals on the 7:00am to 7:00pm shift, and she estimated she spent 30-45 minutes each shift serving meal trays. -She was usually the only PCA assigned to the AL	D 189		

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 189	Continued From page 10 hall from 7:00am to 7:00pm on the days she worked. Interview with the Memory Care Manager (MCM) on 05/17/24 at 4:49pm revealed: -PCAs on day and evening shifts were responsible for washing residents' laundry. -The PCA left the Special Care Unit (SCU) for brief periods to load the washer, load the dryer and pick up cleaned laundry to fold on the SCU. Interview with the Administrator on 05/17/24 at 5:50pm revealed: -The facility usually scheduled 2 staff members on the AL hall and 2 staff members in the SCU on each shift. -There was usually one medication aide (MA) and a PCA for the AL hall and 2 PCAs for SCU. -All staff members worked 12-hour shifts and there was a day shift and an evening shift. -The PCAs were responsible for assisting residents with ADLs. -When the housekeeper was off work, the PCAs cleaned bathroom sinks and took trash out of residents' rooms. -There was no designated laundry staff. -PCAs were responsible for doing residents' laundry on all shifts. -Dietary aides were responsible for serving the residents' meals. -PCAs were not responsible for serving residents' meals in the dining room. -PCAs were only responsible for assisting residents to and from the dining room.	D 189		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 11 Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, 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 ensure supervision for 2 of 6 sampled residents (#3, #6) related to one resident in the Special Care Unit (SCU) having multiple falls resulting in multiple emergency room visits and two head injuries (#3), and one resident having multiple falls with multiple bone fractures and injuries contributing to the resident's death (#6). The findings are: Review of the facility's undated safety measures for fall reduction policy revealed: -The facility will evaluate fall risk on admission and document interventions according to care needs and physician orders. -Residents are evaluated with each fall and reports are completed with documentation of each new intervention. -Vital signs and observations for any changes are completed every shift by medication aides and documented using the shift progress note. -Within 24-28 hours of each fall a manager will complete the post fall care plan evaluation for interventions. -A new intervention must be added for each additional fall. -The Resident Care Coordinator (RCC) or	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 12	D 270		

designee will add the Fall Risk Banner to the face sheet in the electronic health record.
-The RCC or designee will add the Fall Risk Emblem to the door name plate.

Review of the facility's undated accident or incident policy revealed:
-When an incident or accident occurs, staff should check the resident for injuries.
-Staff should evaluate the situation and call 911 or have someone call 911 if necessary.
-If a severe injury is apparent or possible, the resident should not be moved until emergency medical services (EMS) arrive.

Review of the facility's undated guidelines for incident reporting policy revealed:
-Incident reports must be completed for accidents and incidents.
-Incident reports should be completed for any incident involving a resident.

1. Review of Resident #6's current FL2 dated 04/03/24 revealed:
-Diagnoses included type 2 diabetes mellitus without complications, hyperlipidemia, essential (primary) hypertension, hypothyroidism, vitamin D deficiency, and epilepsy.
-Her recommended level of care was assisted living facility.
-She was constantly disoriented.
-She was semi-ambulatory.

Review of Resident #6's Resident Register revealed:
-Resident #6's admission date to the facility was 03/14/24.
-Special aids included eyeglasses, top and bottom dentures, walker, and wheelchair.

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 13	D 270		

Review of Resident #6's facility progress notes dated 03/14/24 at 2:27pm revealed Resident #6's personal assistive devices brought to the facility included wheelchair.

Review of Resident #6's neurosurgery consultation note dated 01/29/24 revealed computerized tomography (CT) (Computerized tomography is a type of screening used to identify diseases or injuries) of Resident #6's head was without any intercranial abnormalities (Intercranial is a term meaning within the skull).

Review of Resident #6's care plan dated 03/19/24 revealed:
-She had wandering behaviors.
-She was ambulatory with aid or devices.
-Devices needed included wheelchair.
-She was sometimes disoriented.
-She was forgetful and needed reminders.
-She needed extensive assistance with ambulation.
-She needed extensive assistance with transfers.
-There was no documentation of increased supervision or fall interventions.

Review of Resident #6's fall risk admission evaluation dated 03/14/24 revealed:
-Resident #6 had fallen in the last year.
-Resident #6 was unsteady when walking or standing.
-Resident #6 worried or had a fear about falling.

Review of Resident #6's accident/incident report dated 03/16/24 at 8:47am revealed:
-The location of the incident was Resident #6's room.
-Resident #6 was sitting on the floor.
-The incident was unwitnessed.
-Resident #6 was trying to get to the restroom.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 14 -Resident 6 had no injuries. Review of Resident #6's fall risk intervention care plan dated 03/16/24 revealed: -There were no medical condition/medication factors indicated. -There were no environmental factors indicated. -The fall was safety related. -The resident was cognitively impaired. -Interventions selected were increase supervision and other. -The explanation for other was documented as "PT is in place" (PT is an abbreviation for physical therapy). -A safety awareness emblem was placed on the name plate on 03/17/24. -A fall risk banner was added to resident's electronic health record on 03/17/24. Review of Resident #6's accident/incident report dated 03/25/24 at 6:15am revealed: -The type of incident was skin related-skin tear on left arm. -The location of the incident was Resident #6's room. -Resident bumped her arm going to the bathroom. -The skin tear was cleaned, triple antibiotic ointment applied, covered. Review of Resident #6's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fall: monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall scheduled for 7:00am-3:00pm and 11:00pm-7:00am from 03/16/24 to 03/19/24. -There was no monitor status entry scheduled for 3:00pm-11:00pm from 03/16/24 to 03/19/24.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 15 -Monitor status was documented as completed for 7:00am-3:00pm from 03/16/24 to 03/19/24. -Monitor status was documented as completed for 11:00pm-7:00am from 03/16/24 to 03/19/24. -There was an entry for fall: check vital signs every shift for 72 hours scheduled for 7:00am-3:00pm and 11:00pm-7:00am from 03/16/24 to 03/19/24. -Vital signs were documented as completed for 7:00am-3:00pm from 03/16/24 to 03/19/24. -Vital signs were documented as completed for 11:00pm-7:00am from 03/16/24 to 03/19/24. -There was no entry to check vital signs from 3:00pm-11:00pm from 03/16/24 to 03/19/24. -There was an entry for increase supervision every shift with the instructions: resident has been monitored at least every hour throughout the shift with a start date of 03/25/24 and an end date of 03/28/24. -Increase supervision was documented as completed for 7:00am-7:00pm from 03/25/24 to 03/28/24. -Increase supervision was documented as completed for 7:00pm-7:00pm from 03/25/24 to 03/28/24. Review of Resident #6's accident/incident report dated 04/09/24 at 8:15am revealed: -The location of the incident was hallway. -The incident was unwitnessed. -Another resident discovered the incident. -The resident was bleeding. -The section labeled location of injury had no documentation of the body part injured. Review of Resident #6's fall risk intervention care plan dated 04/09/24 revealed: -There were no medical condition/medication factors indicated. -There were no environmental factors indicated.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 16	D 270		

-The fall was not medication related.
-The fall was not safety related.
-The resident was cognitively impaired.
-Intervention selected was appropriate footwear.

Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for fall: monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall scheduled for 7:00am-3:00pm and 11:00pm-7:00am from 04/09/24 to 04/12/24.
-There was no monitor status entry scheduled for 3:00pm-11:00pm from 04/09/24 to 04/12/24.
-Monitor status was documented as completed for 7:00am-3:00pm from 04/09/24 to 04/12/24.
-Monitor status was documented as completed for 11:00pm-7:00am from 04/09/24 to 04/12/24.
-There was an entry for fall: check vital signs every shift for 72 hours scheduled for 7:00am-3:00pm and 11:00pm-7:00am from 04/09/24 to 04/12/24.
-Vital signs were documented as completed for 7:00am-3:00pm from 04/09/24 to 04/12/24.
-Vital signs were documented as completed for 11:00pm-7:00am from 04/09/24 to 04/12/24.
-There was no entry to check vital signs scheduled for 3:00pm-11:00pm from 04/09/24 to 04/12/24.
-There were no entries to increase supervision noted on the April 2024 eMAR.

Review of Resident #6's hospice skilled nursing assessment dated 04/09/24 revealed:
-Resident #6's start of care date with the hospice agency was 04/08/24.
-There was a section titled hospitalization preference, and documentation in this section included the patient and/or caregiver expressed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

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D 270	Continued From page 17	D 270		

the desire for the patient to remain at home and not be transferred or admitted to a hospital again.
-Resident #6 had a recent decline in functional status which included multiple recent falls, increased weakness, sleeping during the day, increased agitation, and decreased appetite.
-There was a section titled hospice eligibility, and documentation included patient and/or family have elected a course of palliative care.
-Resident #6's primary hospice diagnosis was Alzheimer's late onset.
-Resident #6's comorbidities listed included syncope, transient ischemic attack, atrial fibrillation, anemia, seizure, coronary artery disease, essential hypertension, pacemaker, osteoporosis, and congestive heart failure (Comorbidity is a term meaning a patient has the simultaneous presence of two or more medical conditions or diseases).
-There was a section titled history and progression of disease, and documentation included Resident #6 had 3 falls in January 2024, with a fall on 01/28/24 resulting in a left hip fracture and hospitalization prior to admission to the facility.

Review of Resident #6's hospice agency's notes dated 04/09/24 at 6:12pm revealed:
-A registered nurse (RN) and social worker (SW) made an initial assessment of Resident #6.
-Resident #6 had a diagnosis of Alzheimer's disease.
-Resident #6 fell the morning of 04/09/24 coming from the dining room after breakfast.
-Resident #6 had multiple purpuras on both arms (A purpura is flat red or purple skin discoloration).
-Resident #6 had skin tears to her left elbow, left wrist, and right wrist.

Review of the facility's progress notes dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 18 04/10/24 at 4:51pm revealed: -The reason for the progress note was follow-up from a fall. -Resident #6 had no complaints of pain. -There were no additional injuries seen since the fall. -There were no mental status changes since the fall Review of facility's progress notes dated 04/11/24 at 12:16am revealed: -The reason for the progress note was follow-up from a fall. -Resident #6 had not complained of pain since the fall. -There were no additional injuries seen since the fall. -There were no mental status changes since the fall. Review of facility's progress notes dated 04/11/24 at 12:17am revealed that Resident #6 was agitated and beating on front door repeatedly. Review of facility's progress notes dated 04/11/24 at 10:01am revealed: -The reason for the progress note was follow-up from a fall. -Resident #6 had not complained of pain since the fall. -There were no additional injuries seen since the fall. -There were no mental status changes since the fall. Review of Resident #6's accident/incident report dated 04/11/24 at 1:26pm revealed: -The location of the accident/incident was Resident #6's room. -The incident was unwitnessed.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 19	D 270		

-Another resident reported the incident.
-Resident #6 was sitting on the side of the bed and bleeding from her chin.
-First aid administered was documented as applied pressure.
-Resident #6 was sent to the hospital via EMS transport.

Review of Resident #6's hospice agency's notes dated 04/11/24 at 1:30pm revealed:
-Resident #6 had an unwitnessed fall and was bleeding from her chin.
-The facility called EMS to transport Resident #6 to the hospital per facility protocol.

Review of Resident #6's facility progress notes dated 04/11/24 at 2:11pm revealed:
-Resident #6 was sent to hospital via EMS at 1:58pm due to a fall.
-The hospice agency was notified of the incident.
-Resident #6's family member was notified of the incident.

Review of Resident #6's after visit summary from a local hospital emergency department (ED) dated 04/11/24 revealed:
-The reason for Resident #6's visit was a fall.
-Resident #6's diagnoses included fall and chin laceration.
-Instructions included to return to the ED immediately if new symptoms worsen or new symptoms present, and follow-up with primary care provider (PCP).

Review of Resident #6's facility progress notes dated 04/11/24 at 11:37pm revealed:
-Resident #6 had not complained of pain since the fall.
-There were no additional injuries seen since the fall.

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 20 -Mental status changes included agitation and aggression. Review of Resident #6's facility progress notes dated 04/11/24 at 11:38pm revealed Resident #6 was agitated and combative toward staff. Review of Resident #6's fall risk intervention care plan dated 04/12/24 revealed: -There were no medical condition/medication factors indicated. -Environmental factors included poor lighting at the time of the fall. -Interventions selected were to educate resident on the use of their emergency call system and increase supervision. -Resident #6 was not cognitively impaired. Review of Resident #6's accident/incident report dated 04/12/24 at 1:56pm revealed: -The location of the accident/incident was Resident #6's room. -The incident was unwitnessed. -First aid was applied pressure. -There was no location of injury noted. Review of Resident #6 facility progress note dated 04/12/24 at 2:25pm revealed the hospice agency was notified Resident #6 had a fall. Review of Resident #6's April 2024 eMAR revealed: -There was an entry for fall: check vital signs every shift for 72 hours scheduled for 7:00am-3:00pm and 11:00pm-7:00am from 04/11/24 to 04/14/24. -Vital signs were documented on 04/11/24 for 7:00am-3:00pm as "resident unavailable". -Vital signs were documented as completed for 7:00am-3:00pm from 04/12/24 to 04/13/24.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 21 -Vital signs were documented as "H" for 7:00am-3:00pm on 04/14/24. -Vital signs were documented as completed for 3:00pm-11:00pm from 04/11/24 to 04/13/24. -Vital signs were documented as 'H" for 3:00pm-11:00pm on 04/14/24. -Vital signs were documented as completed for 11:00pm-7:00am from 04/11/24 to 04/12/24. -Vital signs were documented as 'H" for 04/13/24 for 11:00pm-7:00am from 04/13/24 to 04/14/24. -There was no explanation of the meaning of "H" on the information key on the eMAR. -There were no entries to increase supervision noted on the April 2024 eMAR. Review of Resident #6's hospice agency's notes dated 04/12/24 at 2:30pm revealed: -The facility reported Resident #6 had an unwitnessed fall. -Resident #6 was found on the floor between her bed and chair. -Facility staff reported Resident #6 did not have any injuries and was propelling herself in wheelchair in hallways. Review of Resident #6's hospice agency's notes dated 04/12/24 at 2:51pm revealed: -The hospice nurse (HN) found Resident #6 sitting with staff in the front office of the facility. -Resident #6 was confused. -Resident #6 repeatedly tried to get out of wheelchair during visit. -The laceration to Resident #6's chin was glued (A tissue adhesive is sometimes used instead of stitches for smaller cuts and lacerations). -Old scabs were noted to both of Resident #6's arms. -New onset bruising was noted to Resident #6's right hand. -Staff reported a fall today, 04/12/24.	D 270		

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 22 -There were no obvious injuries noted. -The HN reviewed fall precautions with staff and Resident #6. Review of Resident #6's progress note dated 04/12/24 at 5:02pm revealed hospice staff instructed the medication aide (MA) to continue monitoring Resident #6 and there was not much that could be done about her falling. Review of Resident #6's progress note dated 04/12/24 at 6:43pm revealed: -The reason for the progress note was follow-up from a fall. -Resident #6 had not complained of pain since the fall. -There were no mental status changes since the fall. -There were no additional injuries seen since the fall. Review of Resident #6's accident/incident report dated 04/12/24 at 6:47pm revealed: -The location of the accident/incident was hallway. -The incident was witnessed by a staff member. -The description of the incident was Resident #6 was "laying on floor in hallway holding head". -There was no location of injury noted. -The hospice agency was notified on 04/12/24 at 6:48pm. Review of Resident #6's progress note dated 04/12/24 at 6:47pm revealed the hospice agency was notified of Resident #6 having a fall and a knot on her head. Review of Resident #6's progress note dated 04/12/24 at 7:02 pm revealed: -The physician's assistant (PA) instructed staff	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 23	D 270		

not to send Resident #6 to the emergency room.
-The staff was instructed to monitor Resident #6 for the next 72 hours and keep ice on her head.

