Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		1141 070040			R <b>09/19/2024</b>	
		HAL073010	1		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	annual and follow-u	ensure Section conducted an up survey and a complaint September 17 to September				
D 074	10A NCAC 13F .03 Furnishings	06(a)(1) Housekeeping And	D 074			
	10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;					
	failed to ensure the windowsills were keethe hallway and in to the findings are:  Review of the environments.	ons and interviews, the facility floors, doors, walls and ept clean and in good repair in hree resident rooms.				
	from the local coun 06/24/24 revealed: -The facility receive -There was docume gaps in the flooring collect and needed Observations of half	ty health department dated of three demerits. entation of an observation of allowing dirt and debris to				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CO	ORRECTION	IDENTIFICATION NUMBER:			COMP	LETED
					F	۱
		HAL073010	B. WING		1	9/2024
NAME OF PROVI	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADI E 11510		2065 CHU	JB LAKE RO	AD		
MAPLE HEIG	HTS ASSISTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 074 Cor	ntinued From pa	ge 1	D 074			
roo -Th lam -Th are sou -Th floo war haz -Th lam deb ven -Th and floo fror -Th and ove -Th and ove -Th floo resi -Th floo resi -Th whe -Th whe -Th	ms were; the no e flooring in the inate flooring wi ere were severa a that were trip hath hall. Here was an area oring was wet, are ped and were card. Here was a corne inate planking the oris leading into the inate planking the original to cover the inate was a seam of the north hall the original to cover the inate planking in the inate was dirt and in the inate planking planking planking planking planking in the planking planking in the planking in the inate planking in the	rth hall and the south. hallways was a brown th individual planks. I gaps, chips and a raised hazards on the floor on the in the south hall where the had the laminate planks had curling up and were a trip  r missing from a piece of hat had collected dirt and he bathroom next to a hat he south hall. in the middle of the south hall hat had a raised strip of he seam; the raised strip ran hoss each hallway. flooring had dirt and debris the edge. he served lifting their walkers up hat strip with both hands to cross hous chips and missing sides had a raised strip ran hoss each hallway. flooring had dirt and debris he edge. he served lifting their walkers up hat had separated in the haminate planks on the north had bris collected in the haminate flooring were had separated and the had curl upward. had bris collected in the area	D 0/4			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7. BOILDING.			₹
		HAL073010		B. WING			19/2024
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING		IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED   SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 074	Continued From page 2			D 074			
	-There were two pieces of laminate plank in front of the sofa in the common area that had separated where they came together and had curled up in opposite directions; dirt and debris had collected under the raised section.						
	Observations of res at 12:04pm reveale -There was dirt and furniture and behind -There was a thick baseboards. -There were three of of dust on the wind	ed: I debris on the floo d the beds in room buildup of dust on dead flies and a thi	rs around #N2. the				
	Observations of resident room #N3 on 09/18/24 at 12:08pm revealed:  -There was a thick buildup of dirt and debris on the floors around the furniture and behind the beds.  -There were empty coat hangers on the floor in front of the closet.  -There were dead flies and gnats on the windowsills.  -There was a layer of brown residue that coated the door around the doorknob on the inside and outside of the door.  -There were two piles of clothes on the floor near a full laundry basket at the foot of the bed.						
	at 12:11pm reveale -There was a thick on the floors around -There was a build windowsillThere were heavy the headboard and beds. Interview with a res	buildup of dust, dir d the furniture and up of dust and deb black marks on the on the wall next to	the beds. ris on the e wall above one of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3) DATE  COMF			SURVEY LETED	
					F	₹
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	JB LAKE RO O, NC 2757:			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 074	revealed: -He usually cleaned: -He had not seen all and row seepershalls or his room exhe would not tripHe knew to step of he would not know if under his bed or the He had not noticed windowsills.  Review of the Septicleaning schedule in the floors were to daily; there was not the floorsThere were initials swept and dust mo to 09/16/24The floors were to was nothing indicated to the residual documenting the fronthere were initials was moved and cleaning the fronthere with a second the fronthere with a second the fronthere with a thir soften with a thir	d his room not housekeeping. housekeeper this week. did not sweep and mop the very day. ver the strip in the hallway so the housekeepers cleaned e windowsills. d the dirty floors or the  ember 2024 housekeeping revealed: be swept and dust mopped thing indicating the location of documenting the floors were pped once daily from 09/01/24 be mopped once daily; there ing the location of the floors. documenting the floors were from 09/01/24 to 09/16/24 be moved and cleaned under ent room; there was nothing	D 074			

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AND FLAN OF CORRECTION   IDENTIFICATION NOWIDER.   A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	R	
HAL073010 B. WING	09/19/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING 2065 CHUB LAKE ROAD		
ROXBORO, NC 27573		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG DEFICIENCY)	D BE COMPLETE	
D 074  Continued From page 4  around the facility.  -He used his hands and his feet to propel his wheelchair.  -He struggled with getting the wheelchair over the raised strips across the floor in the hallways.  -He would keep pushing until he could get over the raised strip or get help from another resident.  -When he used his walker to ambulate, he would have to stop at the raised strip and pick his walker up and over it so he would not trip.  -He had not tripped over the raised strip but he was always very careful when he crossed it so he would not trip and fall.  Telephone interview with a resident's family member on 09/17/24 at 10:59am revealed:  -She visited the resident at the facility in July 2024.  -The flooring in the resident's room was dirty and had hair on the floor from a haircut the resident was given two weeks before by another family member.  -There were piles of clothing on the floor; she did not know if they were clean or dirty.  -She did not recall seeing housekeeping at the facility when she visited.  Interview with the facility's maintenance staff on 09/18/24 at 4:21pm revealed:  -He received a list from the Manager when there were repairs that needed to be done in the facility.  -He knew there were pieces of the flooring that were damaged and were coming up in the hallway.  -There was a large chip missing from the flooring near the bathroom and the vending machine.  -He would replace the flooring pieces all at once when there were more planks that were damaged and needed replacing.		

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
					F	2
		HAL073010	B. WING		09/19/2024	
		HALU/3010			03/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHL	IB LAKE RO	AD		
MAPLE H	HEIGHTS ASSISTED L	IVING	O, NC 27573			
0(1) ID	CLIMMA DV CTA			PROVIDER'S PLAN OF CORRECTION		(2/5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
D 074	Continued From pa	go 5	D 074			
D 014	Continued From pa	ge 5	D 074			
	the halls was install	ed by the company that				
	installed the flooring	g.				
	Telephone interview	wwith the facility's primary care				
	provider (PCP) on (	09/19/24 at 1:30pm revealed:				
	-The facility was no	t very clean and orderly.				
	-She had noticed th	ne floors needed to swept and				
	dust webs in the fac					
	-The resident's room					
		m were cluttered with clothes				
	lying on the floor.					
		ooms increased the risk of				
	falls for the residen					
		nt would go a long way in				
	increasing the mora	ale of the residents.				
		usekeeper on 09/19/24 at				
	11:17am revealed:					
		ed at the facility for a few days				
	and worked until 2:					
		pped the residents' rooms				
	daily.					
		ng schedule to do the daily				
	cleaning.					
	,	vorked she moved the beds in				
	them.	nts' rooms and swept under				
		us many hode as abo sould				
	but she did not mov	is many beds as she could,				
		d all the beds and swept under				
	them yet.	a an the beas and swept under				
		ome damaged flooring; she				
	did not report it to a					
	-She had not notice					
		of the cleaning had been				
	neglected and undo	•				
		get the cleaning caught up.				
	-one was trying to g	get the cleaning caught up.				
	Interview with the M	lanager on 09/19/24 at				
	2:25pm revealed:	lanagor on our lorz+ at				
	∠.∠opm revealed:					

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DIVISION	<u>of Health Service Re</u>	egulation				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
				<del></del>	-	,
			B. WING		F	
		HAL073010	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS CITY S	STATE, ZIP CODE		
10 10 1	TO VIDER OR GOLF EIER					
MAPLE I	HEIGHTS ASSISTED L	LIVING	UB LAKE RO			
		ROXBOR	RO, NC 2757	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				22. (8.2.(8.7)		
D 074	Continued From pa	age 6	D 074			
		was new and had only worked				
		ew days and was off that day,				
	on 09/17/24.					
	-When there was no	ot a housekeeper usually, she				
	or one of the other:	staff would take over the				
	responsibility of hou	usekeeping				
	-There was a clean	ning schedule for the facility;				
		eaning schedule daily.				
		if the doors and windowsills				
	were on the cleaning	na schedule.				
		d the facility daily and even				
	went into the reside					
		napped together; the				
		was working on the flooring.				
		what he was doing exactly.				
		at on 09/05/24 or 09/06/24 but				
		then he was going to work on				
	the flooring.	men he was going to work on				
		the purpose of the raised strip				
	that ran across the					
		iny complaints from anyone				
		rip or difficulty maneuvering				
	over it with a walker					
		er fallen over the raised strip				
	in the flooring					
	Tolophana internit	waith the Administration				
		w with the Administrator on				
	09/19/24 at 11:40ar					
		ng in the hallways needed to				
		es that were chipped and				
	separated.					
		ave the maintenance staff				
		d flooring in the next 90 days;				
	he did not have a d					
		the hallways was an				
		ooring planks could expand				
	and contract.					
		o complaints of the flooring or				
	the raised strip.	_				
	-There had been no	o reports of trips or falls from				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		,	₹
		HAL073010	B. WING		<b>I</b>	19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 074	Continued From pa	ige 7	D 074			
	housekeepingThe resident room the beds and furnituunder.	wept and mopped every day by s were deep cleaned monthly; ure were moved and cleaned adowsills were cleaned when				
D 075	10A NCAC 13F .03 Furnishing	06(a)(2) Housekeeping And	D 075			
	10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities.					
	reviews the facility t	et as evidenced by: ions, interviews, and record failed to maintain an was free from unpleasant				
	The findings are:					
	from the local coun 06/24/24 revealed: -The facility receive -There was docume observation of carp	entation of two demerits for an ets not being odor free. facility on 09/17/24 at various				
	times from 8:00am	to 4:30pm revealed there was ine upon entrance to the				

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	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
74401044	OF CONTRACTION	IDEI <b>V</b> III IX	SATION NOMBER.	A. BUILDING:			
		HAL07	73010	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADIE	HEIGHTS ASSISTED I	IVING	2065 CHU	IB LAKE RO	AD		
WAPLE	TEIGHTS ASSISTED I	LIVING	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 075	Continued From pa	ge 8		D 075			
	facility and through	out the day t	hat lingered in the				
	Observation of the times from 8:00am -There was a strong to the facility and do the hallwaysThere was a house floors to the hallway after she had mopp Observation of the times from 8:00am -There was a strong to the facilityThe housekeeper resident rooms with product earlier in the There was a strong after lunch.	to 6:45pm reg smell of ururing the day ekeeper that ys, but the upped.  facility on 09 to 5:00pm reg smell or urupped the a strong scenorning.	evealed: ine upon entrance that lingered in mopped the rine odor returned  1/1/24 at various evealed: ine upon entrance halls and the ented cleaning				
	Review of the Septicleaning schedule in The bathrooms incomplies and the cleaned after earthere were initials bathrooms were considered after the bathrooms were considered and the complete the constant of the complies of the complied periodic were initials documenting the tranship cannot be emptied periodic were initials documenting the tranship cannot be complied periodically from 09/01/24. The trash cans in the emptied periodically from the complies of the complete t	revealed: cluding the b the toilet and ch use. documented mpleted onc 4. ere to be spo our, there we sk was done 4. che residents cally through enting the ta to 09/16/24 che bathroon	aseball boards, d shower were to d the task in the se daily from at checked every ere initials e once daily from s' rooms were to each shift, there ask was done once ins were to be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
			A. BUILDING.			₹
		HAL073010	B. WING			19/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 075	Continued From page 9		D 075			
	were initials docum daily from 09/01/24	enting the task was done once to 09/16/24.				
	revealed he though	ident on 09/18/24 at 6:15pm t the facility had a smell like a had not been flushed.				
	member on 09/17/2 -She had visited the -There was a strong	w with a resident's family 24 at 10:59am revealed: e facility in July 2024. g smell of urine in the facility. In the staff about the smell of at the facility.				
	09/17/24 at 11:23ar	wwith a resident's guardian on m revealed she had noticed the facility when she had arlier that week.				
	Telephone interview with the facility's primary care provider (PCP) on 09/19/24 at 1:30pm revealed: -She had noticed a strong odor of urine in the facility when she visited, but not every timeShe thought the facility was doing a better job of cleaning and controlling the urine odor.					
	provider on 09/19/2 -When she entered smell.	v with an ancillary services 4 at 3:36pm revealed the facility, it was an awful d like urine every time she was d "awful."				
	11:17am revealed: -She had only work daysShe had noticed a	usekeeper on 09/19/24 at ed at the facility for a few n odor when she came to lled like used adult briefs in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED	
			A. BOILDING	·		R
		HAL073010	B. WING			19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED I	LIVING	UB LAKE RO RO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 075	the trashcansShe had a check licleaningShe emptied the trand bathrooms every on the floors to help linterview with the Marger gave on the floors to help linterview with the Marger gave on the floors to help linterview with the Marger gave on the floors to help linterview with the Marger gave on the floors to help linterview with the Marger gave on the floors to help linterview as a clean or one of the other responsibility of horeof the was a clean she had not notice. There was expected facility due to heavy an inspector from complained recentlareaThere was a name to the housekeeper eliminate the odor in Telephone interview 09/19/24 at 11:40ar linterview 09/19/24 at 11:40ar linterview of the had not noticed. A sewer line had be the odor may have backed up.	ist she followed to do the rash in the residents' rooms ery day she worked. It has a cleaning product to use to with the odor.  Manager on 09/19/24 at was new and had only worked few days and was off that day, not a housekeeper usually, she staff would take over the usekeeping. In the facility another agency had y of a strong urine smell in one and in the facility.				
D 079	10A NCAC 13F .03 Furnishings	806(a)(5) Housekeeping and	D 079			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
			201251110			R
		HAL073010	B. WING		•	19/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING	HUB LAKE RO DRO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 079	Continued From pa	age 11	D 079			
	Furnishings (a) Adult care hom (5) be maintained in orderly manner, free hazards; This Rule shall app facilities.	in an uncluttered, clean and se of all obstructions and oly to new and existing				
	This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live flies and gnats, and unsecured oxygen tanks in a resident's room.					
	The findings are:					
	1. Observations of resident room #N3 on 09/18/24 at 12:08pm revealed:  -There five live gnats on the wall beside one of the beds in resident room #N3.  -There were multiple gnats flying around the room and landing on the furniture and walls.		m			
	at 12:11pm reveale	sident room #N5 on 09/18/24 d there were live flies flying nd landing on the furniture an				
	revealed: -He had seen flies a facilityHe had seen the fl he was watching te -He had to swat the they would not land	em away with his hands so				

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	?
		HAL073010	B. WING			9/2024
		IIAE010010			03/1	3/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MADIEL	HEIGHTS ASSISTED L	1VING 2065 CH	UB LAKE RO	AD		
MAPLL	ILIGITIO AGGIGTED I	ROXBO	RO, NC 27573	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DAIL
				,		
D 079	Continued From pa	ge 12	D 079			
	-He had not compla	ained to the staff, but he had				
	asked them if they saw the flies and gnats and					
	they told him "yes tl					
	,, <b>,</b>	,				
	Interview with a se	cond resident on 09/18/24 at				
	9:00am revealed:					
	-He saw flies in the	dining room and would wave				
	them away.					
	<ul><li>-He would see one to two flies in his room.</li><li>-The staff had flyswatters they used to kill flies</li></ul>					
	inside.					
		d resident on 09/18/24 at				
	9:07am revealed:	flice in the facility				
	-He saw gnats and	ained because the staff knew				
		nd flies; he had seen them				
	shoo them away.	id files, the flad seem them				
	31100 them away.					
	Telephone interview	v with a resident's family				
		24 at 10:59am revealed:				
		flies around a trash can in the				
	resident's room in J					
	-There were flies in	the bathroom and around the				
	trashcan in the bath					
	-There were flies ar	round the resident's bed.				
		usekeeper on 09/19/24 at				
	11:17am revealed:	and at the facility for a form				
	-	ed at the facility for a few				
	days.	ed flies or gnats in the facility.				
	-one nau not notice	or mes or griats in the facility.				
	Interview with the M	Manager on 09/19/24 at				
	2:20pm revealed:	lanagor on our lorza at				
	•	ten bad over the last two				
	weeks.					
		itting at flies in her office and				
	had seem them at t					

-She had a spray she used to keep the gnats and
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL073010		B. WING			R <b>19/2024</b>
	PROVIDER OR SUPPLIER	IVING	2065 CHU	DRESS, CITY, S B LAKE RO D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 079	flies away from her -There had been no -The pest control or and flies in the facil last time they were -She had not conta about the flies and Telephone interviev 09/19/24 at 11:40ar -He was not aware gnats or fliesThe Manager should himThe pest control or handle the gnats ar  2. According to guid Protection Associat oxygen (O2) cylinders oxygen (O2) cylinders oxygen (O2) cylinders one was by the foor were by the doorThere was no gaug the amount of oxyg -There were two O2 resident's bed in a re-	office. complaints of gnats are properly did not spray fity because it was not at the facility. cted the pest control cognats. with the Administrator revealed: there was an issue with the was an issue with the was an issue with the facility. Company could be contained flies.  Idance from the National ion (NFPA) compressed in the pring over.  Ident room C on 09/17/ Is were standing on the contained flies of the resident's bed at the contained in the tanks. It is contained in the tanks.	for gnats bad the ompany or on the live ssues to for acted to acted to al Fire ed a rack 24 at floor, and two ondicate	D 079			
	-Three O2 cylinders one was by the foot were by the door.	s were standing on the of the resident's bed age on the cylinders to item in the tanks.	and two				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	₹
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 079	Continued From pa	ge 14	D 079			
	-There were two O2 cylinders beside the resident's bed in a metal rack.					
		dication aide (MA) on revealed no one told her how ks.				
	Interview with the Manager on 09/18/24 at 2:48pm revealed: -She had seen oxygen stored in a crate at other facilitiesShe did not know oxygen needed to be secured in a crate.					
	Telephone interview with a representative from the facility's contracted oxygen provider on 09/19/24 at 8:30am revealed:  -Oxygen tanks should be secured upright.  -Oxygen tanks "definitely" needed to be secured in a way that would prevent the tanks from falling.  -Depending on what was around the tank if it was knocked over, it could cause damage.					
	O9/19/24 at 1:56pm -Oxygen tanks shown something to preven fracturing the headOxygen tanks that pressure of 2000 powhen full but could pressure when the -Empty tanks should with a gage reading way of knowing if the empty.	uld always be secured to nt them from tipping over and were three to four feet tall had si (pounds per square inch) still contained oxygen and indicator gage reads empty. d be secured because even g at zero there was truly no ne tanks were completely with a fractured head could				
	Telephone interviev	wwith the Administrator on				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	l ` ′			LETED
					 	,
		HAL073010	B. WING			9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MARIE	IFICUTO ACCIOTES :	2065 CHI	JB LAKE RO	AD		
MAPLE	HEIGHTS ASSISTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 079	Continued From pa	ge 15	D 079			
	provided by the oxy -If one of the oxyge	uld be stored in the rack				
D 083	3 10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings		D 083			
	10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities.					
	interviews, the facili	et as evidenced by: ons, record reviews, and ity failed to provide window dent room that had blinds that				
	The findings are:					
	09/17/24 at 8:00am -There was a windo missing a large are they were in a set o	ow with blinds that were a in the middle of the blinds; if double windows. broken blinds was visible from				
	12:04pm revealed: -There was a doubl -There was a set of	e window in the room. blinds hung on each window. that was three feet by three				

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NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  IDENTIFICATION NOMBER:  A. BUILDING:  B. WING  O9/19/2024  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  B. WING  09/19/2024				A. BOILDING.			D
MAPLE HEIGHTS ASSISTED LIVING 2065 CHUB LAKE ROAD			HAL073010	B. WING			
MAPI E HEIGHTS ASSISTED LIVING	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	MAPLE	HEIGHTS ASSISTED I	IVING				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
feet on the set of blinds on the left window of the room had many slats missing and multiple damaged slats that would not close.  -There was a pillow case folded in half and hanging across one of the damaged slatsThe parking lot and the road in front of the facility could be seen around the pillow case and through the opening caused by the missing and damaged slats.  Interview with the resident who resided in room 3 on 09/18/24 at 5:05pm revealed: -He had hung the pillow case on the broken blind in attempt to have some privacy and block out the lightThe blinds had been broken for a whileThe staff knew because he complained about the broken blinds about a month agoHe wanted the blinds repaired because he did not want someone to look in and see him while he slept.  Interview with the facility's maintenance staff on 09/18/24 at 4:21pm revealed: -He ordered a large number of blinds at one timeThe Manager would give him a list of rooms that had damaged blinds that needed to be replacedHe replaced blinds when there was a large enough list to do all at one time.  Interview with the Manager on 09/19/24 at 2:25pm revealed: -She tried to peak into the residents' rooms at least once a weekThe facility had replaced the blinds in resident room 3 at least three different times but he always broke themThe resident who resided in the room would hang shirts and paper towels on the slats to the	D 083	feet on the set of bl room had many slat damaged slats that -There was a pillow hanging across one -The parking lot and could be seen arout the opening caused slats.  Interview with the re on 09/18/24 at 5:05 -He had hung the pin attempt to have slight.  -The blinds had been -The staff knew been the broken blinds and -He wanted the blind had supported by the broken blinds and the slept.  Interview with the factory with the fact	inds on the left window of the its missing and multiple would not close. case folded in half and of the damaged slats. If the road in front of the facility and the pillow case and through by the missing and damaged esident who resided in room 3 pm revealed: illow case on the broken blind some privacy and block out the en broken for a while. It is to look in and see him while to look in and see him while entity's maintenance staff on revealed: In number of blinds at one time. If a list of rooms that is that needed to be replaced. It when there was a large at one time.  It is a large and one time. It is the residents' rooms at the laced the blinds in resident the different times but he lesided in the room would	D 083			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R	
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 083	Continued From page 17		D 083			
	on the blinds, and h-She did not know i light or trying to kee -She had not tried a shade for the reside.  Telephone interview 09/19/24 at 11:48ar -The facility replace but the resident key -The blinds had bee -He did not know w blinds in his roomThe facility replace	v with the Administrator on m revealed: ed the blinds in resident room 3				
D 125		03(a) Qualifications Of	D 125			
	Medication Staff (a) Adult care hom medications, herea aides, and their dire training, clinical skil written examination 131D-4.5B. Person occupational licens	e staff who administer fter referred to as medication ect supervisors shall complete lls validation, and pass the as set forth in G.S. s authorized by state ure laws to administer empt from this requirement.				
	facility failed to ensimedications had co	et as evidenced by: s, and record reviews, the ure staff who administered empleted the state-approved 5, ication aide (MA) training				

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING			B LAKE RO			
(VA) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	O, NC 27573			(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 125	5 Continued From page 18		D 125			
	courses as required prior to administering medications for 1 of 3 sampled staff (Staff C).					
	The findings are:					
	personnel record re- She was hired on 0 -There was docume Medication Compet checklist on 09/03/2 -There was docume written medication a -There was no certi completed the 5, 10 -There was no docu verification for the r	04/11//24. entation Staff C completed the tency Validation Clinical Skills				
	administration reco was documentation	s' July 2024 medication rds (MARs) revealed there staff C administered dents on 21 of 31 days.				
	there was documer	s' August 2024 MARs revealed ntation Staff C administered dents on 17 of 31 days.				
	Review of residents' September 2024 MARs from 09/01/24-09/17/24 revealed there was documentation Staff C administered medications to residents on 10 of 17 days.					
	revealed: -She had a medical fourteen years agoShe was not sure	C on 09/19/24 at 4:27pm tion class she took "about " who taught the class. earned to pass medications,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.	<del></del>	F	,
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING	B LAKE RO			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D, NC 27573	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
D 125	5 Continued From page 19		D 125			
	check blood pressure, and check finger stick blood sugar (FSBS).  -The class was an all-day class; she did not recall if the class was more than one day.  Interview with the Manager on 09/19/24 at 4:29pm revealed:  -She was responsible for making sure all staff had the required qualifications before the staff member administered medications.  -She had audited staff records and had seen Staff C's 15-hour certificate.  Telephone interview with the Administrator on 09/19/24 at 4:34pm revealed:  -The Manager was responsible for ensuring staff qualifications were completed.  -He was not aware Staff C did not have proof of completing the 15-hour medication aide training.  -Staff C had been working at the facility for a long					
	timeHe expected all recompleted.	quired MA training to be				
D 234	10A NCAC 13F .07 Medical Exam & Im  10A NCAC 13F .07 Examination & Imm (a) Upon admission resident shall be tes in compliance with by the Commission	03 Tuberculosis Test, Medical nunizations to an adult care home each sted for tuberculosis disease the control measures adopted for Public Health as specified 0205 including subsequent	D 234			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073010			R 09/1	9/2024
NAME OF I			<u>I</u>		09/1	9/2024
	PROVIDER OR SUPPLIER	2065 CHU	IB LAKE RO	STATE, ZIP CODE AD		
MAPLE	HEIGHTS ASSISTED L	IVING	O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 234	4 Continued From page 20		D 234			
	facility failed to ensi (#1 and #3) were te tuberculosis (TB) di	et as evidenced by: view and interviews, the ure 2 of 3 sampled residents ested upon admission for isease in compliance with the or the Commission for Health				
	Review of Resident #3's FL2 dated 11/10/23 revealed:     Diagnoses included dementia, hyperlipidemia, hypertension, bipolar and cerebrovascular accident.     There was an admission date of 10/06/22.					
		#3's Resident Register ned on 10/11/22 but there was documented.				
	revealed: -There was a TB co TB injection dates, there were no dates documented on the -There was no documented	#3's tuberculosis (TB) form onsent form for documenting results and result dates, but s for injections or results form. umentation of a TB skin test If the form was not dated.				
		dent #3 on 09/18/24 at 8:52am know what a TB skin test was d one.				
	4:03pm revealed:	lanager on 09/17/24 at				

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AND PLAN OF CORRECTION IDENTIF	DER/SUPPLIER/CLIA FICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
		A. BOILDING.			₹
HALC	73010	B. WING			9/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING		B LAKE RO. O, NC 27573			
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
sometime in 2022. Resident #3 was admitted fro hospital. She thought she had seen and documented on a form in Resinger Resident #3 had to have a TE was admitted, and a second to was at the facility. She had reached out to Reside for TB results that morning, 09 guardian did not have the resule ither.  Telephone interview with the A 09/19/24 at 10:20am revealed Resident #3 should have had administered since his admiss October of 2022. Resident #3 needed to be tested he could be positive and not know an	TB skin test result ident #3's record. 8 skin test before he est done once he est done once he dent #3's guardian 0/17/24, but the alts of a TB skin test administrator on : two TB skin tests ion to the facility in sted for TB because now it. add sure Resident ted.  Manager on  We with the 0:20am.  Trent FL-2 dated included diabetes, onary artery  dent Register of 02/21/23.  Inization record on	D 234			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO			
040.15	CLIMMA DV CTA		O, NC 27573		DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
D 234	Continued From page 22		D 234			
	care provider (PCP revealed: -She did not admini-Resident #1 should prior to being admiti-If Resident #1 was infect other residen Interview with the M 4:00pm revealed: -Resident #1 was a local hospitalShe thought the loskin test before he -She had not taken department to rece-She notified the loc 09/19/24, to reques skin test.  Interview with the A 9:59am revealed: -Resident #1 should	d have been tested for TB ted to the facility.  positive for TB he could easily ts in the facility.  Manager on 09/19/24 at  dmitted to the facility from the cal hospital administered a TB left the hospital.  Resident #1 to the health live a TB skin test.  cal hospital this morning, at a copy of Resident #1's TB  dministrator on 09/19/24 at  d have a TB on admission and				
	a second TB with a year of living at the facilityResident #1 could have TB and the facility would not be awareIf Resident #1 had TB, it could spread to other residents.					
	Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.					
	Refer to the intervie 09/19/24 at 4:00pm	ew with the Manager on				
	Refer to the telepho Administrator on 09	one interview with the 0/19/24 at 10:20am.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				A. BUILDING.			٦
		HAL0730	10	B. WING			9/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE H	IEIGHTS ASSISTED I	LIVING		IB LAKE RO. O, NC 27573			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L			PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
D 234	Continued From pa	ige 23		D 234			
	Interview with the M 4:00pm revealed: -She was responsit residents had a TB they were admitted completed after the -She tried to do an every other month.  Telephone interview 09/19/24 at 10:20ar responsible for ens for TB prior to being	ole for making s skin test comp and a second by were admitte audit of the res w with the Admi m revealed the uring all resided g admitted to the	sure the leted before TB skin test d to the facility. idents' records nistrator on Manager was nt were tested he facility.				
D 273	10A NCAC 13F .09	02(b) Health C	are	D 273			
	10A NCAC 13F .09 (b) The facility sha to meet the routine of residents.	Il assure referra	al and follow-up				
	This Rule is not me TYPE A1 VIOLATION		l by:				
	Based on observation reviews, the facility care provider (PCP (#1) regarding elevated readings and refuse ensure referrals we residents (#2) for howound, physical the vascular surgery climates.	failed to notify for 1 of 3 sam ated blood presal of medication are made for 1 come health materapy, the woun	the primary upled residents ssure (BP) us; and to of 3 sampled unagement of a				
	The findings are:						
	1. Review of Reside FL-2 dated 08/08/2		al discharge				

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DIVISION	Division of Health Service Regulation						
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CONIF LE LED		
					R		
		HAL073010	B. WING		09/1	9/2024	
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	STATE, ZIP CODE			
		2065 CH	JB LAKE RO				
MAPLE H	IEIGHTS ASSISTED L	IVING	O, NC 2757				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 273	Continued From page 24		D 273				
D 273	-Diagnoses included left 5th toeResident #2 require and dressingResident #2 was seThere was an order left foot, toe number Review of Resident summary dated 08/-Resident #2 present department with a certain term of the left toeThe resident was done of the left toeThe resident under amputationThe resident under amputationThe resident was to osteomyelitisThe resident was to with dry gauze.  a. Review of Resident was to with dry gauze.  a. Review of Resident summary dated 08/- an order for physical weakness and balar Review of Resident summary dated 08/- home health PT for walker.  Interview with Resident revealed:	d sepsis and gangrene of the ed assistance with bathing emi-ambulatory. For wet to dry dressing daily, for 5.  #2's hospital discharge 1/08/24 revealed: nted to the emergency complaint of foot pain. discovered to have gangrene rwent surgery for a left fifth toe was positive for acute sepsis. The primary care der dated 08/09/24 revealed all therapy for generalized					
	was doing okay with "easier."	h his walker; it had gotten ble to walk without a walker.					
				I.			

