Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		HAL012007	B. WING		09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	THVIEW STREE' ITON, NC 28655		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	County Department of an annual and follow-complaint investigation 2024 and exited on S	sure Section and the Burke f Social Services conducted up survey along with a on from September 17 - 20, eptmenber 23, 2024. gation was initiated by the ment of Social Servicies			
D 139	(a) Each staff person (7) have a criminal ba in accordance with G.	(a)(7) Other Staff Other Staff Qualifications at an adult care home shall: ackground check completed a.S. 131D-40 and results berson's personnel file;	D 139		
	facility failed to ensure	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff kground check completed			
	The findings are:				
	-Her hire date was 09	iption dated 09/06/24 was de (PCA) . al background check cation aide (MA) on			
	-Staff A was responsil criminal background o	ble for paying for the check, and giving it to the			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			SURVEY PLETED		
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		HAL012007		B. WING		09	/23/2024
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII		VIEW STREET ON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	HOROANT	ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)
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D 139	Continued From page	e 1		D 139			
	with Staff A before Sta	-					
	Interview with the Administrator on 09/19/24 at 1:57pm revealed: -He did not check to make sure Staff A's criminal background check was completed before she starting work at the facilityStaff A was responsible for paying for and completing the criminal background checks and giving the to the Resident Care Coordinator (RCC)The previous RCC was responsible for ensuring						
	criminal background of before hire.	checks were completed riminal background check					
D 161	Validation For LHPS and Validation For Lioux and Validation For Lioux Support Tasks (a) When a resident personal care tasks lioux through (a)(28) of Subchapter, the task non-licensed staff or line their licensed capa professional has validate competent to perform (b) The licensed hea evaluate the staff personal care task. T	A Competency Evaluation censed Health Profession requires one or more of the sted in Subparagraphs (a Rule .0903 of this may be delegated to licensed staff not practicing after a licensed health dated the staff person is a the task. Ith professional shall son's knowledge, skills, at the performance of each	al he a) ng h	D 161			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		R
		HAL012007	B. WING		09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
MODGAN	TON LONG TERM CARE	151 SOU	THVIEW STREE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII MORGAN	ITON, NC 28655	5	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 161	Continued From page	2	D 161		
	has the knowledge, si demonstrate the perfo	kills, and abilities and can primance of the task(s) prior erformed on a resident.			
	facility failed to ensure A) was competency v	as evidenced by: ews and interviews, the e 1 of 3 sampled staff (Staff alidated on the care of estrained and the use of a			
	Hoyer lift.	estrained and the use of a			
	The findings are:				
	-Her hire date was 09 -Her signed job descr for a personal care ai included to be familia	ersonnel record revealed: /06/24. iption dated 09/06/24 was de (PCA) and her duties r with the use of restraints s in and out of bed as			
	Support (LHPS) validation. -There was no restrait documentation.	ed Health Professional ation check list available. nt usage training lift training available for			
	and proof of Hoyer lift 4:15pm were not prov	LHPS validation check list training on 09/20/24 at rided by the survey exit date.			
	Review of Staff A's wo worked on 09/07/24 a	ork schedule revealed she t 10:00pm to 2:00am,			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
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		HAL012007	B. WING		I	/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		151 SOL	ITHVIEW STREE	т		
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII MORGA	NTON, NC 28655	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 161	D 161 Continued From page 3		D 161			
		to 2:30pm, 09/09/24 at				
	•	09/11/24 at 11:05pm to				
	2:00am, 09/13/24 at 09/14/24 12:00am to	•				
		7.00am, 09/10/24 at 09/17/27 at 10:50pm to				
	•	at 11:18pm to 7:15am.				
	7.004111 4110 03/10/24	rat 11.10pm to 7.10am.				
	Review of the facility'	s Policy Regarding the Use				
	1	eptember 2003 revealed:				
		ining would be provided for				
		ng direct care to residents				
		renewed annually by a				
	registered nurse (RN					
	-Physical restraint tra	ining included types of				
	physical restraints us	ed, potential risks and				
	benefits, how to moni	itor and care for residents				
	requiring physical res	straints, and how to				
	accurately document	restraint monitoring and				
	releasing.					
	Interview with Staff A revealed:	on 09/19/24 at 7:45am				
		aints on the residents during				
		not consider full bed rails up				
	-When she needed to	provide incontinent care to				
	a resident who had fu	ıll beds rails up, she would				
		to help with safety while				
	she provided incontin					
	-She was not trained	•				
		30 minutes, or every 2 hour				
		se on residents who were				
	_	cument during the night				
	shifts she worked.	7.00				
	-Every morning, before					
		g the four residents up who				
	required the Hoyer lif					
		she used a Hoyer with, one				
		Geri chair with it reclined, a transferred to a Geri chair				
	Second resident was	uansieneu wa Gen Chall	1	1		1

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 151 SOUTHWEW STREET MORGANTON LONG TERM CARE, SOUTHVIEW FACIL 151 SOUTHWEW STREET MORGANTON LONG TERM CARE, SOUTHVIEW FACIL 151 SOUTHWEW STREET MORGANTON, NO. 286655 152 SUMMANY STATELENT OF DEPICIENCIES 153 CONTROLL FROM THE APPROPRIATE OF DEPICIENCIES 154 CONTROLL FROM THE APPROPRIATE OF DEPICIENCY MUST SEE PRECEDED BY FULL 154 FEGULATORY OR LSC IDENTIFYING INFORMATION) 155 CONTROLL FROM THE APPROPRIATE ONE 155 CONTROLL FROM THE APPROPRIATE ONE 156 CONTROLL FROM THE APPROPRIATE ONE 157 CONTROLL FROM THE APPROPRIATE ONE 158 CONTROLL FROM THE APPROPRIATE ONE 159 CONTROLL FROM THE APPROPRIATE ONE 150 CONTROLL FROM THE APPROPRIATE ONE 151 CONTROLL FROM THE APPROPRIATE ONE 152 CONTROLL FROM THE APPROPRIATE ONE 153 CONTROLL FROM THE APPROPRIATE ONE 154 CONTROLL FROM THE APPROPRIATE ONE 155 CONTROLL FROM THE APPROPRIATE ONE 155 CONTROLL FROM THE APPROPRIATE ONE 156 CONTROLL FROM THE APPROPRIATE ONE 157 CONTROLL FROM THE APPROPRIATE ONE 158 CONTROLL FROM THE APPROPRIATE ONE 158 CONTROLL FROM THE APPROPRIATE ONE 159 CONTROLL FROM THE APPROPRIATE O		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDITIVISION STREET MORGANTON LONG TERM CARE, SOUTHVEW FACII 151 SOUTHVEW STREET MORGANTON, NC 28655 PROVIDERS 1AN OF CORRECTION (EACH CORRECTION STANLARS OF PERCENDEDS OF VILL PREPARA THE CONTINUES DESCRIPTING OF PROVIDERS OF PROVIDE				7 20122to. <u>-</u>		ь .