Review of Resident #6's hospice agency's notes dated 04/12/24 at 6:45pm revealed:
-The facility called to report that Resident #6 had fallen again.
-The HN contacted hospice on-call staff and informed them of Resident #6's second fall within hours.
-Resident #6 had a knot on her head.
-The HN informed staff that the on-call staff would come to the facility and if Resident #6 needed to go to the emergency department, hospice staff would arrange.

Review of Resident #6's hospice agency's notes dated 04/13/24 at 5:53am revealed:
-The HN arrived at the facility around 6:30pm on 04/12/24.
-Resident #6 was in a transport-style wheelchair.
-Resident #6 was constantly insistent on getting out of the wheelchair.
-Resident #6 was easily agitated and combative.
-Resident #6 was given Ativan 1mg (Ativan is a medication used to treat anxiety and agitation).
-The HN assisted Resident #6 with toileting, changing clothing, and assisted Resident #6 to bed.
-Resident #6 attempted to get out of bed every couple of minutes.
-After 1.5 hours, Resident #6 closed her eyes.
-The HN spent 4 hours with Resident #6 during the visit.

Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for fall: monitor status for 72

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 24 hours for bruising, change in mental status/condition, pain, or other injuries related to fall scheduled for 7:00am-7:00pm and 7:00pm-7:00am from 04/12/24 to 04/14/24. -Monitor status was documented as completed for 7:00am-7:00pm from 04/12/24 to 04/13/24. -Monitor status was documented as "H" for 7:00am-7:00pm on 04/14/24. -Monitor status was documented as completed for 7:00pm-7:00am from 04/12/24 to 04/13/24. -Monitor status was documented as "H" for 7:00pm-7:00am on 04/14/24. -There was an entry for fall: check vital signs every shift for 72 hours scheduled for 7:00am-7:00pm and 7:00pm-7:00am from 04/12/24 to 04/14/24. -Vital signs were documented as completed for 7:00am-7:00pm from 04/12/24 to 04/13/24. -Vital signs were documented as "H" for 7:00am-7:00pm on 04/14/24. -Vital signs were documented as completed for 7:00pm-7:00am from 04/12/24 to 04/13/24. -Vital signs were documented as "H" for 7:00pm-7:00pm on 04/14/24. -There was no explanation of the meaning of "H" on the information key on the eMAR -There were no entries noted for increase supervision on the April 2024 eMAR. Review of Resident #6's facility progress note dated 04/13/24 at 8:30am revealed: -The entry was recorded as a late entry on 04/13/24 at 7:32pm. -The reason for the progress note was follow-up from a fall. -Resident #6 had not complained of pain. -Resident #6's mental status changes included agitation and aggression. -Additional injuries seen since the fall included bruising on head, face, chin, and both forearms.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 25 Review of Resident #6's facility progress note dated 04/13/24 at 5:21pm revealed the hospice agency was notified of Resident #6's agitation and behaviors. Review of Resident #6's incident/accident report dated 04/13/24 at 8:30pm revealed: -The type of incident was medical-pain. -The location of the incident was the resident room. -The incident was reported by a personal care aide (PCA) and the HN. -Resident #6 was transported to the hospital at 8:30pm. Review of Resident #6's EMS records dated 04/13/24 revealed: -The EMS call was received on 04/13/24 at 8:47pm. -EMS arrived at the facility on 04/13/24 at 8:55pm. -The caregiver reported hematoma on Resident #6's head and contusions on her left arm. -The caregiver reported Resident #6 walked differently and complained of hip pain. -EMS assessed Resident #6 and Resident #6 stated she had no pain. -EMS left the facility on 04/13/24 at 9:04pm. -EMS arrived at the hospital with Resident #6 at 9:20pm. Review of Resident #6's facility progress notes dated 04/13/24 at 8:30pm revealed: -The entry was recorded as a late entry on 04/17/24 at 7:08pm. -Resident #6 was sent to the hospital on 04/13/24 at 8:30pm via EMS. Review of Resident #6's facility progress notes	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 26	D 270		

dated 04/13/24 at 10:48pm revealed:
-The reason for the progress note was follow-up from a fall.
-Resident complained of hip and leg pain.
-Resident #6 had bruising on forehead and chin.

Review of Resident #6's hospice agency's notes dated 04/14/24 at 12:10pm revealed:
-The visit date was 04/13/24.
-Resident #6 refused vital signs.
-Resident #6 was administered Ativan 1mg.
-Resident #6 was attempting to get out of her wheelchair.
-Resident #6 was yelling out when attempting to stand.
-The HN and PCA assisted Resident #6 with toileting and changing clothing.
-The HN contacted the provider and was given an order to call 911.
-At 8:45pm, 911 was phoned and transport requested.
-At 9:00pm, EMS was present in the facility and the HN gave EMS report.
-The HN contacted Resident #6's family member.

Review of Resident #6's emergency department (ED) provider note dated 04/14/24 revealed:
-Resident #6 presented to the ED for evaluation after multiple falls.
-Resident #6 had bruising to her left forehead, her left mandible (The mandible is the jaw area of the face), and her left forearm.
-Resident #6 had no tenderness to her chest wall, abdomen, or upper or lower extremities (Extremities is a term for arms and legs).
-Resident #6 had no pain to upper and lower extremities during passive range of motion (Passive range of motion is when another person moves the patient's arms or legs).
-Resident #6 had a subdural hematoma

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 27	D 270		

measuring 5mm (A subdural hematoma is bleeding near the brain), a small right pneumothorax (A pneumothorax is air leaking into the space between the lungs and chest wall), acute fractures of the right 8th through 10th ribs (Acute is a term used to describe a medical condition that has a recent onset), and an acute nondisplaced (Nondisplaced is a term meaning the bone is aligned in an position acceptable for healing) fracture of the left superior pubic ramus (The pubic ramus is one of the bones that makes up the pelvis).

Review of Resident #6's hospital history and physical note dated 04/14/24 revealed:
-Resident #6's chief complaint was listed as ground level fall.
-Known injuries listed included right hydropneumothorax (A hydropneumothorax is an abnormal presence of air and fluid between the lung and chest wall sometimes caused by rib injuries), fractures to the right 8th, 9th, and 10th ribs, a compression fracture to the 3rd thoracic vertebrae (Thoracic vertebrae are bones located in the middle portion of the spine), right maxillary fracture (The maxilla is a facial bone that forms the upper jaw), a subdural hematoma measuring 5mm, left superior pubic ramus fracture, and a thrombus in the left appendage (A blood clot in the left arm).
-Resident #6's family was interested in transferring Resident #6 to a hospice facility but there was not a bed available.
-The family did not likely want to proceed with any aggressive treatments.
-Resident #6 did not have any acute complaints and did not complain of pain.

Review of Resident #6's hospice agency's notes dated 04/15/24 at 5:30pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 28	D 270		

-Resident #6 arrived at the inpatient hospice facility at 4:40pm on 04/15/24.
-Resident #6 was alert and oriented to self and had confusion.

Review of Resident #6's hospice agency's notes dated 04/25/24 at 3:44pm revealed:
-The RN was called to Resident #6's room at 2:40pm.
-Resident #6 was not breathing, vital signs were assessed, and none were found.
-Resident #6's death was pronounced at 2:43pm on 04/25/24.

Interview with Resident #6's family member on 05/13/24 at 1:17pm revealed:
-Resident #6 lived at home until December 2023.
-Resident #6 started having difficulty walking in January 2024.
-Resident #6 had a hip fracture in January 2024.
-Resident #6 was admitted to the facility on 03/14/24 from the rehabilitation facility.
-Resident #6 had a history of falls prior to her admission to the facility.
-She was aware of Resident #6 having at least 4-5 falls at the facility.
-Resident #6 was admitted to hospice services in April 2024.
-Resident #6 was sent to the hospital by a hospice nurse on 04/13/24.
-On 04/13/24, she was informed by providers at the local hospital that Resident #6 had multiple injuries including pelvic fracture, 3 fractured ribs, subdural hematoma, and a punctured lung.
-There was no surgical intervention recommended for Resident #6 due to her condition, so Resident #6's family member decided to transfer Resident #6 to a local hospice facility on 04/15/24.
-Resident #6 passed away on 04/25/24 at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 29	D 270		

hospice facility.

Interview with a day shift medication aide (MA) on 05/15/24 at 12:35pm revealed:
-She was unsure of when Resident #6 was admitted to the facility.
-Resident #6 was at the facility for a while before her family requested for her to receive hospice services.
-Resident #6 needed assistance with bathing, dressing, toileting, and transfers.
-Resident #6 had a walker and wheelchair.
-Resident # 6 was a fall risk.
-Resident #6 used to pack her clothes, look for her car, and sit at the front door often.
-Resident #6 used to attempt to hit staff and needed frequent redirection.
-MAs and PCAs found out when residents were at risk for falls by verbal communication during shift change.
-The residents' electronic health record had a banner at the top of the screen which informed staff members if a resident was at risk for falls.
-When a resident was at risk for falls, the staff increased supervision of the resident.
-Each resident was checked every 2 hours, but a resident may be checked every hour if supervision needed to be increased.
-Each time a resident fell, MAs were required to complete an incident report.
-A fall occurred when a resident was found on the floor.
-Resident #6 had some falls while she lived at the facility, but she was unsure how many.
-On 04/13/24, she worked from 7:00am to 7:00pm.
-When she came in at 7:00am on 04/13/24, the third shift MA informed her that Resident #6 had 2 falls the previous day, 04/12/24.
-Resident #6 was in her wheelchair on 04/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 30	D 270		

and propelled herself in the hallway throughout the shift.
-Resident #6 said she wanted to go home several times during the shift and was redirected from the front door.
-Resident #6 would hit the front door and tried to exit the facility.
-Resident #6 was agitated and combative on 04/13/24 and told staff that she wanted to go home.
-Resident #6 took Ativan for agitation but it did not seem to help.
-She contacted the hospice agency around 4:00-5:00pm on 04/13/24 because Resident #6 was attempting to hit the staff members and did not seem like herself.
-Resident #6 did not complain of pain on her shift on 04/13/24.

Interview with the Activities Director on 05/16/24 at 8:51am revealed:
-His primary responsibility at the facility was activities.
-He sometimes worked as a PCA or MA if the facility needed him, which was usually 1-2 times per week.
-Resident #6 ambulated with a walker and needed reminders to use her walker.
-Resident #6 had a wheelchair and often tried to get out of the wheelchair without assistance from staff.
-Resident #6 would sometimes become combative and attempt to hit or slap staff members.
-He worked from 7:00am to around 1:00pm as a PCA on 04/13/24.
-Resident #6 needed redirection and was attempting to exit the facility on 04/13/24 and told staff that she needed to get to her car.
-He was unsure if Resident #6 had any falls while

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 31	D 270		

he was working on 04/13/24.
-He was told about Resident #6 placing herself on the floor on 2 different occasions but was unsure of the dates.
-He was unsure if Resident #6 placed herself on the floor while he was working on 04/13/24.
-He was aware Resident #6 was a fall risk and he checked on her frequently during his shift on 04/13/24.
-Resident #6 took a nap the morning of 04/13/24 and while she was sleeping, he was in her room putting away her laundry and clothing.

Interview with an evening shift MA on 05/16/24 at 11:15am revealed:
-Resident #6 required assistance with bathing, dressing, and sometimes toileting.
-Resident #6 required assistance of 2 staff members with transfers.
-Resident #6 had some falls and started using a wheelchair.
-She was unsure how many falls Resident #6 had while she was at the facility.
-The staff was informed about residents at risk for falls by verbal communication in shift reports.
-Residents' electronic health records had a banner across the top of the screen if a resident was at risk for falls.
-The staff checked on Resident #6 every two hours.
-If a resident was at risk for falls, staff members checked on them more frequently but there were no specific time frames in place for how often residents should be checked.
-If a resident was on the floor, an incident report should be completed.
-She was told by other staff members that Resident #6 would place herself on the floor.
-She observed Resident #6 place herself on the floor but was unsure of the date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 32	D 270		

-She was scheduled to come in to work at 7:00pm on 04/13/24, but she came in a few hours early that day to relieve the first shift PCA.
-Resident #6 was at the front door on 04/13/24 around 5:00pm, and she struck the door several times with her arms, attempted to open the door, and told staff she needed to get to her car.
-She took Resident #6 to the dining room around 5:00pm for the evening meal.
-After the meal, she took Resident #6 to the television room.
-Resident #6 did not complain of pain at that time.
-The HN came to the facility sometime between 6:00pm and 6:30pm on 04/13/24.
-She left the television room when the HN arrived, and Resident #6 was sitting in a chair when she exited the room.
-She went to count narcotics on the medication cart with the day shift MA and observed the HN propelling Resident #6 in her wheelchair throughout the facility and outside.
-Resident #6 appeared to be calm and was not screaming or yelling.
-Later in the evening, the HN informed her she was going to send Resident #6 to the hospital.