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Interview with the Supervisor on 09/18/24 at

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. DUILDING	·		R	
		HAL073010	B. WING			19/2024	
NAME OF	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE			
MAPLE	HEIGHTS ASSISTED I	LIVING	CHUB LAKE RO BORO, NC 2757				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 273	8:05am revealed: -She was responsil and coordinating tra-Resident #2 had noordinating tra-Resident #2 had noordinating tra-Resident #2 had noordinating tra-She thought the Mosince his toe was an an event with the Mosince his toe was an an event with the Mosince his toe was an an event with the Mosince his toe was an an event with the Mosince his toe was an an event with the Mosince his toe was an an event with the Wordination with the Contact and the contact and the contact another against the wordination with the All th	ble for making appointment ansportation to appointment ansportation to appointment and thad physical therapy. Ianager was trying to find a who accepted Resident #2's Manager on 09/18/24 at not received physical therap amputated. It returned from the hospital apputated, she thought he 2's PCP saw the resident, the home health agency, and the ake Resident #2's insurance and other agency fe's PCP know the home and not accept Resident #2's PCP told her she would ency. If gency Resident #2's PCP not accept the resident's we with the hospital discharged at 9:58am revealed when ischarged from the hospital mputated toe, the resident went therapy at the hospital's	nts.  S  Py  Ine  the  the  the  the  the  the  the  t				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL073010		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED  R 09/19/2024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 03/	13/2024	
	HEIGHTS ASSISTED L	IVING 2065 CH	UB LAKE ROARO, NC 27573	AD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 273	Continued From pa	ge 26	D 273				
	wound and would shealedShe did not think F Resident #2 until hi -Had the facility star could not find a horhave evaluated Resident Had the Market evaluated Resident Had the Market evaluated Resident Had a toe a shear the sheat for the sheat for the supervisor killing her anything appointment with orappointment with the supervisor killing her anything appointment with the supervisor killing her anything appointment with the supervisor killing to verify the allet the Supervisor killing her anything appointment with the supervisor killing her sheat for the supervisor killing her sheat for the supervisor killing her anything appointment with the supervisor killing her sheat for the supervisor killing her s	mited in his mobility by his tay limited until his wound was PT would make a difference for s wound was healed. If contacted her when they me health agency, she would sident #2.  Manager on 09/18/24 at the hospital discharge planner about Resident #2's utpatient PT. Resident #2 had an he outpatient therapy ould have called the outpatient ppointment date and time, and show.  We with Resident #2's PCP on a revealed: It Resident #2 because the amputation and was using a	-				
	safe use of the wall						
	-She would have ex been made as soor	rpected the referral to have n as possible.					
	summary dated 08/	ent #2's PCP's after-visit /27/24 revealed an order for g for dressing changes and					
		t #2's PCP after-visit summary ealed an order to follow up agency.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			₹
		HAL073010	B. WING		I	19/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 273	Continued From page 27		D 273			
	revealed: -He had not had a l toe.	dent #2 on 09/17/24 at 1:56pm nome health nurse look at his oped the toe himself.				
	8:34am revealed: -Resident #2 had n nurse visit since his -When Resident #2 ordered home heal -She called a local agency could not ta -She did not contact -She let Resident # health agency woul insurance and the R contact another age -She thought the age	home health agency, and the ake Resident #2's insurance. It any other agency 2's PCP know the home d not accept Resident #2's PCP told her she would				
	the hospital's outpa department on 09/1 -When Resident #2 home health for wo -Resident #2 "one h wound care."					
	09/19/24 at 9:22am -She ordered home Resident #2 because and needed to be no	wwith Resident #2's PCP on revealed: health for wound care for se his wound was deteriorating nonitored and dressing d by someone other than the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPI F HEIGHTS ASSISTED I IVING			B LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	facility staff.  -The facility staff die when changing ResShe observed the dressing, and the Machania the wound was not she was concerned inconsistent wound resident #2 had a she would have expeed an orange inconsistent wound resident #2 had a she would have expeed an orange inconsistent wound resident #2 had a she would have expeeded:  -She received an orange information to compare to the Manager information to compare the agence limited number of remonth.  -She suggested the suggest	d not have a clean technique sident #2's dressing. MA change Resident #2's MA put the clean dressing on a gon the floor and then onto good. d Resident #2 had received care. very fragile, complex wound. expected the referral to have a spossible. with a representative from ency on 09/18/24 at 9:12am ander on 08/29/24 for Resident complete, and she reached to obtain other needed olete the referral. ger that at this time the agency esident #2's insurance years only able to accept a eferrals with that insurance per end Manager call other agencies. In with the Administrator on the revealed he would have yestaff to reach out to Resident ther home health agencies to	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		R	
		HAL073010	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPI E HEIGHTS ASSISTED LIVING			IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	dehiscence (a surg wound ruptured alo -Resident #2's sutu -A sharp debrident foot was performed -There was an order wound clinic.  Review of Resident 08/27/24 revealed a wound clinic with a an appointment; a relephone interview the [named] wound revealed: -Resident #2 had a and was a "no-show -There were no oth clinic for Resident #2. Telephone interview podiatrist on 09/17/-He had not seen Resident #4. Telephone interview podiatrist, who wound had his toe amputa -He had referred Resident #2. The had referred Resident #2. The had referred Resident #3. The had referred Resident #4. The had referred R	fth toe of the left foot-wound ical complication in which a ng a surgical incision). res were removed. ent of the wound on the left left to refer the resident to a start at 2's PCP order dated an order to please call [named] telephone number to schedule referral had been sent. It with a representative from clinic on 09/17/24 at 1:35pm on appointment on 09/16/24 w." er appointments at the wound the facility's contracted 24 at 1:38pm revealed: Resident #2 since the resident	D 273	DEFICIENCY		
	3:15pm revealed: -Resident #2 had a	n appointment at the wound				

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	IT OF DEFICIENCIES		(Y2) MI II TIDI	E CONSTRUCTION	(X3) DVIL	SLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED	
	-		A. BUILDING:	<del></del>		
			D 14/11/0		F	
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHL	JB LAKE RO	AD		
MAPI F HEIGHTS ASSISTED LIVING			O, NC 27573			
(V4) ID	SLIMMA DV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON.	(VE)
(X4) ID PREFIX	-	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D 273	Continued From pa	ge 30	D 273			
	•					
	clinic on 10/04/24 a					
	ago."	vas made "a couple of weeks				
		n appointment at the wound				
		but the Manager told her the				
		anceled by hospital staff.				
	appointmont was at	and the stand				
	Interview with the M	lanager on 09/17/24 at				
	3:38pm revealed:	· ·				
	-Resident #2's PCF	Preferred the resident to the				
	wound clinic.					
		eferral was after the first				
		08/24, when the resident's toe				
	was amputated.					
		as responsible for making				
	appointments.					
	Telephone interview	v with a medical assistant from				
		ral surgeon's office on				
	09/18/24 at 9:01am					
		een by the surgeon on				
		sutures and debridement of				
	black necrotic tissu	e.				
	-Resident #2 was s	upposed to be seen at the				
	wound clinic.					
		ed to be seen by the wound				
		ocess of wound care because				
		a long time for Resident #2's				
	wound to heal.	nd was debrided but other				
	specialty.	and that was the wound clinic's				
		pintment needed to be made				
		t at the wound clinic.				
	Interview with Resid	dent #2's general surgeon on				
	09/18/24 at 11:57ar	m revealed:				
		ed to be seen by the wound				
		of the resident's wound.				
	-He was concerned	Resident #2 had not been				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF I					09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER		B LAKE RO	STATE, ZIP CODE AD		
MAPLE I	HEIGHTS ASSISTED L	IVING	D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 31	D 273			
	seen by the wound -The wound was no resident was going	clinic. It going to heal, and the to lose his foot.				
	3:43pm revealed: -The Supervisor wa Resident #2's appo -The Supervisor wa to his wound clinic a #2's Licensed Cour the resident to the a -The Supervisor tole	lanager on 09/18/24 at as responsible for making intment with the wound clinic. It is not able to take Resident #2 appointment and Resident aselor was supposed to take appointment on 09/16/24. It is the take appointment on the take appointment of take appointment on the take appointment of take ap				
	4:20pm revealed: -When she schedul the appointment on -She made an apposeen at the wound of -She did not recall to appointmentShe did not recall to but the appointment before the resident' (09/04/24)She could not take clinic because of ar was why Resident to her she would take -Resident #2's Lice supposed to take th -She called Resident tree times on 09/1 voicemail, but she resident.	bintment for Resident #2 to be clinic. When she made the he date of the appointment, t for 09/16/24 was scheduled is second hospitalization Resident #2 to the wound nother appointment and that #2's Licensed Counselor told				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED L	IVING	B LAKE RO. D, NC 27573			
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 273	-She ordered Reside wound care clinic be was deterioratingAfter Resident #2's she saw the resident site was "beautiful." -On her next visit, copen woundResident #2's wout time healing and need best treat the woundered with his wound, the deteriorated as much she talked to the wear "nothing" was happed she spoke to the Mabout changing the wound and making clinic appointment of the wound and making clinic appointmentThe only acceptable have not gone to the was if the resident refuse, the facility sas well as call the cappointmentIf the facility staff hordered, maybe the could have been as	lent #2 to be seen at the ecause Resident #2's wound at toe amputation on 08/05/24, at on 08/13/24 and the surgical of 8/27/24, the resident had an and was going to have a hard eeded experts to know how to do.  In had an earlier intervention wound may have not ch.  Wound clinic herself because ening.  Manager the week of 09/09/24, dressing to Resident #2's sure he went to the wound on Monday, 09/16/24.  Resident #2 was a "no show" appointment.  W with the Administrator on m revealed:  Y staff to have immediately ent with the wound clinic.  Ile reason for Resident #2 to e wound clinic appointment refused and if the resident did taff should let the PCP know clinic to cancel the ead made appointments, as a resident's hospitalization roided.	D 273			
		ent #2's general surgeon's dated 08/21/24 revealed:				

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-Resident #2 was seen in the office for a

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING	HUB LAKE RO			
	I	ROXBO	RO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 33	D 273			
	tomography angiog vessels in the body artery disease of bil -There was an orde	-up appointment. angiography (Computed raphy used to look at blood) revealed severe peripheral lateral lower extremities. ar to refer the resident to refer the management of the				
	Review of Resident #2's PCP after-visit summary dated 08/27/24 revealed an order for vascular surgery for PAD management per the general surgeon.		y			
	discharge summary -Resident #2 preset department with a p -Resident #2 had a -The resident was r peripheral artery dis -There was an orde with dry gauze.	er for daily dressing change o follow up with a vascular				
	after-visit summary	#2's general surgeon's dated 09/06/24 revealed then e resident to follow up with urgeon.	-e			
		dent #2 on 09/17/24 at 1:56pr t been to a vascular clinic.	m			
	the vascular surger 3:32pm revealed: -On 09/11/24, they Resident #2.	w with a representative from y department on 09/17/24 at received a referral for as made for 10/04/24 for an				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			1		   F	,
		HAL073010	B. WING			9/2024
		1175010			1 03/1	312024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADIE	HEIGHTS ASSISTED I	2065 CHL	IB LAKE RO	AD		
WAPLE	HEIGHTS ASSISTED I	ROXBOR	O, NC 27573	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIEIGOT)		
D 273	Continued From page 34		D 273			
	ultrasound and 10/0	08/24 to see a surgeon.				
		pointments scheduled for				
		o the one made on 09/11/24.				
	rtoolaont #2, phor t	5 and one made on 66, 11,2 i.				
	Interview with the S	Supervisor on 09/18/24 at				
	8:05am revealed:					
		#2 to a follow-up appointment				
		rgeon who amputated the				
	resident's toe.					
	-She did not recall when the appointment with the					
		nought it was "about two				
		nt #2's hospitalization."				
		back from the post-op				
		ne general surgeon and had an				
	order to see a vasc					
		nt #2's appointment to see the				
	vascular surgeon o	the wound clinic and the				
		rere two different referrals.				
		2 went to the vascular surgeon				
		esident went back to the				
	hospital.	Sident Went back to the				
	•	her the hospital had made				
		pointment with a vascular				
	surgeon.					
	-She thought the ar	ppointment scheduled for				
		eled after the resident's				
	second hospitalizat	ion.				
	·					
	Telephone interviev	v with a medical assistant from				
		ral surgeon's office on				
	09/18/24 at 9:01am					
		een by the general surgeon on				
		sutures and debridement of				
	black necrotic tissu					
		upposed to be seen by a				
	vascular surgeon.	. 1.1 1.41				
		o blood flow to his lower				
		esident could "possibly" end up				
	with a below-the-kn	iee amputation.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			R
		HAL073010	)	B. WING			19/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED	LIVING		IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEI Y MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From particles and the vascular literview with Resident #2 had particles and particles and particles are sident #2 had particles and particles are sident #2 was and the expected Resident #2 and display and the particles are facility staff should and the properties of the expected Resident #2 was and the properties are sident #2 and the expected Resident #2 was and with the vasc when the order was and with the vasc was and	cointment needed specialist.  dent #2's general m revealed: oor blood supply e foot was restored in the properties of losing his dent #2 to see a vid.  with the hospital dent #2 was constructed at 9:58am revealed: dent #2 was constructed and received at scharged on 09/0 real information h vascular surgery expect a telephoral information had not received at next week, 09/0 call the [named] was provided. In the referral with the with the referral with the with the referral with the restance of a stent to import the surgery clinical surgery clinical with the dent #2 staff to have import to the properties with the vascular surgery clinical with the properties wi	surgeon on and unless ed, the s foot. vascular al discharge aled: sidered to be to inpatient 6/24. ad been clinic and the ne call. a call about 9/24, the clinic and a the clinic and a the strator on amediately ular surgeon.	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL073010		B. WING		R 9/2024
					1 03/1	3/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO O, NC 27573			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
D 273	Continued From pa	ge 36	D 273			
	ordered, maybe the could have been av	e resident's hospitalization /oided.				
	02/21/24 revealed of	ent #1's current FL-2 dated diagnoses included cerebral coronary artery disease, and				
	orders dated 05/06/	ent #1's signed physician /24 revealed there was an ssure (BP) checks twice daily.				
	medication adminis revealed:	t #1's July 2024 electronic stration record (eMAR) y to check and record BP				
	twice daily with a so 8:00pm.	cheduled time of 8:00am and				
		Care Provider (PCP) if eadings were greater than				
	checked 60 of 62 til	entation Resident #1's BP was mes with 33 of the BP an 160/90, ranging from				
	Examples included:	rom 07/01/24 to 07/31/24. : : :0pm, the BP reading was				
	181/102. -On 07/02/24 at 8:0	00pm, the BP reading was				
	170/110. -On 07/06/24 at 8:0 174/99.	Opm, the BP reading was				
	-On 07/12/24 at 8:0 156/111.	Opm, the BP reading was				
	157/101.	Oam, the BP reading was				
	172/104.	00am, the BP reading was				

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Division	of Health Service Re	egulation				_	
	IT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL0	73010	B. WING		R <b>09/19/2024</b>	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	_IVING		IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	MUST BE PRE	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 37		D 273			
	Review of Resident 08/01/24 to 08/08/2 -There was an entry twice daily with a so 8:00pmNotify the PCP if R greater than 160/90 -There was docume checked 10 of 16 till greater than 160/90 216/139, from 08/0 Examples included: -On 08/01/24 at 8:0 216/139On 08/05/24 at 8:0 162/92On 08/06/24 at 8:0 170/105On 08/07/24 at 8:0 152/94On 08/08/24 at 8:0 150/92.	44 revealed: by to check a cheduled time desident #1's checked. desident #1's desident	nd record BP le of 8:00am and le BP readings was lident #1's BP was of the BP readings om 98/58 to 8/24. Preading was Preading was Preading was Preading was Preading was Preading was				
	Review of Resident administration reco 08/31/24 revealed: -There was an entry twice daily with a so 8:00pmNotify the PCP if R greater than 160/90-There was no door BPs obtained.	rd (MAR) from y to check a cheduled time desident #1's ).	om 08/09/24 to  nd record BP ie of 8:00am and BP readings was				
	Review of Resident from 09/01/24 to 09 -There was an entry twice daily with a so	0/17/24 reve y to check a	aled: nd record BP				

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-Notify the PCP if Resident #1's BP readings was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED	
HAL073010 B. WING	R <b>09/19/2024</b>	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573		
(X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD TAG (EACH CORRECTIVE ACTION SHOUL	LD BE COMPLETE	
greater than 160/90There was no documentation of Resident #1's BPs obtained.  Review of Resident #1's PCP's progress notes from 07/01/24 to 08/08/24 revealed there was no documentation the PCP had been notified of elevated BP readings greater than 160/90.  Telephone interview with the PCP on 09/19/24 at 1:30pm revealed: -She had not been notified of any elevated BP readingsShe wanted to be notified of any elevated BP readings was greater than 160/90She wrote an order to be notified for a BP reading was greater than 160/90Since she had not been notified, she thought Resident #1 was maintaining a BP reading below 160/90Resident #1 was maintaining a BP reading below 160/90Resident #1 was at risk for a stroke or a heart attackBP readings that were elevated consistently over a period of time could cause organ damage to the kidneys, eyes and even the brain, and also increasing dementiaShe expected to be notified when Resident #1 had a BP reading above 160/90 so she could adjust medications to assist with lowering his BP.  Interview with a medication aide (MA) on 09/17/24 at 1:53pm revealed: -Resident #1's BP was checked every morning and every eveningShe did not notify the PCP of Resident #1's BP readingsResident #1's BP did not run high; his systolic pressure was between 140-160.		

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Division	<u>of Health Service Re</u>	egulation					
	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	I IDENTIFIC	CATION NUMBER:	A. BUILDING:		COMP	LETED
						R	
		HAL07	73010	B. WING			9/2024
NAME OF F	PROVIDER OR SUPPLIER	-	QTDEET AN	DRESS CITY S	STATE, ZIP CODE		
NAME OF F	-NOVIDEN ON SUFFEIEN			B LAKE RO			
MAPLE H	HEIGHTS ASSISTED I	_IVING		D, NC 27573			
	OLIMANA DV. OTA	TEMENT OF DE				ON	0.5-1
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DE MUST BE PRE		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L			TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
D 273	Continued From pa	ge 39		D 273			
	-She did not realize	Resident #1	1's PCP was to be				
	notified for BP read						
	-She should have notified the PCP of BP readings						
	greater than 160/90.						
	Interview with a sec	cond MA on (	09/17/24 at				
	2:25pm revealed:		55. 11, <b>2</b> 1 GC				
	-She took Resident	#1's BP twice	ce daily.				
	-She did not call Re	esident #1's I	PCP regarding the				
	BP readings.						
	-She did not realize						
	for BP readings and readings was great						
	-She had taken Res						
	higher than 160/90.		and it had boom				
	Interview with the M	1anager on 0	)9/18/24 at				
	4:00pm revealed:	otify the DCE	of DD roadings				
	-The MAs should no greater than 160/90		of BP readings				
	-The MAs should for		P's orders.				
	-The MAs were able						
	message to the PC	Ps when nee	eded.				
	-If the MAs were ha						
	PCP, the MAs shou	ıld have con	tacted her.				
	Telephone intention	v with the Ad	ministrator on				
	Telephone interview 09/19/24 at 9:59am		แบบเอนสเปา ปไ1				
	-The MAs were exp		ify the PCP of				
	elevated BP reading						
	parameters.	-					
	-The MA should do		n they notify the				
	PCP of elevated BF		lasidant #41-				
	-The PCP may wan						
	medication based of -An elevated BP co						
	#1, such as a stroke		arm to resident				
	, 23311 43 4 54 610						
	Based on observati						
	reviews, it was dete	ermined Res	ident #1 was not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING			R <b>19/2024</b>
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED L	IVING 2065 C	ADDRESS, CITY, S HUB LAKE RO DRO, NC 27573	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	interviewable.  b. Review of Reside orders dated 05/06/ order for nicotine pacessation) apply on Review of Resident 08/01/24 to 08/31/2-There was an entry apply one patch every 24 ho at 8:00am and from 8:00am.  There was no doct 08/04/24; the eMAF-There was document nicotine patch was from 08/09/24 to 08-There were no excound of the complete was an entry apply one patch every 24 ho of the complete was an entry apply one patch every 24 ho of the complete was an entry apply one patch every 24 ho at 8:00am.  Review of Resident from 09/01/24 to 09-There was an entry apply one patch every 24 ho at 8:00am.  Observation of mediate 2:22pm revealed	ent #1's signed physician (24 revealed there was an atches 21mg (for smoking e patch every 24 hours.  #1's August 2024 MAR from 4 revealed: y for nicotine patch 21mg ery day; remove old patch new patch, with a scheduled of 8:00am. entation nicotine patch was ours from 08/01/24 to 08/02/2 to 08/05/24 to 08/08/24 at 1 cmentation on 08/03/24 and 12 was blank. entation on the MAR the not applied to Resident #1 to 1/31/24. eptions documented from 4.  #1's September 2024 MAR 1/18/24 revealed: y for nicotine patch 21mg ery day; remove old patch new patch, with a scheduled of 8:00am. entation nicotine patch was ours from 09/01/24 to 09/18/24 there was a sealed box of 1 ailable for administration tha	4			

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Division	Division of Health Service Regulation								
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		LETED			
					R				
		HAL073010	B. WING		1	9/2024			
			ET ADDDESS SITV (	27475 7/D 00D5	, , ,				
NAME OF F	PROVIDER OR SUPPLIER		ET ADDRESS, CITY, S						
MAPLE H	HEIGHTS ASSISTED L	IVING	CHUB LAKE RO						
		ROX	BORO, NC 2757	3					
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE			
1710		,	1710	DEFICIENCY)					
D 070	O	44	D 070						
D 213	Continued From pa	ige 41	D 273						
	Interview with a MA	on 09/17/24 at 1:53pm							
	revealed:	·							
	-Resident #1 refuse	ed the nicotine patches.							
		of nicotine patches on the							
	medication cart.								
		ne nicotine patches to							
		se he would not allow her t	:O						
	apply the nicotine p								
		smoked anymore; he may	/						
	smoke 2 to 4 cigare								
		efused the nicotine patche	s for						
	months.	ata d tha DOD was addings							
		cted the PCP regarding ng the nicotine patches.							
		#1 to tell the PCP on the n	evt						
		fusing to wear the patches							
		circled her initials on the Ma							
		n the back of the MAR that							
		d the nicotine patch.	•						
		а по тосите разет.							
	Interview with a sec	cond MA on 09/17/24 at							
	2:25pm revealed:								
		ed the nicotine patches.							
	-Resident #1 had re	efused the nicotine patche	S						
	about 2 months.								
		with the PCP about Resid	ent						
	#1 refusing the nice								
		the PCP needed to be noti	fied						
	of Resident #1 refu	<u> </u>	• •						
		circled her initials on the Man	чк.						
		re on the paper MAR to							
	document when res	sidents refused medication	15.						
	Telephone intension	wwith the DCD on 00/10/2	1 at						
	1:30pm revealed:	v with the PCP on 09/19/24	t al						
		notified that Resident #1 w	/as						
	refusing the nicotine		,,,,						
	•	cotine patches were being							
		tent #1 smoked very little							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		HAL073010	B. WING		09/1	R 9/2024			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE					
2065 CHUB LAKE ROAD									
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573						
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
TAG	Continued From parallel Interview with the M 4:00pm revealed: -The MAs should not refused medication: -She expected the Interview 09/19/24 at 9:59am - The MAs were expanded a resident continual - The PCP may wan medication.  Based on observation reviews, it was detering the was a detering the managed; an order dressing changes of was not arranged; and an order for a ron 08/21/24 and 08 arranged until the resident was a "no sand an order for a ron 08/21/24 and 08 arranged until the resident was a "no sand an order for a ron 08/21/24 and 08 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until the resident was a "no sand an order for a ron 08/21/24 and 108 arranged until th	ge 42  Manager on 09/18/24 at  Detify the PCP when a resident of 3 days or more.  MAs to notify the PCP when a yrefused medications.  What with the Administrator on revealed: Dected to notify the PCP when ally refused a medication.  It to change or discontinue the ensure referral and follow up who had a toe amputation on der for a physical therapy and 08/27/24 that was not for home health nursing for on 08/27/24 and 09/03/24 that an order for a referral to the 21/24 and 08/27/24 that was ed for 09/16/24, but the show" for the appointment; referral to a vascular surgeon was re-hospitalized on ensure the failure to sident at further risk for wound due to a delay in his	TAG D 273	CROSS-REFERENCED TO THE APPR		DATE			
	an order to notify th readings greater that of 60 times in July 2	l a second resident who had e PCP of blood pressure an 160/90 which occurred 33 2024 and 5 of 10 times in sing the resident's risk of							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
				A. BUILDING:	A. BUILDING:		₹
		HAL0	73010	B. WING			19/2024
NAME OF PROVIDER O	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS A	ASSISTED	LIVING		IB LAKE RO O, NC 27573			
PREFIX (EACI	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
stroke ar organs (; physical A1 Viola The facil accordar	#1). This fa harm and tion.  ity providence with G RRECTIO ON SHALI	tack and lor ailure resulte neglect whi d a plan of p S. 131D-34	ng-term injuries to ed in serious ch constitutes an protection in on 09/18/24. PR THE TYPE A1 EED OCTOBER	D 273			
(c) The f following (3) writte a physicia and (4) imple orders sprule.  This Rule.  This Rule TYPE A2  Based or interview physician (#1, #2) stick blood dressing  The finding 1. Review	AC 13F .09 acility shall in the resign procedurian or other ementation pecified in a construction observation observation observation of sugars changes the construction of sugars changes the construction of Residents and sugars changes the construction of Residents and sugars changes the construction of Residents are:	02 Health Of assure door dent's record res, treatmer licensed has evident Subparagrated as evider DN door 2 of 3 sapplood press (FSBS) che hat were not dent door 2 of 3 sapplood press (FSBS) che hat were not dent were not dent were not dent were not dent door 2 of 3 sapplood press (FSBS) che hat were not dent were not dent were not dent were not dent were door dent were not dent were dent dent dent dent dent dent dent den	Care cumentation of the rd: ents or orders from ealth professional; res, treatments or aph (c)(3) of this need by:	D 276			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING			R 09/19/2024	
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED I	IVING 2065 C	ADDRESS, CITY, S' HUB LAKE ROA DRO, NC 27573	AD .			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)				
D 276	left 5th toeResident #2 requir and dressing and we Review of Resident dated 08/08/24 reve dressing daily to the Review of Resident summary dated 08/0rder for daily dress.  Review of Resident (PCP) order dated (-Apply betadine (and disinfection) to the dailyCover with dry dreschange daily and a soiled/drainage.  Review of Resident summary dated 08/0-Resident #2 did not the podiatry appoints a cleaned the weand a fabric band-athe resident was a daily until healed.  Review of Resident after-visit summary order for daily dress the ulcer on the left Review of Resident aftersident (a band dressing every 3 daily and dressing every 3 daily every 3 daily dressing every 3 daily dressing every 3 daily every 3 daily every 3 daily every 3 daily every 4 daily every 3 daily every 3 daily every 3 daily every 3 daily every 4 daily every 4 daily every 3 daily every 3 daily every 3 daily every 4 daily every 5 daily every 4 daily every 5 daily every 5 daily every 5 daily every 6 daily ev	ed assistance with bathing vas semi-ambulatory.  ##2's hospital discharge FL-2 ealed an order for wet-to-dry e left foot, toe number 5.  ##2's hospital discharge 108/24 revealed there was an sing change with dry gauze.  ##2's primary care provider 108/09/24 revealed:  antiseptic used for skin site of left toe amputation site of left toe amputation as needed (PRN)  ##2's podiatrist's after-visit 20/24 revealed:  thave a dressing on his toe them.  ound and applied betadine id.  advised he must do the same after the same of the sam	at to ly				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. D, NC 27573			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 276	Continued From pa	ge 45	D 276			
	home health nurse.					
	dated 09/03/24 reviencouraged to apply wound care) to the Review of Resident summary dated 09/daily dressing chandry gauze.  Review of Resident administration reco 08/09/24-08/31/24 -There was an entrigently cleanse the valine and pat dry va	t #2's surgeon's after-visit /06/24 revealed an order for ges to the left foot ulcer with  t #2's August 2024 medication rd (MAR) from revealed: y for sodium chloride 0.9% wound on the left foot using vith clean gauze before				
	applying new hydrocolloid dressing every 3 days with a scheduled time of 8:00am.  -There was no documentation that dressing changes were done from 08/09/24-08/31/24.  -There was an entry for betadine applied as directed to the skin once daily.  -There was no documentation that betadine had been applied from 08/09/24-08/31/24.					
	from 09/01/24-09/1 -There was an entr gently cleanse the v saline and pat dry v applying new hydro with a scheduled tir -There was docume been applied from 0 -There was an arro that the order was of	y for sodium chloride 0.9% wound on the left foot using with clean gauze before colloid dressing every 3 days me of 8:00am. entation that the dressing had 09/01/24-09/09/24. w drawn and documentation discontinued 09/06/24. y for betadine applied as				