Discrimination Summary statement of Deficiencies Summary statement of Deficiencies Deficiency Summary statement of Deficiencies Deficiency Must statement of Deficiencies Deficiency Must statement of Deficiencies Deficiency Must statement of Deficiency Deficien			HAL012007	B. WING		
Discrimination Summary statement of Deficiencies Summary statement of Deficiencies Deficiency Summary statement of Deficiencies Deficiency Must statement of Deficiencies Deficiency Must statement of Deficiencies Deficiency Must statement of Deficiency Deficien	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS CITY STA	TE ZIP CODE	
MORGANTON LONG TERM CARE, SOUTHVIEW FACI MARCH MORGANTON, NC 28655 MORGANTON, NC 28655 MORGANTON MORGANTON, NC 28655 MORGANTON PREPIX MORGANTON PREPIX MORGANTON PREPIX MORGANTON PREPIX MORGANTON PREPIX MORGANTON PREPIX MORGANTON MORGANTON PREPIX MORGANTON MORG	TVAINE OF T	NOVIDEN ON GOLT EIEN		, ,	,	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 161 Continued From page 4 and reclined and two of the residents were transferred to a wheelchair and she applied a three-point soft belt restraint. -There was another resident that she transferred to a wheelchair and applied a three-point soft belt restraint. -There was another resident that she transferred to a wheelchair and applied a three-point soft belt restraint as well. -Since she started at the facility about 3 weeks ago, she used the Hoyer lift by herself. -The 2nd shift MA trained her how to use the Hoyer and she was not told two staff should operate the Hoyer lift at all times. -She was not trained to get the Administrator to help with the Hoyer lift. Telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12-48pm revealed: -She was a Registered Nurse and provided clinical training to the staff at the facility. -Staff A was to be trained and checked off by an RN prior to providing resident assistance with the use of the restraints. -The restraint training included recognizing and responding to a residents hydration needs, circulation, sign and symptoms of injury, distress and agitation, skin integrity, mental status, hygiene and elimination. -Staff training also included the "visual" inspection/monitoring of a resident in restraints per the physician's order every 30 minutes to check for the above issues/needs and every two hours to "visually and physically" release the restraint and inspect/monitor for the above issues/symptoms. -She did not train or check off Staff A for providing care to residents which included the use of	MORGAN	TON LONG TERM CARE,	. SOUTHVIEW FACII			
and reclined and two of the residents were transferred to a wheelchair and she applied a three-point soft belt restraint. -There was another resident that she transferred to a wheelchair and applied a three-point soft belt restraint as well. -Since she started at the facility about 3 weeks ago, she used the Hoyer lift by herself. -The 2nd shift MA trained her how to use the Hoyer and she was not told two staff should operate the Hoyer lift at all times. -She was not trained to get the Administrator to help with the Hoyer lift. Telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm revealed: -She was a Registered Nurse and provided clinical training to the staff at the facility. -Staff A was to be trained and checked off by an RN prior to providing resident assistance with the use of the restraints. -The restraint training included recognizing and responding to a residents hydration needs, circulation, sign and symptoms of injury, distress and agitation, skin integrity, mental status, hygiene and elimination. -Staff training also included the "visual" inspection/monitoring of a resident in restraints per the physician's order every 30 minutes to check for the above issues/symptoms. -She did not train or check off Staff A for providing care to residents with clinded the use of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
transferred to a wheelchair and she applied a three-point soft belt restraint. -There was another resident that she transferred to a wheelchair and applied a three-point soft belt restraint as well. -Since she started at the facility about 3 weeks ago, she used the Hoyer lift by herself. -The 2nd shift MA trained her how to use the Hoyer and she was not told two staff should operate the Hoyer lift at all times. -She was not trained to get the Administrator to help with the Hoyer lift. Telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm revealed: -She was a Registered Nurse and provided clinical training to the staff at the facilityStaff A was to be trained and checked off by an RN prior to providing resident assistance with the use of the restraintsThe restraint training included recognizing and responding to a residents hydration needs, circulation, sign and symptoms of injury, distress and agitation, skin integrity, mental status, hygiene and eliminationStaff training also included the "visual" inspection/monitoring of a resident in restraints per the physician's order every 30 minutes to check for the above issues/symptomsShe did not train or check off Staff A for providing care to residents which included the use of	D 161	Continued From page	e 4	D 161		
-The use of a Hoyer lift with a resident was to be provided by two staff for safetyThere was an increased risk with one person		and reclined and two transferred to a wheel three-point soft belt reto a wheel three-point soft belt reto a wheelchair and a restraint as well. Since she started at ago, she used the Ho-The 2nd shift MA trail Hoyer and she was not operate the Hoyer lift. She was not trained help with the Hoyer lift. Telephone interview well LHPS Nurse on 09/20. She was a Registere clinical training to the Staff A was to be trail RN prior to providing use of the restraints. The restraint training responding to a reside circulation, sign and sand agitation, skin into hygiene and eliminations and agitation, skin into hygiene and eliminations. Staff training also incomper the physician's or check for the above is hours to "visually and restraint and inspect/rissues/symptoms. She did not train or coare to residents which restraints. The use of a Hoyer liprovided by two staff in provided by two staff in provided by two staff in the provided in the same and the provided in the provided i	of the residents were Ichair and she applied a sestraint. Sesident that she transferred pplied a three-point soft belt the facility about 3 weeks yer lift by herself. In the her how to use the ot told two staff should at all times. It to get the Administrator to fit. With the facility's contracted 20/24 at 12:48pm revealed: It the facility. In the facility is ned and checked off by an aresident assistance with the simple included recognizing and the entire hydration needs, symptoms of injury, distress to segrity, mental status, on. Soluded the "visual" of a resident in restraints der every 30 minutes to seues/needs and every two physically" release the monitor for the above theck off Staff A for providing the included the use of the for safety.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		0.9	R 0/ 23/2024
NAME OF D	DOMBED OD GUDDINED			- 7ID 00DE	1 00	TEOTEUL+
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	=, ZIP CODE		
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	THVIEW STREET NTON, NC 28655			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF C	ORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 161	Continued From page	e 5	D 161			
	bruises to catastrophi brain bleed and death -She did not train or o	ch included bumps and ic which included fractures, in. Sheck off Staff A for providing the included the use of a				
	facility's contracted P on 09/21/24 at 7:33pr risks while using the raccidental injury/deat increased risk for pre- tone, contractures, de loss of balance; loss of decreased ability to a	sage response from the rimary Care Provider (PCP) m revealed the potential restraints were as follows; h from the restraints; ssure sores; loss of muscle ecreased ability to ambulate; of independent mobility, mbulate; incontinence; and inon, withdrawal and reduced				
	1:57pm revealed: -The previous Reside was responsible befo shift MA for contacting complete the LHPS selt was his understand new staff with the Hoyer lift and LHPS Nurse would could be did not know Staff validated and signed	kills check off. ding the MAs could train the yer lift and restraints and uld provide the assistance I restraints and then the complete the skills check off. If A was not trained in the				
	The facility failed to e competency validated	nsure Staff A was I by a registered nurse on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ED.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL012007	1	B. WING		R 09/23/2024
	ROVIDER OR SUPPLIER TON LONG TERM CARE	, SOUTHVIEW FACII	STREET ADDRE	IEW STREET	· T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 161	perform transfers of rusing the proper skills resulted in restraint mompleted and unsafulift with only one staff failure was detrimentated welfare of the resident Violation. The facility failed to pof protection in accord 09/19/24 for this violation.	restraints and how to esidents with a Hoyer lift and knowledge which nonitoring not being transfers using the Horistead of two. The factal to the health, safety, atts and constitutes a Typerovided an acceptable pagance with G.S. 131D-3	ft byer ility's and be B blan 84 on	D 161		
D 181	With A Capacity Or 10A NCAC 13F .0602 With A Capacity Or C Residents In a facility with a centre but less than 31 resident administrator or manager carried out in the following arrangement a facility with a censural (1) the administrator feet of the facility with telecommunication with the facility with a manager is in the facility with a man	ing that all required duti- facility. One or more of its shall be used to man is of seven to 30 resider is in the facility or within a means of two-way ith the facility at all times he facility or within 500	ties y en es the hage hts: n 500 s; feet	D 181		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
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		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	HVIEW STREE TON, NC 2865		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 181	each with a census of there shall be at least live in or on a shift bat facilities. In addition, administrator or mana of each home with a stelecommunication wand directly responsitive required duties are cathe purpose of the rul of licensed facilities."	cluster of licensed facilities, f 12 or fewer residents, t one staff member, either sis in each of these there shall be at least one ager who is within 500 feet	D 181		
	overall management, of facility policies and the facility remained i with the rules and ger competency evaluation health professional sustaffing, resident right restraints and alternative facility's license was a facility's license was a facility's license was a facility of facility's license was a facility of facili	n, record reviews and istrator failed to ensure the operations, implementation procedures and to ensure n substantial compliance neral statutes related to on and validation for licensed upport tasks (LHPS), ts, and use of physical			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		'	2) MULTIPLE (BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		R
		HAL012007	В.	WING	<u>.</u>	09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	SI	TREET ADDRES	S, CITY, STAT	re, zip code	
		18	51 SOUTHVIE	W STREET	7	
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII	ORGANTON,	NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETE
D 181	Continued From page	≥ 8	D	181		
	Observation of the facility on 09/17/24 at 9:00am revealed there were 13 residents in the facility. Interview with a medication aide (MA) on 09/17/24 at 8:30am revealed: -She worked as a first shift MA (7:00am to 3:00pm).		m			
	-In the past 3 weeks, first shift MAs worked alone on some days and if alone, were responsible for cooking, resident care, checking on residents,					
	housekeeping, laundry, calls to the physician and they had to go get the Administrator if they needed help because he did not provide any					
	resident care.	•				
	-The Administrator co where he lived in the	ould be found in his room, facility.				
	-The previous Reside	ent Care Coordinator (RCC	' I			
	_	operations of the facility ur st 2024; now she was not				
	sure who managed the facility.	ne daily operations of the				
	not two staff members	_	•			
		ions when she arrived at rator was the only staff that the only staff the	at			
		uld be two staff members				
	operating the Hoyer li	ift by themselves because e available to assist during				
		ities with the residents who always have time.	en			
	Interview with the Adr 9:15am.	ministrator on 09/17/24 at				
	-He lived in the facility	dications to the residents. y and did not keep any orked because he was				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY IPLETED
		HAL012007	B. WING		0!	R 9/ 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
MODOAN	TON 1 ONO TERM OARE	151 SOU	THVIEW STREET			
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII MORGAI	NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 181	Continued From page	9	D 181			
	always thereHe covered the third					
	1:57pm. -He knew he was res operations of the faci members had resigned. -He expected one of the day-to-day operations are aide (Pashowing up for work.) -He did not try to arrast staffing on third shift. -He did not try to continue the high cost and he were trustworthy. -He covered and work himself. -He did not always do	ed which left him in a bind. the first shift MAs to handle cions of the facility if he was if a lot due to the third shift CA) not calling out and not inge any other coverage for tact a staffing agency due to did not feel agency staff ked third shift a lot by				
	worked third shift alor -He knew Hoyer lifts to operateStaff were not allowed without a second staf -He had not witnesse lift by themselves but because residents whalready up in the mor staff person had beer -Two staff members withird shift due to residents to get the staff of the residents to get the staff of the residents to get the staff of the sta	required two staff members ed to use the Hoyer lift of member present. d any staff using the Hoyer suspected they had no required a Hoyer lift were nings when only one other n working. were not required on the lents sleeping with no need et out of bed. continence care by himself				

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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	
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	HVIEW STREETON, NC 28655		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 181	use a Hoyer lift and wof their beds by the bound interview with a second 4:16pm revealed: -When she worked see Administrator was not anytime when the Administrator was not represent the staff nor available and the told them to complete the told them told them told the told them told the told them told the told them told them told the told them told the told them to	e would not take the time to yould drag the residents out ed sheet. and MA on 09/17/24 at econd shift, the tusually in the building. In the making rounds to check on to help with resident care and get him if the staff eras responsible for the daily lity and resigned about the 4. Insible for scheduling staff, ent and staff records,	D 181		
	everything ran smoot -There was no official Administrator stated to new RCCWhen staff called out work, there had been staff called in so they aloneAbout 2-3 weeks agountil 3:00am because next dayThe Administrator known to assist herThere had been number arrived at work and of the facilityShe knew there were the assistance to trans-She admitted to using the restated to the state of the state	hly.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		09	R 0/ 23/2024
	ROVIDER OR SUPPLIER TON LONG TERM CARE	. SOUTHVIEW FACII	DDRESS, CITY, STATE ITHVIEW STREET NTON, NC 28655	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 181	5:22pm revealed: -She worked second -There had been num over to work on third no call, no showShe sometimes wou if the third shift PCA c -When she left the fact the only staff member -The Administrator livoccupied two resident 200 hallwayThe Administrator die to assist while she wo Telephone interview wo 09/18/24 at 3:29pm re -There was an Admin was the manager and was responsible for the the facility until she re -She was in charge of resident funds, time of administration Record cart audits, any audits the Administrator eith the facilitySince she resigned the help with the schedul food orders, or anythi handling, because she Administrator. Interview with the coor revealed: -The Administrator wa overall management -The previous RCC was	shift (3:00pm until 11:00pm). herous times she stayed shift due to the PCA being a Id work until around 3:00am did not come to work. cility, the Administrator was r in the facility. ed in the facility and t rooms at the end of the Id not come out of his room orked. with the previous RCC on evealed: istrator of the facility but she d she was the person that he overall daily operations of esigned in August 2024. If the schedule, staff, payroll, eards, electronic Medication d (eMAR) audits, medication d (eMAR) audits, medication s, you name it she did it and her stayed in his room or left the MAs were calling her for he, staff pay, residents' funds, hing the Administrator was not he did it all, not the	D 181			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		HAL012007	B. WING		09/23/2024
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STAT	E ZIR CODE	,
NAME OF P	ROVIDER OR SUPPLIER		THVIEW STREET		
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	NTON, NC 28655		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TON (X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
D 181	Continued From page	e 12	D 181		
	the other staff, and w	orking with the physicians.			