Second interview with a day shift MA on 05/16/24 at 3:18pm revealed:
-She heard reports from other staff members that Resident #6 placed herself on the floor.
-She did not witness Resident #6 place herself on the floor while she lived at the facility.
-The PCA working the morning of 04/13/24 reported that Resident #6 placed herself on the floor around 12:00pm.
-When she entered Resident #6's room, Resident #6 was sitting on the side of her bed.
-Resident #6 did not complain of pain.
-She did not complete an incident report after receiving a report that Resident #6 placed herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 33	D 270		

on the floor.
-She contacted the Resident Care Coordinator (RCC) and reported Resident #6 placed herself on the floor on 04/13/24.
-She contacted the hospice agency on 04/13/24 and notified the HN that Resident #6 placed herself on the floor.

Interview with a PCA on 05/16/24 at 3:32pm revealed:
-She worked the evening shift, which was 7:00pm to 7:00am.
-Resident #6 needed assistance with dressing, toileting, and ambulation.
-Resident #6 had a walker and a wheelchair.
-Resident #6 needed frequent reminders to use her walker and would often get up from the wheelchair without assistance when using her wheelchair.
-She observed Resident #6 place herself on the floor in the hallway one evening, but she was unsure of the date.
-At the time Resident #6 placed herself on the floor, she was agitated.
-She reported this to the MA but was unsure if an incident report was completed.
-PCAs were not responsible for completing incident reports, the MAs completed incident reports when a resident fell.
-PCAs were informed of a resident being a fall risk during shift change reports,
-She was unsure if there was any documentation of a residents' fall risk and fall interventions.
-She could not recall being instructed on any fall interventions to keep Resident #6 from falling.
-She checked on Resident #6 approximately every 30 minutes to an hour during her shifts because she knew Resident #6 was at risk for falls.
-No one instructed her to check on Resident #6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 34	D 270		

more frequently, she did it on her own because she was afraid that Resident #6 would fall.
-She came in for her shift at 7:00pm on 04/13/24.
-When she arrived for her shift on 04/13/24, Resident #6 was in the television room with the HN.
-She was asked by the HN for assistance with changing Resident #6's clothing and providing incontinence care for her.
-When she and the HN changed Resident #6's clothing and provided incontinence care, Resident #6 did not complain of pain.
-Shortly after she left the room, when she was walking in the hallway, the HN stopped her and informed her that she thought Resident #6 was in pain and needed to call EMS.
-Resident #6 left the facility with EMS a short time later.

Interview with the HN on 05/15/24 at 2:25pm revealed:
-She was an on-call nurse with the hospice agency and usually saw patients after regular business hours.
-When the hospice agency was notified of a resident's fall at a facility, a nurse would go to the facility to assess the resident's injuries.
-The hospice agency did not usually advise the facilities to send a resident to the hospital until a nurse came out to assess the resident.
-If a resident had clear injuries, distress, or unresolved shortness of breath, they may go to the hospital or the inpatient hospice facility.
-She first saw Resident #6 on 04/12/24.
-Resident #6 had a fall on 04/12/24 and struck her head.
-She noted a hematoma on Resident #6's head on 04/12/24 and noted it to be the size of a softball.
-The hematoma on Resident #6's head was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 35	D 270		

visible at that time but when she touched Resident #6's head, she felt the hematoma.
-She was with Resident #6 for several hours on 04/12/24, until Resident #6 went to sleep.
-She received a call from the MA at the facility on 04/13/24 who reported that Resident #6 was voluntarily placing herself on the floor.
-She arrived at the facility on 04/13/24 around 6:00pm to assess Resident #6.
-Resident #6 was sitting in a chair in the television room and she assisted Resident #6 into her wheelchair.
-She did a quick assessment on Resident #6 and noted bruises on her face, both arms, and swelling in her left foot.
-Resident #6 moaned and groaned while she was propelling her in her wheelchair.
-She did not send Resident #6 to the hospital at that time because she did not have permission from the hospice provider.
-She took Resident #6 to her room and asked a PCA for assistance with helping Resident #6 to bed.
-When she and the PCA transferred Resident #6 to her bed, Resident #6 was unable to bear any weight on her legs.
-She and the PCA changed Resident #6's incontinence brief and clothing while Resident #6 was in bed.
-Resident #6 was moaning and grimacing while she was assisting her.
-She contacted the hospice provider and got permission to send Resident #6 to the emergency department.
-She contacted EMS at approximately 8:45pm on 04/13/24 and EMS arrived around 9:00pm.

Second interview with Activities Director on 05/16/24 at 4:00pm revealed:
-He worked as a PCA the morning of 04/13/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 36	D 270		

-He observed Resident #6 sitting in the wheelchair and then sliding out of the wheelchair to place herself on the floor around 10:00am-11:00am on 04/13/24.
-He assisted Resident #6 from the floor to her bed, and Resident #6 sat on the side of her bed.
-When Resident #6 placed herself on the floor on 04/13/24, she was talking about needing to leave the facility and wanted to find her car.
-He reported to the MA on duty that Resident #6 had placed herself on the floor.
-The MA came to Resident #6's room to check on her when he told her Resident #6 placed herself on the floor.
-He did not complete an incident report on 04/13/24 because he was working as a PCA.
-MAs were responsible for completing incident reports and should complete an incident report any time a resident was on the floor.
-He thought there were some fall interventions in place for Resident #6, but he was unsure what the interventions were.
-Any fall interventions for residents were communicated during staff meetings, which occurred every two weeks.

Interview with an intake RN and chief executive officer (CEO) of the hospice agency on 05/16/24 at 4:22pm revealed:
-The hospice agency assessed all patients after a fall whether in a home setting or facility.
-If a patient had an obvious injury such as bleeding or a broken bone, the agency would advise that the patient should be sent to the hospital.
-If a patient had a fall and did not have an obvious injury or had struck their head during a fall, the nurse would assess and contact the provider.
-The nurse would follow the provider's instructions on treatment or if the patient needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 37	D 270		

to be sent to the hospital.
-All hospice patients were assessed as soon as possible after a fall and again in 24 hours.

Interview with the Resident Care Coordinator (RCC) on 05/17/24 at 1:34pm revealed:
-Anytime a resident was on the floor it would be considered a fall.
-If a resident was injured, the MA should call EMS and send them to the hospital.
-The MA should also notify the residents' PCP, family, and the RCC or Memory Care Director.
-If a resident placed themself on the floor, an incident report should still be completed.
-Residents were checked every 2 hours, and every hour if they had a fall or behaviors that required increased supervision.
-Resident #6 was admitted to the facility from a rehabilitation facility and had physical therapy when she was admitted to the facility.
-Resident #6 required assistance with bathing, dressing, toileting, and showering.
-Resident #6 required stand by assistance of 1 staff member for transfers.
-Resident #6 used a wheelchair for mobility.
-Resident #6 was able to verbalize her needs.
-Resident #6 often sat near the front door and struck the front door with her arms, attempting to open the front door.
-The only report she received of Resident #6 placing herself on the floor was on 04/13/24.
-There was not an incident report completed the day Resident #6 placed herself on the floor.
-An incident report should have been completed if staff observed Resident #6 placing herself on the floor on 04/13/24.
-She thought the MAs completed incident reports for all of Resident #6's other falls.
-Resident #6 could have injured herself placing herself on the floor on 04/13/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 38 -She was notified of Resident #6's falls on 04/11/24 and 04/12/24. -She instructed the MAs to contact hospice after each fall on 04/11/24. -She was unsure of any other fall interventions put in place after Resident #6's falls on 04/11/24 and 04/12/24. -She was unsure how Resident #6 received multiple injuries and fractures. -She did not hear Resident #6 complain of pain during the time Resident #6 was at the facility, but now thought maybe some of Resident #6's agitation was because of pain -The facility should have called EMS after Resident #6 fell on 04/12/24 instead of waiting for hospice to come and assess her. Interview with the Administrator on 05/17/24 at 11:50am revealed: -When a resident went from one level to another level, that was considered a fall. -When a resident was found on the floor, the MA should check the resident for obvious injuries and the MA should call EMS if the resident was injured. -If a resident was known to place themself on the floor and that information was in their care plan, the staff should document when residents placed themselves on the floor. -If a resident placed themself on the floor and this information was not on their care plan, an incident report should be completed. -Residents could injure themselves by placing themselves on the floor. -All residents were checked at least every 2 hours. -Resident #6 did have a history of falls prior to her admission to the facility. -She felt that when Resident #6 was admitted, the facility could meet her needs.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 39 -When Resident #6 was admitted, the plan to prevent her from falling was for Resident #6 to continue physical therapy, ensure she had appropriate footwear, and have adequate lighting in her room. -Resident #6 was checked at least every 2 hours but she felt it was more often than every 2 hours. -Resident #6 had to be supervised frequently due to being at risk for falls. -The staff provided increased supervision by always keeping Resident #6 close to them or observing Resident #6. -She was never informed that Resident #6 placed herself on the floor. -If Resident #6 placed herself on the floor at any point, an incident report should have been completed. -The staff were aware of residents at risk for falls by an "F" fall emblem placed on the residents' doors and by a banner at the top of the residents' electronic health record. -Staff members were notified that a resident was at risk of falls by verbal communication at each shift change. -Fall interventions were documented in the residents' records. -She was unsure if the direct care staff had access to what fall interventions were put in place for each resident. -Resident #6 had a walker and would often attempt to walk without her walker. -She was aware that Resident #6 had 1 fall on 04/11/24 and 2 falls on 04/12/24. -Interventions for the falls on 04/11/24 and 04/12/24 included supervising Resident #6 and communicating with hospice. -The facility's policy was to send a resident to the hospital for serious injuries. -The facility contacted hospice first instead of sending Resident #6 to the hospital.	D 270		

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

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SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 40	D 270		

-The facility should have sent Resident #6 to the hospital immediately when she fell on 04/12/24 and not waited on hospice to come and assess Resident #6.

Interview with Resident #6's primary care provider (PCP) on 05/17/24 at 10:10am revealed:
-She saw Resident #6 for the first time at the facility on 03/19/24.
-Resident #6 was oriented to person and place.
-Resident #6 was able to verbalize if she had pain.
-She was informed of Resident #6 having a fall without injury on 03/19/24.
-She did not order physical therapy for Resident #6 because she was admitted to the facility with therapy orders and was receiving physical therapy.
-She did not order any medical equipment for Resident #6 while she was Resident #6's PCP.
-She was not in the office on the week that Resident #6 was admitted to hospice.
-She did not order hospice services for Resident #6.
-Resident #6's family initiated contact with the hospice agency and she did not have to give an order.
-The facility staff contacted her office on 04/08/24 about Resident #6 having swelling in her left foot and ankle.
-The provider on duty ordered an x-ray of Resident #6's left foot and ankle and the results were negative, there were no injuries.
-She was not aware that Resident #6 was sent to the hospital on 04/13/24 and had multiple injuries.
-She was informed that Resident #6 moved out of the facility on 04/16/24 but the facility did not give any additional information.

Interview with the medical examiner on 05/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 41 at 2:18pm revealed: -His office was informed that Resident #6 had fallen at a facility. -An autopsy was not performed on Resident #6. -Autopsies were performed when there were unexpected deaths that could not be explained. -Autopsies were not usually ordered with falls or accidents. -An external exam was performed, and any visible bruises, wounds, and skin injuries were noted. -A toxicology report was not done because Resident #6's body had been embalmed at the time of the examination. -Resident #6's injuries contributed to her death. -Resident #6's cause of death was due to multiple blunt force injuries. -Resident #6's manner of death was accidental. 2. Review of Resident #3's current FL-2 dated 03/26/24 revealed diagnoses included dementia with behaviors, anxiety, gastro-esophageal reflux disease, and coronary artery disease. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 12/20/23. Review of Resident #3's unscheduled electronic assessment and care plan dated 05/14/24 revealed: -Resident #3 was always disoriented and had significant memory loss. -Resident #3 had limited ambulation ability and used a wheelchair. -There was no documentation of increased supervision or fall prevention measures. Review of Resident #3's previous care plan dated 01/08/24 revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 42	D 270		

-Resident #3 was sometimes disoriented and forgetful.
-Resident #3 was ambulatory without assistance and wandered.
-Resident #3 required supervision with ambulation and transfers.
-There was no documentation of increased supervision or fall prevention measures.

Review of Resident #3's electronic progress note dated 03/03/24 revealed staff contacted the primary care provider (PCP) to request an x-ray order (reason unspecified).

Review of Resident #3's PCP visit note dated 03/05/24 revealed:
-Resident #3 was seen for x-ray follow up.
-Staff notified the on-call provider of a presumed fall and requested a right hip x-ray.
-The x-ray showed no evidence of acute bone injury.

Review of Resident #3's electronic progress note dated 03/30/24 revealed the resident was sent to the emergency room (ER) via Emergency Medical Services (EMS) for a fall.

Review of Resident #3's accident/incident report dated 03/30/24 revealed:
-Resident #3 had a witnessed fall in the day room at 11:23am without injury.
-Resident #3 was sitting on the floor was documented under description of event.
-There was documentation Resident #3 was sent to the ER at 11:49am.
-There was documentation 72-hour monitoring for bruising, change in condition, pain, or other injuries every shift was implemented.
-There was no documentation that increased supervision or fall prevention measures were

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 43 implemented. Review of Resident #3's Fall Risk Intervention Care Plan dated 04/01/24 revealed: -Appropriate footwear was the intervention documented. -The safety awareness emblem was placed on the resident room nameplate on 04/01/24. -The fall risk banner was added to the electronic charting system on 04/01/24. Review of Resident #3's PCP visit note dated 04/02/24 revealed: -Resident #3 was seen for an ER follow up. -Resident #3 was seen in the ER and diagnosed with a fall on 03/30/24. -Resident #3 had computed topography (CT) scans of her head and neck completed at the ER. -The PCP wrote an order for fall precautions per facility policy. Review of Resident #3's electronic progress note dated 04/19/24 revealed the resident was sent to the ER via EMS for a fall. Review of Resident #3's accident/incident report dated 04/19/24 revealed: -Resident #3 had a witnessed fall in her room at 2:28pm with injury. -Resident #3 leaned over unbalanced and bumped her head on the wall was documented under description of event. -There was documentation Resident #3 had an unspecified injury to the left side of her head. -There was documentation Resident #3 was sent to the ER at 11:49am. -There was documentation 72-hour monitoring for bruising, change in condition, pain or other injuries every shift was implemented. -There was no documentation that increased	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 44	D 270		

supervision or fall prevention measures were implemented.

Attempted telephone interview on 05/17/24 at 5:29pm, with the PCA who witnessed Resident #3's fall on 03/30/24 and 04/19/24 was unsuccessful.