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	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL07	3010	B. WING		R <b>09/19/2024</b>	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OT T	NOVIDER OR COLL FIELD			JB LAKE RO			
MAPLE I	HEIGHTS ASSISTED I	LIVING		O, NC 27573			,
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
D 276	Continued From pa	ge 46		D 276			
	-There was docume been applied from ( -There was an arro that the order was o	09/01/24-09/0 w drawn and	09/24. documentation				
	Review of Resident Professional Suppo 09/18/24 revealed: -Resident #2's currous cleanse the left 5th and apply hydrocoll -Resident #2's dres quarter-size serosa serum), with no odd -The LHPS nurse rounurse for dressing of	ent order was toe area with oid dressing sing was sat nguinous flui or. ecommende	s to gently n saline, pat dry, every 3 days. urated with a id (blood and				
	Telephone interview LHPS nurse on 09/-On 09/18/24, she sends the MA Resident #2's toesen she did not see wheremoved from Resident #2's toesen the dressing had send to blood and serum tissue) drainage, with the MA reported the MA reported the MA reported the MA recommended nursing and follows.	19/24 at 10:15 aw Resident to remove the saw Resident of she could shat type of drawn at type of drawn are sults thout odor. The same of concepts are for Resident for Residen	11am revealed: t #2 at the facility. the dressing on see the wound. the sessing was the sessing was the sessing was the sessing was the sessing the sessing the sessing the sessing the sessing was the sessing was the sessing was the sessing was the sessing the session that the sessi				
	Interview with the M 3:38pm revealed R hospital on 08/08/2	esident #2 re	turned from the				

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amputated with no orders for wound care.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		R	,
		HAL073010	B. WING		09/19/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	LIVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	Continued From pa	age 47	D 276			
	planner on 09/18/24 -Resident #2 was a 08/05/24 and disch -The facility staff re care person who co wound careShe could not say was, but typically sl -Resident #2 was s gauze to use until co obtained.  Telephone interview facility's contracted 9:45am revealed:	w with the hospital discharge 4 at 9:58am revealed: admitted to the hospital on arged on 08/08/24. ported the facility had a wound ould provide Resident #2's for sure who the staff person he spoke to the Manager. Sent back to the facility with dressing supplies were  w with a pharmacist from the pharmacy on 09/18/24 at e was dispensed on 08/27/24.				
	-Sodium chloride fo 08/27/24.	or irrigation was dispensed on been dispensed for Resident				
	Counselor on 09/19 -She saw Resident have a dressing on -On 08/11/24, 08/12 08/19/24, 08/20/24, Resident #2 did not -On 08/24/24 at 3:5 and the resident's t itShe asked the MA dressing, and she w have any dressings had the only key to were stored.	w with Resident #2's Licensed 9/24 at 3:36pm revealed: #2 on 08/09/24 and he did not his toe. 2/24, 08/13/24, 08/14/24, 08/21/24, and 08/22/24, t have a dressing on his toe. 64pm, she saw Resident #2 oe did not have a dressing on who was working about a was told the resident did not available and the Manager the area where the bandages er no one would help him wrap				

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573  (X5)	STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEAD AND ASSISTED LIVING  MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEAD LIVING  MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEAD LIVING  MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEAD L							{
CALL   DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   CROCK   DEFICIENCY   DEFI			HAL073010	B. WING			
CALL   DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 276  Continued From page 48  -She went to a local pharmacy and purchased gauze for Resident #2On 08/26/24 and 08/27/24, Resident #2 did not have dressing on his toeOn 08/27/24, she saw Resident #2's toe was more infected than she had seen it beforeThe PCP wrapped Resident #2's toe with the gauze provided by the Licensed CounselorOn 08/29/24 and 08/30/24, Resident #2 had a dressing on his toe and reported he and his roommate had applied the dressingOn 09/04/24, Resident #2 had a dressing on his toe on 09/04/24, but the white sock on the resident's foot was visibly solled with a greenish-yellow drainageOn 09/04/24, Resident #2 was transported by emergency medical services to the local hospitalShe had not seen Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2's wound should be covered to prevent exposure to germs and reduce the risk of infection.	MAPLE HEIGHTS ASSISTED LIVING						
-She went to a local pharmacy and purchased gauze for Resident #2.  -On 08/26/24 and 08/27/24, Resident #2 did not have dressing on his toe.  -On 08/27/24, she saw Resident #2's PCP, and the PCP was concerned Resident #2's toe was more infected than she had seen it before.  -The PCP wrapped Resident #2's toe with the gauze provided by the Licensed Courselor.  -On 08/29/24 and 08/30/24, Resident #2 had a dressing on his toe and reported he and his roommate had applied the dressing.  -On 09/04/24, Resident #2 called her and complained of pain and asked her to come to the facility.  -She could not tell if Resident #2 had a dressing on his toe on 09/04/24, but the white sock on the resident's foot was visibly soiled with a greenish-yellow drainage.  -On 09/04/24, Resident #2 was transported by emergency medical services to the local hospital.  -She had not seen Resident #2's noce he returned from the hospital.  Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2's wound should be covered to prevent exposure to germs and reduce the risk of infection.	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE
gauze for Resident #2On 08/26/24 and 08/27/24, Resident #2 did not have dressing on his toeOn 08/27/24, she saw Resident #2's PCP, and the PCP was concerned Resident #2's toe was more infected than she had seen it beforeThe PCP wrapped Resident #2's toe with the gauze provided by the Licensed CounselorOn 08/29/24 and 08/30/24, Resident #2 had a dressing on his toe and reported he and his roommate had applied the dressingOn 09/04/24, Resident #2 called her and complained of pain and asked her to come to the facilityShe could not tell if Resident #2 had a dressing on his toe on 09/04/24, but the white sock on the resident's foot was visibly soiled with a greenish-yellow drainageOn 09/04/24, Resident #2 was transported by emergency medical services to the local hospitalShe had not seen Resident #2 isnce he returned from the hospital.  Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2's wound should be covered to prevent exposure to germs and reduce the risk of infection.	D 276			D 276			
revealed: -He went to the hospital a couple of weeks ago because the amputated toe needed to be cleaned; he was there for 3 daysHis toe was wrapped every day until the toe		gauze for Resident -On 08/26/24 and 0 have dressing on hi -On 08/27/24, she si the PCP was conce more infected than -The PCP wrapped gauze provided by t -On 08/29/24 and 0 dressing on his toe roommate had appl -On 09/04/24, Resid complained of pain facilityShe could not tell in on his toe on 09/04/ resident's foot was greenish-yellow dra -On 09/04/24, Resid emergency medical -She had not seen if from the hospital.  Interview with Resid assistant on 09/19/2 Resident #2's woun prevent exposure to infection.  Interview with Resid revealed: -He went to the hosp because the amput cleaned; he was the	#2.  08/27/24, Resident #2 did not is toe. Saw Resident #2's PCP, and erned Resident #2's toe was she had seen it before.  Resident #2's toe with the the Licensed Counselor.  08/30/24, Resident #2 had a and reported he and his lied the dressing.  dent #2 called her and and asked her to come to the f Resident #2 had a dressing /24, but the white sock on the visibly soiled with a sinage.  dent #2 was transported by I services to the local hospital. Resident #2 since he returned dent #2's podiatrist's medical 24 at 2:05pm revealed and should be covered to be germs and reduce the risk of dent #2 on 09/17/24 at 1:56pm spital a couple of weeks ago sated toe needed to be ere for 3 days.				

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Observation of Resident #2's left foot on 09/17/24

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING		R <b>09/19/2024</b>	
		HAL0/3010			09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING			JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 49	D 276			
	at 1:56pm revealed the outside of the foot/toe area was covered with a dressing.					
	revealed:	dent #2 on 09/19/24 at 8:11am ity put a dressing on his toe				
		essing came off. ssings available for him to use counselor purchased some				
	dressings for him to useWhen he asked a MA about dressings, he was					
		sock on the foot with the				
		ect it, but the sock hurt it. In the pain until he got				
	-His foot was hurtin	g this morning, 09/19/24, ng had come undone during				
	the night, but he ha					
	-Staff had never us	er and bandaged his toe. ed betadine on his foot.				
	-He had dressing it	d wound cleanser on his foot. ems in his room that his r purchased for him to use.				
	Observation of Resident #2's left foot on 09/19/24 at 8:11am revealed the outside of the foot/toe area was covered with a dressing.					
	revealed:	on 09/18/24 at 2:28pm				
		ent dressing was to spray the cleanser and cover it with				
	-At one time betadi	ne was used every day. why the wound care was not				
			1			

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Interview with another MA on 09/19/24 at 8:09am

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	of Health Service Re				r	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN	O. COMMEDITION	IDENTIFICATION NOWIDEN.	A. BUILDING:			1-0
					F	₹
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHI	JB LAKE RO			
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIEIIO I )		
D 276	Continued From pa	ge 50	D 276			
	revealed:					
		nd dressing would not be				
	-Resident #1's wound dressing would not be changed again for a couple of days because a					
	nurse changed the	dressing yesterday, 09/18/24.				
		Resident #2's dressing was				
	"usually" changed e					
	-She did not answe	r what usually meant.				
	Interview with the Manager on 09/19/24 at					
	11:07am revealed:					
		ed from the hospital after his				
		uze and tape but no				
	instructions for usin					
		Resident #2's PCP for				
	orders.					
		's PCP saw the resident after				
	fine and did not nee	PCP stated the wound looked				
		ne back again, (the PCP				
		eks), the wound was not				
		the PCP wrote an order for a				
	dry dressing change					
		ordered betadine to be used;				
	<u> </u>	after the 2nd visit that the				
	betadine was delive					
		vent back to the hospital and arged, the new order was for				
		bottle of betadine was				
	returned to the pha					
		ent order for dressing changes				
	was every three day	ys using a duoderm dressing				
	(hydrocolloid).	_				
	Talamban (204) or 1	with Desident HOLE DOD				
	Telephone interview 09/19/24 at 9:22am	with Resident #2's PCP on				
		an open wound, it needed to				
	be covered.	an open would, it lieeded to				
		sident #2 after his toe had				
		s amputation area looked fine.				
		ave protected the area from				

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DIVISION	of Health Service Re	guiation				_	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
and Plan	OF CORRECTION	IDENTIFICATION NUMB	BER:	A. BUILDING:		COMP	LETED
						F	2
		HAL073010		B. WING		09/19/2024	
NAME OF	DOMED OF CHEST ISS		TDEET ASS	DECC OITY	STATE ZID CODE		<u> </u>
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING		B LAKE RO			
			KOXBORO	, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 51		D 276			
	rubbingResident #2 could that was fine, but as open wound it shoutand the facility staff did when changing Resident was nother sing, and the Market floorPutting the dressing the wound was nother wound was	have the area open to a soon as the resident and have been covered. It have been covered. It have been covered. It have a clean technication of the sident #2's dressing. It has not the clean dressing on the floor and then good. In order for a dry dressing the dream of the country of the cou	had an inique 2's ang on onto ored eived eived orders another on anould ds. atted rascular				
		ent #1's signed physicia 24 revealed there was					

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order for blood pressure (BP) checks twice daily.

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AND PLAN OF CORRECTION IDENTIFIC.	ATION NUMBER:	A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
HAL07	3010	B. WING			R 19/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING		B LAKE RO			
		O, NC 27573			
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 276 Continued From page 52		D 276			
Review of Resident #1's August administration record (MAR) from 08/31/24 revealed:  -There was an entry to check and twice daily with a scheduled time 8:00pm.  -Notify the Primary Care Provided Resident #1's BP readings were 160/90.  -There was no documentation of review.  Review of Resident #1's Septem from 09/01/24 to 09/18/24 revea -There was an entry to check and twice daily with a scheduled time 8:00pm.  -Notify the PCP if Resident #1's greater than 160/90.  -There was no documentation of review.  Telephone interview with the PC 1:30pm revealed:  -She could not adjust Resident # without BP readings.  -Resident #1 had a history of streeded to be monitored.  -If Resident #1's BP was extrem could have a stroke or a heart at BP readings that were elevated a period of time could cause org kidneys, eyes and even the brait increase the risk for dementia.  -She expected Resident #1's BP and recorded twice daily so she Resident #1's BP.	d record BP of 8:00am and or (PCP) if greater than f BP readings to the record BP of 8:00am and BP readings were f BP readings to P on 09/19/24 at the record BP older and his BP ely elevated he ttack consistently over an damage to the n, and also				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 20.22 10.			2
		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO			
	T		O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 53	D 276			
	09/17/24 at 1:53pm -Resident #1's BP v and every eveningShe documented h indicating she had o -She did not documented h there was nowhere -She should have d the back of the MAI  Interview with a sec 2:25pm revealed: -She took Resident -She documented F paper, but it was the dayShe did not documented MAR; there was no the MARShe could have do	revealed: was checked every morning her initials on the MAR checked Resident #1's BP. hent the BP reading because to document it on the MAR. locumented the BP reading on R. cond MA on 09/17/24 at #1's BP twice daily. Resident #1's BP on a sheet of rown away at the end of the hent Resident #1's BP on the where to document the BP on becumented the BP on the back				
	-She had not menti	one had told her to. oned to the Manager there cument the BP readings.				
	4:00pm revealed: -The facility change week of August 202 -The facility had be 08/09/24She reviewed the pin the facilityShe did not notice document the BP, lielectronic systemThe MAs had not a BP, until today, 09/2-She did not know the Resident #1's BP to	en on paper MARs since caper MARs when they arrived there was nowhere to ike there had been on the asked were to document the 19/24. he MAs were not documenting				

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1141 070040	B. WING		R <b>09/19/2024</b>	
		HAL073010			09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	B LAKE RO D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 276	adjust medications.  Telephone interview 09/19/24 at 9:59am -The MAs were expreadings on the MA-The facility docume time but there was BP readings on the -The PCP would readjust Resident #1'.  Based on observatireviews, it was determine was dated 05/06/2-There was an order times daily before nother was an order sugar) for blood suggive 0 units; 201-25/4 units; 301 to 350/2 units; greater than a Review of Resident 08/09/24 to 08/31/2-There was an entry sugar four times dated bedtime.	with the Administrator on revealed: pected to document the BP IR. pented on paper MARs at this no reason not to document the back of the MAR. fer to the BP readings to s BP medications.  ons, interviews, and record ermined Resident #1 was not pent #1's signed physician with a signed physician	D 276	DEFICIENCY)		
	readingsThere was an entry blood sugar reading 201-250 give 2 unit to 350 give 6 units; greater than 400 ca	y for Novolog SSI Insulin for gs of 200 or below give 0 units; s; 251 to 300 give 4 units; 301 351 to 400 give 8 units;				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
			A. BOILDING	· · · · · · · · · · · · · · · · · · ·		R
		HAL073010	B. WING			19/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING	HUB LAKE RO DRO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From pa	age 55	D 276			
	but no documentation if or how much Novolog insulin was administered.					
	from 09/01/24 to 09 -There was an entry sugar four times da bedtimeThere was no docureadingsThere was an entry blood sugar reading 201-250 give 2 unit to 350 give 6 units; greater than 400 ca -There was docume but no documentati insulin was adminis  Review of Resident dated 09/03/24 reve sugar readings doc	ry to check Resident #1's block aily before meals and at umentation of blood sugar by for Novolog SSI Insulin for gs of 200 or below give 0 units; 251 to 300 give 4 units; 30 351 to 400 give 8 units; all the PCP. entation of the MA's initials, ion if or how much Novolog stered.  It #1's PCP progress note ealed there was no blood cumented on the MAR for ptember 2024; monitor blood	s;			
	09/18/24 at 10:05ar -The current date of 06/02/24 at 11:34ar -There were two blood glucometerOn 06/01/24 at 1:00 reading of 300.	on the glucometer was				
	09/19/24 at 1:30pm	adjust Resident #1's insulin				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS CITY S	STATE, ZIP CODE		
		2065 CH	JB LAKE RO			
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 276	Continued From pa	age 56	D 276			
	-She was concerned that if she adjusted Resident #1's insulin he may have a hypoglycemic or hyperglycemic episode.					
	revealed: -Resident #1's blootimes daily before in She documented hindicating she had do sugarShe did not documbecause there was the MARShe should have downed readings on the bactory she administered when his blood sugus 200She looked at the Novolog insulin per was to administer.	A on 09/17/24 at 1:53pm od sugar was checked four meals and at bedtime. her initials on the MAR checked Resident #1's blood ment the blood sugar readings nowhere to document it on documented the blood sugar ck of the MAR. Novolog insulin to Resident #1 par readings were greater than prescription label on the box of its to see how many units she ment how many units she				
	administeredShe should have dunits of insulin on the There were some were below 200 and Novolog insulinShe checked Residual administered insulin MA.  Interview with the second control of the s	documented the number of				
	morning using his g	ot have a glucometer on the				

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-This morning was the first time she had used

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMPLETED	
					R	
		HAL073010	B. WING		1	9/2024
NAME OF E	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE ZID CODE		
NAIVIL OF F	-NOVIDEN ON SUFFEIEN					
MAPLE H	HEIGHTS ASSISTED L	IVING	HUB LAKE RO ORO, NC 2757:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D 276	Continued From pa	ge 57	D 276			
	Resident #1's gluco	ometer.				
	Interview with a second MA on 09/17/24 at					
	2:25pm revealed:					
	-Resident #1's blood sugar was checked four					
		neals and at bedtime.				
		Resident #1's blood sugar or	Га			
	sheet of paper, which was thrown away at the end of the day.					
	-She administered Novolog SSI to Resident #1 based on his blood sugar readings.					
		e insulin box to see how man	У			
		esident #1 was to receive. ot administered Novolog				
		s blood sugar was checked;				
		ecause his blood sugar was				
	below 200.	3				
		d sugar was below 200 befo	re			
		ot require Novolog insulin.				
		d sugar was high before lun	cn			
	Novolog insulin.	resident "always" needed				
		e to document how many				
	units of Novolog wa					
		oned to the Manager there				
		cument the blood sugar				
	readings.					
	Interview with the s	econd MA on 09/18/24 at				
	11:00am revealed:	233.74 17.7 CO. 107 107 L 1 dt				
		ed a new glucometer				
	yesterday, 09/17/24	1.				
		te the old glucometer, so sh	е			
	got a new one for R	kesident #1.				
	Interview with the S	Supervisor on 09/18/24 at				
	2:30pm revealed:	apor 1001 on 00/10/24 at				
		a new glucometer for Reside	nt			
	#1 before lunch on					

-There should have been 3 blood sugar readings
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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	0/ <b>202</b> 4
		2065 CHI	JB LAKE RO			
MAPLE	HEIGHTS ASSISTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 276	Continued From pa	ge 58	D 276			
	Resident #1's glucor checked the glucon -She did not know vereadings in his glucon the substitution in the	why there were only two				
	4:00pm revealed:  -The facility changed to a new pharmacy the first week of August 2024.  -The facility had been on paper MARs since 08/09/24.  -She reviewed the paper MARs when they arrived in the facility.  -She did not notice there was nowhere to document the blood sugar readings, like there had been on the electronic system.  -The MAs had not asked where to document the blood sugar readings, until today, 09/19/24.  -She did not know the MAs were not documenting Resident #1's blood sugar readings.  -The blood sugar readings were important for the PCP to review to adjust Resident #1's insulin.					
	9:59am revealed: -The MAs were exp sugar readings and -The facility docume time but that was no blood sugar reading -The PCP would re	dministrator on 09/19/24 at pected to document the blood the Novolog SSI on the MAR. ented on paper MAR at this preason not to document the gs on the back of the MAR. fer to the blood sugar readings ocumentation to adjust n.				
		ons, interviews, and record ermined Resident #1 was not				
	The facility failed to	implement orders for a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL073010	•	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	HALUTSUIC			STATE, ZIP CODE	09/	19/2024
	HEIGHTS ASSISTED I	IVING		IB LAKE RO	,		
WAPLE	HEIGH 13 A33131ED I	IVING	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI  MUST BE PRECEDEI  CONTROL  TEMENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	resident, who had a his left fifth toe was care was not compresident was admitt time with osteomyeresident, who had a stroke and an order daily that were not on substantial risk oconstitutes a Type A The facility provided accordance with G. CORRECTION DAY VIOLATION SHALL 19, 2024.	an order for wound amputated and to the hospital litis to his wound a history of hypertor to obtain BP reachtained. This fair f serious physical A2 Violation.  The for the TY  NOT EXCEED 1	the wound and the I a second (#2); and a second and a sension and adings twice lure resulted I harm, which stion in 19/19/24.  PE A2 DCTOBER	D 276			
D 282	10A NCAC 13F .09 Service  10A NCAC 13F .09 (a) Food Procurem Homes: (1) Facilities with a residents shall ensure Rules Governing the Care Facilities set for which are hereby in including subseque storage, preparation beverage under said This Rule is not mediated and preparation of the	04 Nutrition and litent and Safety in licensed capaciture food services e Sanitation of Rorth in 15A NCAC corporated by rent amendments, n, and serving foonitary conditions.	Food Service Adult Care  y of 7 to 12 comply with esidential C 18A .1600 ference, assuring od and  by: ws and e all food	D 282			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		HAL073010	B. WING			R <b>19/2024</b>
		HAL073010			1 09/	19/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADIFI	HEIGHTS ASSISTED L	IVING 2065 CHU	JB LAKE RO	AD		
	ILIOITIO AGGIGTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 60	D 282			
	dining room tables a dirty reach-in cool opener, dirty stove, and windowsills, dir and storage contair shelves and floors i floors in the kitchen dining room and kitchen	ary conditions related to dirty and floors in the dining room, ler and freezer, a dirty can dirty hood vent, dirty walls ty cups and mugs, dirty bowls ners, rodent droppings on n the dry storage area, dirty, and live flies and gnats in the chen.				
	The findings are:					
	Review of the local health department (LHD) food establishment inspection report for the kitchen dated 03/26/24 revealed:  -The facility received a score of 94.5.  -There was documentation of observations of rodent droppings found on shelves in the [dry] storage room and the need to notify the pest control company.					
	8:00am revealed: -There were four lor room; three tables had bee juice, cups of milk, coffee mugs, a disp spoonThere was rice on dining room chairs atablesThere were multipl substitute on the flot-There was rice on place settingsThere was debris a scattered on the tables.	a place setting at one of the and pieces of dried food				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	·		₹
		HAL073010	B. WING			9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE H	IEIGHTS ASSISTED I	IVING	JB LAKE RO 20, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	hair stuck to it at or -There were red co the glaze that were -There were blue co stain coating the ins brownish black on t -There were brown jagged rim that wer -There were opaqu scuffed rough rims smooth and had a t and insideThere were flies fly and landing on the orange juice and cu -There were gnats and landing on the orange juice and cu -The tables were a large areas that we grayish-blackStaff were swatting set the tables and s  Observation of the 8:37am revealed m at flies while they at Observation of the revealed: -There was no cleak kitchenThere were flies of the book with the th counters, the dishw the kitchen.	e powder. It substance with a long black he place setting. Iffee mugs that had cracks in black. In plack. Iffee mugs that had a brown side of the cup and was the outside. If coffee cups that had a rough e not smooth. If reusable plastic cups with and chips that were not black buildup on the outside wing around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk. If ying around the dining room utensils and the rims of the lups of milk.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		E SURVEY PLETED
		HAL073010	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING	IUB LAKE ROA	AD.		
		ROXBO	RO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 62	D 282			
	there were flies and	nts eating their snack and I gnats landing on the tables. vatting and waving away flies				
	revealed: -There was a reach -There was a buildu handles of the reac scrapped off with a -The inside of the c residueThere was water d the cooler and colle top shelfThere was a case lemonade and iced of a deli turkey store pan of waterThere was a dried bottom of the coole of the cooler; there sitting on the liquidThere was a dried	ooler doors had grayish-black ripping from the fans inside ecting in a pan of water on the of fresh tomatoes, pitchers of tea, a gallon of milk and a hated on the shelves under the and wet red liquid in the r that extended to both sides was a pan of ground beef	e			
	wall of the coolerThere was thick but a blackish red substand the ledges whe coolerThere was a reach in the dry storage at a -There was a sticky smudges on the hafreezerThere was a black freezer doors and that the bottom of the	uild-up of food and debris and tance on the metal shelves are the shelves sat in the in freezer with double doors rea.  I substance and black andles and the outside of the film on the gaskets to the here was a dried liquid pooled				

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		HAL073010	B. WING		00/1	₹ 9/2024
					1 09/1	3/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO O, NC 27573			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES			ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 63	D 282			
D 282	covering the can opsupport plate and ethe support plate and ethe support plate mander of the support plate mander of the support plate mander of the support plate of the support	pener handle, blade, the extended piece that went into counted to the table. Ilaneous pieces of equipment ading bowls, mugs and cups with black smudges on the of the equipment and there ough areas on the surfaces of the mugs and cups. Torage containers with food in udges, the surfaces and the ough and sticky to the touch. It black layer of baked on the grates on the stove. Too on the burners on the sames to the pilot lights were rease and debris around the electory. It is a surface and pans. It is a surface and a county of yellow and brown to of the stove. It is a surface and a county of yellow grease and	D 282			
	food preparation ar	ea, food sinks, shelving and eas in the kitchen. ebs hanging from the walls				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL07301	0	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
		11/11/0		B LAKE RO			
MAPLE	HEIGHTS ASSISTED I	LIVING	ROXBOR	O, NC 27573	<b>;</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 64		D 282			
	and ceiling with thic hanging from them.	ck layers of grayi	sh black dust				
	Review of the Septe for the kitchen reve		ining schedule				
	-The floors in the di be swept and mopp -The floors in the pa to be mopped daily.	oed daily after ev antry [dry storage	ery meal.				
	-The table and chai be wiped off and cle snack.	rs in the dining re eaned after ever	y meal and				
	-There were initials were completed on 09/17/24.	ce daily from 09/	01/24 to				
	-The freezer shelve to be cleaned week documenting the ta and 09/07/24.	ly; there were in	itials				
	-The hood [vent] an were to be cleaned	weekly; there wa	as nothing				
	documented on the had been complete						
	-The shelves in the be wiped and clean documenting the ta and 09/12/24.	ed weekly; there	were initials				
	-The grates on top be cleaned weekly; documenting the ta 09/07/24.	there were initia	ls				
	-The windowsills we there was nothing o completed from 09/	locumenting the	task was				
	Interview with a res revealed:		•				
	-He had seen flies of the had swatted the						

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDING.		_	,
		HAL073010	B. WING		F 09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADIE	HEIGHTS ASSISTED I	1VING 2065 CHU	B LAKE RO	AD		
WAFLE	HEIGHTS ASSISTED I	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 282	Continued From page 65		D 282			
	dining room eating.					
	9:00am revealed: -He saw flies in the them awayThe staff had flysw inside.	cond resident on 09/18/24 at dining room and would wave vatters they used to kill flies flies in the dining room after				
	from the county's L revealed: -The kitchen was in four monthsShe had inspected revisited a verification the rodent droppingShe had cited the from the scoreThe pest control or come out and treat verification dateThe rodent dropping verification visitShe had deducted the kitchen not beir -She did not note the inspection report, breports she had not and soot on the particular she cited the stove reports but did not on the remaining flame there was improper were dirty and need -The improper flame	droppings and deducted points ompany was scheduled to the facility before the ang were cleaned up at the points for the equipment in a maintained and clean. The hood in the kitchen on the ut on previous inspection ted the buildup of grease, dirt as and the stove. The in previous inspection deduct points. The pilot light indicated a airflow because the burners				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL07301	10	B. WING		<b>I</b>	R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
		N/IN/O		IB LAKE RO			
MAPLE	HEIGHTS ASSISTED I	LIVING	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG		TEMENT OF DEFICII ' MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 66		D 282			
	her visits.						
	Telephone interview fire suppression system 209/18/24 at 4:33pm -They had done an suppression system 2024They included record the reports they pre-The were required local Fire MarshallIf the flame on the there was soot on the dirt and greaseHe did not have an turned in for the Fire	stem inspection revealed: inspection of the inspection of the interest of the	company on e fire [hood] in July or cleaning on orts into the ng orange and ns it was due to on the stove. the report he				
	Telephone interview on 09/19/24 at 1:56 -He was new to his inspected the facilit complianceThe ductwork for the cleaned by a private year but was not regard but was not regard dust and the stand dust and the stand dust and the stand have to law hen he did is inspeciallyThe grease and did be a potential risk for the working correctly.	pm revealed: position and ha y to make sure the he hood vent sh e contractor at le quired. huld have been f ove should also dirt buildup. ook at the stove ection. yould not preven rt buildup on the or a fire.	d not they were in ould be east once a free of grease have been e and the hood at it from e stove could				
	Interview with the crevealed: -The stove did not viblack soot in the kit	work correctly a	•				

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ווטופועום	of Health Service Re	guiation	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
					F	2
		HAL073010	B. WING			9/2024
					1 00/1	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S			
MAPLE I	HEIGHTS ASSISTED L	IVING	HUB LAKE RO			
		ROXBO	PRO, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 67	D 282			
	and pans used on t touched the soot we hands.  -The staff would touk itchen and transfer.  -The cleaning scheroffice.  -She washed all the machine.  -Once the soot from she could not get it.  -The tables and floor supposed to be cleared meal.  -She did not work the notice the floors and been cleaned from the flies had been building for about two	dule was kept in the Manage kitchen equipment in the distributed in the stove was on something to come off. Or sin the dining room were aned three times a day after the day before, so she did not distributed the day before.  In the day before, so she did not distributed the day before.  In the day before, and the day before.	rs sh g,			
	Second interview w 2:23pm revealed: -There was a clean -She was the only of -She had deep cleat about a month agoShe removed the grands with oven clean -She tried to deep of to the stove about of -The stove was on once weeklyShe wiped the stove -The Supervisor over with meals; the Supervisor over	cook and kitchen staff. Inned the grates to the stove grates and sprayed them in the ner. It is also the grates	s t			