	-	RCC resigned in August			
	The state of the s	or did not take charge			
	because he told one				
		arge of passing medications,			
	housekeeping, laundi				
	the physician.	sues and notifications with			
		gement at all now because			
	-	s not managing the facility.			
1		5 5 7			
	Interview with the Adr	ministrator on 09/18/24 at			
	4:15pm revealed:				
		vas in charge of the day to			
	day operations of the				
		nsible for supervising the			
	_	lles, approved new staff, and needed anything related			
	to the facility.	ie needed anything related			
	•	nind the RCC because she			
	knew more about thin				
		an Administrator, but he put			
	her in charge of the d staff and residents.	aily operations of the facility			
		round the middle to the end			
		ook the "brain" of the facility			
	_	ortable computer) drive.			
		the capability to complete			
		for staff, resident funds			
	information, and polic	cy's and procedures.			
	-He put a MA in char	ge at that point but she			
	needed training.				
	Interview with a third	shift PCA on 09/19/24 at			
	7:45am revealed:				
		ft (11:00pm to 7:00am).			
		as in the building because			
		did not assist her with			
	personal care for the				
	-If a resident needed	any prn (as needed)			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SU COMPLE	
				_		R	
		HAL012007		B. WING		1	3/2024
NAME OF P	ROVIDER OR SUPPLIER	\$	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII	151 SOUTH	IVIEW STREE	г		
MORGAN	TON LONG TERM CARE,	, SOUTHVIEW TACII	MORGANT	ON, NC 28655	3		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 181	Continued From page	÷ 13		D 181			
	from his room becaus floor.	to get the Administrator se he did not work on the					
	Interview with the Administrator on 09/20/24 at 9:40amThe second shift MA was good about staying over and working until about 3:00am if the third						
	shift PCA was a no ca	all/no show.					
	 -He would be notified by the second shift MA around 11:00pm when the third shift PCA did not come into work. -He did not make rounds when the third shift PCA was on duty, but he was available if needed. 		not				
			PCA				
	Non-compliance was in the following rule a	identified at a violation le reas:	evel				
	facility failed to ensure A) was competency v residents who were re	d Health Professional	taff				
	reviews, the facility fa members were working to provide the care not (Resident #1, # 2, #3, person transfers with who required a two post (#6). [Refer to tag 193	es, observations and reco- iled to ensure two staff- ing on third shift at all time seeded for four residents and #5) who required two a Hoyer lift and one residerson assist with transfer 3, 10A NCAC 13F .0607(es with a Census of 13 to	es /o dent s d)				
		rs and record reviews, the e 1 of 5 sampled resident					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	HVIEW STREET			
	T	MORGAN	TON, NC 28655			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 181	Continued From page	2 14	D 181			
	Refer to tag 338, 10A Rights (Type A1 Viola 4. Based on observat interviews, the facility performing the require residents with restrain	espiratory distress (#4). A NCAC 13F .0909 Resident tion)]. ions, record reviews, and failed to ensure staff were ed monitoring and care for its for 5 of 5 sampled				
		#5 and #6). [Refer to tag .1501(a) Use of Physical				
		ives (Type A1 Violation)].				
	management and oper failing to provide care who was found in severespiratory compromishe could die during to not checked on througher from going into secare was not provided. One staff operated a which put four resider harm or death if there the residents if life through the providence of the providence of the residents with remonitored to ensure the secare was not provided.	ed to ensure the overall erations of the facility by and services to a resident ere distress caused by se and pain when thought he night. The resident was ghout the night to prevent evere distress and comfort d to her while she was dying. Hoyer lift instead of two ints at risk of serious physical evas the need to evacuate eatening events occurred. Straints were not properly heir safety. This failure glect which constitutes a				
	The facility provided a protection in accordar 09/17/24 for this Viola	nce with G.S. 131D-34 on				
		DATE FOR THIS TYPE A1 IOT EXCEED OCTOBER				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII	THVIEW STREET TON, NC 28655		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 193	With A Census Of 13 10A NCAC 13F .0607 With A Census Of 13 (d) Each facility shall member per shift to poservices and supervision by the residents. The shall not perform food shift of rendering care. The staff member so a housekeeping duties acre services and sup (1) between the hour p.m., and then only with duties are incidental to services; and (2) between the hour a.m., and then only to housekeeping duties at staff's duties of care or residents, nor impedemember's ability to me (e) There shall be ad housekeeping and food. This Rule is not met at TYPE A2 VIOLATION. Based on interviews, reviews, the facility farmembers were working to provide the care net (Resident #1, # 2, #3, person transfers with	assign at least one staff rovide personal care ion of residents as needed staff member so assigned a service duties during the exervices and supervision. Assigned shall not perform during the shift of rendering pervision, except; as of 7:00 a.m. and 9:00 hen the housekeeping to the rendering of care are sof 9:00 p.m. and 7:00 at the extent that the do not hinder the assigned or immediate response to the assigned staff conitor the residents. ditional staff to provide daily as evidenced by:	D 193		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION		E SURVEY PLETED
		HAL012007	B. WING		09	R 9/ 23/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
MODCAN	TON LONG TERM CARE	SOUTHWEN FACIL 151 SOL	THVIEW STREET			
WORGAN	TON LONG TERM CARE	MORGA	NTON, NC 28655			
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 193	Continued From page	÷ 16	D 193			
	The findings are:					
	facility's license was	s license revealed the effective 01/01/24 through ty of up to 64 residents.				
	08/04/24 through 08/ 10:08am, 09/18/24 at	y's census report from 16/24 on 09/17/24 at 4:20pm and on 09/20/24 at vided by the survey exit				
	Interview with a medio 09/20/24 at 2:30pm re had been less than 1 months including the	evealed the facility census 7 for the past several				
		cility during the initial tour on evealed there was a census facility.				
		cility on 09/19/24 at 5:10pm census of 14 residents in				
	through 08/17/24 reverse on 08/04/24, there we the facility from 2:57are on 08/05/24, there we the facility from 2:44are on 08/06/24, there we the facility from 2:50are on 08/07/24, there we the facility from 2:45are on 08/08/24, there we the facility from 2:45are on 08/08/24, there we the facility from 2:45are on 08/08/24, there we the facility from 2:45are	vas only one staff member in m through 7:10am. vas only one staff member in m through 6:46am. vas only one staff member in m through 5:36am. vas only one staff member in m through 6:51am. vas only one staff member in				

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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	
		HAL012007		B. WING		09	/23/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MORCAN	TON LONG TERM CARE	SOUTHVIEW EACH	151 SOUTH	IVIEW STREE	г			
WORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII	MORGANT	ON, NC 28655	j			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 193	Continued From page	= 17		D 193				
	-On 08/10/24, there we the facility from 2:22a -On 08/11/24, there we the facility from 2:34a -On 08/12/24, there we the facility from 2:25a -On 08/13/24, there we the facility from 2:57a -On 08/14/24, there we the facility from 2:00a -On 08/15/24, there we the facility from 2:01a -On 08/16/24, there we the facility from 12:50	was only one staff mem am through 6:52am. was only one staff mem am through 7:00am. was only one staff mem am through 6:57am. was only one staff mem am through 7:00am. was only one staff mem am through 7:04am. was only one staff mem am through 6:08am. was only one staff mem oam through 6:49am. was only one staff mem oam through 6:49am.	ber in ber in ber in ber in ber in ber in					
	Review of five sampled residents' records revealed the residents required two staff members to provide personal care services and supervision on third shift through 08/04/24 through 08/17/24.		and					
	07/17/24 revealed: -Diagnoses included Parkinson's disease, and moderate anxiety	nstantly disorientated.						
	revealed: -The resident was ad 06/29/16The resident require dressing, bathing, na and out of bed, toileti mouth care, feeding,	t1's Resident Register mitted to the facility on d assistance by staff fo il care, ambulation, getting, hair/grooming, skin positing/turning, schedientation to time and pl	ting in care, uling					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	ISENTING TOTAL CONTROL OF THE CONTRO		A. BUILDING: _		J
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	THVIEW STREE ITON, NC 2865		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 193	Continued From page	e 18	D 193		
	-The resident had sig was to be redirected.	nificant memory loss and			
	assistive devices, fee residents with swallow blood sugars, medica restraints and/or alter Review of Resident 1 revealed: -Resident #1 was tota toileting, ambulation, and groomingResident #1 other ca	(LHPS) tasks dated esident #1 required fers, ambulation using eding techniques for wing difficulties, finger stick ations through injection and			
	Refer to interview with on 09/19/24 at 7:45ar	h a third shift staff member m.			