Review of Resident #3's Fall Risk Intervention Care Plan dated 04/20/24 and completed 05/10/24 revealed:
-Interventions included referral to PCP for evaluation and hospice.
-The safety awareness emblem was placed on the resident room nameplate on 04/22/24.
-The fall risk banner was added to the electronic charting system on 04/22/24.

Review of Resident #3's PCP visit note dated 04/23/24 revealed:
-Resident #3 was seen for ER follow up.
-Resident #3 was seen in the ER and diagnosed with a fall and closed head injury on 04/19/24.
-Resident #3 had CT scans of her head and neck completed at the ER.
-The PCP wrote an order for fall precautions per facility policy.

Interview with the Administrator on 05/17/24 at 11:51am revealed:
-She completed the accident/incident report dated 04/19/24 for Resident #3 because the MA was on a break at the time of the fall.
-Resident #3 was leaning against the wall when she saw her on 04/19/24 and was up and moving around before leaving with EMS technicians.

Review of Resident #3's hospice admission note dated 04/23/24 revealed:
-Resident #3 was ambulatory with a very

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 45	D 270		

unsteady gait.
-She was caught by the hospice nurse (HN) twice during the visit for near falls.

Upon request on 05/14/24, Resident #3's PCP referral order for hospice, was not provided for review.

Review of Resident #3's electronic progress notes dated 04/26/24 revealed:
-The resident was sent to the ER via EMS for a fall at 12:15pm.
-There was documentation at 5:11pm that Resident #3 had increased confusion and agitation and bruises on her right hand and the top of her head.

Review of Resident #3's accident/incident report dated 04/26/24 revealed:
-Resident #3 had a witnessed fall in the day room at 11:39am without injury.
-Resident #3 was laying on the floor was documented under description of event.
-There was documentation Resident #3 was sent to the ER at 12:15pm.
-There was documentation 72-hour monitoring for bruising, change in condition, pain, or other injuries every shift was implemented.
-There was no documentation that increased supervision or fall prevention measures were implemented.

Review of Resident #3's Fall Risk Intervention Care Plan dated 04/26/24 and completed 05/10/24 revealed:
-Interventions included walking the resident up and down the hall for exercise and increased supervision.
-The safety awareness emblem was placed on the resident room nameplate on 04/26/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 46	D 270		

-The fall risk banner was added to the electronic charting system on 04/26/24.

Review of Resident #3's PCP visit note dated 05/01/24 revealed:
-Resident #3 was seen for ER follow up.
-Resident #3 was seen in the ER and diagnosed with a fall on 04/26/24.
-Resident #3 had bloodwork completed at the ER.
-Resident #3 was admitted to hospice services and hospice was aware of the fall.
-The PCP wrote an order for fall precautions per facility policy.

Interview with a personal care aide (PCA) on 05/17/24 at 1:34pm revealed:
-She saw Resident #3 put herself on the floor on 04/26/24.
-Resident #3 was not hurt.
-She thought MAs had to send Resident #3 to the ER because she fell.

Review of Resident #3's electronic progress notes dated 05/01/24 revealed:
-There was documentation that the HN was notified Resident #3 fell, hit her head, and was sent to the ER at 10:42am.
-There was documentation the HN was notified that Resident #3 returned from the ER and had increased drowsiness and confusion at 3:54pm.
-There was documentation the HN ordered a hospital bed, high back wheelchair, and fall mat for Resident #3 at 7:25pm.
-There was documentation Resident #3 fell at 10:00pm.
-There was documentation the resident's family member did not want her sent to the ER at 10:44pm.

Review of Resident #3's accident /incident report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 47	D 270		

dated 05/01/24 revealed:
-Resident #3 had a witnessed fall in the day room at 10:42am without injury.
-Resident #3 was observed sitting on her knees on the floor was documented under description of event.
-There was documentation Resident #3 was sent to the ER at 10:55am.
-There was documentation 72-hour monitoring for bruising, change in condition, pain, or other injuries every shift was implemented.
-There was no documentation that increased supervision or fall prevention measures were implemented.

Attempted telephone interview on 05/17/24 at 5:30pm, with the PCA who witnessed Resident #3's fall on 05/01/24 at 10:42am, was unsuccessful.

Review of Resident #3's second accident/incident report dated 05/01/24 revealed:
-Resident #3 had a witnessed fall in her room at 10:00pm without injury.
-Resident #3 was observed laying on the floor was documented under description of event.
-There was documentation 72-hour monitoring for bruising, change in condition, pain, or other injuries every shift was implemented.
-There was no documentation that increased supervision or fall prevention measures were implemented.

Review of Resident #3's electronic progress notes dated 05/02/24 revealed there was documentation that Resident #3 had increased confusion and agitation and bruising on her forehead.

Review of Resident #3's HN visit note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 48	D 270		

05/01/24 revealed:
-Resident #3 was seen for a fall.
-Resident #3 was trying to get out of bed with her eyes closed, fell on the floor, and hit her head.
-Resident #3's family member declined a hospital visit.

Review of Resident #3's HN visit note dated 05/02/24 revealed:
-Resident #3 was seen after a fall and ER visit.
-Staff reported Resident #3 was unable to hold her trunk in the sitting position.
-Staff reported prior to the fall Resident #3 was ambulatory with assistance.

Review of Resident #3's Fall Risk Intervention Care Plan dated 05/01/24 and completed 05/02/24 revealed:
-High back wheelchair was the intervention documented.
-The safety awareness emblem was placed on the resident room nameplate on 05/02/24.
-The fall risk banner was added to the electronic charting system on 05/02/24.

Review of Resident #3's PCP visit note dated 05/07/24 revealed:
-Resident #3 was seen for ER follow up.
-Resident #3 was seen in the ER and diagnosed with a fall from a chair and minor head injury on 05/01/24.
-Resident #3 had CT scans of her head and neck completed at the ER.
-The PCP wrote an order for fall precautions per facility policy.

Upon request to the facility on 05/14/24, 05/16/24 and 05/17/24, Resident #3's ER discharge instructions dated 03/30/24, 04/19/24, 04/26/24, and 05/01/24, were not provided for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 49 Telephone interview with Resident #3's PCP on 05/17/24 at 9:17am revealed: -Resident #3 required supervision at all times on the SCU especially with her history of falls. -She instructed staff to implement fall precautions per facility protocol in her ER fall follow up visits on 04/02/24, 04/23/24 where she had a closed head injury, and 05/01/24. -She did not know the details of the facility's fall precautions protocol, only that the facility had a falls precautions protocol. Observation upon entering the Special Care Unit (SCU) on 05/14/24 at 9:24am revealed: -The housekeeper was in the hallway near the closed entrance to the dining room. -There were 13 residents in the day room. -There was no staff in the day room. -Residents seated on both sides of the day room were not visible from the hallway. -The housekeeper went into the dining room. -The Activity Director arrived in the day room at 9:26am. Observation on the SCU on 05/15/24 at 8:32am revealed: -There were 12 residents in the day room with no staff present. -At 8:34am, the Resident Care Coordinator (RCC) arrived in the day room. Interview with a PCA on 05/14/24 at 10:18am revealed: -PCAs did not work with an assigned group of residents in the SCU. -PCAs working on the SCU worked together to care for and supervise residents. -PCAs checked residents on the SCU every 1-2 hours to see if they needed toileting and/or	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 50	D 270		

incontinence care.
-There were no residents that required increased supervision for falls, exit seeking or behaviors.

Interview with the Memory Care Manager (MCM) on 05/17/24 at 11:00am revealed:
-03/30/24 was a Saturday when Resident #3 fell in the day room.
-Normally the PCA witnessing the fall reported the fall to the MA who then checked the resident.
-The medication aide (MA) was responsible for documenting on the accident/incident report what they first saw when checking the resident.
-Most falls resulted in the resident being sent to the ER for evaluation.
-Residents were not sent to the ER when the fall was witnessed and there was no injury.
-She did not know why Resident #3 was sent to the ER for witnessed falls in the day room with no injury on 03/30/24, 04/26/24, and 05/01/24.
-The MA was expected to document any obvious injuries on the accident/incident report.
-There was supposed to be one staff in the day room with residents at all times.
-Either she, the MA or Activity Director were present in the day room with residents when the PCA were providing care to a resident in their room or the bathroom.
-Staff in the day room were expected to monitor residents and try to prevent falls; some falls could not be prevented.
-After a fall the resident was placed on 72 hour monitoring which included the MA checking the resident every shift for 72 hours.
-The MA checked the resident for changes in condition, symptoms such as dizziness, and signs of injuries such as bruising and pain.
-Residents with a change in condition were sent to the ER.
-She was responsible for completing post fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 51	D 270		

care plans and interventions the same day as the fall or the next day.
-She immediately communicated to post fall interventions to the PCAs and MAs on duty the shift the fall occurred.
-PCAs and MAs on duty were expected to report the fall interventions implemented to the next shift at shift change.
-She did not remember the details of Resident #3's falls on 04/19/24 or 04/26/24.
-She did not remember what interventions were put in place to reduce falls and injury.
-On 05/01/24, Resident #3 got up from one of the armchairs in the day room and fell to her knees.
-Resident #3 leaned over while on her knees and hit her head on the wall.
-One of the PCAs was on the hall monitoring near Resident #3's room after the first fall on 05/01/24.
-Hospice implemented a fall mat (05/01/24) and it was used when the resident was lying down in her bed.
-Checking Resident #3 every hour or more was hard because the resident was always moving around.

Interview with the Administrator on 05/17/24 at 11:51am revealed:
-PCAs and MAs were responsible for rounding every 2 hours minimum for all residents.
-Residents at risk for falls were identified with an "F" emblem on their door and a fall risk banner on their electronic face sheet.
-The electronic resident face sheet was visible to all staff accessing the resident's electronic record.
-Fall prevention intervention were communicated verbally to staff on duty by the MCM or RCC when prevention measures were implemented.
-Staff on duty was responsible for communicating fall prevention interventions to the next shift.
-Normally the MA completed accident/incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 52	D 270		

reports.
-There should be staff present with residents in day room at all times for all safety risks including falls and behaviors.
-Resident #3 could have been sent to the ER on 03/30/24 for cognitive reasons, but she was not sure.
-Resident #3 could have fallen in the day room on 04/26/24 trying to pick up imaginary things.
-She had witnessed Resident #3 bending over and trying to pick up things.
-She did not know why Resident #3 was sent to the ER on 05/01/24 with no injury documented on the accident/incident report.
-72 hour post fall monitoring was implemented by the MA when completing the accident/incident report.
-The MA clicked on the intervention on the electronic accident/incident report which resulted in the monitoring entry on the electronic charting system for the MA to follow up and document each shift.
-MAs were responsible for making sure PCAs were checking residents every 2 hours.
-MAs were responsible for laying eyes on each resident at least once every shift.
-It was possible that staff might have been giving care to another resident and not in the day room when Resident #3 fell in the day room.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

_____

The facility failed to ensure supervision of Resident #3 and Resident #6. The facility's failure resulted in Resident #3 having six falls, two head injuries, and being sent to the emergency room four times within two months and Resident #6 having five documented falls in less than one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 270	Continued From page 53 month and sustaining multiple injuries including three rib fractures, a punctured lung, a head injury, a compression fracture, a facial fracture and a pelvic fracture resulting in hospitalization and transfer to an inpatient hospice care facility, where the resident later died. This failure resulted in serious physical harm and death and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/17/24. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 6 sampled residents (#3 and #8) related notifying the primary care provider (PCP) for low blood pressure results outside the PCP's ordered parameters (#8), and multiple meal refusals and significant weight loss prior to the initiation of hospice services (#3). The findings are:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 54 1. Review of the National Institute of Health definition of low blood pressure (hypotension) revealed: -Hypotension is blood pressure that is lower than 90/60 mmHg (millimeters of mercury). -It may be linked to a health problem. -It can be dangerous, as it could mean the heart, brain, or other vital organs are not getting enough blood flow. -Hypotension can place the patient at risk of a heart attack or stroke. Review of Resident #8's current FL-2 dated 03/19/24 revealed: -Diagnoses included essential hypertension, chronic atrial fibrillation, syncope and collapse, and dementia. -She was semi-ambulatory and a wanderer. -She was intermittently disoriented. -There was an order for weekly blood pressure (BP) and pulse with instructions to call the primary care provider (PCP) for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, call for pulse of 140 or greater or less than 50. Review of primary care provider (PCP) notes dated 03/12/24 revealed: -Resident #8 was being seen for a follow up from a hospitalization 03/02/24 - 03/05/24 for syncope (temporary loss of consciousness caused by a drop in blood pressure). -The facility sent Resident #8 out to the local emergency department for evaluation on 03/02/24 for multiple behavioral outbursts followed by a 5-minute syncopal episodes (also known as fainting). -The discharge summary reviewed by the PCP on 03/05/24 revealed that Resident #8 had alternating episodes of tachycardia (heart rhythm	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 55	D 273		

disorder with heartbeats faster than usual, greater than 100 beats per minute) and bradycardia (heart rate slower than 60 beats per minute) while in the hospital and the cardiologist ordered the atenolol to be decreased to 12.5mg.

Review of Resident #8's daily vital signs for March 2024 revealed:
-On 03/21/24 at 9:43am, the BP was 84/54 mmHg.
-On 03/25/24 at 9:57am, the BP was 83/53 mmHg.
-On 03/26/24 at 9:40am, the BP was 68/51 mmHg; with a notation the Acceptable Range: 80 to 200 mmHg/50 to 110 mmHg.
-On 03/30/24 at 10:15am, the BP was 80/51 mmHg.

Review of Resident #8's daily vital signs for April 2024 revealed:
-On 04/09/24 at 9:25am, the BP was 80/58 mmHg.
-On 04/15/24 at 10:44am, the BP was 83/49 mmHg with a notation the Acceptable Range: 80 to 200 mmHg/50 to 110 mmHg, pulse 42/minute with a notation the Acceptable Range: 50 to 120 per minute.
-On 04/16/24 at 10:34am, the BP was 97/50 mmHg, pulse 41/minute with a notation the Acceptable Range: 50 to 120 per minute.
-On 04/17/24 at 9:54am, the BP was 98/55 mmHg.

Review of Resident #8's daily vital signs for May 2024 revealed:
-On 05/07/24 at 9:24am, the BP was 84/53 mmHg.
-On 05/14/24 at 9:49am, the BP was 88/56 mmHg.
-On 05/15/24 at 12:31pm, the BP was 88/56

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 56	D 273		

mmHg.