-She soaked equipment in bleach and detergent
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DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMP	LETED
					F	,
		HAL073010	B. WING			9/2024
			<u>.                                    </u>		1 00/1	0/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADIFI	HEIGHTS ASSISTED L	IVING 2065 CHU	JB LAKE RO	AD		
	ILIOITIO AGGIGTED I	ROXBOR	O, NC 27573	3		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				,		
D 282	Continued From pa	ge 68	D 282			
	every other day incl	luding coffee mugs, drinking				
		od storage containers but				
		soot from the stove she could				
	not remove at all.	Soot from the Stove She Sould				
		why there was so much soot				
	from the stove.	,				
		upervisor about the soot from				
		and the Supervisor was going				
	to tell the maintena					
	-The coffee mugs a	and drinking cups had wear				
		nd had been at the facility and				
	used for a while.	•				
		ne chips in the cups; there				
		or new ones to replace the				
	chipped cups.					
		ne buildup on the cups.				
		the last time the hood system				
	was cleaned.					
		tside company had to clean				
		he did not know the kitchen				
		ble for the cleaning.				
		ne hood was dirty and needed				
	company come to c	he Supervisor to have a				
		ed the floor in the kitchen or				
	the dry storage area					
		ipposed to be swept and				
		at the end of the day.				
		nad swept and mopped the				
		week and a half ago.				
		staff in the kitchen and she just				
		itine going to get everything				
	done.					
	-She had seen the	rodent dropping and she had				
	seen live mice whe	n she first started working at				
	the facility about for					
		control company representative				
	about a month ago					
		ompany had put sticky traps				
	down to catch the n	nice; she had not seen mice				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		1141.072040	B. WING			
		HAL073010	B: Willo		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHL	JB LAKE RO	AD		
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573			
	OLIMAN DV OTA		1		N. I	0.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
D 000	0 " 15	20	D 000			
D 282	Continued From pa	ige 69	D 282			
	since then, but she	was still seeing the droppings.				
		ne dirty, smut, spider webs,				
		the windowsills but she had not				
	had the chance to c					
		ere not on the cleaning				
	schedule.	ore not on the oleaning				
		each in cooler and freezer				
		be cleaned every other day.				
		pler had been dripping since				
		acility, the pan that collected				
		changed every day because				
		ed the previous week.				
		elves the walls and the bottom				
	of the cooler every	er had been defrosted and				
	cleaned the previou					
		e freezer door were supposed				
	to be cleaned every					
		as not on the cleaning				
		ould be cleaned with soap and				
		y day; it had to be removed				
	•	ne table and washed in the				
	sink.	U . I ( C				
		the last time the can opener				
	had been cleaned.					
	Jakam darrinda a					
		acility's maintenance staff on				<b>]</b>
	09/18/24 at 4:21pm					
		from the Manager when there				<b>]</b>
	were repairs neede					
		th the internal dripping was not				<b>]</b>
	on his list for repairs					<b>]</b>
		would soot the pots and pans				<b>]</b>
	and the kitchen.					<b>]</b>
		someone from the kitchen				<b>]</b>
		es on the pilot light on the				
	stove needed to be					<b>]</b>
		e burners on the stove himself				<b>]</b>
		they were dirty again.				<b>]</b>
	-He thought the hoo	od system in the kitchen had				

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						,
		1141 070040	B. WING		F	
		HAL073010	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHI	JB LAKE RO	ΔD		
MAPLE H	HEIGHTS ASSISTED L	IVING	O, NC 27573			
			U, NC 2757			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
17.0		,	1710	DEFICIENCY)		
D 282	Continued From pa	ge 70	D 282			
	heen cleaned by a	contracted company about a				
	•	contracted company about a				
	year ago.					
	Intorvious with the S	Supervisor on 09/18/24 at				
	3:28pm revealed:	upervisor on 03/10/24 at				
	•	itahan ingluding the training				
	the cooks and the s	itchen including the training,				
		on the cleaning schedule for				
		ay; but she did walk around				
	and look every day.					
		ngs, but she thought the				
	sanitation in the kito					
		ne kitchen would get bad if it				
	was not kept up wit					
		and weekly cleaning schedule				
	in the kitchen.					
		clean the stove once a week.				
		the daily cleaning schedule				
		deep cleaning were on the				
	weekly schedule.					
		olash, shelf, and oven door				
	were to be wiped of					
		stove were to be removed				
	_	ser and food scrubbed off				
	when they were dee					
	, .	on the stove were cleaned				
	monthly.					
		he stove before and two days				
		ame as it had before she				
	cleaned it.					
		oot up the pots and pans and				
		ouching other equipment				
		soot onto the equipment.				
		the equipment it was hard to				
	get off.					
		ean the coffee mugs, cups,				
		orage containers to remove the				
	soot as much as sh					
	-She had soaked th	ne coffee mugs and cups once				

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a week to try and destain them and remove as

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DIVISION	of Health Service Re	egulation			T	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		HAL073010	B. WING			9/2024
NAME OF I				OTATE ZID CODE		<u></u>
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED L	IVING	B LAKE RO			
		ROXBOR	O, NC 27573	3		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
IAG	REGOLATOR OR E	oo ibertii Tiito iiti ottiiktiotti	TAG	DEFICIENCY)	10/112	
			5.000			
D 282	Continued From pa	ge /1	D 282			
	much as she could,	, but she could not get it all off.				
	-The mugs and cup	s were supposed to be thrown				
		ere damaged or cracked.				
		e there were cracks in any of				
	the coffee mugs.	•				
	-She had noticed th	ne hood needed to be cleaned				
	and was on the clea	aning schedule either weekly				
	or monthly.					
	-The last time the h	lood was cleaned was by a				
	professional compa	any in December 2023.				
		e dining room were supposed				
	to be cleared and c	leaned after every meal and				
	after every snack.					
		ining room were supposed to				
		ped once a day or as needed				
	and were on the cle					
		posed to check the dining				
		ent home in the evening.				
		kitchen and the dry storage				
		eaning schedule and were				
		ept and mopped at the end of				
	and shelves.	inder and behind equipment				
		ced behind the equipment or				
		n the dry storeroom in about a				
	week.	if the dry storeroom in about a				
		er was supposed to be deep				
		luding the inside and the				
		ne cleaning schedule.				
		er was defrosted and cleaned				
		and was on the cleaning				
	schedule for deep of					
		each in freezer were not				
		reezer was recently defrosted.				
		ne rodent droppings in the dry				
		e, but she had not been back				
		y, 09/10/24, the week before				
	and she did not lool					
		ice were coming from the				
	basement of the fac					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		   F	,
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPIFI	HEIGHTS ASSISTED I	IVING	B LAKE RO			
	TILIGITIO AGGIGTED I	ROXBOR	D, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 72	D 282			
	company treating for the pest control or down to capture migotten better.  The shelves in the supposed to be cleand were on the cleaning schedule on them.  She could not recate the cleaning schedule on them.  She had noticed the yesterday; the walls schedule.  She thought the griftom the doors when the doors when the doors when the flies and gnate ago.  She had just not not set to the pest control of the set to the pest control of the pest co	contracted pest control or mice, flies and gnats. It is company had put sticky traps ce and she thought it had a dry storage area were aned by the cook once a week caning schedule. It if the windowsills were on the windowsills were on the week had noticed they were see they had soot and dead flies are cobwebs on the walls is were on the weekly cleaning that and flies were coming in they were opened. It is had gotten bad about a week to tified the pest control the increase in flies and				
	Interview with the Manager on 09/19/24 at 8:26am revealed: -She checked on the kitchen cleaning schedule every day and looked at certain things in the kitchen at least once a dayShe checked to see if the floors were swept and mopped every morning when she came inThe cook was supposed to sweep and mop the floors in the dining room, dry storage area and the kitchen at the end of the day and after meals as neededThe stove was supposed to be wiped down once a day and was on the daily cleaning scheduleThe stove grates were supposed to be removed and deep cleaned as needed; when she looked at the stove on Monday, 09/16/24, she noticed the stove was not clean.					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.2510.		R	
		HAL073010	B. WING		1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADIF	HEIGHTS ASSISTED L	IVING 2065 CHU	B LAKE RO	AD		
WAFELI	ILIGITIO AGGISTED I	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 282	Continued From pa	ge 73	D 282			
D 282	been cleaned in a vicleaned in July 202 -She believed the his schedule to be cleat longer than a month. There had been ar company that would not recall the name the facilityShe had seen the 109/16/24, and notice. She had cleaned the 2024 or May 2024 at last time it had been she was concerned from the hood into the cookedThere was no reast cleaned and was diened and she diened and would discard them she had looked at tables on Monday been if they were chiened and she did not known and s	d vent in the kitchen had not while; she knew it was not 4 or August of 2024. ood vent was on the cleaning ned monthly, but it had been in since it had been cleaned. In outside hood cleaning diclean the hood, and she did or the last time they were at thood vent on Monday, ed it needed to be cleaned. The hood vent herself in April and she believed that was the indone. If the debris could drip and fall the food while it was being the cups and mugs to see if the cups and mugs about would be soaked in bleach as the cups and mugs on the out had not inspected them to pped, cracked or damaged. The kitchen had soot because the had been worse this year	D 282			
	windowsills.	cted the pest control company				

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Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BUILDING.			₹
		HAL0730	10	B. WING		l l	19/2024
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING		IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 282	Continued From pa	_	it the nest	D 282			
	because she had n control company be flies and gnats.  -The pest control co and putting sticky tr  -The facility was do gaps in the doors a down at the outside.  -She called the pes was a report of eve would return to the -She had seen a liv night before and a l month ago.  -The shelves in the weekly cleaning scl-These staff would floor in the shelves droppings.  -The staff should had floors when they sale a weekly deep clead cleaning schedule to the shelp the call the shelp the shelp the call the shelp the shelp the shelp the shelp the call the shelp the	eing able to do a company was spraps down for ming all they could had ordered a doors to keep to control compand facility. The mouse at the ive one in the horder would ave cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the woroppings. It is a down the could have cleaned the could have could have could have cleaned the could have could have could have could have could have could have could h	raying monthly nice. Id do about the a strip to put mice out. In y when there and they fireplace the all over a ea were on the as needed. In y so fif the do be more  shelving and freezer were on and a daily spills.				
	cleaning schedule a every use. -She had used the	and should be w can opener on I	viped off after Monday,				
	09/16/24, and wiped it off after she used itShe did not know if the windowsills were on the cleaning scheduleShe had noticed this week the windowsills needed to be cleaned because of the soot.						
	Telephone interview 09/19/24 at 11:40ar -The staff in the kito that they were to fo -She reviewed the devening and had keepless.	n revealed: chen had a clea llow. cleaning schedu	ning schedule ule every				

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DIVISION	of Health Service Re					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	{
		HAL073010	B. WING		1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	QTDEET ADI	DRESS CITY S	STATE, ZIP CODE		
NAME OF F	TROVIDER OR SUFFEIER		B LAKE RO			
MAPLE H	HEIGHTS ASSISTED L	IVING	D, NC 27573			
	O. III 41 4 D. / O.T.				211	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 282	Continued From pa	ge 75	D 282			
	morning of 09/17/24	4.				
		ng on the stove was supposed				
		e burners were supposed to				
		y and deep cleaned.				
		complaint of soot from the				
		a problem with soot the flame				
	needed to be turned					
		hood vent needed to be taken				
		ashed or taken to a car wash it once a quarter or as needed;				
		chen staff to maintain the				
	ventilation system.	onon otan to maintain the				
		outside company to clean the				
	duct work in the hoo					
		kitchen and dining room were				
		pped and swept daily; he did				
		re on the cleaning schedule.				
		control company that came to				
		for the issue with rodents. there was a visit report from				
	the pest control con	•				
		of a live fly or gnat issue; the				
	Manager had not re	, ,				
		supposed to monitor the				
	_	chen let him know when there				
	were issues.					
	A41					
		e interview with the facility's				
	3:01pm were unsuc	ntrol company on 09/19/24 at				
	o.o ipini were unsuc	oossiui.				
D 206	104 NCAC 12E 00	04/b)/1) Nutrition and Faad	D 286			
ט ∠00	Service	04(b)(1) Nutrition and Food	D 200			
	OCI VIOC					
	10A NCAC 13F .09	04 Nutrition and Food Service				
		on and Service in Adult Care				
	Homes:					
		all include a napkin and				
		ce setting consisting of at least				

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Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE S COMPL	
			B. WING		R	
		HAL073010	D. WING		09/19	)/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
МДРІБІ	HEIGHTS ASSISTED I	IVING 2065 CHU	B LAKE RO	AD		
	ILIGITIO AGGIGILD I	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 286	Continued From pa	ge 76	D 286			
	•	, plate, and beverage				
	failed to offer table consisting of a non-	et as evidenced by: ons and interviews, the facility service with a place setting disposable knife, fork, spoon, containers for each meal.				
	The findings are:					
	Observation of the dining room on 09/17/24 at 8:00am revealed:  -The tables were preset with a disposable napkin a non-disposable fork and a non-disposable spoon.  -There was a coffee cup, a cup of water and a cup of juice at each place setting.  -There was no knife at any of the place settings.					
	8:37am revealed: -Scrambled eggs, a toast, jelly packets, coffee were served -There were three r to spread their jelly -There was a reside the sausage patty in and ate the edges were to pick up their sausage. There was one resumd tore her sausage and tore her sausage.	esidents who used their forks				

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DIVISION	Division of Health Service Regulation							
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED		
					F	,		
		HAL073010	B. WING			9/2024		
			-		1 00/1	0,2024		
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE				
MAPLE H	HEIGHTS ASSISTED L	IVING	UB LAKE RO					
		ROXBO	RO, NC 27573	3				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE		
140			IAG	DEFICIENCY)				
D 200	0		D 200					
D 286	Continued From pa	ige //	D 286					
	Observation of the lunch meal on 09/17/24 at							
	11:49am revealed:							
		reset with a napkin, a fork, a						
		ced tea; there were no knives						
	on the table.							
		e served a porkchop with nalf of a baked potato, green						
	0,7	nan of a baked potato, green wheat roll, fruit cocktail, water,						
	and iced tea.	wheat foll, Ifult cocktall, water,						
		ed up his porkchop by placing						
		er of the porkchop and lowered	1					
	his head to the plate							
		requested a knife; staff						
	brought the residen							
		empted to use the side of her						
	•	chop; after several attempts						
		chop up with her fork and						
		d her head to the plate to take						
	bites.							
		icked his porkchop up with his						
	fingers and took bit	es. one resident's porkchop for						
		side of the fork to cut.						
	and about the	side of the fork to out.						
	Observation of the	kitchen on 09/17/24 at 1:52pn	ı					
		e four knives available for						
	residents to use du	ring meals.						
		ident on 09/17/24 at 2:42pm						
	revealed:	Lauren de la contra del la contra del la contra del la contra de la contra del la contra de la contra de la contra del la co						
		knife to eat his breakfast or						
	lunch with.	for a knife because he never						
	thought to ask for o							
		nis meat with his fork or his						
		e could not cut it with his fork.						
	goro to out it il lic	oddia not dat it with the fork.						
	Interview with a sec	cond resident on 09/18/24 at						

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9:00am revealed:

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DIVISION	of Health Service Re	guiation				_	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUP		` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION	NUMBEK:	A. BUILDING:		COMP	LETED
						F	₹
		HAL073010		B. WING			9/2024
		12.20.0010				1 00/1	0,202-
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING		IB LAKE RO			
	12.011.07.00.0122		ROXBOR	O, NC 27573	3		
(X4) ID		TEMENT OF DEFICIEN		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		' MUST BE PRECEDED SC IDENTIFYING INFO		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	REGOLATOR OR E	OO IDEIVIII TIIVO IIVI O	raw arion)	TAG	DEFICIENCY)	71 10/11	
D 286	Continued From pa	ge 78		D 286			
	-He had never been given a knife to use while						
	eating.	. 9					
	-He did not know he	e could ask for a l	knife.				
	-He would use the						
	-When he could not						
	his fork, he would ju	ust pick it up with	his fingers				
	and chew on it like						
	day before.	•	·				
	Interview with a third resident on 09/18/24 at		18/24 at				
	9:07am revealed:						
	-The staff did not gi	ve the residents I	knives; he did				
	not know why.						
	-The staff cut up the						
	residents who could	d not chew or had	swallowing				
	problems.						
	-He cut his own foo						
	the food still and us	ed the side of his	fork to cut				
	with.						
	-Sometimes he wou		at with his				
	fork and eat it off th						
	-He had never aske		did not know				
	if he was allowed to	nave a knite.					
	Interview with the c	ook on 00/17/24 :	at 2:14nm				
	revealed:	OUR OII 09/11/24 8	aι				
	-The residents did r	not use knives the	n they ate				
	their meals.	iot use milves tile	on they ate				
	-The kitchen staff c	ut food up for the	residents				
	that needed to have		1001401110				
	-The residents coul		nife if thev				
	wanted one.						
	-The residents coul	d ask the staff to	cut their food				
	for them.						
	Second interview w	ith the cook on 09	9/18/24 at				
	2:23pm revealed:						
	-The Supervisor ga	ve her a supply o	f knives to				
	use in the kitchen a						

09/17/24.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING		R 09/19/2024	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/1	0/2024
MAPLE	HEIGHTS ASSISTED I	2065 CHU	B LAKE RO			
		ROXBORO	D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 286	Continued From pa	ge 79	D 286			
	residents because to the residents because to the residents because safe for the residents and a safe for the resident was safe for the resident with the Saider resident with a knife them out for the residents could because they did not bec	give the residents knives of use them. In that threatened another e, so they stopped putting sidents to use about four to d ask for a knife if they wanted ould cut their meat if they				
	Interview with the Manager on 09/19/24 at 8:26am revealed:  -The residents should have each had a knife at their place setting.  -She had not noticed the residents did not have knives to eat their meals with.  -There were knives in storage and the kitchen should have had plenty of knives for the residents.  Telephone interview with the Administrator on 09/19/24 at 11:40am revealed:  -Knives should always be part of the place setting.  -The facility had knives for each resident and some extra.  -He did not know why the staff did not put knives at the place setting for the residents.					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL073010	B. WING		R 09/19/2024	
			l		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER		BLAKE RO	STATE, ZIP CODE An		
MAPLE H	IEIGHTS ASSISTED I	IVING	D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 299	Continued From pa	ge 80	D 299			
D 299	10A NCAC 13F .09 Service	04(d)(3) Nutrition And Food	D 299			
	(d) Food Requirem (3) Daily menus for on the U.S. Departr guidelines for Amer hereby incorporated subsequent amend guidelines can be for https://dietaryguidelines/	04 Nutrition And Food Service ents in Adult Care Homes: regular diets shall be based ment of Agriculture Dietary icans 2020-2025, which are d by reference including ments and editions. These bund at lines.gov/sites/default/files/202 elines_for_Americans-2020-20				
	interviews the facilit	et as evidenced by: ons, record reviews and ty failed to ensure a serving of ree times daily to residents.				
	The findings are:					
	Review of the facility's posted week at a glance menu for the week of 09/16/24 to 09/20/24 revealed milk was listed on the menu three times daily for breakfast, lunch and dinner.					
	11:49am to 12:18pr -The residents were onions and gravy, h bean casserole, a v and iced tea.	lunch meal on 09/17/24 from m revealed: e served a porkchop with half of a baked potato, green wheat roll, fruit cocktail, water, e not offered or served milk to				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
					R	
		HAL073010	b. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 299	Continued From pa	ge 81	D 299			
	Observation of the 11:45am to 12:12pr -The residents were mashed potatoes wheat roll, Peach co-The residents were drink.	lunch meal on 09/18/24 from revealed: e served meatloaf with gravy, vith gravy, green beans, a obbler, water, and iced tea. e not offered or served milk to				
	Observation of the kitchen on 09/17/24 at 1:52pm revealed there were three and a half gallons of whole milk in the reach in cooler.					
	Interview with a resident on 09/17/24 at 2:42pm revealed: -He had never been offered milk at lunch and dinner or at his snackHe did not want to drink milk all day long but would drink it sometimes with certain meals.					
	Interview with a second resident on 09/18/24 at 9:00am revealed: -He was only served milk at breakfastHe liked to drink milk and would drink it more often if it was offered or given to him.					
	9:07am revealed: -He drank milk ever -Milk was not serve day or offered to hir -He had to ask for r milk, he would be g -If milk was offered	ed to him any other times of the m.  milk at other meals; if they had liven it when he asked.  to him, he would drink it more ked it; he might drink it at				
	revealed: -Milk was only serve	ook on 09/18/24 at 2:23pm ed at breakfast. now many times a day milk				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING			R <b>19/2024</b>
	PROVIDER OR SUPPLIER	IVING 2065 CHU	DRESS, CITY, S JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 299	was supposed to be- She did not know water a day to the resider started working at the ago.  Interview with the Started working at the ago.  Interview with the Started working at the ago.  Interview with the Started working at the residents were breakfast and it was and the residents and the resident working would not drink.  The yused to pour they would not drink.  The staff asked the at meals and the resident tomorrow they would interview with the Materials.  Some of the resident residents that did not milk.  The milk was presented it.  She was not award menu three times did not was not award menu three times did not know was not kn	e served to the residents.  why milk was only served once ats, it was that way when she he facility about four months  upervisor on 09/18/24 at e served milk every day at a available if they requested it. not like to drink milk at other  milk for the residents, and a it and it would get wasted. It residents if they wanted milk sidents would say "no". Is would want the milk and ad not.  Ilanager on 09/19/24 at  ents did not like milk, the bot like milk were not served et at the place settings for the arred it. It dalways ask for milk any time that dairy should be on the aily.  With the Administrator on an revealed: enu three times a day; the staff	D 299			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		HAL073010		B. WING			R 1 <b>9/2024</b>
	PROVIDER OR SUPPLIER	IVING		DRESS, CITY, S	STATE, ZIP CODE		
WAPLE	TEIGHTS ASSISTED I	LIVING	ROXBOR	O, NC 27573	}		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 309	Continued From pa	ge 83		D 309			
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service			D 309			
	10A NCAC 13F .09 (e) Therapeutic Die (3) The facility sha residents with phys for guidance of food  This Rule is not me Based on observati interviews, the facil residents was accur	ets in Adult Care I Il maintain a curre ician-ordered the d service staff. et as evidenced b ions, record reviev ity failed to ensure rate listed with a c	Homes: ent listing of rapeutic diets  y: ws, and e 1 of 3 (#1) cardiac heart				
	healthy diet (CHH) therapeutic diets lis guidance of the foo	t that was availab					
	The findings are:						
	Observation of the 09/17/24 at 8:36am -There was a diet li a bulletin board in t -The list included the physician's ordered -Resident #1 was li concentrated sweet -The cook was plat the diet list.	revealed: st dated 07/17/23 he kitchen. he resident's name therapeutic diet. sted to be served ts diet (LCS).	hanging on e and their a low				
	Review of Resident 02/21/24 revealed of artery disease (CAI	diagnoses include	d of coronary				

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	Of Fleatill Service IN		1			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
AND I LAN	S. SOMEOTION	DENTI IOMION NOMBEN.	A. BUILDING:	<del></del>		
			B 14/11/0	D WING		₹
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING 2065 CH			JB LAKE RO	AD		
WAPLE	TEIGHTS ASSISTED I	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 309	Continued From pa	ge 84	D 309			
	(CVA), and hyperlip	idemia.				
		#1's hospital discharge 20/24 revealed there was an heart healthy diet.				
	revealed: -She followed the the hanging on the bulk-She was not sure vertically support of the s	nerapeutic diet list that was etin board in the kitchen. who updated the list. nce the list, but she knew the diets now. resident one was ordered a				
	11:58am revealed: -He did not have a	on a diet for "low sugar"				
	care provider (PCP revealed: -Resident #1 did a l -She wanted the fac	w with Resident #1's primary ) on 09/19/24 at 9:48am ot of "snacking". cility to follow the CHH diet the had ordered for Resident #1.				
	3:28pm revealed: -She and the mana therapeutic diet list resident or a diet or -She did not think th 2023 and posted in current diet listShe did not know t diet list had been u	ger would update the when there was a new der change from the PCP. The diet list that was dated July the kitchen was the most the last time the therapeutic podated.				

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OTATEMENT OF RESIDENCE TO A PROVIDENCE TO A PR		(VO) MUUTIDI	E CONCEDITORION	L(VO) DATE	OLIDVEV	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	LETED
			A. BUILDING:			
					F	₹
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHL	JB LAKE RO	AD		
MAPLE	HEIGHTS ASSISTED L	IVING ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
D 309	Continued From pa	ge 85	D 309			
	on a CHH diet she	thought he was on a LCS diet.				
	9:31am revealed: -She did the diet list ordered dietsThe list was update change or a new re -The last time she hamonths agoThe date was on the list was printed from computer, so the da-She was not aware change after his recomputer. Telephone interview 09/19/24 at 11:40ar -The Manager was diet listThe diet list was up when there was a diet sit.	It for the residents' physician and when there was a diet sident with a diet order. In ad updated the list was three the bottom of the diet list; the malist generated on the late was automatically added. Resident #1 had a diet order cent hospital discharge.  What with the Administrator on malist responsible for the therapeutic podated annually or as needed liet order change on an FL-2, let order or care plan.				
D 358	10A NCAC 13F .10 Administration	04(a) Medication	D 358			
	(a) An adult care he preparation and adult prescription and no by staff are in accord (1) orders by a lice which are maintained	nsed prescribing practitioner ed in the resident's record; and ction and the facility's policies et as evidenced by:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		HAL073010		B. WING		<b>I</b>	R <b>19/2024</b>
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED I	LIVING	2065 CHU	DRESS, CITY, S IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED B SC IDENTIFYING INFORM	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Based on observatireviews, the facility were administered (#3, #4, and #5) observation and (#4); a medication of blood thinner and a (#4); a medication of blood thinner, meditreatment, a medication asal spray (#5); arrecord review (#1 apressure medication an insulin (#1); and antibiotics, a blood medication used to the findings are:  1. The medication of evidenced by 8 errord during the 8:00 am amedication pass on a. Review of Reside 03/14/24 revealed of fibrillation, hypertent accident, and diabeted 1. Review of Reside 03/14/24 revealed to 5mg (used to preventive daily.  Observation during on 09/18/24 at 7:37-The medication cart packs, one at a time each bubble pack in each bubble pack in the medication cart packs, one at a time each bubble pack in the medication cart packs, one at a time each bubble pack in the medication cart packs, one at a time each bubble pack in the medication and the medication cart packs, one at a time each bubble pack in the medication cart packs, one at a time each bubble pack in the medication cart packs, one at a time each bubble pack in the medication cart packs.	ons, interviews, and failed to ensure meas ordered for 3 of served during the edication pass inclumedication for blood for cholesterol (#3); cation for constipation of 2 of 3 sampled rund #2) including a lan, an anti-viral media pain medication, pressure medication, pressure medication treat nerve pain (#2) error rate was 25% or sout of 31 opport and 9:00am morning 109/18/24.  Lent #4's current FL-diagnoses included asion, cerebrovasculates mellitus.  Lent #4's current FL-diagnoses and blood the morning medication and revealed:  Lent #4's current flagnoses and blood the morning medication and removed twelves, and popped one	edications 3 residents ding a od sugars and a a nebulizer on, and a esidents for blood lication and multiple on, and a 2).  as unities g 2 dated atrial alar 2 dated for Eliquis od clots) eation pass e drawer of ye bubble	D 358			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		HAL073010	B. WING			9/2024
					, 00/1	J
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING	JB LAKE RO			
		ROXBOR	O, NC 2757	3		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
IAG	REGOE WORLD		TAG	DEFICIENCY)		
	0 " 15		D 050			
D 358	Continued From pa	ge 87	D 358			
	-The MA popped or	ne Eliquis 5mg from two				
		cks, for a total of 10mg.				
		12 tablets to Resident #4,				
		dication cart and began				
		resident's medications.				
		he medication administration				
		mpare the medications to				
	ensure the medicat	ions were correct.				
		t #4's September 2024 MAR				
	from 09/01/24 to 09					
		y for Eliquis 5mg twice daily				
		dministration time of 8:00am				
	and 8:00pm.					
		entation Eliquis 5mg was				
	administered on 09	/18/24 at 8:00am.				
	Observation during	madication on band for				
		medication on hand for				
		18/24 at 8:00am revealed: lbble packs of Eliquis 5mg				
		e for administration with a f 8AM on the top of the bubble				
	packs.	i oalvi on the top of the bubble				
		bubble pack of Eliquis 5mg				
		e for administration with a				
	,	f 8PM on the top of the bubble				
	pack.	i or wron the top or the bubble				
		was dispensed on 09/02/24				
	for 60 tablets.	4100011004 011 00/02/24				
		read "card 1 of 2"; there were				
		g tablets remaining.				
		nird bubble packs read "card 2				
		of 30 Eliquis 5mg tablets				
	remaining in each o					
	_					
		v with a representative from				
		cted pharmacy on 09/18/24 at				
	9:19am revealed:					
		l an order for Eliquis 5mg				
	twice daily.					

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DIVISION	of Health Service Re	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						₹
		HAL073010	B. WING		09/19/2024	
	200//055 25 2/::		DDE65 5:=:::	2747F 7ID 00DF	, , , , ,	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED L	IVING	JB LAKE RO			
		ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
				BEI IOIENOTY		
D 358	Continued From pa	ige 88	D 358			
		not have an order for Eliquis				
	10mg daily.					
		pensed 60 Eliquis 5mg tablets				
	on 08/06/24 and 09					
	disease or blood clo	d thinner used for vascular				
	-If a resident received too much Eliquis the resident could have nose bleeds, blood in their					
	urine, and bruising.					
	-She did not know why there were 3 bubble packs of Eliquis 5mg dispensed on 09/02/24; there		i			
		only two bubble packs of 30				
	dispensed.					
	Talambana intensias	white Decident #41a Drivery				
		w with Resident #4's Primary P) on 09/18/24 at 3:25pm				
		d thinner and was being				
		sident #4 because of his				
	diagnosis of atrial fi	ibrillation.				
		have nose bleeds, blood in his	:			
		ools or bruising due to too				
	much Eliquis being	administered.				
		dent #4 on 09/18/24 at				
	11:35am revealed:					
		a blood thinner but was not				
	sure why he took it.					
		ny problems with nose bleeds,				
	blood in his urine, o	ภ มเนเรแเน				
		/IA on 09/18/24 at 7:55am				
	revealed:	ala administra 10 Floor				
		she administered 2 Eliquis				
	5mg tablets to Resi	ident #4. d have received 1 Eliquis 5mg				
	tablet this morning.	a nave received i Eliquis silig				
		medications to Resident #4				
		andwritten on the bubble pack.				