	Refer to interviews wi aide (MA) on 09/17/2- 09/18/24 at 11:25am.				
	Refer to interview witl 09/17/24 at 5:22pm.	h a second shift MA on			
	Refer to interview with 09/18/24 at 9:25am.	h another first shift MA on			
	Refer to telephone int Marshall on 09/18/24				
	Refer to a review of a from the facility's content Provider (PCP) on 09				

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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		
		HAL012007		B. WING			R 23/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII		IVIEW STREE			
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	WORGANT	ON, NC 28655		ECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 193	Continued From page	: 19		D 193			
	Refer to interview with 09/17/24 at 9:15am.	n the Administrator on					
	Refer to interview with 09/19/24 at 1:57pm.	n the Administrator on					
	Refer to interview with 09/20/24 at 9:40am.	n the Administrator on					
	2. Review of Resident #2's current FL-2 dated 10/02/23 revealed:-Diagnoses included dementia, Parkinson's disease, psychosis, diabetes type II, anemia,						
	hyperlipidemia, depre deficiency.	ssion and vitamin D					
	-He was intermittently-He was non-ambulat-He was incontinent of-He was verbally abus	ory and used a geri cha f bowel and bladder.	air.				
	-A Hoyer lift was requ						
	Review of Resident #. revealed he was adm						
	Review of Resident #. 09/06/24 revealed Re assistance with transf	sident #2 required					
	05/08/24 revealed: -He was totally depen	2's current care plan da dent with eating, toiletir dressing, grooming and	ng,				
	transfersHe was non ambulate knee amputationsA Hoyer lift with a 2-p	ory with bilateral below person assist was requi	the				
	for all transfers. Refer to interview with	n a third shift staff meml	ber				

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PREFIX TAG REGULATORY OR LSC IDENTEYING INFORMATION) D 193 Continued From page 20 on 09/19/24 at 7:45am. Refer to interview with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/18/24 at 10:32am. Refer to interview with another first shift MA on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 10:32am. Refer to interview with the Administrator on 09/19/24 at 19:15am. Refer to interview with the Administrator on 09/19/24 at 10:30am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accident. -She was constantly disoriented. -She was incontinent of bowel and bladder. -She was incontinent of bowel and bladder. -She was on Resident #3's Resident Register		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
MORGANTON LONG TERM CARE, SOUTHVIEW FACII 151 SOUTHVIEW STREET MORGANTON, NC 28655 MORGANTON, NC 28655			HAL012007	B. WING		09	
MORGANTON, NC 28655 MORGANTON, NC 28655	NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 193 Continued From page 20 on 09/19/24 at 7:45am. Refer to interview with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 10:30am. Refer to interview with the Administrator on 09/19/24 at 19:15am. Refer to interview with the Administrator on 09/19/24 at 10:30am. Refer to interview with the Administrator on 09/19/24 at 10:30am. Refer to interview with the Administrator on 09/20/24 at 10:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accident. -She was constantly discriented. -She was constantly A's Resident Register	MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII		•		
on 09/19/24 at 7:45am. Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/17/24 at 1:57pm. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accident. -She was constantly disoriented. -She was incontinent of bowel and bladder. -She was incontinent of bowel and bladder. -She used a wheelchair.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/19/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthrifts and a history of cerebrovascular accident. -She was constantly disoriented. -She was incontinent of bowel and bladderShe used a wheelchair. Review of Resident #3's Resident Register	D 193	Continued From page	20	D 193			
09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/19/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accidentShe was incontinent of bowel and bladderShe was incontinent of bowel and bladderShe used a wheelchair. Review of Resident #3's Resident Register		on 09/19/24 at 7:45ar	n.				
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Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accidentShe was constantly disorientedShe was incontinent of bowel and bladderShe used a wheelchair. Review of Resident #3's Resident Register	C F N		n another first shift MA on				
from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accidentShe was constantly disorientedShe was incontinent of bowel and bladderShe used a wheelchair. Review of Resident #3's Resident Register		•					
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-She was incontinent of bowel and bladderShe used a wheelchair. Review of Resident #3's Resident Register		02/28/24 revealed: -Diagnoses included a osteoarthritis and a hi	Alzheimer's dementia,				
		-She was incontinent	of bowel and bladder.				
-Resident #3 was admitted to the facility on		revealed:	-				

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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		
		HAL012007		B. WING		09	R / 23/2024
	ROVIDER OR SUPPLIER	, SOUTHVIEW FACII	151 SOUTH	RESS, CITY, STA IVIEW STREE ON, NC 28658	т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 193	-Resident #3 required dressing, bathing, na getting in and out of his skin care, mouth care and orientation to tim-Resident #3's memoreminders. Review of Resident # revealed: -Resident #3 required use of a Hoyer lift for chair/bed. Refer to interview with on 09/19/24 at 7:45an Refer to interview with 09/17/24 at 8:40am and Refer to interview with 09/17/24 at 9:25am. Refer to telephone in Marshall on 09/18/24 Refer to a review of a from the facility's con 7:33pm. Refer to interview with 09/17/24 at 9:15am.	d assistance by staff for il care, shaving, ambulated, toileting, hair/groome, scheduling appointme e and place. Try was forgetful and needs as a care plan dated 09/2 of the use of bedrails for the use of bedrails for a two-person assist with transfers to and from the a third shift staff members. The affirst shift MA on and on 09/18/24 at 11:25 of a second shift MA on the another first shift MA of the another first shift	ning, ents, eded 21/23 the ber	D 193			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FEAT OF CONTROL OF THE PARTY OF THE PART		IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
HAL012007 B. WING		R 09/23/2024			
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIR CODE	1 00/20/2024
NAME OF P	ROVIDER OR SUPPLIER		HVIEW STREE		
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	TON, NC 2865		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 193	Continued From page	e 22	D 193		
	Refer to interview with the Administrator on 09/20/24 at 9:40am.				
	01/24/24 revealed: -Diagnoses included hypothyroidism, chroi hypertension, hyperli insomnia, vitamin D o -She was constantly				
	-She was non-ambulatory and used a wheelchairShe needed total assistance with toileting, bathing, dressing, grooming, and transfers, and extensive assistance with eating and ambulationShe was incontinent of both bowel and bladder.				
	revealed: -She was admitted to -She required assista nail care, correspond care/grooming, skin o appointments, orienta well as prompts for fe	care, mouth care, scheduling ation to time and place, as			
	08/01/24 revealed Re	ılation using assistive			
	change Care Plan da	ive assistance with g.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	TIPLE CONSTRUCTION	(X3) DATE	SURVEY	
			A. BUILDI	NG:		
		HAL012007	B. WING _			R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY	, STATE, ZIP CODE		
		15	1 SOUTHVIEW ST	REET		
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII	ORGANTON, NC 2	8655		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 193	Continued From page	e 23	D 193			
	transfers.					
	Refer to interview wit on 09/19/24 at 7:45ar	h a third shift staff member m.				
	Refer to interviews w 09/17/24 at 8:40am a	ith a first shift MA on and on 09/18/24 at 11:25am	1.			
F	Refer to interview wit 09/17/24 at 5:22pm.	h a second shift MA on				
	Refer to interview wit 09/18/24 at 9:25am.	h another first shift MA on				
	Refer to telephone in Marshall on 09/18/24					
		a text message response tracted PCP on 09/21/24 a	t			
	Refer to interview wit 09/17/24 at 9:15am.	h the Administrator on				
	Refer to interview wit 09/19/24 at 1:57pm.	h the Administrator on				
	Refer to interview wit 09/20/24 at 9:40am.	h the Administrator on				
	5. Review of Residen 05/08/24 revealed:	t #6's current FL2 dated				
		ementia with agitation,				
	anxiety and a history					
	-She was constantly					
	-Sne was incontinent	of bowel and bladder.				
	Review of Resident #	6's Resident Register				
		mitted to the facility on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	1 00/20/2024
		151 SOU	THVIEW STREE		
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII MORGAN	ITON, NC 28655	5	
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 193	dressing, bathing, naibed, toileting, hair/grocare, scheduling apportime and placeResident #6's had signeeded to be directed. Review of Resident #revealed: -Resident #6 must be chair requiring two statesWhile in bed, Reside to deter from her attendation. Refer to interview with on 09/19/24 at 7:45ar. Refer to interviews with 09/17/24 at 8:40am at the secondary at the se	I assistance by staff for I care, getting in and out of coming, skin care, mouth cointments, and orientation to gnificant memory loss and I. 6's care plan dated 06/05/24 transferred from bed to aff members. Int #6 used full bedrails to try mpting unsupervised In a third shift staff member in. Ith a first shift MA on ind on 09/18/24 at 11:25am. In a second shift MA on in another first shift MA on in the Administrator on in the Ad	D 193		
	Refer to interview with	n the Administrator on			

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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.			D.	