Review of Resident #8's record revealed there was no documentation where the PCP had been contacted regarding the low blood pressure readings for Resident #8 for March 2024, April 2024, and May 2024.

Telephone interview with Resident #8's primary care provider (PCP) on 05/17/24 at 9:58am revealed:
-The Memory Care Manager (MCM) had contacted her on 05/15/24 regarding Resident #8 having low pulse rates and low blood pressure readings; she had not been contacted about BPs prior to this contact.
-She would have wanted to know about the low blood pressures immediately.
-The blood pressure of 68/51 taken on 03/26/24 was not life sustainable.
-She would have had the blood pressure reading repeated and have sent the resident out to the emergency department if the reading had remained low on the second reading.

Interview with the medication aide (MA) on 05/16/24 at 3:18pm revealed:
-She had worked on 03/26/24 as she had initialed giving medications on that day.
-She measured and recorded Resident #8's blood pressures daily when she worked as a MA.
-She had not called the primary care provider for any blood pressure results for Resident #8 nor reported any to the MCM or the Resident Care Coordinator (RCC).

Interview with a second medication aide on 05/17/24 at 8:55am revealed:
-She had not reported any of Resident #8's BPs to the MCM or RCC or the PCP.

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 57 -The parameters were listed in the eMAR for when to report. Interview with the MCM on 05/17/24 at 10:15am revealed: -She had contacted the PCP on 05/15/24; she emailed the PCP about the BP readings. -The PCP ordered Resident #8 to be seen on the next PCP visit. -She had not reported any of the low BPs to the PCP prior to 05/15/24. Interview with the Executive Director (ED) on 05/17/24 at 1:02pm revealed: -The medication aides were expected to check the residents' vital signs, document them in the eMARs and report any vital signs that were out of the parameters or out of the acceptable ranges to the MCM or RCC. -The MCM or RCC were responsible to notify the PCP immediately of any vital signs that were out of the parameters or out of the acceptable ranges. -The resident should be sent out to the emergency department for "obvious" distress. Review of the PCP typed written orders dated 05/17/24 and electronically signed by the PCP at 10:54am revealed: -The encounter type was documented as a communication note. -Daily blood pressure (BP) and pulse checks as previously ordered. -To call PCP for systolic BP greater than 200 or less than 90, diastolic BP more than 110 or less than 40. -To call PCP for pulse of 140 or greater or less than 50. -To follow up at next facility visit.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 58	D 273		

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

2. Review of Resident #3's current FL-2 dated 03/26/24 revealed diagnoses included dementia with behaviors, anxiety, gastro-esophageal reflux disease, and coronary artery disease.

Review of Resident #3's electronic progress notes dated 03/08/24 revealed:
-There was documentation at 7:35am the resident refused breakfast.
-There was documentation Resident #3's responsible person (RP) and primary care provider (PCP) were not notified.
-There was documentation no interventions were put in place.
-There was documentation at 12:02pm the resident refused lunch.
-There was documentation Resident #3's RP and PCP were not notified.
-There was documentation no interventions were put in place.

Review of Resident #3's electronic progress note dated 03/17/24 revealed the resident was sent to the emergency room (ER) for behaviors.

Review of Resident #3's accident/incident report dated 03/17/24 revealed the resident was sent to the ER at 10:34am for behaviors including pacing, restlessness and bothering other residents in the day room.

Review of Resident #3's hospital discharge summary dated 03/17/24 to 03/22/24 revealed:
-Resident #3 was sent to the ER for aggressive behavior on 03/17/24 and admitted until behavior improved.

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 59	D 273		

-Resident #3's was discharged on 03/22/24 and diagnoses included severe malnutrition.

Review of Resident #3's primary care provider (PCP) visit note dated 03/26/24 revealed:
-Resident #3 was seen for hospital follow up.
-Resident #3 was hospitalized from 03/17/24-03/22/24 for aggressive behaviors and hitting other residents.
-Staff reported improved behavior but the resident was still easily agitated since return from the hospital.
-Staff denied any acute medical concerns.
-There was no notation of meal refusals or malnutrition.

Review of Resident #3's electronic progress notes dated 03/25/24, 03/26/24, 04/03/24, 04/04/24, 04/08/24, 04/09/24, 04/13/24, and 04/14/24 revealed:
-There was documentation that the resident refused breakfast.
-There was documentation Resident #3's RP and PCP were not notified.
-There was documentation no interventions were put in place.

Review of Resident #3's PCP visit notes dated 04/02/24 and 04/23/24 revealed:
-Resident #3 was seen on 04/02/24 for follow up after a fall and emergency room (ER) evaluation on 03/30/24.
-There was no notation of a referral for hospice services.
-Resident #3 was seen on 04/23/24 for follow up after a fall and ER evaluation on 04/19/24.
-There was documentation hospice was evaluating Resident #3 on 04/23/24 for services.

Review of Resident #3's hospice admission note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 273	Continued From page 60 dated 04/23/24 revealed: -Prior to admission at the facility 5 months ago (12/20/24) Resident #3 lived with a family member and was 100% independent with all activities of daily living (ADLs). -She was able to communicate effectively but was having increased confusion and agitation. -She was eating 75% of 3 adult meals daily prior to admission and was now eating 25%. -Resident #3 lost 15 pounds in 2 months and weighed 99 pounds at the time of the visit. Review of Resident #3's hospice nurse (HN) visit note dated 04/25/24 revealed: -Resident #3 cussed and kicked at staff with attempts to have her sit down in the day room or for meals. -Resident #3 was fed all meals and ate 100% but missed meals when she refused to sit down. -Resident #3 was able to feed herself finger foods. Review of Resident #3's electronic progress notes dated 04/28/24 revealed: -There was documentation that the resident refused breakfast and lunch. -There was documentation Resident #3's RP and PCP were not notified. -There was documentation no interventions were put in place. Review of Resident #3's electronic progress notes dated 05/01/24 revealed: -There was documentation that the resident refused breakfast and dinner. -There was documentation Resident #3's RP and PCP were not notified. -There was documentation no interventions were put in place.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 273	Continued From page 61	D 273		

Review of Resident #3's PCP visit note dated 05/07/24 revealed the resident weighed 97 pounds.

Observation on 05/14/24 at 1:45pm revealed:
-Two personal care aides (PCAs) walked with Resident #3 from the Special Care Unit (SCU) to the wheelchair accessible scale day room on the Assisted Living (AL) side.
-The scale was zeroed, and Resident #3 was assisted to stand on the scale.
-The scaled screen showed Resident #3's weight as 89.5 pounds when she stood unassisted.
-Resident #3 was approximately 5 feet and 4 inches tall.

Observation of the breakfast meal on 05/15/24 from 7:27am until 7:53am revealed:
-At 7:27am Resident #3 was served breakfast which included a bowl of grits, 4 ounce container of yogurt, pureed eggs and sausage, and orange juice.
-A PCA sat next to Resident #3 and assisted her with eating breakfast.
-Resident #3 ate 100% of the yogurt and sausage, 50% of the grits, none of the eggs, and drank all the orange juice.

Telephone interview with Resident #3's primary care provider (PCP) on 05/17/24 at 9:17am revealed:
-She normally ordered supplemental shakes for weight loss, poor appetite, or abnormal laboratory results.
-Resident #3 was experiencing a few pounds of weight loss at a time.
-Her visit notes for Resident #3 showed the resident weighed 111 pounds on 03/05/24, 108 pounds on 03/28/24, 107 pounds on 04/02/24, and 99 pounds on 04/28/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 273	Continued From page 62 -The 8-pound drop on 04/28/24 was significant, but Resident #3 was on hospice at that time. -She would not have ordered supplemental shakes for Resident #3 unless staff reported Resident #3 was not eating. -She did not have anything in her visit notes related to staff reporting Resident #3 refusing meals. -Staff did not tell her Resident #3 was refusing meals and weighed 89.5 pounds on 05/14/24. Interview with the Memory Care Manager (MCM) on 05/17/24 at 11:00am revealed: -Resident #3 was usually awake during the day and ate well. -Normally when she saw a resident had weight loss, she talked to the PCP about ordering supplemental shakes. -She did not know if she had talked to the PCP about supplemental shakes for Resident #3. -She did not know if Resident #3's meal refusals were reported to her PCP by her or one of the medication aides (MAs). -The PCP should have been notified and the notification documented in Resident #3's electronic progress notes. Interview with the Administrator on 05/17/24 at 11:51am revealed: -PCAs were responsible for reporting Resident #3 was not eating to the MA. -The MA was responsible to report not eating and weight changes to the MCM, and the MCM notified the PCP. -MAs and the MCM were responsible for documenting PCP notifications in the resident's electronic progress notes. -Resident #3 not eating, a request for supplement shakes and the diagnoses of severe malnutrition on her ER discharge instructions dated 03/22/24	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 273	Continued From page 63 should have been reported to the PCP and documented in the resident's electronic progress notes. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable. _____ The facility failed to notify the primary care provider (PCP) of critically low blood pressure results for Resident #8 who was recently hospitalized and the discharge diagnosis included syncope (sudden fainting), and Resident #3's meal refusals with significant weight loss prior to hospice admission. The facility's failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2024.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 280	Continued From page 64	D 280		

following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed at least quarterly for 3 of 5 sampled residents with LHPS tasks of inhalation medication by machine and oxygen administration and monitoring (Resident #1), with feeding techniques, enemas, suppositories, and vaginal douches, ambulation using assistive devices that requires physical assistance transferring semi ambulatory or non-ambulatory residents (Resident #4) and a change in condition of a diabetic resident with a wound to his left great toe which required dressing changes (Resident #5).

The findings are:

1. Review of Resident #4's current FL-2 dated 01/09/24 revealed:
-Diagnoses included dementia, essential hypertension, major depressive disorder, anxiety, muscle weakness, and mild cognitive impairment
-She was semi-ambulatory and a wanderer.
-She was constantly disoriented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 280	Continued From page 65 Review of Resident #4's Resident Register dated 07/31/17 revealed she was admitted on 07/31/17. Review of Resident #4 records revealed: -There was an LHPS dated 11/16/23 with observation at 2:30pm. -The LHPS was listed as a quarterly LHPS. -The personal care tasks were marked as feeding techniques, enemas, suppositories, and vaginal douches, emulation using assistive devices that requires physical assistance transferring semi ambulatory or non-ambulatory residents. -The completion date was 01/15/24 at 9:59pm. -There was an LHPS dated 02/15/24 with observation at 4:44pm. -The LHPS was listed as a quarterly LHPS. -The personal care tasks were marked as feeding techniques, enemas, suppositories, and vaginal douches, emulation using assistive devices that requires physical assistance transferring semi ambulatory or non-ambulatory residents. -The completion date was 05/14/24 at 12:06pm. -There was an LHPS dated 05/09/24 with observation at 2:00pm. -The LHPS was listed as a quarterly LHPS. -The personal care tasks were marked as feeding techniques, enemas, suppositories, and vaginal douches, emulation using assistive devices that requires physical assistance transferring semi ambulatory or non-ambulatory residents. -The completion date was 05/14/24 at 12:08pm. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. 2. Review of Resident #5's current FL-2 dated 03/20/24 revealed: -Diagnoses included hyperlipidemia, testicular	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 280	Continued From page 66	D 280		

hypofunction and abnormalities in gait and mobility.
-He was semi-ambulatory.
-He was constantly disoriented.

Review of Resident #5's Resident Register revealed an admission date of 02/23/24.

Review of Resident #5 progress notes dated 03/05/24 revealed:
-Resident #5 had a wound to his left great toe.
-The primary care provider was contacted, and antibiotic therapy was ordered.
-On 04/03/24, Resident #5 was ordered to be seen at the wound clinic

Review of Resident #5 records revealed:
-There were no Licensed Health Professional Support (LHPS) tasks review and evaluation completed for the resident when there was a change in condition on 03/05/24.
-There was an LHPS dated 04/18/24 with observation at 11:30am.
-The LHPS was listed as an updated LHPS.
-The personal care task was marked as clean dressing changes.
-The completion date was 05/14/24 at 1:04pm.

Interview with Resident #5 on 05/16/23 at 12:00pm revealed:
-He was a diabetic.
-He had a sore on his big toe and had been going to the wound clinic and nurses came to change his bandage.
-That was about a month ago, but it was gone now.

3. Review of Resident #1's current FL-2 dated 05/14/24 revealed:
-Diagnoses included chronic obstructive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 280	Continued From page 67	D 280		

pulmonary disease, malignant neoplasm right lung - upper lobe, pulmonary nodule, prediabetes, secondary malignant neoplasm of the brain, hyperlipidemia, and atherosclerosis arteries of both legs.
-He was ambulatory with a walker or wheelchair.
-He was on oxygen at 3 liters/minute via nasal cannula.

Review of Resident #1's Resident Register dated 09/14/20 revealed he was admitted on 09/14/20.

Review of Resident #1 records revealed:
-There was an LHPS dated 02/15/24 with observation at 11:00am.
-The LHPS was listed as a quarterly LHPS.
-The personal care tasks were marked as inhalation medication by machine and oxygen administration and monitoring.
-The completion date was 05/13/24 at 2:28pm.
-There was an LHPS dated 05/14/24 with observation at 1:10pm.
-The LHPS was listed as a quarterly LHPS.
-The personal care tasks were marked as inhalation medication by machine and oxygen administration and monitoring.
-The completion date was 05/14/24 at 1:42pm.

Interview with Resident #1 on 05/16/23 at 12:30pm revealed:
-He used a walker to help him walk.
-He used oxygen continuously and had breathing treatments three times a day.

Interview with the LHPS nurse on 05/16/24 at 4:40pm revealed:
-She came to the facility to perform the observations and record reviews of the residents who needed to have the LHPS form completed.
-She used the optional paper form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 280	Continued From page 68 (DHSR/AC4619) for the LHPS when she came to the facility to see the residents to do their LHPS evaluations. -When the facility began to move to computerized records, she continued to use the paper form and then would input the information into the computer system. -The observation date was the date she did the actual observation. -There were times it was difficult to complete the process in the computer due to lack of internet service at home. Interview with the Administrator on 05/17/24 at 4:05pm revealed: -The LHPS nurse did not report to her. -She reported to the Corporate Clinical Director. -She expected the LHPS for the residents who had tasks to be done and completed in a timely manner. -The LHPS being completed months after the observation was done was not acceptable.	D 280		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure water was	D 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 306	Continued From page 69	D 306		

served at breakfast and lunch for both Assisted Living (AL) and Special Care Unit (SCU) residents.