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-She needed to read the directions on the bubble

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ווטופועום	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		CONFLETED	
					R	}
		HAL073010	B. WING		09/19/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	NDRESS CITY S	STATE, ZIP CODE		
TW WILL OT T	NOVIDEN ON GOLF EIEN		JB LAKE RO			
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573			
0(4) ID	CUMMADV CTA	TEMENT OF DEFICIENCIES	-		2NI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 89	D 358			
	pack when administering medicationsShe should use the MAR when administering medications.					
	03/14/24 revealed t	ent #4's current FL-2 dated here was an order for sed to improve blood sugar				
	on 09/18/24 at 7:37 -The MA opened the cart and removed to time, and popped or pack into a souffle of the MA popped or different bubble pack. She administered returned to the median preparing the next results.	e drawer of the medication welve bubble packs, one at a ne tablet from each bubble				
	from 09/01/24 to 09 -There was an entry a scheduled admini	y for Jardiance 10mg daily with stration time of 8:00am. entation Jardiance 10mg was				
	#4 on 09/18/24 at 8 -There were two bu daily available for a handwritten entry of packsEach bubble pack	bble packs of Jardiance 10mg				

read 30 tablets were dispensed.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		F	,
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 90	D 358			
	-Each bubble pack read card 1 of 1One bubble pack contained 11 of 30 tablets of Jardiance and the second bubble pack contained 19 of 30 tablets Jardiance.					
	the facility's contract 9:19am revealed: -The pharmacy had dailyThe pharmacy dispensed on 08/06/24-Jardiance was a locontrol the resident-She did not know tablets of Jardiance there should have a dispensed.  Telephone interview 09/19/24 at 12:33pi	ong-acting medication to help 's blood sugar. Why 2 bubble packs of 30 were dispensed on 09/02/24; only been one bubble pack with Resident #4's PCP on				
	to assist with blood failure.  -The maximum dos -She had not notice Resident #4 receivi instead of 10mg da -Resident #4 did no sugar checksShe expected the sas ordered.  Interview with Resident:35am revealed: -He was a diabetic blood sugar.	sugar control and heart se was 25mg daily. ed any complications with ng Jardiance 20mg daily ily. ot have an order for blood staff to administer medications dent #4 on 09/18/24 at and took medication for his ny problems with excessive				

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	UT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(X3) DATE	CLID\/EV
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		` '	LETED
			A. BUILDING.			
		1141.070040	R WING		F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	B LAKE RO			
		ROXBOR	O, NC 27573	3		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	<b>Y</b>	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
				DEFICIENCY)		
D 358	Continued From pa	ge 91	D 358			
	_					
	revealed:	1A on 09/18/24 at 7:55am				
		she administered 2 Jardiance				
	10mg tablets to Re					
		d have received 1 Jardiance				
	10mg tablet this mo					
		medications to Resident #4				
		written on the bubble pack.				
		d the directions on the bubble				
	pack when administering medicationsShe should have used the MAR when					
	administering medi					
	3					
		ame MA on 09/18/24 at				
	7:55am revealed:					
	to 7 days a week.	medications to the resident's 5				
	1	edications each resident was				
	ordered without loo					
		ld handwrite the time the				
		e on the bubble pack of each				
	medication.	and the first of the second to the				
	she would write "8A	as to be given in the morning				
		as to be administered in the				
		write "8PM or 9PM".				
		medications based on what				
	was written on the l	oubble pack.				
	Intorvious with the A	Appagor on 00/49/94 -+				
	3:11pm revealed:	lanager on 09/18/24 at				
		ed medications arrived, she				
	_	e the medications were				
	scheduled to be ad	ministered on each bubble				
	pack.					
		were administered at				
	8:00am/9:00am or					
	-This was to help the medications to be a					
		d be administered by referring				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			A. BOILDING.			R
		HAL073010	B. WING			19/2024
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING	CHUB LAKE RO ORO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pa	age 92	D 358			
	to the MAR, not the time entered on the bubble packs.					
	Refer to the intervie 09/18/24 at 2:30pm	ew with the Supervisor on า.				
	Refer to the interview with the Manager on 09/18/24 at 3:11pm.					
	Refer to the telepho Administrator on 09	one interview with the 9/19/24 at 9:59am.				
	b. Review of Resident 11/10/23 revealed of hyperlipidemia.	ent #3's current FL-2 dated diagnosis included				
	dated 01/25/24 rev	t #3's signed physician order ealed there was an order for (used to treat high cholester				
	on 09/18/24 at 7:45 -The medication aid the medication cart one at a time, and p bubble pack into a -She administered returned to the med preparing the next -Atorvastatin was n prepared for admin -She did not open t	de (MA) opened the drawer tremoved six bubble packs, popped one tablet from each souffle cup. 6 tablets to Resident #3, dication cart and began resident's medications. not 1 of the 6 medications histration. the medication administration mpare the medications to	of n			
	from 09/01/24 to 09 -There was an entr	t #3's September 2024 MAR 9/18/24 revealed: y for atorvastatin 40mg daily dministration time of 8:00am	,			

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Division of Health Service Regulation

A. BUILDING:  HAL073010  NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  B. WING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD	
MAPLE HEIGHTS ASSISTED LIVING 2065 CHUB LAKE ROAD	024
MAPI E HEIGHTS ASSISTED LIVING	
NOADONO, NO 21010	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) OMPLETE DATE
D 358  Continued From page 93  -There was documentation atorvastatin 40mg was administered on 09/18/24 at 8:00am.  Observation of medication on hand for Resident #3 on 09/18/24 at 8:00am revealed: -There was a bubble pack of atorvastatin 40mg on the medication cart and available for administration with a hand-written entry of "8PM" on the top of the bubble packThere were 30 atorvastatin 40mg tablets, dispensed on 09/02/24 and there were 20 remaining and available for administration.  Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -Resident #3 had an order for atorvastatin 40mg dailyThe pharmacy dispensed 30 tablets on 08/06/24 and 09/02/24Atorvastatin was scheduled for 8:00am because that was the time the previous pharmacy had it scheduled.  Interview with the MA on 09/18/24 at 7:55am revealed: -There was a bubble pack of atorvastatin 40mg on the medication cartShe did not administer atorvastatin 40mg to Resident #3 this morning because it had 8PM written on the bubble packResident #3 should receive his atorvastatin at nightShe did not realize atorvastatin was scheduled for 8:00am on the MARShe administered medications to Resident #3 based on the times that were handwritten on the bubble packsShe administered medications to the residents 5	

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	IB LAKE RO. O, NC 27573			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 94	D 358			
	ordered without loo -The Manager wou medication was due medicationIf the medication w she would handwrit -If the medication w evening she would -She administered was written on the I Interview with the N 3:11pm revealed: -When the cycle-fill would write the time scheduled to be ad packMost medications "8:00am/9:00am" o -This was to help th medications should	Id handwrite the time the e on the bubble pack of each was to be given in the morning the "8AM or 9AM".  Was to be administered in the handwrite "8PM or 9PM".  Immedications based on what bubble pack.  Manager on 09/18/24 at the medications arrived, she ethe medications were ministered on each bubble the were administered at the medications were ministered at the medications were administered at the medications were ministered at the medications were ministered at the medications were administered at the medications were ministered at the medications were administered at the medications were administer				
		ions, interviews, and record ermined Resident #3 was not				
	Refer to the intervieu 09/18/24 at 2:30pm	ew with the Supervisor on				
	Refer to the intervie 09/18/24 at 3:11pm	ew with the Manager on				
	Refer to the telepho Administrator on 09	one interview with the 9/19/24 at 9:59am.				
	c. Review of Reside	ent #5's current FL-2 dated				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			A. BUILDING.			₹
		HAL073010	B. WING		I	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	LIVING	JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358	Continued From pa	age 95	D 358			
	obstructive pulmon  1. Review of Resident	diagnoses included ertension and chronic ary disease (COPD). ent #5's signed physician /24 revealed there was an				
		mg (used as a blood thinner)				
	on 09/18/24 at 8:15 -The medication aid the medication cart one at a time, and p bubble pack into a -The MA administe #4.	de (MA) opened the drawer of and removed 8 bubble packs, popped one tablet from each souffle cup. red the 9 tablets to Resident and one of the 9 tablets				
	from 09/01/24 to 09 -There was an entr scheduled administ -There was docume administered from 9:00am.	y for aspirin 81mg daily with a tration time of 9:00am. entation aspirin was 09/01/24 to 09/17/24 at umentation aspirin 81mg was				
	#5 on 09/18/24 at 8 -There was a bubb 81mg tablets availa	le pack with 24 of 30 aspirin able for administration. nad a handwritten entry of				
		w with a representative from cted pharmacy on 09/18/24 at				

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					F	₹
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO			
			O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 96	D 358			
	-The pharmacy had dailyThe pharmacy displand 28 tablets on 0 -The aspirin was so the time consistent previous pharmacy Telephone interview Care Provider (PCF revealed: -Resident #5 had b for heart healthShe was not concereceived his aspiring morning.	If an order for aspirin 81mg Densed 31 tablets on 08/06/24 9/10/24. Cheduled at 9:00am to keep with scheduling as the  W with Resident #5's Primary O on 09/19/24 at 1:30pm Deen on aspirin for a long time Derned that Resident #5 Derned that Reside				
	Interview with Resident #5 on 09/19/24 at 7:55am revealed: -He thought he took and aspirin every dayHe was not sure if he took it in the morning or at night.					
	Interview with the MA on 09/18/24 at 8:30am revealed:  -There was a bubble pack of aspirin 81mg on the medication cart.  -She did not administer aspirin 81mg to Resident #4 this morning because "9PM" was handwritten on the bubble pack.  -Resident #5 would receive his aspirin 81mg tonight.  -She did not realize aspirin was scheduled for 9:00am on the MAR.  -She administered medications to Resident #5 based on the times that were handwritten on the bubble packs.  Interview with the Manager on 09/18/24 at 3:11mm revealed:					
	3:11pm revealed:	g <del></del>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  R  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	ETED
HAL073010    A. BOILDING:   R   R   D. WING   09/19/19/19/19/19/19/19/19/19/19/19/19/19	
HAL073010 B. WING 09/19/	
11AL070010 03/13/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/2024
MAPLE HEIGHTS ASSISTED LIVING 2065 CHUB LAKE ROAD	
ROXBORO, NC 27573	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358 Continued From page 97 D 358	
-When the cycle-filled medications arrived, she would write the time the medications were scheduled to be administered on each bubble pack.  -Most medications were administered at 8:00am/9:00am or 8:00pm/9:00pm.  -This was to help the MAs identify the medications to be administered.  -Medications should be administered by referring to the MAR, not the time entered on the bubble pack.  2. Review of Resident #5's signed physician orders dated 01/17/24 revealed there was an order for amantadine (used to treat tremors)100mg twice daily.	
Observation during the morning medication pass on 09/18/24 at 8:15am revealed:  -The MA opened the drawer of the medication cart and removed 9 bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup.  -The MA administered 9 tablets to Resident #5.  -Amantadine 100mg was not one of the 9 tablets administered to Resident #5.  Review of Resident #5's September 2024 MAR	
from 09/01/24 to 09/18/24 revealed:  -There was an entry for amantadine 100mg twice daily with a scheduled administration time of 9:00am and 9:00pm.  -There was documentation amantadine 100mg was administered twice daily from 09/01/24 to 09/17/24.  -There was no documentation amantadine 100mg was administered on 09/18/24 at 9:00am.	

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#5 on 09/18/24 at 8:30am revealed there was no

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING		R 09/19/2024	
			<u>I</u>		09/1	3/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	IB LAKE RO. O, NC 27573			
0(4) ID	CUMMA DV CTA		1		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 98	D 358			
	amantadine 100mg	available for administration.				
	the facility's contract 9:19am revealed: -The pharmacy begast week of July 20 -The facility faxed to the pharmacy the laresidents in the facility faxed to the pharmacy begandications on 08/4-Resident #5 had a twice dailyThe order was rectable 19:19 and	the signed physician orders to last week of July for all the sility. If you servicing the facility with 106/24. If order for amantadine 100mg leived the last week of July				
	-The pharmacy had reached out 7 times to the facility and the primary care provider (PCP) for a new prescription to continue with the medication, but the pharmacy had not received a response.  -The cycle-filled medications were sent on 09/02/24, but amantadine was not sent because the pharmacy did not have an order for refills.  -The facility had not notified the pharmacy as to why the medication was not available for administration.					
	administration.  Telephone interview with Resident #5's Mental Health Provider (MHP) on 09/19/24 at 2:40pm revealed: -Amantadine was ordered to help control tremors due to other medications Resident #5 was administeredResident #5's tremors could get worse if he was not administered the medications as orderedShe had not been notified that a refill for amantadine 100mg was needed for Resident #5.  Observation of Resident #5 on 09/18/24 at 8:15am revealed Resident #5 had fine tremors of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						₹
		HAL073010	B. WING		09/1	9/2024
NAME OF PROVIDER O	R SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPI F HEIGHTS ASSISTED I IVING			IB LAKE RO O, NC 27573			
PREFIX (EACH	H DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358 Continue	ed From pa	ge 99	D 358			
both han	ıds.					
revealed -He took handsHis hand -He thou him each Interview revealed -She did Resident on the m -She did re-ordere -She did -She did amantad	a medicat ds shook n ight his me morning. with the M interpretation of not adminit #5 because ledication of not know i led or not. not re-orde not tell the line on the	dent #5 on 09/19/24 at 7:55am ion for his tremors in his nost of the day. dication was administered to MA on 09/18/24 at 8:30am ister amantadine 100mg to se there was no amantadine eart. If amantadine had been er amantadine. Manager there was no medication cart for				
orders da order for 0.5-3mg/by nebuli Observa on 09/18 bromide/ was not a Review of from 09/6-There was not serve or 0.5-There was not serve or 0.5	w of Reside ated 01/17/ ipratropiur /3ml (used izer three t tion during 6/24 at 8:15 /albuterol 0 administero of Resident 01/24 to 09/ /as an entr	the morning medication pass am revealed ipratropium .5mg-3mg/3ml by nebulizer				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				7 50.2510.		R	
		HAL0730	10	B. WING			9/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	_IVING		IB LAKE RO O, NC 27573			
(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)		
D 358	Continued From particles bromide/albuterol 0 three times daily from the times daily from the times daily from the times daily the daministered on 09 the facility's contract of the facility contract of the facility contract of the facility would be the facility would be the facility would be the facility had not of the pharmacy had since the pharmacy had since the pharmacy had since the pharmacy had since the pharmacy of medication on had pharmacy.  Telephone interview of the facility she did not realize still scheduled.  She was not concerned the contract of the contract	.5-3mg/3ml was om 09/01/24 to umentation ipra .5-3mg/3ml by /18/24 at 9:00a dication on hand :30am revealed e/albuterol 0.5m for administration with a represented pharmacy of the medication of	09/17/24. tropium nebulizer was m.  d for Resident d there was no ng-3mg/3ml on through the entative from on 09/18/24 at for ipratropium by nebulizer luly 2024. I led medication. he pharmacy harmacy that in. I the medication this facility the #5 had ampules evious  #5's PCP on reatments were rder to change dent #5 was not tments.	D 358			

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STATE FORM 6899 W91Y11 If continuation sheet 101 of 177

Division of Health Service Regulation

CTATEMENT OF DEFICIENCIES (VA) PROVIDED/CURRUED/CURR			(VO) MILITIDI	E CONOTRILOTION	(VO) DATE	OLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	0. 0020		A. BUILDING:	<del></del>		
					F	₹
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			IB LAKE RO			
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573			
			·			
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
D 358	Continued From pa	ge 101	D 358			
	necessary unless R	Resident #5 was having an				
	acute flare-up of sy	mptoms related to COPD or a				
	cold.					
	Interview with Pecie	dent #5 on 09/19/24 at 7:55am				
	revealed:	dent #3 on 09/19/24 at 7.33am				
		zer treatments twice daily.				
		ials of medication in his				
	drawer.					
		ny medication now and had not				
		r treatment in a month.				
		y problems with shortness of				
	breath.					
	Interview with the M	1A on 09/18/24 at 8:30am				
	revealed:	17 011 09/10/24 at 0.30am				
	-She did not admini	ister ipratropium				
		.5mg-3mg/3ml by nebulizer to				
	Resident #5.	3 3 ,				
	-She thought Resid had been discontinu	ent #5's nebulizer treatments ued.				
	-She did not realize	the nebulizer treatment was				
	on the MAR to be a	dministered.				
		tropium bromide/albuterol				
		pules available on the cart to				
	administer.	NA				
		Manager there was no e/albuterol 0.5mg-3mg/3ml				
	ampules on the medication cart for administration.					
	auriii iisti atiori.					
	4. Review of Reside	ent #5's signed physician				
		/24 revealed there was an				
	order for polyethyle	ne glycol 17gms (used to treat				
	constipation) in 8-o	unces of water daily.				
	Observation during	the morning medication need				
		the morning medication pass am revealed polyethylene				
	glycol 17gms was r					

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		HAL073010	B. WING		09/1	R 9/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/1	72021
		2065 CHI	JB LAKE RO			
WAPLE	HEIGHTS ASSISTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 102	D 358			
	Review of Resident from 09/01/24 to 09 -There was an entry 17gms daily with a of 9:00amThere was docume 17gms was adminis 09/17/24 at 9:00am -There was no dock was administered of the composition of medical and the composition of the composition of medical and the composition of medical and the composition of the compo	#5's September 2024 MAR b/18/24 revealed: y for polyethylene glycol scheduled administration time entation polyethylene glycol stered daily from 09/01/24 to b. cumentation polyethylene glycol on 09/18/24 at 9:00am.  dication on hand for Resident s:30am revealed there was no available for administration.  w with a representative from sted pharmacy on 09/18/24 at eived an order for polyethylene the last week of July 2024. glycol 17gms daily was not a ion. have to notify the pharmacy on was needed. It notified the pharmacy that d the medication. I not dispensed the medication what acquired this facility the ion of had acquired this fac				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
							R	
		HAL073010		B. WING		09/	19/2024	
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
MAPLE	HEIGHTS ASSISTED	LIVING		IB LAKE RO O, NC 27573				
(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 (X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
D 358	Continued From pa	nge 103		D 358				
	polyethylene then t would have probler -She had not been that Resident #5 was constipation. -She expected the implemented as wr	ns with constipatio contacted by the fa as having problems medication orders	n. acility staff s with					
	Interview with Resident #5 on 09/19/24 at 7:55am revealed: -He did not take a medication for constipationHe did not drink any medication; he only took his inhaler and pillsHe denied problems with constipation.							
	Interview with the MA on 09/18/24 at 8:30am revealed:  -She did not administer polyethylene glycol to Resident #5 this morning because there was no polyethylene glycol on the medication cart.  -She did not know if polyethylene glycol had been re-ordered or not.  -She did not re-order polyethylene glycol today.  -She did not tell the Manager there was no polyethylene glycol on the medication cart for administration.							
	5. Review of Resident #5's signed physician orders dated 09/10/24 revealed there was an order for fluticasone propionate 120 metered nasal spray (used to treat symptoms of seasonal allergies) into each nostril daily.							
	Observation during the morning medication pass on 09/18/24 at 8:15am revealed fluticasone propionate 120 metered nasal spray was not administered on 09/18/24 at 8:00am.							
	Review of Resident from 09/12/24 to 09		//AR 2024					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
				A. BOILDING.		,	R	
		HAL073	010	B. WING			19/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAPLE I	HEIGHTS ASSISTED L	IVING		B LAKE RO. O, NC 27573				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From para-There was an entry nasal spray into ear scheduled administ -There was documenasal spray was ad to 09/17/24.  -There was no documenasal spray was no documenasal spray was ad to 09/18/24 at 9:00am.  Observation of med #5 on 09/18/24 at 8 fluticasone propional administration.  Telephone interview the facility's contract 9:19am revealed:  -The pharmacy recupropionate nasal splast week of July 20.  -The fluticasone procycle-filled medication.  The facility would have the medication of the pharmacy had since the pharmacy had since the pharmacy last week of July 20.  -There was a possi of nasal spray on hapharmacy.  Telephone interview 09/19/24 at 1:30pm -Resident #5 complitichy eyes, and a ruallergies.	y for fluticasor ch nostril daily ration time of entation flutica ministered daily mentation flutication on har 30am revealed ate nasal spray with a represented pharmacy eived an order ray into each 24. Spionate nasal on nave to notify the medication of the medication of dispense thad acquired 24. Spility Resident and from the part with Resident revealed: a not of sneed and for sneed and sneed of sneed and for	with a 9:00am. Isone propionate ily from 09/12/24 ticasone stered on and for Resident ed there was no y available for sentative from y on 09/18/24 at a for fluticasone nostril daily the substantial spray was not a substantial the pharmacy fluticasone in this facility the substantial the previous at #5's PCP on zing, watery and	D 358				
	-She ordered flutica	sone nasal sp	oray for Resident					

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DIVISION	of Health Service Re	egulation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING			R 09/19/2024	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS CITY S	STATE, ZIP CODE	1 00/1		
		2065 CH	UB LAKE RO				
MAPLE I	HEIGHTS ASSISTED L	IVING	RO, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
D 358	Continued From pa	ge 105	D 358				
	experiencing.	s of seasonal allergies he was nasal spray to be administered	i				
	revealed: -He was not admini -He had seasonal a -He had complained eyes to the MA.	dent #5 on 09/19/24 at 7:55am istered a nasal spray. allergies. d of a runny nose and itchy ave a medication for his					
	revealed: -She did not admininasal spray to Resithere was no flutication on the medication of the medication of the medication of the spray had been resorated and not resorated spray todayShe did not tell the	f fluticasone propionate nasal ordered or not. er fluticasone propionate nasa e Manager there was no ate nasal spray the medicatior	I				
	3:11pm revealed: -The MA should not medication was not	Manager on 09/18/24 at tify the Manager if a tavailable for administration. The pharmacy the medication ministration.					
	Refer to the intervie 09/18/24 at 2:30pm	ew with the Supervisor on n.					
	Refer to the intervie	ew with the Manager on					

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Division of Health Service Regulation STATE FORM

09/18/24 at 3:11pm.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING.			R
		HAL07301	0	B. WING			19/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED	LIVING		JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X: (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 358	Continued From pa	age 106		D 358			
	Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.						
	2. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed: -Diagnoses included sepsis and gangrene of the left 5th toeThe resident had a left fifth toe amputation.						
	-The resident's toe osteomyelitis.						
	Review of Resident #2's hospital discharge summary dated 09/06/24 revealed the resident was re-admitted to the hospital for osteomyelitis and left foot infection.						
	a. Review of Reside FL-2 dated 08/08/2 levofloxacin (used 750mg daily (there	4 revealed an or to treat bacterial	der for infections)				
	Review of Resident summary dated 08, levofloxacin 750mg	/08/24 revealed	an order for				
	Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed: -There was no entry for levofloxacin 750mg dailyThere was no documentation levofloxacin was administered.						
	Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was no levofloxacin 750mg available to be administered.						
	Telephone interview facility's contracted						

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DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING	B. WING		9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	UB LAKE RO. RO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 107	D 358			
	750mg with the inst	7-day supply of levofloxacin tructions to administer one pensed on 08/08/24.				
	09/18/24 at 2:28pm	dication aide (MA) on revealed she did not recall if desident #2's levofloxacin or				
	Interview with the Manager on 09/18/24 at 2:48pm revealed: -She did not recall seeing Resident #2's levofloxacin 750mg orderShe did not recall any MA telling her Resident #2's levofloxacin 750mg was not entered on the MAR.					
	summary dated 08/ -Resident #2 had si fifth toe, left foot, tw -Mild erythema, was surrounding the wo -Resident #2 report antibioticsResident #2 was of antibiotic used to tro -A prescription for Co twice daily to be tak	tatus post amputation of the volume v				
	08/09/2024-08/31/2 -There was no entry daily.	y for Cefuroxime 500mg twice umentation Cefuroxime was				

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Division of Health Service Regulation STATE FORM

Observation of Resident #2's medications on

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
		HAL073010	B. WING	B. WING 09		R <b>19/2024</b>
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED I	IVING 2065 CI	ADDRESS, CITY, S	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	hand on 09/17/24 a Cefuroxime 500mg Telephone interview at the [named] phar revealed Resident #2's orde daily was not receiv not dispensed.  Telephone interview facility's contracted 4:45pm revealed: -Resident #2's orde daily was not receiv -Cefuroxime was an medication was not resident could have Interview with a MA revealed she did no administered Resid Interview with the M 8:34am revealed: -Resident #2 had gr his toe was amputa pleased with what s to have a follow-up -The podiatrist start for an infection.  Second interview w at 2:48pm revealed MAs telling her Rese entered on the MAF Interview with the M 11:07am revealed:	at 11:05am revealed no available to be administered with a pharmacy technician reacy on 09/18/24 at 4:30pm or for Cefuroxime 500mg twice at the pharmacy and was with a pharmacist from the pharmacy on 09/18/24 at er for Cefuroxime 500mg twice at the pharmacy. In antibiotic and if the administered as ordered the an ongoing infection.  If on 09/18/24 at 2:28pm of trecall if she had or had not lent #2's Cefuroxime.  If anager on 09/18/24 at one to see a podiatrist after ated and the podiatrist was not she saw and told the resident appointment with his surgeous ted Resident #2 on antibiotics with the Manager on 09/18/24 at she did not recall any of the sident #2's Cefuroxime was not sident #2's Cefuroxime was	t t			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					   F	₹
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	resident to the apportune a common to the called the common the order be transfer pharmacy.  Telephone interview Counselor on 09/18-She took Resident appointment.  The podiatrist was #2's foot; the podiatrist order wery infected.  The podiatrist order #2.  She told the Manareturned to the facilicalled into a local [r-The Manager told the [named] pharmatit.  Interview with Resident #2 nosistant on 09/19/2-When Resident #2 08/20/24, the resident #2 nosistant order #2.  -If Resident #2 report antibiotics.  -The podiatrist order #2.  -If Resident #2 had antibiotics as order hospitalization on 0 been avoided.	pointment with his podiatrist. Preturned to the facility, the reported the antibiotic was at by, med] pharmacy and requested erred to the facility's contracted erred at 4:58pm revealed:  ##2 to his podiatry  ##2 to his podiatry  ##2 concerned about Resident trist said the resident's toe was ered an antibiotic for Resident  ##2 ger when Resident #2  ##2 did not use acy and that she would handle  ##2 dent #2's podiatrist's medical erred at 2:05pm revealed:  ##2 was seen by the podiatrist on ent's incision site looked  ##2 that he had not been taking ered antibiotics for Resident  ##2 been administered the end on 08/20/24, the resident's 9/04/24 could have possibly	D 358			
	Interview with a MA revealed:	on 09/18/24 at 11:13am				

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	of Fleatiff Service IN		T		T	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:	<del></del>		
		1141.070040	B WING		F	
		HAL073010	D. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPIFI	HEIGHTS ASSISTED L	IVING	JB LAKE RO			
	TEIGHTO AGGIGTED I	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D 358	Continued From pa	ge 110	D 358			
	matched the medic with the MARs.	stered medications, she ation on the medication cart,				
		the MARs she would talk to				
	the Manager.					
	-She documented r on the MAR.	nedications she administered				
		s not documented, the				
		ve not been given but may ocumenting the medication.				
		tched the MAR and the				
	medication in the ca	art, administered the				
		en forgot to document it.				
		any antibiotics the resident				
	took "every last dos	tibiotics were on the				
		e administered the antibiotic.				
	1	nber what medications				
		nd did not have" but she could				
	look at the MAR to	know what was administered.				
	Interview with a sec 2:28pm revealed:	cond MA on 09/18/24 at				
		l verbally if there were any				
	changes in a reside Manager.	ent's medications by the				
		nged the MARs when there				
	were new medication					
	medications.	madications based on the				
	MAR and medication	medications based on the on available.				
		as in the medication cart, but				
	not listed on the MA	AR, she would let the Manager				
	know.	- Badad and the NAAD bedeen Co				
		s listed on the MAR but not in , she would let the Manager				
	know.	_				
		not documented, the e considered not given.				