		HAL012007	B. WING		م ا	R / 23/2024	
		HALU12007			08	1/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE			
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACIL	THVIEW STREET				
MOROAN	TON LONG TERM OAKE	MORGAN	ITON, NC 28655				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
D 193	Continued From page	e 25	D 193				
	09/19/24 at 1:57pm.						
	Refer to interview with the Administrator on 09/20/24 at 9:40am.						
	Interview with a third	shift staff member on					
	09/19/24 at 7:45am re -She started work at t	evealed: the facility about 3 weeks go.					
	-She was hired as a F work from 11:00pm to	PCA and was scheduled to 57:00am.					
		e required 80 hour PCA					
	-The 2nd shift MA wa	s training her on how to					
	had not been able to	for the residents but she work with the 2nd shift MA					
	muchShe was working on	3rd shift by herself providing					
	personal care for the -If she needed the Ad	residents. Iministrator to administer					
	medications during th	nird shift, she could go get					
	-Every morning, before	re 7:00am she was g the four residents up who					
	required the Hoyer life	t and one female resident					
	who was 2+ assistSince she started at	the facility about 3 weeks					
	ago, she used the Ho	oyer lift by herself. ined her how to use the					
	Hoyer lift and she wa	s not told to use two staff at					
	all times when operat	ting the Hoyer ιιπ. to get the Administrator to					
	help with the Hoyer life	~					
	Interviews with a first	shift MA on 09/17/24 at					
		3/24 at 11:25am revealed: t shift MA from 7:00am to					
	3:00pm.	ot Stillt IVIA ITOTTI 7.UUAITI LO					
	· ·	e several times there were s covering third shift.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				_			R
		HAL012007		B. WING		09	9/23/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			151 SOUTH	IVIEW STREE	Т		
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII		ON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIO		PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D 193	Continued From page	e 26		D 193			
	-On numerous occasi	ions when she arrived a	t				
	work on first shift, the						
	Administrator in the b	•					
	-She knew there were	•					
		Hoyer lift and one resid	ent				
	who required a two p	erson assist with transfe	ers.				
	-She knew there show	uld be two staff member	'S				
	operating the Hoyer I						
	operating the Hoyer lift by themselves because there was no one else available. -The facility census for the month of June was around 13 to 17 residents.		se				
			S				
		nd shift MA on 09/17/24	at				
	5:22pm revealed:	1:66 000 111					
		shift from 3:00pm until					
	11:00pm.	vho was scheduled to w	ork				
	_	am had a history of not					
	calling in and/or not s						
		nerous times she stayed	l				
	over to work on third	shift due to the PCA bei					
	no call, no show.	ld work until around 3:0	Oom				
		was a no call, no show.	Ualli				
		cility, the Administrator v	was				
	the only staff member						
	-The Administrator liv						
		t rooms at the end of the	е				
	200 hallway.						
		d not come out of his ro	om				
	to assist while she wo						
		the Administrator if the t					
		w up around 11:00pm a					
		w she could only work t	ıntıl				
	around 3:00am.	uld be two staff man-					
		uld be two staff member					
		ift together, but she had herself because no one					
	else was available.	norsen because no one	•				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED		
		HAL012007	B. WING _			R / 23/2024	
	ROVIDER OR SUPPLIER	. SOUTHVIEW FACII	REET ADDRESS, CITY, 1 SOUTHVIEW STR DRGANTON, NC 28	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 193	Continued From page	e 27	D 193				
	9:25am revealed: -She worked as a firs 3:00pmThere had been numarrived at work and of the facilityShe knew there were required the use of a Telephone interview of 09/18/24 at 10:32amThe last facility fire in the facility had sprinkeep a fire in check of thereIn a fire, the biggest Assisted Living Facility inhalationOne staff member were residents to safety be happenedThe killer was not the inhalation.	Hoyer lift. with the Fire Marshall on revealed: aspection was on 11/27/23. klers which was designed intil the fire department got concern with residents in a ty was death from smoke as not capable of getting 1 afore smoke inhalation	n to				
	facility's contracted P revealed:	CP on 09/21/24 at 7:33pm					
	-The potential risks w were as follows; accidented restraints; increased of muscle tone, contrambulate; loss of balamobility, decreased a	nptoms of depression,	s				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		09	R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	THVIEW STREET			
		MORGA	NTON, NC 28655			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 193	Continued From page	e 28	D 193			
	Interview with the Adr 9:15amHe also worked as a -He lived in the facility record of when he wo always thereHe was responsible -He worked on the floshortage. Interview with the Adr 1:57pmHe covered third shift PCA being a no call/r	MA. y and did not keep any orked because he was for the third shift schedule. For if there was a staffing ministrator on 09/19/24 at ft a lot due to the third shift no show.				
	PCA being a no call/no show. -He did not try to arrange any other coverage for staffing on third shift. -He did not call a staffing agency due to the cost of sing a staffing agency. -He covered and worked third shift a lot by himself. -He did not always document or complete 30-minute rounds or two-hour rounds when he					
	to operateStaff were not allowed without a second staff -He had not witnesse lift by themselves but because residents whalready up in the more staff person had beer -Two staff members withing shift due to reside for the residents to get -He could perform individual without having to use -If there was a fire, he	required two staff members and to use the Hoyer lift of member present. It do any staff using the Hoyer suspected they had no required a Hoyer lift were nings when only one other of working. It were not required on the lents sleeping with no need bet out of bed. It continence care by himself of a Hoyer lift. It would not take the time to would drag the residents out				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII	UTHVIEW STREE ANTON, NC 28658		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 193	Continued From page	29	D 193		
	9:40amThe second shift MA over and working unti shift PCA was a no ca-He would be notified around 11:00pm when show upHe did not make roun was on duty, but he was on duty, but he was on 14 of 14 shifts betwo 8/17/24 which result serious physical harm were to experience a evacuate residents whas sist with transfers. residents at a substar	by the second shift MA in the third shift PCA did not ands when the third shift PCA was available if needed. rovide two staff for third shift ween 08/04/24 through ed in substantial risk of and/or death if the facility fire, without enough staff to the required two person The failure placed the			
	•	rovide an accepted plan of nce with G.S. 131D-34 on tion.			
		DATE FOR THIS TYPE A2 IOT EXCEED OCTOBER			
D 317	10A NCAC 13F .0905	i (d) Activities Program	D 317		
	of planned group activities that promote	Activities Program least 14 hours of a variety vities per week that include e socialization, physical complishment, creative			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	ITHVIEW STREE ^T NTON, NC 28655		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 317	new skills. This Rule is not met Based on observation failed to ensure reside hours of a variety of pweek. The findings are: Observation on the fat to 9:00am revealed: -After breakfast the pplaced the residents in on the TVThere was a workingThere was no activity facility. Observation of the fat to 9/17/24 from 8:30am there were no activitied. Observation of the fat to 9/18/24 from 8:00am there were no activitied. Observation of the fat to 9/19/24 from 8:00am there were no activitied. Observation of the fat to 9/19/24 from 8:00am there were no activitied. Observation of the fat there were no activitied. Interview with a resident there were no activitied.	d knowledge, and learning of	D 317		
	facility and she was be nothing to do at the fa	ored because there was acility.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			A. BOILDING		_
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	•
NAME OF T	NOVIDER OR GOLF EIER		ITHVIEW STREE	•	
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	NTON, NC 2865		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
D 317	Continued From page	31	D 317		
		ns, record reviews, and 1 was not interviewable.			
		ns, record reviews, and 2 was not interviewable.			
		ns, record reviews, and 3 was not interviewable.			
		ns, record reviews, and 5 was not interviewable.			
	Interview with a medion 09/17/24 at 11:14am	` ,			
	was responsible for c				
		eft about mid to late August			
		there were no monthly npleted or time for activities			
	,	ot enough staff to help with			
		as responsible but he had			
		tivity calendars or activities			
	Telephone interview v 09/18/24 at 3:29pm re	vith the previous RCC on evealed:			
		director at the facility.			
		strator was responsible for			
		Intil January 2024 and then			
	it was the responsibili	ty of the current			
	AdministratorThere was some him	go every now and then but			
		ffed to complete activities.			
	Interview with the Adr 1:57am revealed:	ministrator on 09/19/24 at			
	-The staff was respon	sible for completing			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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	
		HAL012007	B. WING		I	3/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	IVIEW STREET			
240.15	CLIMMADV CT.		ON, NC 28655		1	2/5
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 317	Continued From page	32	D 317			
	there was no activity of -Bingo was an activity money as prizes and	rector but he did not know calendar. vuntil the residents wanted he could not afford that. ber just how long it had				
D 338	10A NCAC 13F .0909	Resident Rights	D 338			
	10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.					
	This Rule is not met a TYPE A1 VIOLATION					
	Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents received the appropriate care related to a resident who was in respiratory distress (#4).					
	The findings are:					
	07/03/24 revealed dia	4's current FL-2 dated ignoses included is (a type of bacteria that				
	revealed: -Resident #4 required eating and transfersResident #4 was total	I's care plan dated 07/17/24 I extensive assistance with ally dependent on toileting, dressing and grooming.				