The findings are:

Review of the facility's menu dated for the week of 05/12/24 - 05/18/24 revealed at the bottom of the menu there was a notation that water was offered at each meal.

Observation during the breakfast meal on 05/15/24 from 7:27am until 8:45am revealed there was no water on the tables in the dining room or offered to residents during the breakfast meal for the first seating which included SCU residents (7:27am - 7:53am) and the second seating which included AL residents (8:05am - 8:45am).

Observation of lunch on 05/15/24 from 11:53am until 12:00pm revealed there was no water on the tables in the dining room or offered to residents in the SCU who were eating lunch in the dining room.

Interview with the dietary aide on 05/15/24 at 12:00pm revealed:
-She normally served water at meals when residents requested water.
-She served water during dinner but not usually during breakfast and lunch.
-When she served water, it was often left untouched on the table.

Interview with a personal care aide (PCA) assisting a resident with eating on 05/15/24 at 12:00pm revealed residents on the Special Care Unit (SCU) got water throughout the day so she did not request water when she assisted

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

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SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 306	Continued From page 70 residents with eating. Interview with a second PCA assisting a resident with eating on 05/15/24 at 12:00pm revealed she offered water when the resident finished drinking their tea. Interview with a medication aide (MA) on 05/15/24 at 12:00pm revealed: -Residents were supposed to have water at each meal: breakfast, lunch, and dinner. -Residents had water with snacks during the day. -She provided water when she administered medications. Interview with the Kitchen Manager on 05/17/24 at 1:30pm revealed: -The dietary aide was responsible for serving water with every meal. -The dietary aide on duty on 05/15/24 was experienced and knew she was supposed to serve water at every meal. -Not serving water for breakfast and lunch on 05/15/24 was a slip up by the dietary aide. -Normally he checked the dining room service to ensure water was served with meals, but he missed checking on 05/15/24. Interview with the Memory Care Manager (MCM) on 05/15/24 at 12:05pm revealed: -Water was supposed to be on the table for each resident at each meal. -The dietary aide was responsible for putting the water at each plate setting at every meal. -The Kitchen Manager was responsible for ensuring water was served to each resident at each meal. -She normally observed one meal a day when she was working. -She did not notice water was not served.	D 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 306	Continued From page 71 Interview with the Administrator on 05/15/24 at 12:08pm revealed: -Water should be on the table with every meal. -The dietary aide was responsible for serving water at each meal. -The Kitchen Manager was responsible for making sure water was served at each meal. -She observed a minimum of 3 random meals each week. -She did not notice water was not served.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure meal supplements were served as ordered for 2 of 2 sampled residents (#2 and #4). The findings are: Review of an undated handwritten list revealed there were 13 residents who had orders for meal supplements. 1. Review of Resident #2's current FL-2 dated 02/06/24 revealed: -Diagnoses included dementia with behavioral disturbance, type II diabetes mellitus, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and vitamin D deficiency.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 310	Continued From page 72 -There was an order for supplement shakes 3 times daily between meals. Review of Resident #2's March, April, and May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for supplement shakes (house stock*pharmacy could not provide) 3 times daily at 8:00am, 2:00pm and 8:00pm. -There was documentation supplement shakes were administered to Resident #2 at 8:00am, 2:00pm and 8:00pm from 03/01/24 through 05/13/24 except at 8:00am on 04/14/24 (refused) and 05/05/24 at 2:00pm (on hold). Observation during the Special Care Unit (SCU) breakfast meal on 05/15/24 from 7:27am until 7:53am revealed there were no supplement shakes served to residents. Observations of the SCU medication cart on 05/15/24 at 7:25am and 8:00am revealed there were no supplement shakes in the bowl of ice on the cart or on the cart. Observation on the SCU on 05/15/24 at 2:30pm revealed: -Snacks including water and oatmeal crème pies were served to residents in the day room. -There were no supplement drinks served. Telephone interview with Resident #2's primary care provider (PCP) on 05/17/24 at 9:17am revealed the original order for supplemental shakes for Resident #2 was from August 2023 and she could not remember the reason. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 310		

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 310	Continued From page 73 Refer to interview with the Kitchen Manager on 05/15/24 at 11:25am. Refer to review of the facility's food service order invoice dated 03/04/24. Refer to telephone interview with a representative of the facility's contracted food distributor on 05/16/24 at 1:46pm. Refer to interview with a medication aide (MA) on 05/16/24 at 2:30pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 05/17/24 at 9:17am. Refer to interview with the Memory Care Manager (MCM) on 05/17/24 at 11:00am . Refer to interview with the Administrator on 04/16/24 at 4:08pm. 2. Review of Resident #4's current FL-2 dated 01/09/42 revealed: -Diagnoses included dementia, vitamin B12 deficiency, anemia, muscle weakness, hypertension, encephalopathy, mild cognitive impairment, major depressive disorder, anxiety, and gait and coordination abnormalities. -There was an order for supplement shakes three times daily with meals. Observation during the Special Care Unit (SCU) breakfast meal on 05/15/24 from 7:27am until 7:53am revealed there were no supplement shakes served to Resident #4. Based on observations, interviews and record	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 310	Continued From page 74 reviews, it was determined Resident #4 was not interviewable. Refer to interview with the Kitchen Manager on 05/15/24 at 11:25am. Refer to review of the facility's food service order invoice dated 03/04/24. Refer to telephone interview with a representative of the facility's contracted food distributor on 05/16/24 at 1:46pm. Refer to interview with a medication aide (MA) on 05/16/24 at 2:30pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 05/17/24 at 9:17am. Refer to interview with the Memory Care Manager (MCM) on 05/17/24 at 11:00am. Refer to interview with the Administrator on 04/16/24 at 4:08pm. _____ Interview with the Kitchen Manager on 05/15/24 at 11:25am revealed: -There were no supplement shakes on hand in the kitchen. -Supplement shakes had been out of stock for approximately 2 weeks. -He was not able to order from the supplier due to the supplement shake being on back order. -There was no substation for the supplement shake. Review of the facility's food service order invoice dated 03/04/24 revealed: -One case of 75 - 4 ounce containers of	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 310	Continued From page 75	D 310		

chocolate supplement shake was delivered on 03/04/24.
-One case of 75 - 4 ounce containers of strawberry supplement shake was delivered on 03/04/24.

Telephone interview with a representative of the facility's contracted food distributor on 05/16/24 at 1:46pm revealed:
-One case of supplement shakes contained 75 - 4 ounce cartons.
-There were no supplement shakes on the facility's order invoices since 03/04/24.
-She did not have information on supplement shakes being out of stock.
-There were currently 180 cases of supplement shakes available.

Interview with a medication aide (MA) on 05/16/24 at 2:30pm revealed:
-The facility was out of supplement shakes for the past 2-4 weeks.
-She had been using protein shakes that belonged to 2 other residents.
-The protein shakes for those two residents came from the pharmacy for just those two residents.
-There were enough protein shakes to borrow for other residents who had orders for supplement shakes.

Telephone interview with the facility's contacted primary care provider (PCP) on 05/17/24 at 9:17am revealed:
-She monitored nutritional status by following the resident's weight and blood work including protein and albumin levels.
-She expected supplemental shakes to be administered as ordered.
-She normally ordered supplemental shakes for weight loss, poor appetite, or abnormal laboratory

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	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 310	Continued From page 76	D 310		

results.
-She expected staff to contact her if the facility was unable to stock supplemental shakes.

Interview with the Memory Care Manager (MCM) on 05/17/24 at 11:00am revealed:
-No one told her the supplemental shakes were out of stock.
-The MAs should have notified her, and the Kitchen Manager and the Kitchen Manager should have notified the Administrator.

Interview with the Administrator on 04/16/24 at 4:08pm revealed:
-The food service order invoice was the last invoice with an order for supplement shakes.
-She borrowed supplement shakes from a sister facility in another county.
-The supplement shakes were transported in the facility's transport van.
-There was no record of the supplement shakes borrowed.
-She knew how much was borrowed and needed to be returned to the sister facility.
-The facility borrowed 2 cases per week.
-Staff should have known about and had access to the borrowed supplement shakes from the sister facility.
-Staff also borrowed protein shakes from other residents.
-MAs were responsible for notifying the MCM or Resident Care Coordinator (RCC) if there were no supplement shakes available on hand to administer.
-The MCM/RCC were responsible for notifying her.
-No one notified her until now that there was a problem with ordering supplement shakes since the last order on 03/04/24.
-She thought supplement shakes were in stock

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 310	Continued From page 77 and available for administration.	D 310		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#8) observed during the medication pass including an error with a medication used to treat high blood pressure, heart associated chest pain, and prevent heart attack or heart damage after a heart attack and for 2 of 5 sampled residents (#2 and #4) related to administering insulin when it was supposed to be held for blood glucose less than 150 (#2) and an antidepressant (#4). The findings are: Review of the facility's Medication Administration Training Course for Adult Care Homes dated March 2021 revealed: -The medication aid must always refer to the Medication Administration Record (MAR) when giving medications. -Never give medications from memory.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 78	D 358		

-Three medication checks should always be done when giving medications to make sure the medication aide has the right medication.
-During the three medication checks, the medication aide will not only make sure a particular medication is labeled for a particular resident, but during the process medication aide also makes sure that the medication name, dose, time, and route on the medication label matches information on the MAR.
-Check (One) the medication name, dose, time, and route on the package against the MAR when container is removed from the shelf, drawer, or other storage place, check (two) medication name, dose, time, route on the actual drug package or unit dose label against the MAR. As the medication is poured, package is open or before the medication is placed in the medicine cup, check (three) the medication name, dose, time, and route on the package when the medication container is returned to the shelf drawer storage place or before it is opened and placed in the medicine cup just prior to giving the medication to the resident.

Review of the facility's New Order Process (not dated) revealed:
-All orders received are processed according to the Company's policies and procedures; an order should never be filed in a Resident's chart until the Care Manager has reviewed it.
-Electronic Medication Administration Record (eMAR): Order Implementation System process #
-1. All orders are reviewed by the Resident Care Coordinator or designee.
-2. Orders must be complete. If incomplete, call contact the prescriber immediately for clarification.
-3. The Resident Care Coordinator will (Medication Aide if after hours/weekends) fax the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 79	D 358		

order to the pharmacy and scan the order into the electronic scan (EHR scan).
-4. The Resident Care Manager or designee will wait for the order to be placed in the electronic medication system for approval and then approve the order for administration and follow the steps of the Order Process System.
-5. Medication aides will review the Facility Activity Report at the beginning of each shift for order changes when a new order, or change order is received.
-6. Whenever there is a medication change, the Resident Care Coordinator/ designee discusses the change with the Resident and responsible party or guardian as appropriate and documents.
-Note: The Resident Care Coordinator/designee will follow up timely to receive any necessary clarifications for Physician's Orders.

1. The medication error rate was 4% as evidenced by 1 errors out of 25 opportunities during the 8:00am and 9:00am medication passes on 05/15/24.

Review of Resident #8's current FL-2 dated 03/19/24 revealed:
-Diagnoses included essential hypertension, chronic atrial fibrillation, syncope and collapse, and dementia.
-She was intermittently disoriented.
-There was an order for atenolol 25mg give ½ tab (12.5mg) to be administered each day. (Atenolol is a medication used to treat high blood pressure, heart associated chest pain, and prevent heart attack or heart damage after a heart attack.)

Observation of the 8:00am medication pass on 05/15/24 revealed:
-The medication aide (MA) removed the multidose medication pack from the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 80	D 358		

cart for Resident #8.
-The MA compared each of the oral medications in the multidose pack to the medications listed on the electronic medication administration record (eMAR) on the computer.
-The MA noted that the atenolol 25mg (a medication used to treat high blood pressure, heart associated chest pain, and prevent heart attack or heart damage after a heart attack) (1/2 tab) that was in the multidose pack was not listed on the eMAR to be given.
-The MA removed the paper label from the multidose pack and compared each medication to the pictures of each medication until she located the atenolol 25mg (1/2 tablet) and removed it from the plastic multidose pack with a plastic spoon and discarded it.
-The MA proceeded to administer the remaining oral medication to Resident #8 at 7:52am.

Review of primary care provider (PCP) notes dated 03/12/24 revealed:
-Resident #8 was being seen for a follow up from a hospitalization 03/02/24 - 03/05/24 for syncope (temporary loss of consciousness caused by a drop in blood pressure).
-The facility had sent Resident #8 out to the local emergency department for evaluation on 03/02/24 for multiple behavioral outbursts followed by a 5-minute syncopal episode (also known as fainting).
-The discharge summary reviewed by the PCP on 03/05/24 revealed that Resident #8 had alternating episodes of tachycardia (heart rhythm disorder with heartbeats faster than usual, greater than 100 beats per minute) and bradycardia (heart rate slower than 60 beats per minute) while in the hospital and the cardiologist ordered the atenolol to be decreased to 12.5mg.
-The PCP ordered the following on 03/12/24 visit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 81	D 358		

to discontinue atenolol 25mg daily and a new prescription for atenolol 12.5mg daily e-prescribed per Resident #8's discharge summary narrative.

Review of Resident #8's PCP typed written orders dated 05/17/24 and electronically signed by the PCP at 10:54am revealed:
-The encounter type was documented as a communication note.
-The charting notes documented the PCP had been notified by the facility's staff that Resident #8 had not been receiving the ordered atenolol 12.5mg daily since it was written in mid-March.
-The staff requested a clarification order "for compliance" to state discontinuance and restart of the medication.
-Multiple requests had led to confusion.
-New orders for Resident #8 were to discontinue ALL previous atenolol orders.
-Start atenolol 12.5mg daily (first dose given 05/16/24).
-To follow up with the PCP at next facility visit.

Review of Resident #8's electronic medication administration record (eMAR) for May 2024 revealed there was no entry for atenolol 25mg (1/2 tablet=12.5mg) to be administered each day.

