STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL060150			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 08/16/2024	
		B. WING				
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
NORTHLA	KE HOUSE		AMES ROAD DTTE, NC 28216			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
D 000	Initial Comments		D 000			
	Mecklenburg County					
D 464	10A NCAC 13F.130 Profile & Care Plan	7 Special Care Unit Res.	D 464			
	10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan					
	and .0802 of this Su (1) Within 30 days of care unit and quarter written resident profile conta describes the reside selfhelp abilities, leve management needs, disabilities, and degr (2) Develop or revise required in Rule .080 on the resident profile and s involves environment strategies to help the	uirements in Rules .0801 bchapter, the facility shall: f admission to the special rly thereafter, develop a aining assessment data that nt's behavioral patterns, el of daily living skills, special physical abilities and ree of cognitive impairment. e the resident's care plan 02 of this Subchapter based specify programming that tal, social and health care e resident attain or maintain of functioning possible and abilities.				
	facility failed to ensu had Special Care Ur updated on a quarte #3, #4 and #5) and f	t as evidenced by: iews and interviews, the re 5 of 5 sampled residents nit (SCU) resident profiles rly basis (Residents #1, #2, ailed to ensure a SCU as updated and completed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL060150		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NONDER.	A. BUILDING:			
		B. WING	08	R 3/16/2024		
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
NORTHLA	KE HOUSE		AMES ROAD OTTE, NC 28216			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN ((X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLET
D 464	Continued From page	e 1	D 464			
	annually for 1 of 5 sa #5).	mpled residents (Resident				
	The findings are:					
	1. Review of Resident #5's current FL2 dated 05/29/24 revealed:					
	•	dementia due to schizophrenia and diabetes. evel of care was enhanced				
	Review of Resident #5's Resident Register revealed an admission date of 05/31/22. Review of Resident #1's record on 08/16/24 revealed:					
	-There was a SCU quarterly profile completed on 12/06/23.					
	-There was a SCU care plan completed on 11/16/23 with no Primary Care Provider (PCP)					
	signature. -There was a SCU ca 12/06/23 with no PCF	are plan completed on 2 signature				
	-There was no addition quarterly profiles wer	onal documentation SCU e completed after 12/06/23. onal documentation of a				
		h the Special Care Unit n 08/16/24 at 3:45pm.				
	Refer to interview wit 08/16/24 at 4:07pm.	h the Administrator on				
	06/25/24 revealed:	it #1's current FL2 dated				
	-Diagnoses included impairments and adjudepressed mood.	-				

STATE FORM

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If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060150				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		08	R 8/ 16/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
NORTHLA	KE HOUSE		EAMES ROAD OTTE, NC 28216				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 464	Continued From page	e 2	D 464				
	-The recommended l care.	evel of care was enhanced					
	Review of Resident # revealed an admissio	#1's Resident Register on date of 08/25/21.					
	revealed:	f1's record on 08/15/24					
	10/23/23. -There was a care pla -There was no additio	an completed on 06/24/24. onal documentation SCU e completed between					
	Refer to interview wit 3:45pm.	h the SCC on 08/16/24 at					
	Refer to interview wit 08/16/24 at 4:07pm.	h the Administrator on					
	3. Review of Resider 06/21/24 revealed:	nt #2's current FL2 dated					
	disturbance, pulmona hypertension, stage 3	3 chronic kidney disease, isease, and non-Insulin					
	-She was constantly						
	Review of Resident # revealed she was ad	0					
	12/11/23.	[#] 2's record revealed: esident profile completed on an completed on 02/25/23					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
F		HAL060150	B. WING	B. WING		R 08/16/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
ORTHLA	KE HOUSE		AMES ROAD OTTE, NC 28216				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
D 464	Continued From page	e 3	D 464				
	plan.	cian signature on the care onal documentation of a					
	Refer to interview with the SCC on 08/16/24 at 3:45pm. Refer to interview with the Administrator on 08/16/24 at 4:07pm.						
	06/25/24 revealed: -Diagnoses included Alzheimer's.	nt # 3's current FL2 dated dementia due to evel of care was enhanced					
	Review of Resident revealed an admission	#3's Resident Register on date of 05/27/22.					
	revealed:	#3's record on 08/15/24					
	12/11/23. -There was a SCU qu	uarterly profile completed on uarterly profile completed on					
		onal documentation SCU re completed 12/11/23 and					
	Refer to interview wit 3:45pm.	th the SCC on 08/16/24 at					
	Refer to interview wit 08/16/24 at 4:07pm.	th the Administrator on					
	5. Resident of Reside 06/25/24 revealed:	ent #4's current FL2 dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL060150		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING		R 08/16/2024		
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
	KE HOUSE	9108-RE	AMES ROAD			
		CHARLO	DTTE, NC 28216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 464	Continued From pag	e 4	D 464			
	ischemic attack (a br hypertension and typ	vascular dementia, transient rief stroke-like attack), be 2 diabetes. level of care was enhanced				
	Review of Resident #4's Resident Register revealed an admission date of 02/01/24.					
	revealed: -There was a care pl -There was a care pl -There was no additi	#4's record on 08/15/24 an completed on 02/11/24. an completed on 06/21/24. onal documentation of a CU) profile completed nd 06/21/24.				
	Refer to interview wit 3:45pm.	th the SCC on 08/16/24 at				
	Refer to interview wi 08/16/24 at 4:07pm.	th the Administrator on				
	revealed:	CC on 08/16/24 at 3:50pm				
	resident care plans. -She knew SCU resi	ent profiles and SCU dent profiles were to be				
	quarterly basis. -She knew SCU resi	days of admission and on a dent care plans were to be				
	days of a significant -She did not know re	days of admission, within 10 change and annually. sidents' #1, #2, #3, #4 and				
	completed SCU care	esident #5 did not have a plan.				
		e for keeping a schedule of profiles and SCU care plans				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED R		
			A. BUILDING:			
		HAL060150	B. WING		08/16/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
ORTHLA	KE HOUSE					
			OTTE, NC 28216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 464	Continued From pag	e 5	D 464			
	 #3, #4 and #5 SCU n -She had missed concare plan. Interview with the Add 4:07pm revealed: -The SCC was respondent of the second care plans being second care plans being profiles and care plan timely. 	Impleting resident #5's SCU Iministrator on 08/16/24 at possible for the SCU profiles g completed. of any issues with the SCU ns not being completed when the SCU profiles and				

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