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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	
		HAL012007	B. WING		09	R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	UTHVIEW STREE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ANTON, NC 2865	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 338	Continued From page	÷ 33	D 338			
	-Resident #4 required	I the use of restraints.				
	dated 08/09/24 revea -A personal care aide found Resident #4 at sweatingShe notified the 1st s when the MA arrived a Review of the staff tin was only one staff me was the only staff who 2:45am to 7:05am. Review of Resident # Medication Administra revealed on 08/09/24	(PCA) documented she 7:05am gasping for air and shift medication aide (MA) at the facility. ne records revealed there ember on 08/09/24; the PCA orecorded they worked from 4's August 2024 electronic				
		4's progress notes dated e MA documented Resident				
		4's progress notes dated e MA documented Resident es for the shift.				
	revealed: -On 08/09/24 at 7:05a facility, she found RessweatingShe was the only star-She went to the Admiknocked on his door a-She stayed with Res	on 09/17/24 at 11:02am am when she arrived at the sident #4 gasping for air and aff working with residents. All the sident sidents of the sident and he did not answer. All the Resident CC) arrived about 10-15				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL012007	B. WING		09	R 9/ 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
		151 SOL	ITHVIEW STREET			
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII MORGA	NTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 34	D 338			
	-The RCC notified Reand Primary Care Pro	esident #4's hospice nurse ovider (PCP). as on hospice, hospice and				
	4:00pm revealed: -When she left at 2:4 the only staff in the fa PCP did not come int -She reported to the was administered as pain, and anxiety that	5am the Administrator was ucility because the 3rd shift o work. Administrator Resident #4 needed medications for a allowed the resident to without pain or anxiety.				
	09/18/24 at 3:29pm r-On 08/09/24 at 7:05a to find the PCA there by the PCA about Re-Resident #4 was blu was 52% on room air and 100% on room a -She called Resident nurseResident #4's PCP of for oxygen at 4 liters -On 08/09/24 around Administrator's room he was asleep in his -The Administrator to on Resident #4 for a she let him know what Resident #4The Administrator she personal care rounds	am, she arrived at the facility by herself and was informed sident #4's condition. e and her oxygen saturation (normal was between 95% ir). #4's PCP and hospice gave her a telephone order via nasal cannula. 7:30am, she went to the and opened his door, and chair. Id her that he did not check while during the night and at was going on with sould have been completing every 2 hours and restraint utes for Resident #4 who				

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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	
		HAL012007		B. WING		1	3/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
				IVIEW STREE			
MORGAN	TON LONG TERM CARE,	, SOUTHVIEW FACII	MORGANT	ON, NC 28655	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 338	Continued From page	35		D 338			
	72% on 4 liters via nasal cannula. -The hospice nurse took over care at that time.						
	nurse on 09/18/24 at -On 08/09/24, a little a notified Resident #4 v distressShe arrived at the facShe found Resident is oxygen saturation of 7 of 30After her assessmen actively passing and v -She administered me #4 comfortableIn her opinion and af Resident #4 was in se respiratory compromis -The resident had bee couple of hoursResident #4 died tha Review of Resident # 08/09/24 revealed a ti	after 8:00am she was vas found in respiratory cility around 8:45am. #4 on 4 liters of oxygen 79%, and a respiratory of the second secon	, an rate t #4 ent nt, y a m. ed and				
	decline in cognitive fu as the cause of death		age)				
	facility's contracted Porevealed: -If the Administrator wevery 15 minutes, the saturation would have by making sure Resider. -That was likely the sachecks.	sage response from the CP on 09/21/24 at 7:33 was checking on Reside in Resident 4's oxygen be been able to be correctent #4 was getting oxygame for every 30-minutes would have been the	pm nt #4 cted gen. e				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY	
		HAL012007	B. WING			R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	SOUTHVIEW STREE			
		MOF	RGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	distress for 1-2 hours the hospice nurse's d condition when the numeasures the nurse if #4 back to baseline. Interview with the Adr 4:15pm revealed: -On 08/09/24 from abwas the only staff in tilled -He checked on Residence he thought Foundation -There were no signs #4 displayed, but he would be was breathing by rising and fallingResident #4 and he even had to wo she was breathing by rising and fallingResident #4 did not coalarmed himHe last checked on Foundation -He denied being asked his roomHe was up checking then completed another then started fixing breather the star	and been in respiratory or longer, consistent with escription of Resident #4's arse arrived and what had to take to get Resident with escription on 09/18/24 at a cout 3:00am to 7:00am he he facility. I dent #4 every 10-15 minutes Resident #4 "might die". or symptoms that Resident was worried, "just a feeling." in Resident #4 every 10-15 was "peacefully" sleeping, ralk up to her and make sure making sure her chest was display any behavior that Resident #4 at 7:00am. Her resident #4 at 7:00am, her resident's FSBS and eakfast.				
	severe distress cause compromise and pain thought she could die resident was not chec care to prevent sever she was actively dyin	en Resident #4 was found in ed by respiratory a after staff stated they during the night. The cked on and did not receive e distress or comfort while g. This failure resulted in a constitutes a Type A1				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL012007	B. WING		R 09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII	THVIEW STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 338	Continued From page	: 37	D 338		
D 442	protection in accordar this violation. THE CORRECTION [D 442		
	listed under Paragrap made immediately for (1) a resident death of home within seven date physical restraint or por (2) a resident death of the resident zs transfet to a hospital, if the deadys of physical restrates resident. This Rule is not met a Based on interviews a	occurring in an adult care lys of the the use of a hysical hold on the resident; occurring within 24 hours of er from the adult care home ath occurred within seven aint or physical hold of the as evidenced by: and record reviews, the			
	Social Services (DSS Health Service Regula	the local Department of) and the Department of ation (DHSR) for a death of n days after the use of a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		HAL012007	B. WING		09	R 9/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, STA			··
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	1 SOUTHVIEW STREET DRGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 442	Continued From page	e 38	D 442			
	The findings are:					
	07/03/24 revealed dia	4's current FL-2 dated agnoses included tis (a type of bacteria that				
	for restraints dated 08 -The type of restraint wheelchair soft belt to -The restraint was to was in the wheelchair -The restraint was to minutes and released -The potential risks w were as follows; accid restraints; increased if of muscle tone, contra ambulate; loss of bala mobility, decreased a	used was for a three-point of be applied around her. be used when Resident #4 or and unattended. be checked every 30 di/loosened every two hours while using the restraints dental injury/death from the risk for pressure sores; loss actures, decreased ability to annoe; loss of independent ability to ambulate; mptoms of depression,				
	Documentation form IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		s			
	(PCA) on 09/18/24 at -On 08/09/24, Reside three-point restraints day.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL012007		B. WING		R 09/23/2024	4
NAME OF P	ROVIDER OR SUPPLIER		TREET ADDR	ESS, CITY, STA	TE ZIP CODE	09/23/2024	•
		15		/IEW STREE			
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII	ORGANTO	N, NC 28655	S		
(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 COM	(5) PLETE ATE
D 442	Continued From page	39		D 442			
	in respiratory distress bed through the even Resident #4 passed a -On 08/09/24, she do in three-point soft beli 9:00am and from 12:0 "habit"On 08/08/24, she do in restraints from 7:30 12:00pm to 1:30pm. Review of Resident # dated 08/09/24 at 7:0 -A personal care aide found Resident #4 at sweatingShe notified the 1st swhen the MA arrived Review of Resident # 08/09/24 revealed at Interview with the Adr 1:57pm revealed: -Hospice was responsappropriate people wi 08/09/24He did not know he willocal DSS or DHSR for within seven days after restraint.	and did not get her out of ing on 08/09/24 when away. cumented Resident #4 wat restraints from 7:30am to 00pm to 1:30pm because of cumented Resident #4 wat of the interest of a physical water the use of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of a physical of the interest of the interest of the interest of a physical of the interest of the	of of ort				
	-He did not notify the	local DSS or DHSR.					
D 482	10A NCAC 13F .1501 Restraints And Alterna			D 482			
	10A NCAC 13F .1501 And Alternatives (a) An adult care hor	Use Of Physical Restraint	ts				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024
	ROVIDER OR SUPPLIER	151 SOU	DDRESS, CITY, STATI	E, ZIP CODE	
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII MORGAN	NTON, NC 28655		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 482	device attached to or body that the resident which restricts freedo access to one's body, (1) used only in those resident has medical use of restraints and resident has medical use of restraints and resolvenience purpose (2) used only with a wexcept in emergencie (e) of this Rule; (3) the least restrictive provide safety; (4) used only after alto safety to the resident decline in the resident tried and documented (5) used only after an planning process has emergencies, according Rule; (6) applied correctly a manufacturer's instructive order; and (7) used in conjunction effort to reduce restration Note: Bed rails are rear resident from volunt opposed to enhancing while in bed. Examplare: providing restorationabilities to stand safel device that monitors abed, placing the bed I frequent staff monitor in toileting and ambuliproviding activities, compared to the providing activities acti	adjacent to the resident's cannot remove easily and m of movement or normal shall be: circumstances in which the symptoms that warrant the not for discipline or s; written order from a physician s, according to Paragraph e restraint that would ernatives that would provide and prevent a potential t's functioning have been and prevent and care been completed, except in the resident's record. assessment and care been completed, except in the physician's excording to the ctions and the physician's in with alternatives in an int use. Estraints when used to keep carily getting out of bed as gomobility of the resident es of restraint alternatives	D 482		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUR COMPLETE		
		HAL 042007	B. WING		R	2024
		HAL012007			09/23/2	2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	THVIEW STREET NTON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE DATE
D 482	Continued From page	2 41	D 482			
	and providing support cushions.	tive devices such as wedge				
	This Rule is not met TYPE A2 VIOLATION					
	interviews, the facility					
	The findings are:					
	of Restraints dated So-Physical restraint tra all employees providinitially upon hire and registered nurse (RN)-Physical restraint tra physical restraints usbenefits, how to moni requiring physical res	ining included types of ed, potential risks and tor and care for residents				
	07/17/24 revealed: -Diagnoses included	schizoaffective disorder, /. istantly disoriented.				
	revealed:	1's Resident Register mitted to the facility on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
						R
		HAL012007	B. WING		09	9/23/2024
NAME OF D	ROVIDER OR SUPPLIER	etdeet af	DDRESS, CITY, STAT	E ZIR CODE	•	
NAME OF P	ROVIDER OR SUPPLIER		THVIEW STREET	E, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	ITON, NC 28655			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 482	Continued From page	e 42	D 482			
	06/29/16.					