Observation of Resident #8's medications on hand on 05/16/24 at 2:20pm revealed:
-The multidose pack of medication included atenolol 25mg ½ tablet with a red line drawn through it and D/C written beside the red line.
-The labeled date to be given was Friday morning 05/17/24.
-The multidose packs for the following week of 05/18/24- 05/24/24 all contained the atenolol 25mg ½ tablet.
-There was no handwritten documentation on any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 82 of those multidose packs for the week of 05/18/24- 05/24/24. Telephone interview with the pharmacist at the facility's contracted pharmacy on 05/15/24 at 10:03am revealed: -Resident #8's atenolol 25mg give ½ tab (12.5mg) once a day was not an active order in the eMAR computer system that the facility used. -The pharmacy's order system was a different system than the eMAR that the facility used. -The pharmacy could access the eMAR system the facility used. -The atenolol 12.5mg order was active in the pharmacy's system. -The reason it was not showing to be administered in the facility eMAR system was the facility had to go into their eMAR system to review and approve the atenolol order before it would show up in the facility's system for administration. -The pharmacy had been dispensing the atenolol in the weekly batches since they received the order on 03/12/24. Telephone interview with Resident #8's primary care provider (PCP) on 05/17/24 at 9:58am revealed: -The Memory Care Manager (MCM) had contacted her via email on 05/15/24 requesting clarification for the atenolol order. -She was informed that there were medication errors with the atenolol. -She had been told that the facility was unsure if the atenolol had been given as ordered since it was in a multidose pack or if it had been being held since the order was not in the computer system. Interview with a medication aide (MA) on 05/15/24 at 10:30am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 83 -She was supposed to do three checks when preparing the residents' medications. -She compared what was in the multidose pack or the bubble packs with what "popped" up at 8:00am medication pass on the computer screen to administer. -It was hard with the multidose packs because you had to look and compare the pictures to the medications to make sure you removed the right one. -She could not see any orders until the pharmacy put them into the system and the MCM or Resident Care Coordinator (RCC) went into the computer and approved them. -The MAs could not approve the orders only the MCM and RCC and maybe the Administrator could do the approvals. Second interview with the MA on 05/17/24 at 8:55am revealed: -She had been off on Tuesday (05/14/24) so during the observation of the medication pass on Wednesday (05/15/24) the atenolol was not on the computer screen for her to give so she took it out of the pack and did not administer it. -She did not recall having to remove the atenolol before Wednesday. -She did not work on Thursday (05/16/24) but when she came in today (05/17/24), the atenolol came up on the screen to give but the atenolol on the label of the multidose pack had been crossed out in red with "D/C" written beside it. -Since the atenolol was now an active order in the eMAR, she did not remove it from the pack and administered it along with the other medications in the multidose pack for 8:00am. Interview with a second MA on 05/15/24 at 2:20pm revealed: -The facility's contracted pharmacy provided most	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 84	D 358		

of the medications for most of the residents in the facility.
-They provided multidose packages of a weekly amount of medications for their residents.
-If a medication was discontinued in the middle of the multidose cycle, the MAs would draw a line through the discontinued medication and write D/C beside it.
-When the pharmacy filled the next week's cycle of medications, they would not include the medication that was D/Ced in that week's pack.
-If the MAs saw the lined-out medication and the D/C written on the pack, they would look for that medication in the pack and remove and dispose of it.
-She had just been told by the MCM today (05/16/24) "just a little bit ago" that the atenolol had been D/Ced.
-She had given the atenolol during the 8:00am medication pass this morning (05/16/24); she did not recall if the atenolol was on the eMAR to give or not, but it was in the multidose pack.
-She was checking in all the medications received from the pharmacy.
-She located Resident #8's medication multidose packs.
-The multidose packs still contained atenolol.
-She had to line out the atenolol and write D/C beside it since it was discontinued.

Telephone interview with the PCP's office staff on 05/17/24 at 10:07am revealed she had received an email from the facility and received the order from the PCP to use her signature stamp to approve the order to D/C the atenolol on 05/15/24.

Interview with the MCM on 05/17/24 at 10:15am revealed:
-She had been looking at orders on 05/14/24 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 85 randomly chose Resident #8's medications to review. -She had contacted the PCP on 05/15/24; she emailed the PCP about the atenolol order. -The PCP ordered the atenolol to be discontinued and for Resident #8 to be seen on the next PCP visit. -MAs were supposed to report any medication that was in the multidose pack but not in the eMAR system. -The MA had told her on Tuesday, 05/14/24 after the medication pass (medication pass was observed on 05/15/24) that the atenolol was in the package but not in the eMAR system. -She may have her dates mixed up. -The PCP came on Tuesdays, so it was Wednesday when she emailed the PCP about the atenolol order and error that the MA had not administered it during the medication pass that morning (05/15/24). -The PCP ordered the atenolol to be discontinued and for Resident #8 to be seen on the next PCP visit. -When the PCP electronically prescribed (escribed) a medication, it went directly to the pharmacy and the pharmacy put the order into the eMAR system. -The MCM, RCC, or Administrator had to review the order and then approve it before it showed up in the eMAR system for the MAs to administer it at the appropriate time. -The medication error report was completed on 05/15/24 at 11:55am and sent to the PCP at 12:30pm, along with a D/C order for the atenolol 12.5mg. Review of the printed copy of the email that was sent to the PCP revealed: -It was dated 05/15/24 at 12:56pm -It included attachments for Resident #8.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 86 -There was an attachment of a medication error report, Resident #8's vital signs, and the D/C order for the atenolol. -It did not include the order to restart medication in 24 hour as provided by the MCM. Review of the medication error report emailed from the MCM to the PCP dated 05/15/24 at 12:56pm revealed: -The medication error report was for Resident #8 with the date of the event was 05/15/24 at 11:56am and completed date of 05/15/24 at 12:26pm. -The medication error report documented the date of discovery was 05/14/24 at 5:00pm. -The dates of error listed all the dates 03/14/24 -05/14/24. -The number of errors was documented as 61 days. -The medication was documented as atenolol 12.5mg daily. -The medication error description was documented as incorrect order entry. -The reason for making the error was documented as the order had an end date and it was supposed to be a continuous medication. -The person listed as who discovered the error and who contacted the PCP was the MCM. -The date/time of the discovery of the medication error was documented as 05/14/24 at 4:49pm. -The date/time the PCP was contacted was documented as 05/14/24 at 4:24pm. -The order given by the PCP for resident care was to discontinue the Atenolol. -The precautions to be taken in the future to prevent similar errors were documented to have the order in hand before verification. -The first page of the medication error form had a signature stamp and was dated 05/15/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 87	D 358		

Interview with the Administrator on 05/17/24 at 4:05pm revealed:
-The Memory Care Manager (MCM) or the Resident Care Coordinator or the Administrator could approve the medication orders that the pharmacy put into the electronic Medication Administrator Record (eMAR).
-The MAs were expected to administer medications as ordered.
-The MAs were supposed to report any medication discrepancies to the MCM or the RCC.
-The MCM or RCC were responsible to notify the PCP immediately of any medication discrepancies and errors.
-The MCM and RCC were expected to review the medication orders and approve them as soon as they were received to ensure medications were administered as ordered by the PCP.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

2. Review of Resident #4's current FL-2 dated 01/09/24 revealed:
-Diagnoses included dementia, essential hypertension, major depressive disorder, anxiety, muscle weakness, and mild cognitive impairment
-She was semi-ambulatory and a wanderer.
-She was constantly disoriented.
-There was an order for trazodone 50mg (used to treat depression and sleep disorders like insomnia) at bedtime.

Review of Resident #4's mental health care provider (MHCP) visit dated 03/21/24 revealed:
-There was a printed electronic order to discontinue the current trazodone order.
-There was a printed electronic order to begin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 88	D 358		

trazodone 100mg 1 tablet at bedtime.

Review of Resident #4's MHCP order dated 04/12/24 revealed:
-There was a printed electronic order to discontinue the current trazodone 100mg order due to daytime sedation.
-There was a printed electronic order to begin trazodone 50mg 1 tablet at bedtime.

Observation of Resident #4's medications on hand on 05/16/24 at 11:51am revealed:
-There was a multidose package dated 05/08/24 which contained the morning medications for 05/17/24 and the bedtime medications for 05/16/24 and 05/17/24.
-The bedtime multidose packages dated 05/16/24 and 05/17/24 contained trazodone 1-50mg tablet and 1-100mg tablet for a total of 150mg.

Review of Resident #4's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for trazodone 50mg take 1 tablet at bedtime.
-There was documentation that trazodone 50mg was administered from 03/01/24 - 03/22/24 at 8:00pm.
-There was an entry for trazodone 100mg take 1 tablet at bedtime.
-There was documentation that trazodone 100mg was administered from 03/22/24-03/31/24 at 8:00pm.

Review of Resident #4's April 2024 eMAR revealed:
-There was an entry for trazodone 100mg take 1 tablet at bedtime.
-There was documentation that trazodone 100mg was administered from 04/01/24 - 04/30/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 89	D 358		

8:00pm.
-There was an entry for trazodone 50mg take 1 tablet at bedtime.
-There was documentation that trazodone 50mg was administered from 04/13/24-04/30/24 at 8:00pm.

Review of Resident #4's May 2024 eMAR revealed:
-There was an entry for trazodone 100mg take 1 tablet at bedtime.
-There was documentation that trazodone 100mg was administered from 05/01/24 - 05/13/24 at 8:00pm.
-There was an entry for trazodone 50mg take 1 tablet at bedtime.
-There was documentation that trazodone 50mg was administered from 05/01/24 - 05/13/24 at 8:00pm.

Interview with the medication aide (MA) on 05/15/24 at 2:20pm revealed:
-She had seen Resident #4 sleeping during the day a month or so ago.
-She did not work third shift and did not know about Resident #4's medication that was administered at bedtime.
-The facility's contracted pharmacy provided most of the medications for most of the residents in the facility.
-They provided multidose packages of a weekly amount of medications for their residents.
-If a medication was discontinued in the middle of the multidose cycle, the MAs would draw a line through the discontinued medication and write D/C beside it.
-When the pharmacy filled the next week's cycle of medications, they would not include the medication that was D/Ced in that week's pack.
-If the MAs saw the lined-out medication and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 90 D/C written on the pack, they would look for that medication in the pack and remove and dispose of it. Interview with the Memory Care Manager (MCM) on 05/17/24 at 10:15am revealed: -She was not aware of Resident #4's trazodone orders without reviewing them. -When the PCP electronically prescribed (escribed) a medication, it went directly to the pharmacy and the pharmacy put the order into the eMAR system. -The MCM, Resident Care Coordinator (RCC), or Administrator had to review the order and then approve it before it showed up in the eMAR system for the MAs to administer it at the appropriate time. Interview with the Administrator on 05/17/24 at 4:05pm revealed: -The MCM or the RCC or the Administrator could approve the medication orders that the pharmacy put into the electronic Medication Administrator Record (eMAR). -The MAs were expected to administer medications as ordered and follow the facility's policies on medication administration. -The MCM and RCC were expected to review the medication orders and approve them as soon as they were received to ensure medications were administered as ordered by the PCP. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/24 at 3:40pm revealed: -The pharmacy had received Resident #4's trazodone order for 100mg at bedtime on 04/12/24 but did not receive any order to discontinue the 50mg of trazodone. -The pharmacy continued to package both the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 91	D 358		

100mg and 50mg of trazodone in the bedtime multidose packs for Resident #4 since they had not received any order to discontinue either.

Telephone interview with Resident #4 's MHCP on 05/17/24 at 12:36pm revealed:
-The facility staff had told her on the 03/21/24 visit that Resident #4 was not sleeping well.
-She discontinued the current trazodone 50mg at bedtime order.
-She ordered to start trazodone 100mg at bedtime.
-When she saw Resident #4 on 04/12/24, the staff had told her that Resident #4 was sleeping during the day.
-She discontinued the current trazodone 100mg at bedtime order.
-She ordered trazodone 50mg at bedtime.
-She had not been made aware that Resident #4 had been receiving 150mg of trazodone at bedtime since 04/13/24.
-Her main concern was the possible gastrointestinal (GI) upset the trazodone could cause at the 150mg dosage.
-She had seen Resident #4 on 05/03/24 and the facility staff had not voiced any concerns with Resident #4 sleeping during the day or any GI upset.
-She expected the orders to be followed as she had given them.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

3. Review of Resident #2's current FL-2 dated 02/06/24 revealed diagnoses included dementia with behavioral disturbance, type II diabetes mellitus, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, and vitamin D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 92 deficiency. a. Review of Resident #2's current FL-2 dated 02/06/24 revealed: -There was an order to check finger stick blood sugar (FSBS) levels 3 times daily before meals. -There was an order for Fiasp insulin 4 units 3 times daily after meals; hold if FSBS less than 150. (Fiasp is a rapid-acting insulin used to control blood sugar levels.) Review of Resident #2's primary care provider (PCP) order dated 04/04/24 revealed: -There was a printed electronic order for Novolog insulin 4 units 3 times daily with meals. (Novolog is a rapid-acting insulin used to control blood sugars.) -At the bottom of the page there was documentation of a verbal order dated 04/23/24 to hold (Novolog) if FSBS was less than 150. -The PCP signed the bottom of the page dated 05/01/24. Upon request on 05/14/24, Resident #2's order to discontinue Fiasp insulin on 04/04/24, was not provided for review. Observation of Resident #2's medications on hand on 05/15/24 at 2:16pm revealed: -There was a Fiasp insulin pen inside a plastic box with Resident #2's name on it which also contained FSBS check supplies. -The Fiasp insulin pen had a pharmacy sticker with Resident #2's name and instructions for 4 units 3 times daily after meals; hold if FSBS less than 150. -The pharmacy sticker indicated the Fiasp insulin pen was dispensed on 02/17/24. -There was a second sticker that indicated the Fiasp insulin pen was opened on 04/15/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 93 -The medication aide (MA) removed 2 plastic bags from the medication refrigerator in the medication room. -There was a Novolog insulin pen inside one plastic bag that had a pharmacy label with Resident #2's name. -The pharmacy label had instructions for 4 units 3 times daily with meals and indicated the Novolog pen for Resident #2 was dispensed on 04/04/24. -There was a second plastic bag that had a pharmacy label with Resident #2's name and a Novolog insulin pen inside the bag. -The pharmacy label had instructions for 4 units 3 times daily with meals; hold if FSBS was less than 150 and indicated the Novolog pen for Resident #2 was dispensed on 04/26/24. -Neither of the Novolog insulin pens appeared as if they had been opened. Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks 3 times daily before meals at 7:00am, 12:00pm and 5:00pm. -There were 93 FSBS results documented ranging from 83 to 283 with 89 FSBS results less than 150 and 4 FSBS results 150 or greater. -There was an entry for Fiasp insulin 4 units 3 times daily after meals at 8:00am, 2:00pm and 8:00pm; hold if FSBS less than 150. -There was documentation that 65 doses of Fiasp insulin were administered with 61 doses administered when the FSBS was less than 150. -For example: on 03/07/24 at 8:00pm the FSBS was 90 and Fiasp was documented as administered, on 03/08/24 at 7:00am the FSBS was 96 and Fiasp was documented as administered, on 03/12/24 at 12:00pm the FSBS was 90 and Fiasp was documented as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 94	D 358		

administered, on 03/12/24 at 5:00pm the FSBS was 93 and Fiasp was documented as administered, on 03/19/24 at 8:00pm the FSBS was 92 and Fiasp was documented as administered, on 03/20/24 at 7:00am the FSBS was 99 and Fiasp was documented as administered, on 03/20/24 at 12:00pm the FSBS was 99 and Fiasp was documented as administered, and on 03/30/24 at 8:00pm the FSBS was 90 and Fiasp was documented as administered.