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Division of Health Service Regulation		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	COMI	PLETED
	R	
HAL073010 B. WING	09/	19/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
2065 CHUB LAKE ROAD		
MAPLE HEIGHTS ASSISTED LIVING  ROXBORO, NC 27573		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		COMPLETE DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	AFFROFRIATE	57112
D 358 Continued From page 111 D 358		
D 358 Continued From page 111 D 358		
-She did not recall any antibiotics being in the		
medication cart but not on the MAR for Resident		
#2.		
Interview with the Manager on 09/18/24 at		
2:48pm revealed:		
-When a resident was discharged from the		
hospital, she wrote the medication on the MAR		
and when the medication was delivered, she drew		
arrows on the MAR to indicate the start of the medication.		
-If Resident #2 had had any other antibiotics, the		
antibiotic would have been written on the MAR.		
-She must have missed entering the other		
antibiotics on Resident #2's MAR.		
Talankana interniannuith Dasidant 40lakanist		
Telephone interview with Resident #2's hospitalist on 09/18/24 at 11:30am revealed:		
-Resident #2 had an infection and antibiotics		
were ordered.		
-He had consulted with Resident #2's surgeon on		
what antibiotics were needed.		
-If Resident #2 did not take the antibiotics as		
ordered, he could potentially have a worsening of the infection.		
uie iiiieotioii.		
Interview with Resident #2's surgeon on 09/18/24		
at 11:57am revealed:		
-Resident #2's infection would not resolve if the		
antibiotics were not administered as ordered.		
-Resident #2 could lose his left foot if the infection was not resolved and the wound healed.		
was not resolved and the would healed.		
Telephone interview with Resident #2's primary		
care provider (PCP) on 09/19/24 at 9:22am		
revealed:		
-She did not know if Resident #2 had been		
administered his antibiotics or not.		
-If the antibiotics were not documented as administered it was the same as the medication		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
						F	₹
		HAL073	3010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING		IB LAKE RO O, NC 27573			
(X4) ID	SUMMARY STA	TEMENT OF DEF		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L			PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETE DATE
D 358	Continued From pa	ige 112		D 358			
	not being administer- She had questioned Resident #2 was be antibiotics and was ended up getting at hospitalized (09/04)	ed the staff at eing administe told he was, n infection and /24).	ered his but the resident d was				
	Telephone interview 09/19/24 at 11:24ar -He expected Residual administered his ar -If Resident #2 had ordered, the infection from the infection fr	m revealed: dent #2 to have ntibiotics as or received the on could have	ve been rdered. antibiotics as e cleared up and				
	c. Review of Reside FL-2 dated 08/08/2 Oxycodone (used t six hours as neede	4 revealed ar o treat severe	order for pain) 5mg every				
	Review of Resident summary dated 08, Oxycodone Immed hours as needed for tablets.	/08/24 reveale iate Release	ed an order for 5mg every 6				
	Review of Resident administration reco 08/09/2024-08/31/2 -There was no entr six hours as neede -There was no door 5mg was administe	rd (MAR) for 24 revealed: y for Oxycodo d for pain. umentation th	one 5mg every				
	Review of Resident count sheets (CSC CSCS for the Oxyc 5mg every 6 hours tablets.	S) revealed the	nere was no diate Release				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 113	D 358			
	hand on 09/17/24 a no punch card for 0 directions to admin	ident #2's medications on t 11:05am revealed there was Oxycodone 5mg with the ister every 6 hours as needed.				
	facility's contracted 2:12pm revealed th 5mg were dispense	pharmacy on 09/17/24 at at 7 tablets of Oxycodone ed on 08/08/24 with the ister one tablet every 6 hours				
	dated 09/10/24, rev	#2's electronic prescription realed an order for Oxycodone tablet every 8 hours for				
	medication adminis 09/10/2024-09/17/2 -There was no entrone-half tablet ever	y for Oxycodone 5mg take y 8 hours. umentation that Oxycodone				
	count sheets (CSC	#2's controlled substance S) revealed there was no odone 5mg take one-half ours for 14 days.				
	hand on 09/17/24 a no punch card for 0	ident #2's medications on t 11:05am revealed there was Oxycodone 5mg with the ne-half tablet every eight				
	facility's contracted 2:12pm revealed 2	w with a pharmacist from the pharmacy on 09/17/24 at whole tablets of Oxycodone gual 42 one-half tablets were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING		F 09/1	₹ 9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED L	IVING	B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 114	D 358			
		n/24 with the directions to take y eight hours for 14 days.				
	revealed: -Resident #2 completed day, every day." -Resident #2 completed day, 09/18/24She had not admin Oxycodone today, 0 medication was PR for the pain medicar-Resident #2 did not Oxycodone, just PR Interview with the M 2:48pm and 3:43pm -Based on the order administered Oxycodone, and 11:00processed days of pain in his toe; here to be a facility's contracted 4:45pm revealed Recontrolled medication the pharmacy.  Telephone interview 69/19/24 at 11:24ar	t have any scheduled RN.  Ilanager on 09/18/24 at revealed: r, Resident #2 should be odone every 8 hours, 7:00am, om.  by yshe had not entered the				
	Interview with Resid	dent #2 on 09/17/24 at 1:56pm				

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-His toe was hurting right now.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.		   F	2
		HAL073010	B. WING			9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPIFI	HEIGHTS ASSISTED I	IVING 2065 CHU	B LAKE RO	AD		
	ILIOITIO AGGIOTED I	ROXBORO	D, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 115	D 358			
	-He did not have a -His toe hurt every	pain pill today, 09/17/24. day.				
		dent #2 on 09/18/24 at 5:25pm d been painful all day.				
	assistant on 09/19/2 Resident #2 reporte	dent #2's podiatrist's medical 24 at 2:05pm revealed ed he had not been taking pain his office visit on 08/20/24.				
	Telephone interview with Resident #2's Licensed Counselor on 09/18/24 at 4:58pm revealed every time she completed an assessment on Resident #2 the resident complained of pain, "every single time."					
	Counselor on 09/19 -She saw Resident complained of excr his eyes.	with Resident #2's Licensed 0/24 at 3:36pm revealed: #2 on 08/09/24 and he uciating pain; he had tears in				
	documented the res -On 08/12/24, 08/13 #2 complained of p					
	-On 08/19/24, 08/20/24, 08/21/24, and 08/22/24, Resident #2 complained of painOn 08/26/24, Resident #2 complained of painOn 08/27/24, she saw Resident #2's PCP, and the PCP was concerned Resident #2's toe was					
	-Resident #2 comp the PCP ordered pa	she had seen it before. ained of pain to the PCP and ain medication. sed the MAs about pain				
	medication for Resi resident had been a -Resident #2 told he medication.	dent #2, she was told the administered pain medication. er he was not getting pain the same answers every time				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		HAL0730 <sup>2</sup>	10	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING		B LAKE RO			
			ROXBOR	O, NC 27573	}		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L:		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 116		D 358			
	she asked him about and was not admini	stered pain me	dication."				
	Telephone interview 09/19/24 at 9:22am		#2 S PCP 011				
	-She ordered Reside administered as a second price of PRN on 09/10/24 make sure the residence of a lot of painShe was angry that received the pain makes and the pain makes and the pain makes and the pain makes and the pain makes are selected to the pain makes and the pain makes are selected his pain makes and the pain makes are pain makes an	lent #2's Oxycoocheduled medial because she was dent received the was Resident #2 had been to be wrote the order ay not get the mask the MA if Reedication, the Ma not complained to deserve to be from pain would the the world would be the world wor	cation instead wanted to le medication. The complained ad not dered. If for a narcotic nedication, sident #2 had MA always told led of pain, in pain; he had all prevent the				
	FL-2 dated 08/08/24 for Amlodipine (use 10mg once daily.	d to treat high b	olood pressure)				
	Review of Resident summary dated 08/ stop Resident #2's	08/24 revealed	an order to				
	Review of Resident (PCP) order dated of stop Amlodipine.						
	Review of Resident administration reco 08/09/2024-08/31/2 -There was an entry	rd (MAR) for 4 revealed:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL073010	B. WING		F 09/1	R 9/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 03/1	3/2024
		2065 CHI	JB LAKE RO			
WAPLE	HEIGHTS ASSISTED L	ROXBOR	O, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 117	D 358			
	9:00amThere was docume was administered dependence of the continued of	#2's September 2024 MAR				
	Review of Resident #2's BP readings revealed: -Resident #2's BP reading was documented as 125/92 on 07/01/24 and 129/86 on 07/15/24Resident #2's BP reading was documented as 128/85 on 08/01/2; there were no other BPs documented in August 2024There was a BP reading of 118/88 documented on a piece of notebook paper with Resident #2's name, the paper was not datedThere were no other BP readings documented for Resident #2 for September 2024.  Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed a punch					
	card for Amlodipine for 30 tablets; 10 ta the card.  Telephone interview facility's contracted 4:45pm revealed: -Resident #2's currereceived on 07/30/2	w with a pharmacist from the pharmacy on 09/18/24 at ent order for Amlodipine was 24 to stop the Amlodipine 5mg once				

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A. BUILDING: R  HAL073010 B. WING 09/19/202		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	AME OF PROVIDER OR SU	
MAPLE HEIGHTS ASSISTED LIVING  2065 CHUB LAKE ROAD  ROXBORO, NC 27573	APLE HEIGHTS ASSI	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENC'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMBINED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH DEF	
D 358  Continued From page 118  A thirty-day supply of Amlodipine 5mg was dispensed on 07/30/24 and on 09/02/24.  -The pharmacy had not received an order to discontinue Resident #2's Amlodipine.  -Amlodipine was used to lower blood pressure.  -If Resident #2' Adi not need the medication and it was administered, the resident could experience low blood pressure, which could lead to falls.  Interview with Resident #2 on 09/17/24 at 1:56pm revealed:  -Staff checked his blood pressure today, 09/17/24, and the reading was 118/88.  -He had times he felt dizzy.  -He could be standing or even sitting down and get dizzy.  -He had a dizzy spell, "not too long ago."  -Staff usually checked his BP once a month.  Interview with the Manager on 09/18/24 at 2:48pm revealed:  -When Resident #2's order to discontinue the Amlodipine was received, she pulled the medication for the medication cart and returned the medication to the pharmacy.  -She did not send the pharmacy a copy of the order to stop Resident #2's Amlodipine.  -She did not know how she missed marking out Amlodipine on the September 2024 MAR since the medication had been discontinued.  -If Resident #2's Amlodipine was still on the medication cart, it was her oversight.  -She was concerned Resident #2 had been administered Amlodipine and the Pb medications, and his BP could have "bottomed out."  Telephone interview with the hospitalist on	-A thirty-day sidispensed or -The pharma discontinue F -Amlodipine sides administ low blood present literview with revealed: -Staff checker 09/17/24, and -He had time -He could be get dizzyHe had a diz -Staff usually literview with 2:48pm revealed: -When Resident sides and content of the medication for the medication of the medicat	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING.		l ,	₹
		HAL073010	B. WING		I	19/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	HUB LAKE RO PRO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	-He had discontinue because the resider resident was on thresident was on thresident was on the life Resident #2 con Amlodipine, the resident had a follooper.  Telephone interview 09/19/24 at 9:22am-Resident #2 had sonot need the Amlod-Resident #2 was sorthostatic hypoten complaints of lighthen Her concern was to making the resident have a fall.  e. Review of Resident have a fall.  e. Review of Resident was desident was a fall.  e. Review of Resident was an entresident was an entresident was an entresident was an entresident with a sof 8:00am, 2:00pm	ed Resident #2's Amlodipine ont's BP was adequate, and the elegational BP medications tinued to be administered the sident could pass out from his rience dizziness, and be tired pected Resident #2's per administered until the ownup appointment with the ownup appointment and had sion as evidenced by neadedness. The medication could be ownup appointment of the treat seizures or nerve pair daily (TID).  It #2's hospital discharge of the ownup appointment of the Gabapentin 100mg, dose the ownup appointment of the Gabapentin 100mg, dose the ownup appointment of the Gabapentin 100mg, dose the ownup appointment of the Gabapentin 100mg three cheduled administration time of the ownup appointment o	e			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 t. BOILBII (O.		   F	
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. D, NC 27573			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
D 358	Continued From pa	ge 120	D 358			
	09/01/24-09/17/24There was documed 100mg was adminited 109/01/24-09/12/24There was documed 100mg was adminited 109/01/24-09/16/24.	entation that Gabapentin stered at 2:00pm from and on 09/16/24. entation that Gabapentin stered at 8:00pm from				
	Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed no Gabapentin 100mg or Gabapentin 300mg was available to be administered.					
	Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed: -Resident #2 had an order for Gabapentin 400mg three times daily dated 08/28/24, but the order was only for a three-day supplyNine capsules of Gabapentin 400mg were dispensed on 08/08/24There was no order for Gabapentin 300mg for Resident #2Gabapentin 300mg nor Gabapentin 100mg had been dispensed for Resident #2.					
	revealed: -He was supposed a day for painHe thought staff ha	dent #2 on 09/19/24 at 8:11am to get Gabapentin three times ad administered Gabapentine did not know what tablets he				
	revealed: -She documented s Gabapentin 100mg administered the m	on 09/18/24 at 2:28pm she gave Resident #2's because she thought she had edication. ister the Gabapentin 100mg				

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	of Health Service Re		1			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	,
		HAL073010	B. WING		R 09/19/202	
		11AE073010			09/1	3/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MADIE	IFICUTE ACCIETED I	2065 CH	UB LAKE RO	AD		
WAPLE	HEIGHTS ASSISTED L	ROXBO	RO, NC 27573	3		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
D 358	Continued From pa	ige 121	D 358			
	to dov. 00/40/04 at	2.00mm haaayaa tha				
		2:00pm, because the				
		t in the medication cart.				
		g attention close enough wher	1			
	she documented ac	dministering medication.				
	Intonvious with the Ma	Janagar on 00/19/24 at				
	2:48pm revealed:	Manager on 09/18/24 at				
	•	apentin was changed on his				
	last hospital admiss					
		nt to the facility when Resident				
	#2 returned from th					
		papentin on Resident #2's				
	MAR.	Dapentin on Nesident #2 s				
		der was for Gabapentin				
	100mg.	der was for Cabaperturi				
		lent #2's Gabapentin was				
	delivered.	ient #23 Gabapentin was				
		ed Resident #2's Gabapentin				
	was not administere					
		s not in the facility, the MAs				
		the pharmacy and let her				
	know.	and production				
		the MAs telling her Resident				
	#2's Gabapentin wa					
	•					
		w with Resident #2's PCP on				
	09/19/24 at 9:22am	revealed:				
		why Resident #2 was ordered				
		sident was taking the				
		he began seeing the resident.				
		ne hospitalist on a gradual				
	reduction of the dos	se of Gabapentin.				
	-Gabapentin neede	ed to be tapered so the				
		nonitored for any changes				
		e or resurgence of pain.				
		w with the Administrator on				
	09/19/24 at 10:21ar	m revealed:				
	-Resident #2's Gab	papentin had been ordered for				

a reason.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
							R	
		HAL073	010	B. WING		09/1	9/2024	
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
MAPLE	HEIGHTS ASSISTED L	LIVING		IB LAKE RO O, NC 27573				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From pa	ge 122		D 358				
	-He was concerned had not been admir							
	Refer to the intervie 09/18/24 at 2:30pm		pervisor on					
	Refer to the intervie 09/18/24 at 3:11pm		anager on					
	Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.							
	3. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included diabetes, cerebrovascular accident, coronary artery disease, and hyperlipidemia.							
	a. Review of Reside dated 08/20/24 reve increase amlodipine elevated blood pres	ealed there wa e to 10mg (us	as an order to					
	Review of Resident administration reco 08/31/24 revealed:							
	-There was an entry with a scheduled ac -There was no docu administered daily f 8:00am.	dministration tumentation an	ime of 8:00am. nlodipine was					
	Review of Resident from 09/01/24 to 09 -There was an entry with a scheduled ac -There was docume administered from 0 8:00am.	9/17/24 reveal y for amlodipi dministration t entation amlod	ed: ne 10mg daily ime of 8:00am. dipine was					
	Observation of med	dication on ha	nd for Resident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		SURVEY PLETED		
				A. BUILDING:			<b>D</b>
		HAL07301	0	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	LIVING		IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	#1 on 09/17/24 at 1 amlodipine 10mg a Observation of Rescheck on 09/17/24 #1's BP reading was Review of Resident from 08/13/24 to 09-00 08/01/24, there of 188/108On 08/06/24, there of 150/92On 08/08/24, there of 150/92On 08/13/24, there of 123/74On 09/03/24, there of 132/78.	vailable for admisident #1's blood at 1:55pm reveals 157/97.  t #1's progress related was a blood progress as blood progress as a blood progress a	inistration.  pressure (BP) iled Resident  notes dated : essure reading essure reading essure reading				
	Telephone interview the facility's contract 3:24pm revealed: -Resident #1 had a from 7.5mg to 10m -The amlodipine or physician who dischospital, with no rei-The pharmacy distablets on 08/22/24 daily administration -The pharmacy had amlodipine 10mg be the original prescription -No one from the fapharmacy regarding refill order receive a response -The pharmacy not	n order to increa g dated 08/21/24 der was received harged Resident fills. pensed 17 amloo which was enou until the cycle-fill not dispensed ecause there was otion. acility had contact g amlodipine 10 ed the prescribir ers and the pharm from the physic	n 09/17/24 at ase amlodipine 4. d from the affirm the dipine 10mg agh tablets for anymore as no refill on acted the ang. ang physician macy did not cian.				

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DIVIDION	OF FIGARITY SETVICE INC	galation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		_	_
		HAL073010	B. WING		F 09/1	≺ 9/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 22.	
		2065 CHL	B LAKE RO			
MAPLE	HEIGHTS ASSISTED L	IVING	O, NC 27573			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 124	D 358			
	prescription was needed for amlodipine 10mg, and the pharmacy did not receive a response from the facility.					
	Care Provider (PCF revealed: -Resident #1 was oblood pressureShe knew Residen 08/19/24 to 08/20/2 discharge summaryShe did not receive summary, and she amlodipine had been sordered until she hospital dischargesResident #1 could	e the hospital discharge did not know Resident #1's en increased to 10mg daily. MAs to administer medications was able to review the				

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Division of Health Service Regulation								
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL073010		B. WING		R <b>09/19/2024</b>		
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
	HEIGHTS ASSISTED I	_IVING	2065 CHU	B LAKE RO. O, NC 27573	AD			
			KONDOK	U, NC 2/5/3				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 358	Continued From pa	ge 125		D 358				
	administered amloo when she did pass -She signed the MA the medication. -She did not realize dispensed enough have amlodipine av -If the amlodipine w she did not adminis -She did not compa she administered m handwritten times p the Manager.	the pharmacy had in the pharmacy had in the pharmacy had in medication for Residual labels to administer that a medication had been medications to the dications based on the bubble of the properties of the prop	ninistered not dent #1 to r. cation cart, ne MAR; n the e packs by					
	Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -If a medication was not on the medication cart, the MAs should let the Director knowThe Manager was the only one who could contact the pharmacy.							
	Interview with the Manager on 09/18/24 at 3:11pm revealed:  -The MA should notify the Manager if the medication was not available for administration.  -She would notify the pharmacy the medication was needed for administration.  Telephone interview with the Administrator on 09/19/24 at 9:59am revealed:  -The MAs should notify the Manager when a medication was not available for administration.  -The Manager should audit the medication cart to ensure the medications were available for administration.  -He was concerned that Resident #1's blood pressure may increase.							

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPI F HEIGHTS ASSISTED LIVING			IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 126	D 358			
	Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.					
	summary dated 08/order for Paxlovid 3 twice daily. Review of Resident 08/23/24 to 08/31/2 -There was an entry with a scheduled at and 8:00pmThere was no documents.	ent #1's hospital discharge (20/24 revealed there was an amg (used to treat a virus)  #1' August 2024 MAR from 44 revealed:  y for Paxlovid 3mg twice daily dministration time of 8:00am  umentation Paxlovid was daily from 08/23/24 to				
		dication on hand on 09/17/24 d there were no Paxlovid 3mg istration.				
	Telephone interview with a representative for the facility's contracted pharmacy on 09/17/24 at 3:24pm revealed:  -The pharmacy received an order for Paxlovid 3mg 3 tablets twice daily for 5 days on 08/22/24.  -The pharmacy dispensed 30 Paxlovid tablets on 08/22/24.					
	revealed: -Resident #1 was o discharged from the -The pharmacy dispadministered the management of the she worked as the -She did not realize MAR that she admit #1.	rdered Paxlovid when he was a hospital on 08/20/24. Densed Paxlovid and she edication to Resident #1 when MA. The she failed to document on the nistered Paxlovid to Resident that she did not document				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING		R 00/1	9/2024
					09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S B <b>LAKE RO</b>	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 127	D 358			
	the administration of	of Paxlovid.				
	2:25pm revealed: -She was sure she Resident #1If the medication w then she administer #1She did not pay att -She thought she d of the PaxlovidShe needed to look she documented co. Interview with the D revealed: -The MAs should do medication was adr -The MARs should wants to review the Interview with the A 9:59am revealed: The MA should adm and document corre medication so the M the PCP to review.  c. Review of Reside order dated 02/21/2	Director on 09/19/24 at 4:00pm				
	Review of Resident dated 06/04/24 reve	gars) every morning.  #1's signed physician's order ealed there was an order to 7 units in the morning.				
		#1's signed physician's order				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 128	D 358			
	order to increase Lantus to 7 units in the morning (the order was written last month, and it had not been added to the MAR).					
	Review of Resident #1's fingerstick blood sugar (FSBS) readings for July 2024 from 07/01/24 to 07/31/24 revealed Resident #1's FSBS readings ranged from 145 to 578.					
	Review of Resident #1's July 2024 electronic medication administration record (eMAR) from 07/01/24 to 07/31/24 revealed:  -There was an entry for Lantus 5 units every morning with a scheduled administration time of 8:00am.  -There was documentation Lantus 5 units was administered at 8:00am from 07/01/24 to 07/03/24.  -There was an entry for Lantus 7 units every morning with a scheduled administration time of 8:00am.  -There was documentation 7 units was administered at 8:00am from 07/04/24 to					
	dated 08/13/24 reve	#1's signed physician's order ealed there was an order to 9 units in the morning.				
	August 2024 MAR -Resident #1's FSB to 400 from 08/01/2	S readings ranged from 126 24 to 08/08/24. BS readings documented from				
	08/01/24 to 08/31/2 -There was an entr	: #1 August 2024 MAR from 4 revealed: y for Lantus 7 units every eduled administration time of				

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	Of Fleatin Service IX		(A(O) MILITARI	F CONCERNATION.	(A) DATE	OLIDA (EX
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` 'col		(X3) DATE	SURVEY LETED
			A. BUILDING:	<del></del>		
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHI	JB LAKE RO	AD		
MAPLE	HEIGHTS ASSISTED I	IVING	O, NC 27573			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT!		(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IGIENGT)		
D 358	Continued From pa	ge 129	D 358			
	8:00am.					
		entation Lantus 7 units was				
		0am on 08/01/24 to 08/02/24				
	and from 08/05/24					
		umentation on 08/03/24 and				
		; the MAR was blank.				
		y for Lantus 9 units every				
	morning as ordered					
	-There was no documentation Lantus 9 units was administered.					
	D . (D					
		t #1's signed physician order				
		ealed there was an order to 10 units every morning and 43				
	units every evening					
	dinis every evening	•				
	Review of Resident	t #1's FSBS readings for				
		om 09/01/24 to 09/17/24				
	revealed there were	e no FSBS readings				
	documented for rev	view.				
		t #1's September 2024 MAR				
	from 09/01/24 to 09					
		y for Lantus 9 units every				
	8:00am.	eduled administration time of				
		entation Lantus 9 units was				
		09/01/24 to 09/17/24 at				
	8:00am					
	-There was no entr	y for Lantus 10 units every				
	morning.	ŕ				
		umentation Lantus 10 units				
	was administered e					
		y for Lantus 40 units every				
		eduled administration time of				
	8:00pm.	umentation Lantus 40 units				
		rom 09/01/24 to 09/17/24 at				
	8:00pm.	10111 00/01/24 to 09/11/24 at				
		y for Lantus 43 units at				

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AND PLAN OF CORRECTION   IDENTIFICATION NOWIDER.   A. BUILDING:	URVEY ETED	
	R	
HAL073010 B. WING 09/19/2	/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING  2065 CHUB LAKE ROAD  ROXBORO, NC 27573		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358 Continued From page 130 bedtimeThere was no documentation Lantus 43 units were administered at bedtime.  Review of Resident #1's laboratory values dated 05/27/24 revealed a hemoglobin A1C (HgbA1C) value of 9.3. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).  Review of Resident #1's Primary Care Provider's (PCP) visit note dated 06/04/24 revealed: -Resident #1's HgbA1C was 9.3 on 05/27/24She increased Lantus to 7 units every morning.  Review or Resident #1's triage note dated 07/30/24 revealed: -Resident #1's blood sugar on 07/24/24 was 578Resident #1's blood sugar on 07/24/24 was 578Resident #1's was given Novolog 9 units (a rapid-acting insulin to lower blood sugar) -Continue to monitor HgbA1C monthly and increase insulin until HgbA1C is down to 8.0.  Review of Resident #1's laboratory values dated 08/05/24 revealed: -The on-call provider was notified of a blood sugar reading of 542The facility's received an order to administer Novolog insulin 12 units and re-check blood sugar in 30 minutes.  Review of Resident #1's record revealed there was no recheck blood sugar reading to review.  Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	t
		HAL073010	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING			B LAKE RO. D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358		not receive the order dated	D 358			
	units.	e Lantus from 5 units to 7 eived the order dated 07/02/24				
	to increase Lantus -The order dated 0	from 5 units to 7 units. 7/02/24 for Lantus 7 units was				
		receive an order dated e Lantus from 7 units to 9				
	unitsThe staff was responsible for handwriting the					
		24 to increase Lantus to 9 units hey were using paper MARS				
	-The pharmacy ent	ered the order to increase and it would be printed on the				
	-The pharmacy rec	eived the order dated 09/03/24 to 10 units in the morning and ing.				
	-The staff were responder to increase La	ponsible for handwriting the antus to 10 units in the ts in the evening on the				
	September MAR sin were being used by	nce they had been printed and the facility.				
	units in the morning	ered the order for Lantus 10 g and Lantus 43 units in the d print on the October 2024				
	dated 09/03/24 reve					
	-Resident #1's type 2 diabetes was managed currently with Lantus 9 units in the morning and 40 units in the evening.					
		sed a sliding scale insulin. A1C dated 08/04/24 was 10.1 emic control.				
	-The order to increa	ase Lantus from 7 units to 9 ed on the MAR for August				

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,		   F	₹
		HAL073010	B. WING		1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	2024 or September - There was no blood on the MAR for Augmonitor blood sugar-She would increas morning and 43 united Telephone interview 09/19/24 at 12:33pr-Resident #1 was a frequent changes to She ordered an incunits in May of 2024 MAR.  - She re-wrote the orange - Resident #1's blood were high which wainsulin.  - On 08/13/24, she is units every morning sugar readings remained a very diffure assed to 10 united in the evening.  - She did not know to Lantus had not bee MAR for administration - She had a very diffure the increments so the remained and extreme look literview with the Second control of the secon	d sugar readings documented gust 2024 or September 2024; r readings closely. e Lantus to 10 units every ts every evening with Resident #1's PCP on m revealed: "brittle" diabetic and required to his insulin orders. crease of Lantus from 5 to 7 that was not entered on the reder again in July 2024. d sugar readings and HgbA1C as why she increased the encreased Lantus insulin to 9 g because Resident #1's blood tained elevated. It added to the MAR until dent #1's Lantus was ts in the morning and 43 units the most recent order for n added to the September tion. Ficult time adjusting Resident e she never knew if he was dose or not. Crease in insulin in small esident would not crash and w blood sugar.	D 358	BETTOLENCT)		
		responsible for reviewing new the new orders on the paper				

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	of Fleatiff Service IN				T	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIP	LLILD
					F	۲
		HAL073010	B. WING			9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	FROVIDER OR SUFFLIER					
MAPLE I	HEIGHTS ASSISTED L	IVING	B LAKE RO			
	T		O, NC 27573			1
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
D 358	Continued From pa	ge 133	D 358			
2 000	-	ge 100	2 000			
	MARs.					
		responsible for faxing the new				
	orders to the pharm	пасу.				
	Interview with the M	lanager on 09/18/24 at				
	3:11pm revealed:	ianager on 05/16/24 at				
		Il new medications orders into				
	the pharmacy.					
		ent the new order on the MAR				
	when the medication	n was in the facility.				
	-She was the only one who documented new					
	orders on the MAR.					
		eceiving the new orders to				
		she had, she would have				
	added them to the I					
		progress notes and triage				
	report completed by	y the PCP. the new orders to increase the				
	Lantus insulin.	the new orders to increase the				
		; she needed to pay more				
	attention to the repo					
	attention to the rept	one and orders.				
	Telephone interview	wwith the Administrator on				
	09/19/24 at 9:59am					
	-The Manager was	responsible for entering new				
	orders on the MAR	S.				
	-He expected new	orders to be entered, and				
	medication adminis	tered as ordered.				
	-The resident could	have problems with elevated				
	blood sugar levels.					
	D					
		ons, interviews, and record				
	,	ermined Resident #1 was not				
	interviewable.					
	Refer to the intensis	ew with the Supervisor on				
	09/18/24 at 2:30pm	•				
	00/10/24 at 2.00pm					
	Refer to the intervie	ew with the Manager on				
	09/18/24 at 3:11pm					