	-	d assistance by staff for				
		il care, ambulation, getting in				
		ng, hair/grooming, skin care,				
	mouth care, feeding,					
	and place.	ents, and orientation to time				
	'	nificant memory loss and				
	was to be redirected.					
	Review of Resident #	1's LHPS tasks dated				
	08/01/24 revealed Resident #1 required					
		fers, ambulation using				
	assistive devices, fee	•				
		wing difficulties, finger stick				
		itions through injection and				
	restraints and/or alter	natives to restraints.				
	Review of Resident 1 revealed:	's care plan dated 01/26/24				
		ally dependent on eating,				
	_	transfers, bathing, dressing				
	and grooming.	l				
	-Resident #1 required	restraints.				
	a. Review of Residen	t #1's current FL-2 dated				
	07/17/24 revealed the	ere was an order for bed				
	rails to be used while	in the bed that were to be				
	checked every 30 mir	nutes.				
		1's signed physician's order				
	for restraints dated 08					
	-The type of restraint					
		aints were ordered was to				
	•	from rolling out of bed.				
	in the bed.	be used any time she was				
	-The restraint was to	he checked every 30				
		I/loosened every two hours.				
		hile using the restraints				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			SURVEY PLETED	
			A. BOILDING:			_
		HAL042007	B. WING			R
		HAL012007	3		09	/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
MODGAN	TON I ONG TERM CARE	SOUTHVIEW FACIL	THVIEW STREET			
WORGAN	TON LONG TERM CARE	MORGAN	NTON, NC 28655			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	DATE
D 482	Continued From page	e 43	D 482			
	were as follows; accid	dental injury/death from the				
		risk for pressure sores; loss				
	of muscle tone, contra	actures, decreased ability to				
	· ·	ance; loss of independent				
	mobility, decreased a	=				
		nptoms of depression,				
	withdrawal and reduc	ed social contact.				
	b Review of Residen	t #1's current FL-2 dated				
		ere was an order for a Geri				
	chair, reclined or with	a tabletop that was to be				
	checked every 30 mir					
		1's LHPS tasks dated				
	08/01/24 revealed Re					
		fers, ambulation using				
	assistive devices, fee	wing difficulties, finger stick				
		itions through injection and				
	restraints and/or alter					
	Review of Resident 1 revealed:	's care plan dated 01/26/24				
	-Resident #1 was tota	ally dependent on eating,				
	toileting, ambulation,	transfers, bathing, dressing				
	and grooming.					
	-Resident #1 required	l restraints.				
	Review of Resident #	1's signed physician's order				
	for restraints dated 08	3/01/24 revealed:				
	-The type of restraint	used was a Geri chair				
	reclined or with a tabl					
	-The reason for the re					
		#1's inability to maintain an				
		aning forward in standard				
	wheelchairs increasing					
	-The restraint was to	pe used at any time le Geri chair unattended.				
	-The restraint was to	_				
		l/loosened every two hours.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL012007	B. WING		R 09/23/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	THVIEW STREE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 482	were as follows; accide restraints; increased of muscle tone, contra ambulate; loss of bala mobility, decreased a incontinence; and syrwithdrawal and reduced of the decreased o	while using the restraints dental injury/death from the risk for pressure sores; loss actures, decreased ability to ance; loss of independent ability to ambulate; mptoms of depression, sed social contact. Byroom on 09/17/24 from evealed: ing in a Geri chair with a locked in place on the arm present who monitored, if the resident's restraint. The a personal care aide in 11:23am. The Staff A on 09/19/24 at interview with the facility's rese on 09/20/24 at 12:48pm. The text message response tracted Primary Care 19/21/24 at 7:33pm. The Administrator on the Administrator on the Administrator on the Administrator on the Hz's current FL-2 dated	D 482		
		agnoses include dementia, psychosis and depression.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		HAL012007	B. WING		09	R 9/23/2024
		1	<u> </u>		1 00	720/2024
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATI			
MORGAN	TON LONG TERM CARE	. SOUTHVIEW FACII	SOUTHVIEW STREET GANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 482	a. Review of Resider 10/02/23 revealed the raised anytime in bedwere to be checked of released every two has released. He required total as ambulation, bathing, transfers. He was non ambulations. He required the use has required the use has required the use has released. The bedrails were to the bed. The restraints dated 0. The bedrails were to the bed. The restraint was to minutes and released. The potential risks was reased of muscle tone, contrambulate; loss of bal mobility, decreased a incontinence; and sy withdrawal and reduction. Review of Resider	at #2's current FL-2 dated ere was an order for bedrails d unattended, and the rails every 30 minutes and ours. #2's LHPS tasks dated esident #2 required ical restraints and/or #2's current care plan dated esistance with eating, toileting, dressing, grooming and tory with bilateral below the of bed rails while in bed. #2's signed physician's order 8/05/24 revealed: be used any time he was in be checked every 30 d/loosened every two hours. While using the restraints dental injury/death from the risk for pressure sores; loss factures, decreased ability to ambulate; mptoms of depression,	D 482			
		r with a tabletop while was to be checked every 30 d every two hours.				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			_	
		HAL012007	B. WING		09	R 9/ 23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	-		
MODCAN	TON LONG TERM CARE	SOUTHWEW FACIL	UTHVIEW STREE	т			
WORGAN	TON LONG TERM CARE	MORGA	NTON, NC 2865	5			
(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 THE APPROPRIATE	(X5) COMPLETE DATE	
D 482	Continued From page	÷ 46	D 482				
	for restraints dated 08 -The type of restraint reclined or with a tabl -The reason for the restraint value of Resident supright position causisThe restraint was to Resident #2 was in the bed unattendedThe restraint was to minutes and releasedThe potential risks was were as follows; accident restraints; increased restraints; increased restraints; increased restraints; loss of balamobility, decreased a incontinence; and syrwithdrawal and reductions.	used was for a Geri chair etop. estraints were ordered was #2's inability to maintain an ing wheelchair to tip forward, be used at any time e Geri chair anytime out of be checked every 30 //loosened every two hours, hile using the restraints dental injury/death from the risk for pressure sores; loss actures, decreased ability to ance; loss of independent bility to ambulate; inptoms of depression, ed social contact					
	9:30am to 11:00am re -Resident #2 was sitti locked in the reclined -There were no staff p	ng in a Geri chair that was					
	Refer to interview with (PCA) on 09/18/24 at	n a personal care aide 11:23am.					
	Refer to interview with 7:45am.	n Staff A on 09/19/24 at					
		interview with the facility's se on 09/20/24 at 12:48pm.					
	Refer to a review of a	text message response					

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	FOF DEFICIENCIES OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	ΓE, ZIP CODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	UTHVIEW STREET ANTON, NC 28655			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETE	
D 482	Continued From page	÷ 47	D 482			
	Provider (PCP) on 09	/21/24 at 7:33pm.				
	Refer to interview with 09/19/24 at 1:57pm.	n the Administrator on				
	Refer to interview with 09/20/24 at 9:40am.	n the Administrator on				
	3. Review of Residen 02/28/24 revealed:	t #3's current FL2 dated				
		Alzheimer's dementia, istory of cerebrovascular				
	-She was constantly of -She was incontinent -She used a wheelch	of bowel and bladder.				
		t #3's physician signed 05/28/24 and 08/02/24				
		dered as the type of restraint dent #3 from rolling out of				
	was anytime Residen	the restraint to be used t #5 was in bed unattended. Is restraint must be checked every thirty minutes.				
	Review of Resident # 06/03/24 and 09/06/2 required bedrails whe	4 revealed Resident #3				
		3's care plan dated 09/21/23 required the use of bedrails				
	restraint orders dated revealed:	t #3's physician signed 05/28/24 and 08/02/24 hair soft belt ordered as the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED	
		HAL012007		B. WING		09	R 0/23/2024
	ROVIDER OR SUPPLIER	s ⁻		RESS, CITY, STA	, and the second	, ,	
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII	ORGANT	ON, NC 28655	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION))	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 482		sist in prevention from		D 482			
	weakness.	elchair due to right sided Is restraint must be check	red				
	was documented as	every thirty minutes.	.ou				
	06/03/24 and 09/06/2 -Resident #3 required	d staff assistance with					
	mobility and transfers via Hoyer liftResident #3 required three-point soft belt when in wheelchair for safety. Review of Resident #3's care plan dated 09/21/23 revealed Resident #3 required the use of three-point soft belt restraint while in wheelchair for safety. Review of Resident #3's July 2024 Restraint Documentation forms revealed Resident #3 was documented in three-point soft belt restraints, with checks every 30 minutes on 07/01/24 to 07/31/24 at 7:00am to 9:00am, 11:30am to 1:00pm and 4:00pm to 6:00pm.		n				
			ıs				
	Documentation forms documented in three-with checks every 30	3's August 2024 Restraint revealed Resident #3 wa point soft belt restraints, minutes on 08 /01/24 to 0 9:00am, 12:00am to to 5:30pm.					
	9:30am to 11:00am re -Resident #3 was sitt three-point soft belt a -There were no staff	ing in a wheelchair, with a	ı				
	Observation of Resid	ent #3 on 09/18/24 at					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		00	R / 23/2024
			I		08	12312024
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA			
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACIL	GANTON, NC 2865			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	e 49	D 482			
	area sitting in a whee soft belt restraint in pl	served in the common living clchair with the three-point lace. It in the room with Resident				
	Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am.					
Refer to interview with Staff A 7:45am.		h Staff A on 09/19/24 at				
		interview with the facility's se on 09/20/24 at 12:48pm.				
	Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.					
	Refer to interview with 09/19/24 at 1:57pm.	h the Administrator on				
	Refer to interview with 09/20/24 at 9:40am.	h the Administrator on				
	01/24/24 revealed: -Diagnoses included hypothyroidism, chroi hypertension, hyperlij insomnia, vitamin D c-She was constantly c-She was non-ambula-She needed total assibathing, dressing, groextensive assistance -She was incontinent	atory and used a wheelchair. sistance with toileting, coming, and transfers, and with eating and ambulation. of both bowel and bladder.				
	Review of Resident #	5's Resident Register				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL012007	B. WING		09/23/2024
		•			03/23/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	·	
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	JTHVIEW STREE		
		MORGA	NTON, NC 2865	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE COMPLETE
				DEFICIENCY)	
D 482	Continued From page	e 50	D 482		
	revealed:				
		the facility on 07/21/20.			
		ance for dressing, bathing,			
	nail care, correspond				
		care, mouth care, scheduling			
	_	ation to time and place, as			
	well as prompts for fe	•			
		memory loss and needed to			
	be directed.	nomery less and nesses to			
	Pavious of Posidont #	t5's LHPS tasks dated			
		esident #5 required bedrails			
	restraints and/or alter	•			
	restraints and/or alter	matives to restraints.			
	Review of Resident #	t5's current significant			
		ited 02/07/24 revealed:			
	•	endent on toileting, transfers,			
	bathing, dressing and				
	-She required extens				
	ambulation and eatin				
	-She required bedrail	_			
		. Wet it is a second of the se			
		nt #5's signed physician's			
		ated 07/24/24 revealed:			
		used was for bedrails.			
		estraints was ordered to			
	assist in the prevention	bit of fails. be used any time she was			
	in the bed.	be used any unle she was			
	-The restraint was to	he checked every 30			
		d/loosened every two hours.			
		hile using the restraints			
		dental injury/death from the			
		risk for pressure sores; loss			
	· ·	actures, decreased ability to			
		ance; loss of independent			
	mobility, decreased a				
	-	mptoms of depression,			
	withdrawal and reduc				

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	AND DIAN OF CODDECTION IDENTIFICATION NUMBER.		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		R 09/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE,	SOUTHVIEW FACII	JTHVIEW STREE NTON, NC 28658			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE	
D 482	order for restraints da -The type of restraint soft belt wheelchairThe reason for the re assist in prevention of gaitThe restraint was to le Resident #5 was in the -The restraint was to le minutes and released -The potential risks we were as follows; accion restraints; increased restraints; increased restraints; increased restraints; increased a incontinence; and syn withdrawal and reduce Observation of the da 9:30am to 11:00am re -Resident #5 was sitti three-point soft belt ar -There were no staff pressed or released Refer to interview with (PCA) on 09/18/24 at Refer to a telephone is contracted LHPS Nurse	t #5's signed physician's ted 07/24/24 revealed: used was for three-point estraints was ordered to falls related to unsteady one used at any time e wheelchair unattended. One checked every 30 //loosened every two hours. In the using the restraints lental injury/death from the isk for pressure sores; loss factures, decreased ability to ambulate; inptoms of depression, ed social contact. Syroom on 09/17/24 from evealed: In a wheelchair with a cross her lap. In the resident's restraint. In a personal care aide 11:23am. In Staff A on 09/19/24 at Interview with the facility's see on 09/20/24 at 12:48pm.	D 482	DEPICIENCY)		
	Refer to a review of a from the facility's cont Provider (PCP) on 09					

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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 50.12510.		R
		HAL012007	B. WING		09/23/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MORGAN	TON LONG TERM CARE,	. SOUTHVIEW FACII	HVIEW STREE		
		MORGAN	ON, NC 2865		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 482	Continued From page	e 52	D 482		
	Refer to interview with 09/19/24 at 1:57pm.	n the Administrator on			
	Refer to interview with 09/20/24 at 9:40am.	n the Administrator on			
	05/08/24 revealed:	t #6's current FL2 dated			
	 -Diagnoses include de anxiety and a history 	ementia with agitation, of falls			
	-She was constantly of				
	-She was incontinent	of bowel and bladder.			
	Review of Resident #6's LHPS tasks dated 05/03/24 and 08/01/24 revealed Resident #6 required full bedrails when in bed unattended. Review of Resident #6's care plan dated 06/05/24 revealed while in bed, Resident #6 used full bedrails to try to deter from her attempting unsupervised ambulation.				
		t #6's signed physician ated 03/07/24, 03/24/24 and			
	due to Resident #6 pr -Documented time for was anytime Residen	as the type of restraint used reviously rolling out of bed. The restraint to be used t #6 was in bed unattended. Is restraint must be checked every thirty minutes.			
	-There were full-lengt right side of the bed.	ent #6 on 09/18/24 at served lying in her bed. h bed rails on the left and vere in the upright and			

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	ID DI AN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL012007	B. WING		0:	R 9/ 23/2024	
	ROVIDER OR SUPPLIER TON LONG TERM CARE	. SOUTHVIEW FACII	ADDRESS, CITY, STATE JTHVIEW STREET NTON, NC 28655	E, ZIP CODE			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 482	orders for restraints of 06/24/24 revealed: -Three-point wheelch type of restraint due to edge of her wheelchary and occumented as edge of the degree of the deg	t #6's signed physician lated 03/07/24, 03/24/24 and air soft-belt ordered as the oresident sliding to the oreset side of the oreset side of the oreset sliding in a wheelchair with a cross her lap. Oresent who monitored, if the resident's restraint. In a personal care aide ore of the oreset side of the or	D 482				
		revealed: PCA and performed checks raints every 30 minutes.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						R
		HAL012007	B. WING		09	0/23/2024
NAME OF D	ROVIDER OR SUPPLIER	STPEET A	DDRESS, CITY, STATE	ZIR CODE	•	
NAIVIL OI I	NOVIDEN ON SOIT EIEN		THVIEW STREET	, ZII GODE		
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACII	NTON, NC 28655			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D 482	Continued From page	e 54	D 482			
	-She also completed	checks/releases on				
	residents with restrai					
		nt all the checks all at once at				
	the end of her shift be	ecause she would get busy				
	with other residents'	care.				
	-When she complete	d her documentation at the				
		documented according to the				
	schedule on the docu					
		lle on everyone's restraint				
		ve use, and she could not				
	•	e residents were in restraints ause the residents could				
		nger or a shorter amount of				
	time than documente	_				
		a MA on how to apply the				
		a resident every 30 minutes				
	and release the restra					
		d a resident in restraint, she				
		times from the door just to				
	make sure the reside	nt was not "hung up" on the				
	restraint and in a con	nfortable position.				
	-She did not physical	ly go to each resident that				
		d check the restraint for				
	placement, or being t	_				
		ne skin integrity, circulation or				
	offer fluids or toileting	g every 30 minutes.				
		on 09/19/24 at 7:45am				
	revealed:	the facility about 2 weeks as				
		the facility about 3 weeks go. personal care aide (PCA)				
		o work from 11:00pm to				
	7:00am.	o work from 11.00pm to				
		e required 80-hour PCA				
	training.					
		r full bed rails up as a				
	restraint.					
	-When she needed to	provide incontinent care to				
		ull beds rails up, she would				
		to help with safety while				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL012007	B. WING			R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY, STAT	TE, ZIP CODE	·	
MORGAN	TON LONG TERM CARE	SOUTHVIEW FACIL	1 SOUTHVIEW STREET	Г		
MORGAN	TON EONO TERM OAKE	MO	ORGANTON, NC 28655			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 482	Continued From page	e 55	D 482			
	every 2-hour checks/ who were using restranght shifts she worked. Telephone interview of LHPS Nurse on 09/20She was a Register of clinical training to the analysis of circulation, sign and so and agitation, skin into the shift training also incomper the physician's or check for the above is	to complete the cument every 30 minutes, monitor/release on residen aints or document during the d. with the facility's contracted 2/24 at 12:48pm revealed: at Nurse and provided staff at the facility. Included recognizing and ent's hydration needs, symptoms of injury, distress egrity, mental status, on. cluded the "visual" of a resident in restraints der every 30 minutes to ssues/needs and every two physically" release the	ts ne			
	Review of a text mes facility's contracted P on 09/21/24 at 7:33prisks while using the accidental injury/deat increased risk for pre tone, contractures, deloss of balance; loss decreased ability to a symptoms of depress social contact. -He did not know staff required 30-minute of release/checks after the statement of the state	ssure sores; loss of muscle ecreased ability to ambulat of independent mobility, imbulate; incontinence; and sion, withdrawal and reduce if were not documenting the necks and the 2 hour	e e; d			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	SURVEY PLETED		
		HAL012007		B. WING		1	R / 23/2024
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MORGAN	TON LONG TERM CARE	, SOUTHVIEW FACII		IVIEW STREE			
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES	MORGANI	ON, NC 28655	PROVIDER'S PLAN OF CORR	ECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FUI LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 482	Continued From page	e 56		D 482			
	PCA being a no call/r -He did not try to arra staffing on third shiftHe covered and work himselfHe did not always do 30-minute rounds or t worked third shift alor Interview with the Adr 9:40am revealed he of	nge any other coverage ked third shift a lot by ocument or complete two-hour rounds when h	e for le at				
	and caring for resider putting 5 residents at injury/death from the pressure sores; loss of contractures, decreased ability to a symptoms of depress social contact. The fa a substantial risk that occur which constitute. The facility failed to p protection in accordant this violation.	restraints; increased risl of muscle tone, sed ability to ambulate; I	k for oss and uced ts at will an of				

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