Review of Resident #2's April 2024 eMAR revealed:
-There was an entry for FSBS checks 3 times daily before meals at 7:00am, 12:00pm and 5:00pm.
-There were 90 FSBS results documented ranging from 88 to 246 with 74 FSBS results less than 150 and 16 FSBS results 150 or greater.
-There was an entry for Fiasp insulin 4 units 3 times daily after meals at 8:00am, 2:00pm and 8:00pm; hold if FSBS less than 150 with an end date of 04/04/24.
-There was documentation that 8 doses of Fiasp insulin were administered with 5 doses administered when the FSBS was less than 150 and 1 dose Fiasp held when the FSBS was 154 at 12:00pm on 04/02/24.
-Fiasp insulin was administered on 04/01/24 when the FSBS was 93 at 5:00pm, 04/03/24 when the FSBS was 126 at 7:00am, 109 at 12:00pm, and 117 at 5:00pm, and when the FSBS was 115 on 04/04/24 at 7:00am.
-There was a second entry for Fiasp insulin 4 units 3 times daily after meals at 8:00am, 2:00pm and 8:00pm; hold if FSBS less than 150 with a start date of 04/04/24 and end date of 04/05/24.
-There was documentation that 4 doses of Fiasp insulin were administered with 2 doses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 95 administered when the FSBS was less than 150: on 04/05/24 at 7:00am FSBS was 115 and on 04/05/24 at 5:00pm FSBS was 148. -There was a third entry for Fiasp insulin 4 units 3 times daily after meals at 8:00am, 2:00pm and 8:00pm; hold if FSBS less than 150 with a start date of 04/19/24 and end date of 04/23/24. -There was documentation that 8 doses of Fiasp insulin were administered with 6 doses administered when the FSBS was less than 150. -There was an entry for Novolog insulin 4 units 3 times daily with meals at 8:00am, 12:00pm and 5:00pm and a start date of 04/05/24 and end date of 04/23/24. -There was documentation that 5 doses of Novolog insulin were not administered because Resident #2's FSBS was less than 150: 8:00am on 04/20/24 FSBS was 122, 12:00pm on 04/20/24 FSBS was 110, 5:00pm on 04/20/24 FSBS was 118, 8:00am on 04/21/24 FSBS was 120, and 5:00pm on 04/21/24 FSBS was 99. -There was documentation both Novolog and Fiasp insulin were administered at 12:00pm on 04/05/24 (FSBS 150), 5:00pm on 04/05/24 (FSBS 148), 5:00pm on 04/19/24 (FSBS 131), 8:00am on 04/22/24 (FSBS 119), 12:00pm on 04/22/24 (FSBS 163), 5:00pm on 04/22/24 (FSBS 122), and 8:00am on 04/23/24 (FSBS 95). -There was documentation only Fiasp insulin was administered on 04/19/24 at 12:00pm (FSBS 132) and on 04/20/24 at 8:00pm (FSBS 118). Interview with a medication aide (MA) on 05/16/24 at 2:30pm revealed: -Resident #2's insulin was administered when his FSBS was more than 150 and not given when the FSBS was less than 150. -She administered Novolog insulin 3 times daily with the entry on the eMAR that did not have the order to hold NovoLog insulin.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 96	D 358		

-Novolog insulin was administered with FSBS results less than 150 because there was no order to hold.
-She documented administering the Fiasp insulin administration on 04/05/24 at 8:00am.
-Resident #2's FSBS was 115 and according to that entry the Fiasp insulin should not have been administered.
-She did not know what happened with her documentation for 2 insulin order entries on the eMAR on 04/05/24.

Interview with a second MA on 05/15/24 at 2:24pm revealed:
-Resident #2's insulin documentation was confusing because there was an order entry that showed on the eMAR that did not include the order to hold for FSBS results less than 150.
-She reported the order entry to the Memory Care Manager (MCM) the same day she noticed the order entry.
-She did not remember exactly when that was.
-The MCM contacted the resident's PCP and got the order changed.
-She documented the entry for Fiasp insulin administration on 04/12/24 at 8:00am.
-The documentation showed the insulin not given by the note "BS under 150" even though her initials did not have parentheses indicating the dose was not administered.

Interview with the MCM on 05/15/24 at 12:28pm revealed:
-There was a reorder issue with Resident #2's insulin and the pharmacy requested an order change.
-The order obtained by the pharmacy did not include the parameter to hold for FSBS results less than 150.
-She contacted Resident #2's PCP and clarified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 97 the order (04/23/24). -Each order change on Resident #2's April 2024 eMAR resulted in different order entries on the eMAR for insulin. Second interview with the MCM on 05/15/24 at 2:50pm revealed: -She investigated the insulin entries on Resident #2's eMAR for April 2024. -There was no comment box on the entry dated from 04/01/24 to 04/04/24 which made it so staff were not able to document the insulin was not administered for FSBS results less than 150. -The eMAR documentation showed insulin was administered on 04/03/24 at 8:00am when the FSBS result was documented as 126. -She did not know there were overlapping administration documentation for Fiasp and Novolog on 04/05/24 and 04/19/24 - 04/23/24 or how it happened. Second interview with a MA on 05/15/24 at 2:50pm revealed: -Resident #2's eMAR showed 2 order entries simultaneously from 04/05/24 to 04/23/24. -That was how she noticed the different orders. -No matter what was documented on the eMAR, she knew she did not administer insulin to Resident #2 when his FSBS was less than 150. -She could not say for sure if she did or did not administer Novolog or Fiasp insulin when there was no order to hold for FSBS results less than 150. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/24 at 3:34pm revealed: -The pharmacy requested an order change for Resident #2's Fiasp insulin because the Fiasp was on back order on 04/04/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 98	D 358		

-The pharmacy received Resident #2's new order on 04/04/24 for Novolog 4 units 3 times daily with meals.
-Resident #2's order for Novolog insulin dated 04/04/24 did not have a hold order.
-The pharmacy did not have an order to hold Novolog if Resident #2's FSBS result was less than 150.

Telephone interview with Resident #2's primary care provider (PCP) on 05/17/24 at 9:17am revealed:
-She expected staff to administer insulin as ordered and to be notified if an error occurred.
-Staff should not rely on their own judgment of what to do when medication errors occurred.
-She was not notified of insulin errors for Resident #2 when the errors occurred.

Interview with the Administrator on 05/16/24 at 4:08pm revealed:
-She did not know the details of what happened with insulin orders and eMAR entries for Resident #2's insulin.
-Any discrepancies on the eMAR with order entries should have been caught with medication cart audits.
-MAs and the MCM were responsible for completing weekly medication cart audits.
-Medication cart audits included review of the physician's orders, eMAR and medications on the medication cart.
-She reviewed completed medication cart audit forms weekly.
-She reviewed a medication cart audit form last week and did not have any concerns.

b. Review of Resident #2's current FL-2 dated 02/06/24 revealed an order for fluticasone 50mcg 2 sprays in each nostril daily. (Fluticasone is used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 99 to treat nasal allergy symptoms.) Observation of Resident #2's medications on hand on 05/15/24 at 2:16pm revealed: -There was a manufacturer's box of fluticasone with a pharmacy label that had Resident #2's name and instructions for 2 sprays in each nostril daily. -The pharmacy label indicated one bottle containing 120 doses was dispensed on 12/21/23. -The bottle of fluticasone inside the box was approximately half full. -There was a second manufacturer's box of fluticasone with a pharmacy label that had Resident #2's name and instructions for 2 sprays in each nostril daily. -The pharmacy label indicated one bottle was dispensed on 12/21/23. -The bottle of fluticasone inside the box was full. Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50mcg 2 sprays in each nostril daily at 8:00am. -There was documentation fluticasone was administered daily from 03/01/24 through 03/31/24. Review of Resident #2's April 2024 eMAR revealed: -There was an entry for fluticasone 50mcg 2 sprays in each nostril daily at 8:00am. -There was documentation fluticasone was administered daily from 04/01/24 through 04/30/24. Review of Resident #2's May 2024 eMAR revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

(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 358	Continued From page 100	D 358		

-There was an entry for fluticasone 50mcg 2 sprays in each nostril daily at 8:00am.
-There was documentation fluticasone was administered daily from 05/01/24 through 05/14/24.

Interview with a medication aide (MA) on 05/15/24 at 2:16pm revealed:
-MAs had to request fluticasone refills from the pharmacy because it was not automatically sent with cycle fills.
-She reordered Resident #2's fluticasone each time she switched out medications in the medication cart.
-She did not know how long one bottle of fluticasone lasted and why there were 2 bottles in the medication cart for Resident #2.
-The fluticasone dispensed on 12/21/23 should have been discarded a long time ago.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/24 at 3:34pm revealed:
-The pharmacy had an order for fluticasone 50mcg 2 sprays in each nostril daily dated 07/11/23 for Resident #2.
-The pharmacy dispensed 1 bottle of fluticasone for Resident #2 on 01/22/24, 03/08/24 and 04/17/24.
-Fluticasone was not on automatic monthly cycle fills and refills needed to be requested.
-There were 120 sprays in each bottle of fluticasone which was a 30 day supply for Resident #2 using 4 sprays daily.

Telephone interview with Resident #2's primary care provider (PCP) on 05/17/24 at 9:17am revealed:
-A bottle of fluticasone on hand from December 2023 sounded like the resident was not getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 101	D 358		

the fluticasone.
-Resident #2 could have refused fluticasone.
-She would not know of any difficulty administering or refusals of a medication if it was not documented on the eMAR.

c. Review of Resident #2's current FL-2 dated 02/06/24 revealed an order for Breo Ellipta 100/25mcg inhale 1 puff daily. (Breo Ellipta is used to treat symptoms of chronic obstructive pulmonary disease.)

Observation of Resident #2's medications on hand on 05/15/24 at 2:16pm revealed:
-There was a manufacturer's box of Breo Ellipta with a pharmacy label that had Resident #2's name and instructions to inhale 1 puff daily.
-The pharmacy label indicated the Breo Ellipta inhaler was dispensed on 04/04/24.
-There was a sticker on the Breo Ellipta box that indicated the box was opened on 04/13/24.
-The manufacturer's box indicated there were 30 doses in the Breo Ellipta inhaler.
-The Ellipta inhaler inside the box had a meter counter on the front of the inhaler that showed "9".
-There was a second unopened manufacturer's box of Breo Ellipta with a pharmacy label that had Resident #2's name and instructions to inhale 1 puff daily.
-The pharmacy label indicated the Breo Ellipta inhaler was dispensed on 05/09/24.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Breo Ellipta 100/25mcg inhale 1 puff daily at 8:00am.
-There was documentation Breo Ellipta was administered daily from 03/01/24 through

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 102 03/31/24. Review of Resident #2's April 2024 eMAR revealed: -There was an entry for Breo Ellipta 100/25mcg inhale 1 puff daily at 8:00am. -There was documentation Breo Ellipta was administered daily from 04/01/24 through 04/30/24 except 04/14/24 (refused) and 04/29/24 (held due to blood sugar under 150). Review of Resident #2's May 2024 eMAR revealed: -There was an entry for Breo Ellipta 100/25mcg inhale 1 puff daily at 8:00am. -There was documentation Breo Ellipta was administered daily from 05/01/24 through 05/14/24. Interview with a medication aide (MA) on 05/15/24 at 2:16pm revealed: -MAs had to request Breo Ellipta refills from the pharmacy because it was not automatically sent with cycle fills. -She reordered Resident #2's Breo Ellipta each time she switched out medications in the medication cart. -She did not know how long the Breo Ellipta inhaler lasted and why there were 9 doses remaining on the inhaler opened on 04/13/24. -The Breo Ellipta inhaler dispensed on 04/04/24 should have been discarded when the inhaler dispensed on 05/09/24 was put in the medication cart. -It was part of the process to discard remaining medications when medications were loaded on the medication cart each month. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/24 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN LAKES ASSISTED LIVING	292 MCDOUGALL DRIVE WEST END, NC 27376

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D 358	Continued From page 103 3:34pm revealed: -The pharmacy had an order for Breo Ellipta 100/25mcg 1 puff daily dated 07/11/23 for Resident #2. -The pharmacy dispensed Breo Ellipta inhaler for Resident #2 on 03/08/24, 04/04/24 and 05/09/24. -Breo Ellipta was not on automatic monthly cycle fills and refills needed to be requested. -There were 30 puffs in each Breo Ellipta inhaler which was a 30-day supply for Resident #2 with 1 puff daily ordered. -If the meter on the Breo Ellipta inhaler showed 9, there were 9 puffs remaining in the inhaler. Telephone interview with Resident #3's primary care provider (PCP) on 05/17/24 at 9:17am revealed: -Breo Ellipta was ordered to control Resident #2's chronic obstructive pulmonary disease. -She expected staff to document if medications were not administered and the reason. -Communication from staff was important so she would know how to tailor the resident's treatment plan. Interview with the Administrator on 05/16/24 at 4:08pm revealed: -Excess amounts of nasal sprays and inhalers should have been caught with medication cart audits. -She had seen MAs remove excess and expired medications from the medication carts during weekly cart audits and did not understand how Resident #2's nasal spray and inhaler were missed. -MAs were responsible for administering medications to the right resident, right medication, right dose, and right time ordered. Based on observations, interviews and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063023	A. BUILDING: _____ B. WING _____	R 05/17/2024

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D 358	Continued From page 104 reviews, it was determined Resident #2 was not interviewable. _____ The facility failed to administer medications as ordered by the provider to Resident #2, Resident #4 and Resident #8. The facility's failure resulted in an antihypertensive medication observed not administered to Resident #8 on the morning medication pass with numerous missed doses; errors in administration of Resident #2's rapid acting insulin; administration of triple the amount of the ordered dose for at least 5 weeks of Resident #4's antidepressant; and not administering an inhaler and nasal spray to Resident #2 which was detrimental to the health, safety and wellbeing of Resident #2, Resident #4 and Resident #8 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/17/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2024.	D 358		