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Division	<u>of Health Service Re</u>	egulation					
	IT OF DEFICIENCIES		DER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTI	FICATION NUMBER:	A. BUILDING:		COMP	LETED
						F	,
		НАІ	.073010	B. WING		1	9/2024
		117 (=		l		1 00/1	0/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADIE	HEIGHTS ASSISTED I	IVING	2065 CHU	IB LAKE RO	AD		
MALEL	ILIGITIO AGGISTED I	-141140	ROXBOR	O, NC 27573	3		
(X4) ID	SUMMARY STA	TEMENT OF	DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIENC)			PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFY	ING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIE	DAIL
					,		
D 358	Continued From pa	ge 134		D 358			
	Refer to the telepho	ne intervi	aw with the				
	Administrator on 09						
	Administrator on os	0/ 13/24 at s	J.JJaiii.				
	Interview with the Supervisor on 09/18/24 at						
	2:30pm revealed:						
	-The MAs should compare the medication to th						
	MAR three times before administering the						
	medication to ensure the medication was correct						
	-She assisted the Manager in auditing the						
medication carts.							
	-She and the Mana	ger would	alternate				
			rt audits every other				
	month.		·				
	-The medication ca	rt audits w	ere completed				
	monthly when the o	ycle-fill me	edications arrived				
	and were placed or						
	-She would compar						
	the medication cart	with the m	nedications entered				
	on the MAR.						
	-She did not find pr						
	cart audit but if she	did, she w	ould notify the				
	Manager.						
	Interview with the N	lanagar ar	00/18/24 at				
	Interview with the M 3:11pm revealed:	ialiayel 01	103/10/24 at				
	-The MAs were exp	ected to a	dminister				
	medications as ente						
	-The MAs should no						
	medication was not	,	•				
			is were not available				
	for administration if						
	-She did not observ						
	medications.						
	-When the cycle-fill	ed medica	tions arrived, she				
	would place the tim						
	scheduled to be ad						
	pack.						
	-Most medications	were admi	nistered at				
	8:00am/9:00am or						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	D.   ' '	PLE CONSTRUCTION G:	(X3) DATE COMF	SURVEY PLETED
						₹
		HAL073010	B. WING		·	9/2024
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY	, STATE, ZIP CODE		
MAPLE H	IEIGHTS ASSISTED L	IVING	065 CHUB LAKE R OXBORO, NC 275			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	L PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE DATE
D 358	Continued From pa	ge 135	D 358			
	-This was to help th medications to be a -It was not to be us	ne MAs identify the administered.  ed to administer the AR was to be reference.	d to			
	09/19/24 at 9:59am -He expected the M as orderedHe expected the M medication adminis	IAs to administer medic Ianager to oversee the tration by ensuring	ations			
	medications were available for administration.  The facility failed to administer medications as ordered to a resident who did not receive his an antibiotic as ordered, was seen by the podiatrist who was concerned the resident's toe was infected and ordered another antibiotic which was not administered and subsequently the resident was hospitalized for an infection. The resident was in pain daily because of the wound and was not administered scheduled pain medication (#2); a resident who had a diagnosis of diabetes and whose blood sugar readings were as high as 584 with a HgbA1C of 10.1. The insulin order had been changed monthly for 4 months without the order being placed on the medication administration record to be administered, a blood pressure medication had not been dispensed and the resident had a history of high blood pressure which could lead to a stroke or heart attack (#1); a resident was administered a double dose of a blood thinner who was at an increased risk of bleeding (#4); a resident who had seasonal allergies and was not receiving his medication and continued to suffer with a runny nose and		is an atrist  ch was ident ent d was on (#2); and eas 584 and ut the liblood ed and ssure ( (#1); of a of l tion			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL07301	0	B. WING			R 19/2024
NAME OF I	PROVIDER OR SUPPLIER	117207001		DRESS CITY S	STATE, ZIP CODE	1 03/	13/2024
				IB LAKE RO			
MAPLE	HEIGHTS ASSISTED L	LIVING		O, NC 27573			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	Continued From pa	ge 136		D 358			
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/24.						
	THE CORRECTION VIOLATION SHALL 19, 2024.						
D 366	10A NCAC 13F .10 Administration	04 (i) Medicatior	า	D 366			
	10A NCAC 13F .10	04 Medication A	dministration				
	(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.						
	This Rule is not me Based on observati reviews, the facility documented on the records (MAR) imm administration of me residents (# 3 and # administration of the sampled residents (8:00am/9:00am me	ons, interviews, failed to ensure medication adn lediately followir edication for 2 o (#4) and did not pedications prior e medication for (#5) during the	and record staff ninistration ng if 3 sampled ore-chart to the				
	The findings are:						
	Observation during medication pass on -The medication aid	09/18/24 at 7:3	7am revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL073010	B. WING			R 19/2024
NAME OF PROVIDER OR SUI	PPI IFR	1		STATE, ZIP CODE	1 03/	13/2024
MAPLE HEIGHTS ASSI		2065 CI	IUB LAKE RO	,		
- INALE REGITTO ACCIO	0120	ROXBO	RO, NC 2757	3		
PREFIX (EACH DEF	ICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Jardiance 10 levels), vitam Eliquis 5mg ( 40mg (used tamsulosin 0) enlarged prosto treat nervely -The MA did administratio following the Resident #4.  2. Observation medication pure pure medication pure pure medication pure placement), replacement), replacement), replacement), replacement), replacement), replacement, seizures) to full the medicationsThe MA did administration following the Resident #3.  Interview with revealed: -She administed: -She administered administered replacement was not administered and was not administered.	I to tre mg (usin D 2 (used to lowed to	eat high blood pressure), sed to improve blood sugar 25mcg (used as a supplement to thin blood), atorvastatin er cholesterol), metoprolol wer blood pressure), (used to treat symptoms of an and gabapentin 100mg (used). Itial the medication ord (MAR) immediately histration of medications to ing the 8:00am morning in 09/18/24 at 7:49am revealed (MA) administered vitamin is a supplement), vitamin B6 upplement), aspirin 81mg ), folic acid 1mg (used as a roxyprogesterone (a hormone levetiracetam (used to prever	d d d d			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		HAL073010	B. WING			) 9/2024
		111.12010010	L		00/1	0/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPIFI	HEIGHTS ASSISTED L	IVING	JB LAKE RO			
1417-41 == 1	ILIGITIO AGGIGILES L	ROXBOR	O, NC 27573	3		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORT OR E	SCIDENTII TING INI ORWATION)	TAG	DEFICIENCY)	INAIL	57112
D 366	Continued From pa	ge 138	D 366			
	-She had administe	red medications to the				
		a week and she knew the				
	medications that each resident was ordered.					
	Interview with the Manager on 09/18/24 at					
	3:00pm revealed:					
	-Medications administered to the residents should					
	be initialed on the MAR immediately after the					
	medications were administered.					
	-When medications were signed off immediately					
	after the medications were administered the MARs would be accurate.					
		ted administration of				
		Il the residents were				
		nedications, there was the mentation would not be				
	correct.	mentation would not be				
		the MAR as a medication was				
		the resident may have				
		tion, or the medication was				
	not on-hand to adm					
		MAs to initial each MAR				
	immediately after th					
	medications to a res	sident.				
		Administrator on 09/19/24 at				
		e expected the MA to				
		ARs immediately after the				
	administration of m	euications.				
	3 Observation duri	ng the 9:00am morning				
		109/18/24 at 8:15am revealed:				
	-The medication aid					
		Omg (used to treat pain),				
		100mg (used to treat				
		um chloride 10mg (used as a				
		pentin 300mg (used to treat				
		done 1mg (used for mood),				
		ised as a supplement), and a				
		00mg (a stool softener).				
		e medication administration				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						F	
		HAL07301	0	B. WING		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MAPLE H	HEIGHTS ASSISTED L	IVING		B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 366	Continued From pa	ge 139		D 366			
	(MAR) record after popping each medication in the souffle cup, before administering the medication to Resident #5.  Interview with the MA on 09/18/24 at 8:30am						
	revealed: -She documented he she popped the pill -When she docume she knew the medicadministeredShe documented cadministered the medication the medication immedication was resident refused to left the resident refuse	ner initials on the into the souffle of the her initials cation was ready on the MAR beforedications. Sed a medication at she had docurrous at the head and the initial and in	MAR when cup. on the MAR, or to be re she n, she would mented. 8/24 at inistration of e medication ne MAR before n case the tion. nedication, the				
	Interview with the A 9:59am revealed he document on the M administration of m	e expected the M ARs immediatel	1A to				
D 367	10A NCAC 13F .10 Administration	04(j) Medication		D 367			
	10A NCAC 13F .10 (j) The resident's n record (MAR) shall following:	nedication admir	nistration				

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NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573  (X5)	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD ROXBORO, NC 27573  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 140  (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,					<del></del>	F	₹
CX4)   ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 367   Continued From page 140   D 367   (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,			HAL073010	B. WING		09/1	9/2024
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 140  (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 140  (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	MAPLE	HEIGHTS ASSISTED I	IVING				
(1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 3 of 5 sampled residents (#1, #2, and #5) including the administration of an anti-anxiety medication (#1), two antibiotics (#2), and a supplement (#5).  The findings are:  1. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included diabetes, cerebrovascular accident, coronary artery disease, and hyperlipidemia.  Review of Resident #1's signed physician orders dated 07/31/24 revealed there was an order for trazodone 50mg (used to treat anxiety) at	D 367	(1) resident's name (2) name of the me (3) strength and do administered; (4) instructions for a or treatment; (5) reason or justific medications or treatmenting the redocumenting the redocumenting the redocumentation of medications or treatmedications or treatmedications or treatmedications or treatmedications or treatmedication or treatmedication or treatmedication or treatmedication or treatmedication recoording (8) name or initials the medication or treatmedication recoording the medication administration recoording the facility medication administration accurate for 3 of 5 and #5) including the anti-anxiety medication administration accurate for 3 of 5 and #5) including the anti-anxiety medication and a supplement (1). Review of Resident disease, and hyper Review of Resident dated 07/31/24 revealed of the facility of the f	dication or treatment order; sage or quantity of medication administering the medication administering the medication of tments as needed (PRN) and sulting effect on the resident; fadministration; of any omission of tments and the reason for the refusals; and, of the person administering reatment. If initials are used, a at to those initials is to be raintained with the medication rd (MAR).  Let as evidenced by: sons, interviews, and record failed to ensure the stration record (MAR) was sampled residents (#1, #2, he administration of an atton (#1), two antibiotics (#2), (#5).  Let #1's current FL-2 dated diagnoses included diabetes, cident, coronary artery lipidemia.	D 367			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
							₹
		HAL073010		B. WING		09/1	19/2024
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	LIVING		IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 141		D 367			
	Review of Resident #1's hospital discharge summary dated 08/20/24 revealed there was an order to discontinue trazodone 50mg.						
	Review of Resident #1's signed physician order dated 08/28/24 revealed there was an order for trazodone 50mg at bedtime.						
	Review of Resident #1' August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry for trazodone 50mg at bedtime with a scheduled administration time of 8:00pmThere was a handwritten entry to discontinue trazodone 50mg on 08/21/24There was no documentation trazodone was administered from 08/22/24 to 08/31/24.						
	Review of Resident from 09/01/24 to 09 -There was an entry bedtime with a sche 8:00pmThere was a handy trazodone 50mg on -There was no docuadministered from 0	0/17/24 revealed: y for trazodone 50nedule administration written entry to discounces 08/21/24. umentation trazodo	ng at n time of continue ne was				
	Observation of med at 12:05pm reveale trazodone 50mg dis	d there were 21 of	30				
	Telephone interview the facility's contract 3:24pm revealed: -The pharmacy rect trazodone 50mg at -The pharmacy dispon 09/02/24.	eted pharmacy on 0 eived an order on 0 bedtime.	917/24 at 08/28/24 for				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BOILDING	·		R
		HAL073010	B. WING			19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY,	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	CHUB LAKE RO BORO, NC 2757			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	but it was discontin restarted on 08/28/3 Interview with the m 09/17/24 at 1:53pm -Resident #1's traze he returned from th -The pharmacy dispin September 2024 -When a medication she administered th -She had administered th -She had administered the -She had administered the seident #1 since 0 was dispensedShe did not realize trazodone 50mg was #1It was an oversight MAR.  Interview with a sec 2:25pm revealed: -She was sure she to Resident #1If the medication we then she administered #1She did not pay attangled to she documented control of the trazodoneShe needed to loo she documented control of the she documented control of the control of the she documented control of the s	n order for trazodone 50mg ued on 08/20/24 and was 24.  nedication aide (MA) on revealed: odone was discontinued when hospital on 08/20/24, pensed trazodone 50mg agon was on the medication can emedication. Fred trazodone 50mg to 09/05/24, since the medication as administered to Resident that she did not sign the cond MA on 09/17/24 at administered trazodone 50 was on the medication cart, red the medication to Resident to the documentation ocumented the administration to the documentation ocumented the administration to the MAR to ensemble of the side of the medication to the documentation ocumented the administration to the MAR to ensemble ocumented the magnetic	men pain part, tion that t mg dent n. tion sure			
	Review of Resident	t #5's signed physician orde	ers			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL073010			F 00/1	
		HAL073010	D: Wii(0		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 143	D 367			
	dated 01/17/24 revealed there was an order for vitamin D3 1000 units (used as a supplement) daily.					
	administration reco 08/31/24 revealed:	#5's August 2024 medication rd (MAR) from 08/09/24 to				
	(25mcg) daily with a time of 9:00am.	y for vitamin D3 1000 units a scheduled administration				
	-There was documentation vitamin D3 was administered daily from 08/09/24 to 08/31/24There was a second entry for vitamin D3 25mcg					
	daily with a scheduled administration time of 9:00am.					
		entation vitamin D3 was from 08/09/24 to 08/31/24.				
	from 09/01/24 to 09	#5's September 2024 MAR 9/18/24 revealed: y for vitamin D3 1000 units				
	(25mcg) daily with a time of 9:00am.	a scheduled administration entation vitamin D3 was				
	administered daily f	from 09/01/24 to 09/18/24.				
	9:00am.	led administration time of				
		entation vitamin D3 was from 09/01/24 to 09/18/24.				
	at 8:15am revealed	dication on hand on 09/18/24 there was a bubble pack of dispensed on 09/02/24 with 19 ning.				
	09/18/24 at 8:30am	nedication aide (MA) on revealed: one vitamin D3 to Resident #5.				

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-She did not realize there were two entries on the

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	₹
		HAL073010	B. WING			9/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 144	D 367			
	entries for vitamin I -It appeared she ad when she only adm -One of the vitamin removed from the N	ve documented on both D3. Iministered two vitamin D3 inistered one. D3 entries needed to be MAR.				
	Interview with the Manager on 09/19/24 at 4:00pm revealed: -She was responsible for reviewing the paper MARs at the end of each monthShe did not notice vitamin D3 was entered on the MAR twiceShe would have marked one of the entries out and called the pharmacy to remove the duplicate entryThe MAs had not mentioned to her there were two entries on the MAR for the same medicationThe MARs should be accurate when the primary care provider (PCP) reviewed them.					
	Refer to the intervie 09/19/24 at 4:00pm	ew with the Manager on				
		one interview with the 0/19/24 at 9:59am and				
	FL-2 dated 08/08/2	ent #2's hospital discharge 4 revealed diagnoses included ne of the left 5th toe.				
	FL-2 dated 08/08/24 Metronidazole (use	ent #2's hospital discharge 4 revealed an order for d to treat infections) 500mg here was no end date).				
		:#2's hospital discharge 08/24 revealed an order for				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
						R
		HAL073010	B. WING		09/	19/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	UB LAKE ROA RO, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 367	days.  Review of Resident administration record 08/09/2024-08/31/2-There was a handy 500mg three times administration time 8:00pm.  -There were arrows date to start the medication 08/15/24.  -There was docume indicating the stop of 08/15/24.  -There were no initiform 08/09/24-08/15 had been administed. There was no other on the August 2024.  Telephone interview facility's contracted 2:12pm revealed two Metronidazole 500m 08/08/24 for a 7-day of 18/24 at 2:28pm she administered R not.	ing three times daily, for 7  if #2's August 2024 medication and (MAR) for the revealed: written entry for Metronidazole daily with a scheduled of 8:00am, 2:00pm, and the redication as 08/09/24 and the redication as 08/09/24 and the redication beside the arrow date, which read, completed als documented on the MAR 5/24 to indicate the medication ered. In entry for the Metronidazole MAR.  If with a pharmacist from the pharmacy on 09/17/24 at venty-one tablets of the medication and were dispensed on the medication of the medication		DEFICIENCY		
	Resident #2's Metro	g the empty punch card for onidazole.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		HAL073010	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	•	
MADIE	IEIGUTO AGGIOTED I	2065 C	HUB LAKE ROA	,		
MAPLE	HEIGHTS ASSISTED L	LIVING ROXBO	DRO, NC 27573	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pa	ge 146	D 367			
	-If Resident #2's Me	etronidazole was not ministered on the MAR, it "did	d			
	summary dated 09/	ent #2's hospital discharge /06/24 revealed an order for otic) 300mg three times daily	7,			
	for 09/01/2024-09/1 -There was a handy three times daily wit time of 7:00am, 3:0 -There were arrows date to start the me 11:00pm doseThere was docume administered at 7:0 11 doses were docu- There was docume administered at 3:0 and on 09/16/24; 7 -There was docume	written entry for Clindamycin th a scheduled administration Opm, and 11:00pm. Son the MAR indicating the edication as 09/06/24 for the entation Clindamycin was 0am from 09/07/24-09/17/24 umented. The entation Clindamycin was 0pm from 09/07/24-09/12/24 doses were documented. The entation Clindamycin was 00pm from 09/06/24-09/16/2	;			
	hand on 09/17/24 a	ident #2's medications on t 11:05am revealed no vailable to be administered.				
	facility's contracted 2:12pm revealed tw	wwith a pharmacist from the pharmacy on 09/17/24 at venty-one tablets of were dispensed on 09/06/2	4			
	revealed she was n	on 09/18/24 at 2:28pm ot paying attention close documented administering				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1141 070040			F	
		HAL073010	D. WINO		09/1	9/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	IVING	B LAKE RO. D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
D 367	Continued From page 147		D 367			
	medication.					
	Refer to the interview 09/19/24 at 4:00pm	ew with the Manager on				
	Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am and 11:24am.					
	Interview with the Manager on 09/19/24 at 4:00pm revealed:  -The MAs should document on the MAR when a medication was administered.  -The MARs should be accurate when the primary care provider (PCP) wants to review the resident's medication.  Interview with the Administrator on 09/19/24 at 9:59am and 11:24am revealed:  -The MAs should administer medications as ordered and document the administration.  -The MA should document correctly on the MAR for each medication so the MARs would be accurate for the PCP to review.					
D 392	10A NCAC 13F .10	08 (a) Controlled Substances	D 392			
	(a) An adult care h controlled substance receipt, administrate controlled substance maintained with the and in such an order	08 Controlled Substances ome shall assure a record of sees by documenting the ion, and disposition of sees. These records shall be resident's record in the facility or that there can be accurate introlled substances.				
	This Rule is not mo					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		HAL073010		B. WING			R 19/2024
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED I	LIVING	2065 CHU	DRESS, CITY, S IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Based on observatireviews, the facility retrievable record the receipt, administrate controlled medication residents (#2, #6) reliever (#2) and an #6).  The findings are:  1. Review of Reside FL-2 dated 08/08/2 sepsis and gangrer  a. Review of Reside FL-2 dated 08/08/2 oxycodone (used to six hours as needed Review of Resident summary dated 08/0 Oxycodone Immediated Now of Resident summary dated 08/0 Oxycodone Immediated Now of Resident administration recount of Review of Resident administration recount sheets (CSC) There was no doctory of Resident count sheets (CSC) CSCS for Oxycodo	ons, interviews, and infailed to ensure a real accurately reconcion, and disposition of the property of the pr	adily illed the if a ain ain ion (#2, charge a included arge or amg every arge der for ery 6 ets. edication gevery odone tance as no e 5mg	D 392			

6899

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION		` ′	E CONSTRUCTION		SURVEY PLETED
				7. BOILDING.			R
		HAL073010	1	B. WING			19/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE H	EIGHTS ASSISTED I	LIVING		IB LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From particles of Continued From particles hand on 09/17/24 and 00xycodone 5mg administer every 6 administration.  Telephone interview facility's contracted 2:12pm revealed: -Seven tablets of Odispensed on 08/08 administer one table-When the pharmac medication, they seemedication to be used MAs.  Based on observation interview with the contraction of MARs and tablets of Oxycodor b. Review of MARs and tablets of Oxycodor b. Review of Resident for 09/10/24 revesus of the contraction of the cont	ident #2's medical to 11:05am reveal with 11:05am reveal with the direction hours as needed with a pharmacy on 09/02/24 with the direction of the company of	ed there was as to available for st from the 17/24 at ere ctions to as needed. trolled drug at the ation by the st on hand, acy, and attation, 7 anted for. Cycodone are for 2024 MAR 5 mg take 20xycodone (24-09/17/24). The prescription of the ations on tablet every ations on	D 392			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	IA (X2) MULTIF	PLE CONSTRUCTION  G:		E SURVEY PLETED
		HAL073010	B. WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	STR	REET ADDRESS, CITY	. STATE. ZIP CODE	-	
		206	55 CHUB LAKE R			
MAPLE	HEIGHTS ASSISTED I	IVING	XBORO, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page 150  no Oxycodone 5mg with the directions to take		D 392			
		y eight hours for 14 days				
	facility's contracted 2:12pm revealed 2' 5mg were split to ed were dispensed on	wwith a pharmacist from pharmacy on 09/17/24 at whole tablets of Oxycocqual 42 one-half tablets at 09/10/24 with the direction	t done and ons to			
	Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation, 21 tablets of Oxycodone were unaccounted for.		21			
	2:48pm revealed: -Based on the orde administered Oxyco 3:00pm, and 11:00pm	why she had not entered	Oam,			
		on 09/17/24 at 11:14am e no other CSCS for Resi	ident			
	2:28pm revealed: -Resident #2 compl day, every day." -Resident #2 compl today, 09/18/24She had not admir Oxycodone today, 0 medication was PR for the pain medica	t have any scheduled				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		HAL073010	B. WING			9/2024
		HALU/3010			03/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2065 CHL	IB LAKE RO	AD		
MAPLE	HEIGHTS ASSISTED I	LIVING ROXBOR	O, NC 27573	3		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
D 392	Continued From pa	ige 151	D 392			
D 002	Continued From pa	ige 101	D 002			
		/lanager on 09/18/24 at				
	2:48pm revealed:					
		ook at the MAR and the				
	medication on hand	d and make sure the order				
	matched.					
	-Once the controlle					
		MAs should document the				
		ne MAR and the CSCS.				
	-She randomly aud					
		all the last time she audited the				
	CSCS.	er CSCS for Resident #2.				
	giving the key to the	pposed to count off before				
		Resident #2's Oxycodone was				
		ontrolled medication could be				
	abused.	ontrolled medication could be				
	abasca.					
	Telephone interviev	v with a pharmacist from the				
		pharmacy on 09/18/24 at				
	4:45pm revealed:	priarriacy on correra				
		n for controlled medication that				
		or was drug diversion.				
		dication that was unaccounted				
		ted to the pharmacy so the				
		ld ensure the medication had				
	not been returned a					
		follow its internal process for				
	an investigation, su					
	enforcement.					
		ot have any controlled				
		d been returned to the				
	pharmacy.					
	   , , ,					
		dent #2 on 09/17/24 at 1:56pm				
	revealed:					
	-His toe was hurting					
		pain pill today, 09/17/24.				
	<ul> <li>His toe hurt every</li> </ul>	aay.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
							₹
		HAL0730	10	B. WING		09/1	9/2024
NAME OF I	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	LIVING		IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page 152			D 392			
	Interview with Resident #2 on 09/18/24 at 5:25pm revealed his toe had been painful all day.						
	Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2 reported he had not been taking pair medication during his office visit on 08/20/24.						
	Telephone interview with Resident #2's Licensed Counselor on 09/18/24 at 4:58pm revealed every time she completed an assessment on Resident #2 the resident complained of pain, "every single time."						
	Telephone interview Counselor on 09/19 -She saw Resident complained of excri his eyes.	9/24 at 3:36pm i #2 on 08/09/24	revealed: and he				
	his eyesOn 08/12/24, 08/13/24, and 08/14/24, Resident #2 complained of painOn 08/19/24, 08/20/24, and 08/21/24, and 08/22/24 Resident #2 complained of painOn 08/26/24, Resident #2 complained of painResident #2 complained of pain to the PCP and the PCP ordered pain medication.						
	-Every time she ask medication for Resi resident had been a -Resident #2 told he medication. -Resident #2 gave to	ked the MAs ab ident #2, she wa administered pa er he was not g	as told the ain medication. etting pain				
	she asked him abo was not administere	ut his pain, he v	vas hurting and				
	Telephone interview 09/19/24 at 9:22am -She ordered Resid administered as a s	revealed: lent #2's Oxyco	done to be				

Division of Health Service Regulation

STATE FORM 6899 W91Y11 If continuation sheet 153 of 177

Division of Health Service Regulation

DIVISION	of Health Service Re	guiation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	ONREK:	A. BUILDING:		COMP	LETED
						F	₹
		HAL073010		B. WING			9/2024
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE		
NAME OF I	-NOVIDEN ON SUFFEIEN			B LAKE RO			
MAPLE I	HEIGHTS ASSISTED L	IVING		O, NC 27573			
	OUR MAN DV OTA	TEMENT OF BEFORENO		1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 392	Continued From pa	ge 153		D 392			
	of PRN on 09/10/24 make sure the residevery time she saw of a lot of pain.  -She was angry that received the pain mandle and the pain mandle and the resident mandle and the received his pain mandle	because she want dent received the may Resident #2, he could transfer to the Resident #2 had resident as ordered wrote the order for any not get the medication, the MA and not complained of the deserve to be in pay with the Administration revealed rolled medication slatered. Sycodone was not do the MAR, and was do it was verified the total the note.	edication. omplained not ed. a narcotic cation. ent #2 had lways told f pain. ain. ator on hould be ocumented not on the pharmacy blem with				
	include notifying lav	v enforcement.					
	c. Review of Reside FL-2 dated 08/08/2 Lorazepam (used to daily.	4 revealed an order	for				
	Review of Resident 08/09/2024-08/31/2 -There was an entry daily with a schedul 9:00am and 9:00pn -There was docume 0.5mg was adminis 08/09/24-08/31/24.	4 revealed: y for Lorazepam 0.5 ed administration ti n. entation that Loraze	omg twice me of pam				
	-There was no docu	umentation that Lora	azepam				

0.5mg was administered at 9:00pm from Division of Health Service Regulation

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		HAL073010	B. WING			R <b>19/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	STATE, ZIP CODE		
		2065 CF	IUB LAKE RO			
MAPLE	HEIGHTS ASSISTED L	LIVING ROXBO	RO, NC 27573	}		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	Continued From pa 08/09/24-08/31/24.  Review of Resident for 09/01/24-09/17/2-There was an entry daily with a schedul 9:00am and 9:00pm - There was docume 0.5mg was adminis from 09/01/24-09/10/09/17/24.  Review of Resident 11:15am revealed: -There were two CS Lorazepam 0.5mg or -One of the CSCS hand at 8:00am Lora and a balance of 29-17he 8:00am CSCS from 08/14/24-08/3 - The amount on hand been initialed a memberThe date and times 09/01/24-09/03/24 hocumentation the outOn 09/04/24 there of Lorazepam was signemaining was 8.	ge 154  #2's September 2024 MAR 24 revealed: y for Lorazepam 0.5mg twice led administration time of n. entation that Lorazepam tered at 9:00am and 9:00pm 6/24 and at 9:00am on  #2's CSCS on 09/17/24 at SCS for 60 tablets of dispensed on 08/08/24. In ad a start date of 08/14/24 (Izepam 0.5mg was signed out 1/24 with a balance of 12. Ind from 08/14/24-08/23/24 (Is checked by a [named] staff of swere completed for out there was no medication had been signed out at 8:00am, and a pocumented. It was documentation one table signed out at 8:00am, and a pocumented. It was documentation that no med out, and the balance is were completed for swas documentation that no med out, and the balance is were completed for swas documentation that no med out, and the balance is were completed for swas documentation that no med out, and the balance is were completed for swas documentation that no med out, and the balance is were completed for swas documented for swas docume	TAG D 392			DATE
	out. -On the second CS	medication had been signed CS, the start date was 00pm Lorazepam 0.5mg was				

Division of Health Service Regulation

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Division of Health Service Regulation

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	ξ
		HAL073010	B. WING			9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	B LAKE RO			
		ROXBOR	O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From pa	ge 155	D 392			
	-The CSCS for 8:00 documented as sig 08/13/24-09/12/24 documentedThe amount on ha been initialed as chmemberThere were 10 tab CSCS sheet dated	alance of 29 was documented. Opm had Lorazepam ned out from and a balance of 0 was and for 08/13/24-08/22/24 had ecked by a [named] staff lets not accounted for on the from 08/14/24 to 09/12/24.  MAs on 09/17/24 at 11:14am e no other CSCS for Resident				
	2:28pm revealed: -These two CSCS of the medication cartThere were two CSC Lorazepam 0.5mg of the CSCS of and the dates were 08/11/24-08/16/24There was no door given, or signature medicationThe beginning amounted down of the counted down of the counted down of the counted down of the second CSCS with a time of 8:00p with a remaining amount of the next entry was 8:00pm, signed by remaining amount of the next entry was 10 cm of the next ent	GCS for 60 tablets of dispensed on 09/11/24. In ad a start date of 08/11/24 documented from sumentation for time, dose of the MA who signed out the count started with 29 tablets to 24 tablets. In a start date of 09/13/24, in the count was verified. In a start date of 09/13/24, in the count of 29 tablets. In a signed by a [named] MA mount of 29 tablets. In a signed by a [named] MA mount of 29 tablets. In a signed by a [named] MA mount of 29 tablets. In a signed by a [named] MA with a time of a [named] MA with a				

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES ROXBORO, NC 27873    C(X)   ID	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  PREFIX  (2010 PREFIX (EACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX (FACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX (FACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX (FACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX PAG  D 392  Continued From page 156  remaining amount of 26 tabletsOn 09/17/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 25 tabletsOn 09/18/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 24 tablets.  Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed: -There was a punch card of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00amThere were 27 of 30 tablets of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00pmThere were 25 of 30 tablets of Lorazepam remaining on the card.  Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed: -Skty tablets of Lorazepam 0.5mg were dispensed on 09/11/24.  Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation revealed 10 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on								
MAPLE HEIGHTS ASSISTED LIVING    X41   ID   SUMMARY STATEMENT OF DEFICIENCIES   CRACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   CROSS-REFERENCED TO THE APPROPRIATE   CONSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CONSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CONSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE CONSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION MODIL DE CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION TAG   CROSS-REFERENCED TO THE APPROPRIATE   CANSTRUCTION THE APPROPRIATE   CANSTR			HALU/3		ı		09/	19/2024
CALL   Day	NAME OF	PROVIDER OR SUPPLIER						
PROVIDED SUMMARY STATEMENT OF DEFICIENCIES   DEFICE PROVIDED STATE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	MAPLE I	HEIGHTS ASSISTED I	LIVING					
remaining amount of 26 tabletsOn 09/17/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 25 tabletsOn 09/18/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 24 tablets.  Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed: -There was a punch card of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00amThere were 27 of 30 tablets of Lorazepam remaining on the cardThere was a punch card of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00pmThere were 25 of 30 tablets of Lorazepam remaining on the card.  Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed: -Sixty tablets of Lorazepam 0.5mg were dispensed on 08/08/24Sixty tablets of Lorazepam 0.5mg were dispensed on 08/08/24Sixty tablets of Lorazepam 0.5mg were dispensed on 08/08/24Sixty tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on	PREFIX	(EACH DEFICIENCY	MUST BE PREC	EDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	HOULD BE	COMPLETE
Interview with the Supervisor on 09/18/24 at 4:20pm revealed:	D 392	remaining amount of On 09/17/24 there time, dose given, of signed out the med was documented and on 09/18/24 there time, dose given, of signed out the med was documented and Observation of Reshand on 09/17/24 and on 09/17/24 and on 09/17/24 and on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11. There were 25 of 3 on the care was a punch dispensed on 09/11 on the care was a punch dispensed on 09/11. Based on observation of the care with the care with the care with the care with the care was a punch dispensed on 09/11. Based on observation of MARs and revealed 10 tablets unaccounted for fro 08/08/24 and 5 table unaccounted for fro 09/11/24. Interview with the State with	of 26 tablets. was no docur r signature of ication; the ar s 25 tablets. was no docur r signature of ication; the ar s 24 tablets.  ident #2's me t 11:05am rev n card of Lora /24 labeled a 80 tablets of L ard. n card of Lora /24 labeled a 80 tablets of L ard. v with a pharm pharmacy on azepam 0.5m 8/24. on of medicar ontracted pha d CSCS docu of Lorazepan m the 60 table ets of Loraze om the 60 table	the MA who mount remaining mentation for the MA who mount remaining edications on vealed: azepam 0.5mg s 8:00am. corazepam azepam 0.5mg s 8:00pm. corazepam macist from the n 09/17/24 at a ng were tions on hand, armacy, and amentation m were lets dispensed on pam were lets dispensed on lets dispensed	D 392			

Division of Health Service Regulation

Division of Health Service Regulation

HAL073010 B. WING 09/19/2	/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	,
MAPLE HEIGHTS ASSISTED LIVING  2065 CHUB LAKE ROAD ROXBORO, NC 27573	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Continued From page 157  -She had signed Resident #2's CSCS when she counted and verified the count was correctIf her initials were not on the CSCS, she did not verify the count and would not have signed the CSCSShe had not verified Resident #2's CSCS counts since 08/23/24.  Refer to the interview with a MA on 09/19/24 at 2:51am,  Refer to the interview with the Manager on 09/18/24 at 2:48pm.  Refer to the interview with the Manager on 09/19/24 at 2:34pm.  Refer to the telephone interview with the Administrator on 09/19/24 at 11:24am.  2. Review of Resident #6's current FL-2 dated 07/01/24 revealed: -Diagnoses included traumatic brain injuryThere was an order for lorazepam (used to treat agitation) 1mg twice daily.  Review of Resident #6's physician orders dated 08/07/24 revealed there was an order for lorazepam 1mg twice daily.  Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg twice daily scheduled at 8:00am and 8:00pmLorazepam was documented as administered 60 of 62 opportunities from 07/01/24 to 07/31/24There were no exceptions documented on the	

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		.   ' '	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:				
			71. 5012511			R	
		HAL073010	B. WING _	B. WING		09/19/2024	
NAME OF F	PROVIDER OR SUPPLIER	STR	EET ADDRESS, CIT	Y, STATE, ZIP CODE			
MAPLE I	MAPLE HEIGHTS ASSISTED LIVING 2065 CH ROXBOR						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D 392	08/01/24 to 08/08/2 -There was an entri- daily scheduled at 8 -Lorazepam was do of 16 opportunities -There were no exc documented on the Review of Resident administration reco 08/31/24 revealed: -The facility change pharmacy did not h for the facilityThe MAR was an emedication adminish handwrittenThere was an entri daily scheduled at 8 -Lorazepam was do of 42 opportunities  Review of Resident from 09/01/24 to 09 -There was an entri daily scheduled at 8 -Lorazepam was do of 37 opportunities  Observation of Res on 09/18/24 at 6:21 -There were two pu 09/11/24 with loraze -Thirty tablets were total of 60 tablets; t and "2 of 2" by the -On the card labele	t #6's August 2024 eMAR 24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administere from 08/01/24 to 08/08/24 ceptions for lorazepam e MAR.  t #6's August 2024 medicated (MAR) from 08/09/24 to ed pharmacies and the neave an eMAR system set electronic print out and the stration documentation was y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 08/09/24 to 08/31/24 to 08/31/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm. ocumented as administered from 09/01/24 to 09/19/24 revealed: y for lorazepam 1mg twice 3:00am and 8:00pm.	e ed 10 4.  ation o w up e is e ed 42 4.  AR e ed 37 4. hand				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			SURVEY PLETED			
							R	
		HAL07	3010	B. WING 09/19/20				
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAPLE H	HEIGHTS ASSISTED L	IVING		B LAKE RO. O, NC 27573				
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 392	Continued From pa	ge 159		D 392				
	-On the card labele handwritten on the tablets available for Review of Resident sheet (CSCS) from revealed: -There were two CS	top left corner administration #6's control 08/12/24 to 6	substance count 09/09/24					
	dispensed on 08/08/24; one CSCS was labeled "1 of 2" and the other was labeled "2 of 2".  -The first CSCS labeled "2 of 2" was for the 8:00am administration.  -There was documentation lorazepam 1mg was signed out from 08/12/24 to 09/06/24.  -From 08/24/24 to 08/28/24, there was nothing documented on the CSCS except a count from 17 to 13 tablets; there were no signatures, no times, no tablets were signed out, nothing documented for waste and no checked off initials.  -From 09/01/24 to 09/03/24, there was nothing							
	documented on the CSCS; there were no counts, no signatures, no times, no tablets signed out, nothing documented for waste and no checked off initials.  -The second CSCS labeled "1 of 2" was for the 8:00pm administration.							
	-There was docume signed out from 08/ -There was nothing 08/28/24, 09/06/24	entation loraz 12/24 to 09/0 documented and 09/08/24	09/24. I on 08/23/24, I; there were no					
	spenddown counts, tablets signed out, if and no checked off -There were 12 table CSCS sheet dated labeled "2 of 2" and the CSCS sheet datalabeled "1 of 2".  Review of Resident	nothing docu initials. lets unaccou from 08/12/2 3 tablets unated from 08/	mented for waste nted for on the 4 to 09/06/24 accounted for on 12/24 to 09/09/24					

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Division of Health Service Regulation

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		R	
HAL073010		HAL073010	B. WING		09/19/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED L	IVING	B LAKE RO D, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	09/18/24 revealed: -There were two CS dispensed on 09/11 of 2" and the other -The first CSCS lab 8:00am administrat -There was docume signed out on 09/13 09/18/24There was nothing except a count on 0 were no signatures out, nothing docume checked off initialsThere was a count CSCS sheet labeled -The second CSCS 8:00pm administrat -There was docume signed out on 09/12 09/16/24There was nothing except a spenddow 09/17/24; there were tablets signed out, if and no checked off -There was a count CSCS sheet labeled -There was a count CSCS sheet labeled -There were two tal CSCS sheet dated labeled "2 of 2" and on the CSCS sheet 09/17/24 labeled "1  Telephone interview facility's contracted 12:05pm revealed:	SCS for the lorazepam 1mg /24; one CSCS was labeled "1 was labeled "2 of 2". weled "2 of 2" was for the ion. entation lorazepam 1mg was 8/24, 09/15/24, 09/16/24, and documented on the CSCS 09/14/24 and 09/17/24; there, no times, no tablets signed ented for waste and no of 24 tables remaining on the d "2 of 2". Is labeled "1 of 2" was for the ion. entation lorazepam 1mg was 2/24, 09/13/24, 09/15/24, and documented on the CSCS on count for 09/14/24 and re no signatures, no times, no nothing documented for waste initials. For 24 tables remaining on the d "1 of 2". Dets unaccounted for on the from 09/13/24 to 09/18/4 two tablets unaccounted for dated from 09/12/24 to of 2".	D 392	DETION NO.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDING.	A. BUILDING:		R	
		HAL073010	B. WING			19/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
MAPLE	HEIGHTS ASSISTED I	LIVING	IUB LAKE RO RO, NC 2757				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	punch card and the and "2 of 2".  -CSCS sheets were dispensed.  -The lorazepam wastaff at the facility.  -The lorazepam wa6:01pm and on 09/-Lorazepam had not facility.  Interview with Residence and the control of the medication aid medication every described.	I/24; there were 30 tablets per e cards were labeled "1 of 2" e provided for each card as signed off as received by as signed off on 08/08/24 at 12/24 at 12:11am. ot been returned from the dent #6 on 09/19/24 at 1:44pm what lorazepam was and he did lorazepam. de (MA) gave him his lay.	1				
	-She did not verify Resident #6's lorazepam with another staff this morning; she did not know why the control count was not verifiedShe would forget to sign the CSCS and do a tablet count when she administered Resident #6's lorazepam.  Interview with the Manager on 09/19/24 at 2:34pm revealed: -The MAs should have always counted Resident #6's lorazepam before the beginning of the next shift and documented the verified count on the CSCSThe MAs knew they had to document lorazepam administration on the CSCS as well as the MAR.  Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation						

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			SURVEY PLETED
HAL073010		B. WING			R <b>09/19/2024</b>	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 037	15/2024
MAPLE I	HEIGHTS ASSISTED I	IVING	UB LAKE RO RO, NC 2757:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 392	Continued From pa	ige 162	D 392			
	revealed 19 tablets of Lorazepam were unaccounted for.					
	Refer to the intervie 2:51am,	ew with a MA on 09/19/24 at				
	Refer to the intervie 09/18/24 at 2:48pm	ew with the Director on				
	Refer to the interview with the Director on 09/19/24 at 2:34pm.					
	Refer to the telephone interview with the Administrator on 09/19/24 at 11:24am.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ъ. Г`	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL073010			WING			R <b>19/2024</b>
NAME OF	PROVIDER OR SUPPLIER	S1	REET ADDRES	SS, CITY, S	TATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	IVING	065 CHUB L OXBORO, N		<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO	L F	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 392	Interview with the Drevealed: -The MAs should lomedication on hand matchedOnce the controlle administered, the Madministration on the CSCSShe randomly aud She could not recard CSCSThe MAs were supsubstances before shift's MA.  Interview with the Drevealed she did not documenting on the Telephone interview 09/19/24 at 11:24ar The MAs should a medication as orderontrolled medication	pirector on 09/18/24 at 20 pok at the MAR and the d and make sure the order of d medication was MAS should document the MAR and signed out sited the CSCS. The last time she audit apposed to count off containing the key to the new pirector on 09/19/24 at 20 pot know why they had not be CSCS.  We with the Administrator of the revealed dominister controlled red. The last time document is made and signed out of the controlled medication is the medication on had a controlled medication on had a c	der der de on the deted the rolled at designation on deted as in the should ind deccurate intained codone ine designation on detection on the designation of the desi	392			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
HAL073010		HAL073010	B. WING		R <b>09/19/2024</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED L	IVING	JB LAKE RO 30, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 392	Continued From pa	ge 164	D 392			
	detrimental to the s the residents and co	for (#6). This failure was afety, health, and welfare of constitutes a Type B Violation.				
	, , ,	d a plan of protection in S. 131D-34 on 09/18/24.				
		N DATE FOR THE TYPE B . NOT EXCEED NOVEMBER				
D 611	10A NCAC 13F .18 Control Policies & F	01(b) Infection Prevention & Pro	D 611			
	PROCEDURES (b) The facility's inf procedures shall be and shall address the shall be and shall be and shall be and shall be accessed by the shall be and shall be accessed by the shall be and shall be and shall be and shall be and shall be accessed by the shall be accessed by the shall be and shall be and shall be accessed by the shall be and shall be accessed by the shall be and shall be accessed by the shall be and shall be and shall be accessed by the shall be acces	ection and control policies and implemented by the facility ne following: and transmission-based ng: atory hygiene and cough atory hygiene and cough mental cleaning and cessing and disinfection of nedical equipment; hygiene; esibility and proper use of equipment (PPE); and of transmission-based are each type is indicated, recautions, droplet d airborne precautions; d how to report to the local				
	health department v	when there is a suspected or e communicable disease or communicable disease				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED		
		HAL073010	B. WING		<b>I</b>	R <b>09/19/2024</b>	
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00:	10,2021	
		2065 CHL	JB LAKE RO				
MAPLE I	HEIGHTS ASSISTED L	IVING	O, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D 611	Section; (3) Measures taking in the event of outbreak to prevent isolating infected re group activities and restricting outside v screening staff, resi illness; and use of st the residents; and (4) Strategies staffing issues and	ge 165 ance with Rule .1802 of this afor the facility to consider of a communicable disease at the spread of illness, such as sidents; limiting or stopping communal dining; limiting or isitation to the facility; idents, and visitors for signs of source control as tolerated by a for addressing potential ensuring staffing to meet the ints during a communicable	D 611				
	reviews, the facility Centers for Disease (CDC) guidelines to control procedures 4 of 4 sampled diab #9) with orders for b						

6899

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD ROXBORO, NC 27573  [X4] ID (CACH DEPICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 611  Continued From page 166  Review of the CDC guidelines for infection control revealed: -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residentsIf the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructionsIf the manufacturer did not list disinfection information, the glucometer should not be shared between residents.  Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose metersThe Food and Drug Administration's (FDA) -Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogensCDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.	STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MAPLE HEIGHTS ASSISTED LIVING  MAPLE HEIGHTS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY PULL PREFIX TAG  CAULD PREFIX TAG  COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION)  D 611  Continued From page 166  Review of the CDC guidelines for infection control revealed: - The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions If the manufacturer's instructions If the manufacturer's manual for Brand A glucometers revealed: - Indirect transmission of Human Immunodeficiency Virus (HIV), hepatitis B Virus (HBV), and hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose meters The Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens CDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for				<del></del>	R			
CALL   Continued From page 166   Continued From page 166   Review of the CDC guidelines for infection control revealed:	HAL073010			B. WING		09/1	9/2024	
CAMPLE HEIGHTS ASSISTED LIVING   ROXBORO, NC 27573	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 611  Continued From page 166  Review of the CDC guidelines for infection control revealed:  -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between resident, it should be cleaned and disinfected per the manufacturer's instructions.  -If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructionsIf the manufacturer did not list disinfection information, the glucometer should not be shared between residents.  -Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of Human Immunodeficiency Virus (HIV), hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose metersThe Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for	MAPLE I	HEIGHTS ASSISTED I	IVING					
Review of the CDC guidelines for infection control revealed:  -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents.  -If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions.  -If the manufacturer did not list disinfection information, the glucometer should not be shared between residents.  Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose meters.  -The Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.  -CDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE	
revealed: -The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residentsIf the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructionsIf the manufacturer did not list disinfection information, the glucometer should not be shared between residents.  Review of the manufacturer's manual for Brand A glucometers revealed: -Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose metersThe Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogensCDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for	D 611	Continued From pa	ge 166	D 611				
Observation of the facility's south-hall medication cart on 09/18/24 at 10:05am revealed there were four black zippered bags labeled with residents' names in the top drawer of the medication cart.  1. Review of Resident #1's current FL-2 dated 02/21/24 revealed: -Diagnosis included diabetes.		Review of the CDC revealed: -The CDC recomm devices (glucomete between residentsIf the glucometer vone resident, it shoper the manufacture information, the glubetween residents.  Review of the manuglucometers reveal-Indirect transmissi Immunodeficiency (HBV), and Hepatitidelivery of healthcaincreasingly reporte monitoring systems sharing of blood glu-The Food and Dru Public Health notific finger-stick device oposed a risk for tranpathogensCDC Clinical Remidevice on more that transmitting blood-but Cobservation of the cart on 09/18/24 at four black zippered names in the top druger.	guidelines for infection control ends blood glucose monitoring ers) should not be shared was to be used for more than uld be cleaned and disinfected er's instructions. r did not list disinfection cometer should not be shared  ufacturer's manual for Brand A ed: on of Human Virus (HIV), Hepatitis B Virus is C Virus (HCV) during the are services have been ed by persons using glucose as a risk group due to acose meters. g Administration's (FDA) cation revealed the use of a on more than one person ensmitting blood-borne  inder: Use of a finger-stick in one person posed a risk for corne pathogens.  facility's south-hall medication 10:05am revealed there were bags labeled with residents' rawer of the medication cart.					

Division of Health Service Regulation

Division of Health Service Regulation

HAL073010  B. WING  NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573  [X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  SUMMARY STATEMENT OF DEFICIENCIES  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD  ROXBORO, NC 27573  ID PROVIDER'S PLAN OF CORRECTION (X5)				A. BUILDING.			
MAPLE HEIGHTS ASSISTED LIVING  2065 CHUB LAKE ROAD ROXBORO, NC 27573  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			HAL073010	B. WING		I	
ROXBORO, NC 27573  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
(,	MAPI E HEIGHTS ASSISTED LIVING						
	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	(X5) COMPLETE DATE
D 611 Continued From page 167 D 611	D 611	Continued From pa	ge 167	D 611			
Observation of a medication aide (MA) during the 8:00am medication pass on 09/18/24 at 7:37am revealed:  -The MA retrieved a black zipped bag from the top drawer of the medication cart.  -The black zipped bag had Resident #1's name on it.  -The glucometer in the black zipped bag did not have a name on it.  -The MA checked Resident #1's blood sugar reading; the reading was 153.  -The MA sanitized her hands before and after donning and doffing gloves  Review of Resident #1's Brand A glucometer on 09/18/24 at 10:05am revealed:  -The current date on the glucometer was 06/02/24 at 11:34am.  -There were two blood sugar readings in the glucometer.  -On 06/01/24 at 1:04pm, there was a blood sugar reading of 300.  -On 06/02/24 at 8:55am, there was a blood sugar reading of 153.  -There were no other blood sugar readings in Resident #1's glucometer.  Review of Resident #1's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed:  -There was an entry to check Resident #1's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.  -There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #1's September 2024 MAR		8:00am medication revealed: -The MA retrieved at top drawer of the management on itThe black zipped be on itThe glucometer in have a name on itThe MA checked for reading; the reading: -The MA sanitized be donning and doffing.  Review of Resident 09/18/24 at 10:05a -The current date of 06/02/24 at 11:34al -There were two bluglucometerOn 06/01/24 at 1:07 -On 06/02/24 at 8:57 -There were no oth Resident #1's glucometerOn 06/02/24 at 8:57 -There were no oth Resident #1's glucometerOn 06/02/24 at 8:57 -There was an entresident #1's glucometerThere was an entresident #1's glucometer.	pass on 09/18/24 at 7:37am a black zipped bag from the redication cart. bag had Resident #1's name the black zipped bag did not Resident #1's blood sugar g was 153. her hands before and after g gloves t #1's Brand A glucometer on m revealed: n the glucometer was h. bod sugar readings in the d4pm, there was a blood sugar er blood sugar readings in bometer. t #1's August 2024 medication and (MAR) from 08/09/24 to by to check Resident #1's blood ally before meals and at eduled administration time of d4:30pm, and 8:00pm. umentation of blood sugar g/24 to 08/31/24.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPI	_ETED	
				<del></del>	-	
					F	
		HAL073010	B. WING		09/1	9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	LIVING	JB LAKE RO			
		ROXBOR	O, NC 27573	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	FRIATE	DAIL
				,		
D 611	Continued From pa	age 168	D 611			
		y to check Resident #1's blood				
		s and at bedtime with a				
		7:30am, 11:30am, 4:30pm, and				
	8:00pm.					
		umentation of blood sugar				
	readings from 09/0	1/24 to 09/17/24.				
	Interview with the MA on 09/18/24 at 10:19am					
	revealed:					
	-She checked Resi	dent #1's blood sugar reading				
	this morning using	his glucometer.				
	-Resident #1 did no	ot have a glucometer until				
	yesterday, 09/17/24					
		cometer was in the facility but				
		ed on the medication cart until				
	yesterday, 09/17/24					
		the first time she had used				
	Resident #1's gluco					
		sident #8's glucometer to check				
	Resident #1's blood		`			
		why the glucometer was not				
		ication cart before yesterday.				
	-	who placed the glucometer on				
	the medication cart					
	the medication cart	•				
	Interview with a sec	cond MA on 09/18/24 at				
	11:00am revealed:	Sond WA On Oar 10/24 at				
		od sugar reading was checked				
	four times daily.	d sugai reading was checked				
		dent #1's blood sugar reading				
	four times on 09/17					
		ved a new meter yesterday,				
	09/17/24.	4. 46				
		ate the previous meter, so she				
	got a new one for F	kesident #1.				
	1	20/40/24				
		Supervisor on 09/18/24 at				
	2:30pm revealed:					
		a new glucometer for Resident				
	#1 before lunch on	09/17/24.				

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AND DUAN OF CODDECTION . DENTIFICATION NUMBER.			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	₹
	HAL073010				1	9/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING 2065 CHUR ROXBORO			JB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	meals and at lunchThere should have readings from yester reading this morning when the surveyor morning, 09/18/24She did not know was ugar readings on Based on observation reviews, it was determined by the surveyor was a surveyor was determined by the surveyor was determin	been three blood sugar erday and one blood sugar g in Resident #1's glucometer checked the glucometer this why there were only two blood Resident #1's glucometer.  ons, interviews, and record ermined Resident #1 was not ew with a second MA on m.				
	09/18/24 at 2:30pm.  Refer to the interview with the Manager on 09/18/24 at 3:11pm.  Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.  2. Review of Resident 7's current FL-2 dated 05/17/24 revealed: -Diagnosis included diabetes mellitusThere was an order to check blood sugars three times a day before meals and at bedtime.  Observation of Resident #7's Brand A glucometer on 09/18/24 at 10:05am revealed: -The glucometer was in a black zippered bag labeled with Resident #7's nameThe glucometer was not labeled with Resident #7's name.					

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AND DIAN OF CORRECTION INDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
HAL073010			B. WING			9/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING			IB LAKE RO O, NC 27573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 611	06/02/24 at 10:34ar -There were 40 blo #7's Brand A glucor 07/09/24.  Review of Resident administration reco 08/31/24 revealed: -There was an entr sugar three times of bedtime with a sche 7:30am, 11:30am, 4 -There was no door readings from 08/02  Review of Resident from 09/01/24 to 09 -There was an entr sugar three times of bedtime with a sche 7:30am, 11:30am, 4 -There was no door readings from 09/0  Interview with Resident 11:02am revealed: -Staff checked his begin on the select -He did not see the glucometerHe did not know if glucometer or not.  Interview with a me 09/18/24 at 11:00ar	n the glucometer was m. od sugar readings on Resident meter from 07/05/24 to #7's August 2024 medication rd (MAR) from 08/09/24 to y to check Resident #7's blood laily before meals and at eduled administration time of 4:30pm, and 8:00pm. umentation of blood sugar 9/24 to 08/31/24.  #7's September 2024 MAR 9/17/24 revealed: y to check Resident #7's blood laily before meals and at eduled administration time of 4:30pm, and 8:00pm. umentation of blood sugar 1/24 to 09/17/24.  Ident #7 on 09/18/24 at blood sugar four times daily. Sugar checked sitting in the lichair. pouch that contained the the staff used the same	D 611	DELITORITY		
	-She did not recall u					

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AND DI AN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		SURVEY PLETED		
HAL073010				B. WING			R <b>09/19/2024</b>	
	PROVIDER OR SUPPLIER HEIGHTS ASSISTED I	LIVING	2065 CHU	DRESS, CITY, S IB LAKE RO O, NC 27573				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2065 CHUB LAKE ROAD ROXBORO, NC 27573   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  CROSS-REFERENCED 10 THE APPROPRIATE DEFICIENCY)  D 611  Continued From page 172  administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry to check Resident #8's blood sugar readings from 08/09/24 to 08/31/24 revealed: -There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry to check Resident #8's blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24.  Interview with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pmThere was no documentation of blood sugar readings from 09/01/24 to 09/17/24.  Interview with Resident #8 on 09/18/24 at 11:12am revealed: -Her blood sugar was checked four times a dayHer blood sugar was checked in her room or	AND DIAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
NAME OF PROVIDER OR SUPPLIER  MAPLE HEIGHTS ASSISTED LIVING  (X4) ID PREFIX TAGS  (X5) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  D 611  Continued From page 172  administration record (MAR) from 08/09/24 to 08/31/24 revealed:  -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:  -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:  -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:  -There was no documentation of blood sugar readings from 09/01/24 to 09/17/24.  Interview with Resident #8 on 09/18/24 at 11:12am revealed:  -Her blood sugar was checked four times a day.				7 BOILBING.			٦
MAPLE HEIGHTS ASSISTED LIVING  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 611  Continued From page 172  administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry to check Resident #8's blood sugar readings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry to check Resident #8's blood sugar treatings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 09/17/24.  Interview with Resident #8 on 09/18/24 at 11:12am revealed: -Her blood sugar was checked four times a day.			HAL073010	B. WING		09/1	19/2024
MAPLE HEIGHTS ASSISTED LIVING  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  (EACH DEFICIENCY WILST BE PRECEDED BY PULL TAG (EACH DEFICIENCY)  (EACH DEFICIENCY WILST BE PRECEDED BY PULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  D 611  Continued From page 172  administration record (MAR) from 08/09/24 to 08/31/24 revealed:  -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:  -There was an entry to check Resident #8's blood sugar treadings from 08/09/24 to 08/31/24.  Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:  -There was an entry to check Resident #8's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.  -There was no documentation of blood sugar readings from 09/01/24 to 09/17/24.  Interview with Resident #8 on 09/18/24 at 11:12am revealed:  -Her blood sugar was checked four times a day.	NAME OF	PROVIDER OR SUPPLIER					
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standing by the medication cart in the hallway.		administration reco 08/31/24 revealed: -There was an entri sugar three times of bedtime scheduled and 8:00pmThere was no door readings from 08/09 Review of Resident from 09/01/24 to 09 -There was an entri sugar three times of bedtime with a sche 7:30am, 11:30am, 4 -There was no door readings from 09/09 Interview with Resid 11:12am revealed: -Her blood sugar with revealed: -Her blood sugar with revealed:	y to check Resident #8's blood laily before meals and at at 7:30am, 11:30am, 4:30pm, umentation of blood sugar 9/24 to 08/31/24.  It #8's September 2024 MAR 9/17/24 revealed: y to check Resident #8's blood laily before meals and at eduled administration time of 4:30pm, and 8:00pm. umentation of blood sugar 1/24 to 09/17/24.  It was checked four times a day. The state of the second of the sec				
		Refer to the intervie 09/18/24 at 2:30pm	ew with the Supervisor on n.				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
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D 611	Continued From pa	ige 173	D 611				
	Refer to the intervie 09/18/24 at 3:11pm	ew with the Manager on					
	Refer to the telepho Administrator on 09	one interview with the 0/19/24 at 9:59am.					
		ent #9's current FL-2 dated diagnosis included diabetes					
	Review of Resident #9's signed physician orders dated 11/06/23 revealed there was an order to check blood sugar readings before meals and at bedtime.						
	Observation of Resident #9's Brand A glucometer on 09/18/24 at 10:05am revealed: -The glucometer was in a black zippered bag labeled with Resident #9's nameThe glucometer was not labeled with Resident #9's name.						
	Review of Resident #9's Brand A glucometer history revealed: -The current date in the glucometer was 06/02/24 at 11:50amThere were two blood sugar readings in Resident #9's glucometerOn 06/01/24 at 1:14pm, there was a blood sugar reading of 105On 06/02/24 at 8:56am, there was a blood sugar reading of 99There were no other blood sugar readings in Resident #9's glucometer.						
	administration reco 08/31/24 revealed: -There was an entr	t #9's August 2024 medication rd (MAR) from 08/09/24 to y to check Resident #9's blood laily before meals and at					

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AND BLAN OF CORRECTION INTERPRETATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED		
			A. BUILDING:			R	
HAL073010			B. WING		<b>I</b>	19/2024	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE I	HEIGHTS ASSISTED I	LIVING		B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>N</sup> REGULATORY OR L	Y MUST BE PRE	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
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	Refer to the interview		oupervisor on				

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HAL073010			B. WING			19/2024	
NAME OF	PROVIDER OR SUPPLIER	S	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE HEIGHTS ASSISTED LIVING			B LAKE RO. O, NC 27573				
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D 611	Continued From pa	age 175		D 611			
	Refer to the interview with the Manager on 09/18/24 at 3:11pm.						
	Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.						
	Interview with a second medication aide (MA) on 09/18/24 at 11:00am revealed:  -There were four residents on the south-hall who received blood sugar checks.  -Each resident had their own glucometer.  -It may be possible that a glucometer was used for multiple residents.  -Glucometers were not to be shared because of blood-borne diseases and cross contamination.  Interview with the Supervisor on 09/18/24 at 2:30pm revealed:  -It appeared the MAs were using the same glucometer to check multiple resident's blood sugars because there were 3 to 5 readings in one glucometer with a 10 to 15 minute time frame.  -The residents could be a risk of cross-contamination with blood.  Interview with the Manager on 09/18/24 at 3:11pm revealed:  -Glucometers were not to be shared among residents.  -Each resident should have their own glucometer with their name placed on the glucometer and the black zippered bag.  -She was not aware the MAs were sharing glucometers among multiple residents.  -Residents could become sick due to blood-borne pathogens.  -There were no residents in the facility with a blood-borne pathogen diagnosis.  -She could not locate the infection control policy.						

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STATEMENT OF DEFICIENCIES (X1) PROV

AND DUAN OF CORDECTION INDENTIFICATION NUMBER.			1` '			X3) DATE SURVEY COMPLETED	
			A. BUILDING:			Б	
HAL073010			B. WING			<b>⊰</b> 19/2024	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	HEIGHTS ASSISTED I	_IVING		B LAKE RO. O, NC 27573			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 611	Continued From pa	ge 176		D 611			
	Telephone interview 09/19/24 at 9:59am -The MAs should not multiple residentsEach resident who checked should have labeled with their national end of the staff shared glucture was a risk of disease.  The facility failed to measures consister Control and Prevent resulting in staff sharesidents for 4 of 4 residents at risk for diseases. This failus health, safety, and constitutes a Type In the facility provided accordance with G. CORRECTION DATES CORRECTION DATES.	w with the Administrate revealed: ot share glucometers had their blood sugate their own glucome ame. ometers between restransmission of infect implement infection aring glucometers be diabetic residents, plucome was detrimental to welfare of the resider	between  ar ster, sidents, tion or  control or Disease stween acing the en the ats, and  in /24.				

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