Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation from 11/13/24 through 11/15/24. The complaint investigation was initiated by the Forsyth County Department of Social Services on 11/02/24.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 2 of 2 sampled residents, (#8 and #9) related to fingernails that needed to be trimmed (#8) and toenails that needed to be trimmed (#9). The findings are: Review of the facility's fingernail and toenail policy dated October 2020 revealed: -Residents fingernails and nailbeds should be check with each bath. -Nail care included daily cleaning and regular trimming. -Proper nail care could aid in the prevention of skin problems around the nail bed. -Trimmed and smooth nails prevented the resident from accidentally scratching and injuring the skin. -Staff should report to the supervisor when nails were too hard or too thick to cut.	D 269	The community has assessed all resident toe nails and fingernails that needed to be trimmed. The community addressed all concerns related and got them corrected. The community is on a shedule with a podiatrist that will treat residents that are in need.The RCC, MCC or designee will be responsible for compliance and will ensure the PCP is notified if needed, and the POA with documentation made in the file. Date of compliance 12/31/24.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristain Walker

TITLE: Executive Director

(X6) DATE: 12/24/24

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D 269	Continued From page 1 1. Review of Resident #8's current FL-2 dated 10/11/24 revealed diagnoses included cerebral vascular accident with right-sided weakness and right-hand contractures. Review of Resident #8's Resident Register revealed: -There was an admission date of 05/27/15. -Resident #8 required assistance with skin care. Review of Resident #8's care plan dated 10/01/24 revealed Resident #8 required extensive assistance with grooming and hygiene. Observation of Resident #8's fingernails on his right hand on 11/14/24 at 9:58am revealed: -Resident #8's right hand was contracted and closed into a fist. -Resident #8 opened his right hand with partial extension of his fingers when asked to do so by the surveyor. -Resident #8's second and third fingernails extended past the fingers ¾ inch. -Resident #8's fourth and fifth fingernails extended past the fingers 1 inch. -There were nail impressions on the palm of Resident #8's right hand. Telephone interview with Resident #8's family member on 11/14/24 at 2:08pm revealed: -He was not able to visit his family member often. -He would call the facility often to speak to the staff about Resident #8. -The facility called him if Resident #8 had a problem. -The last call he received from the facility was today 11/14/24 because Resident #8 fell in the dining room.	D 269		

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D 269	Continued From page 2	D 269		

Interview with the Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed:
-Dirty feet and long dirty nails could cause infection in and around the nail bed.
-She expected Resident #8 to receive care to meet his daily needs.

Interview with the Administrator on 11/15/24 at 10:34am revealed Resident #8 could cause a wound in his hand from his fingernails.

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

Refer to the interview with a personal care aide (PCA) on 11/14/24 at 1:40pm.

Refer to the interview with a second PCA on 11/14/24 1:48pm.

Refer to the interview with a third PCA on 11/14/24 at 1:51pm.

Refer to the interview with a MA on 11/14/24 at 1:01pm.

Refer to the interview with the SCC on 11/14/24 at 2:17pm.

Refer to the interview with the Administrator on 11/15/24 at 10:34am.

2. Review of Resident #9's current FL-2 dated 11/28/23 revealed diagnoses included cognitive impairment, coronary artery disease, and asthma.

Review of Resident #9's Resident Register revealed:
-There was an admission date of 11/04/2020.

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D 269	Continued From page 3 -Resident #9 required assistance with nail care. Review of Resident #9's care plan dated 10/01/24 revealed: -Resident #9 required limited assistance with bathing. -Resident #9 required supervision with grooming and hygiene. Observation of Resident #9's toenails on 11/13/24 at 9:31am revealed: -Resident #9 was seated in his chair with his feet elevated and resting on his rollator walker. -Resident #9 was not wearing shoes or socks. -The bottom of the right and left feet and toenails were soiled with dirt. -The first, second and third toenails on the right foot and the first, second, third, and fourth toenails on the left foot were brown with a rough edges and extended past the end of the toe ¼ inch. Interview with Resident #9 on 11/14/24 at 9:43am revealed: -The doctor would trim his toenails. -The facility staff did not trim his toenails. -He did not know the last time his toenails were trimmed. -His toenails did not bother him. Interview with the Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed: -Long toenails could lead to an infection. -Resident #9's toenails should be cut regularly to prevent a chance of increase infection is his nailbeds. Interview with the Administrator on 11/15/24 at 10:34am revealed Resident # 9 could get an infection if there was a break in the skin.	D 269		

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D 269	Continued From page 4 Attempted telephone interview with Resident #9's family member on 11/14/24 at 3:41pm was unsuccessful. Refer to the interview with a personal care aide (PCA) on 11/14/24 at 1:40pm. Refer to the interview with a second PCA on 11/14/24 1:48pm. Refer to the interview with a third PCA on 11/14/24 at 1:51pm. Refer to the interview with a MA on 11/14/24 at 1:01pm. Refer to the interview with the SCC on 11/14/24 at 2:17pm. Refer to the interview with the Administrator on 11/15/24 at 10:34am. _____ Interview with a PCA on 11/14/24 at 1:40pm revealed: -He assisted the residents with personal care and hygiene. -He had not noticed any residents with long fingernails or toenails. -If he had noticed residents with long fingernails or toenails, he would tell another PCA. Interview with a second PCA on 11/14/24 R 1:48pm revealed: -He assisted residents with personal care and hygiene. -He would trim the nails of residents if the resident was not diabetic. -If the resident was diabetic and needed the nails trimmed, he would tell the medication aide (MA).	D 269		

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D 269	Continued From page 5 -He had not noticed any residents' who needed fingernails or toenails trimmed. Interview with a third PCA on 11/14/24 at 1:51pm revealed: -She did not trim fingernails or toenails of the residents. -If fingernails and toenails needed trimming, she would tell the MA or Special Care Coordinator (SCC). -She had not noticed any residents' fingernails or toenails that needed trimming. Interview with a MA on 11/14/24 at 1:01pm revealed: -The MAs and the SCC were allowed to trim resident's fingernails and toenails if the residents were not diabetic. -She had not noticed any residents' fingernails or toenails that needed trimming. -The PCA assisted residents with their baths and personal care; they would notice if nails needed trimming and tell the MA or the SCC. Interview with the SCC on 11/14/24 at 2:17pm revealed: -She knew there were some residents with long fingernails and toenails. -She was working to get consents signed for the Podiatrist to come to the facility and trim nails. -She had not attempted to trim residents' nails. Interview with the Administrator on 11/15/24 at 10:34am revealed: -The facility staff did not trim nails. -The Podiatrist came to the facility quarterly to trim all resident's nails. -If a resident needed their nails trimmed before the Podiatrist returned, an appointment could be made for the resident to be taken to the Podiatrist	D 269		

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D 269	Continued From page 6 office. -The MAs and SCC were responsible for seeing resident's nails were cleaned and trimmed.	D 269		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: FOLLOW UP TO THE TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to serve a therapeutic diet as ordered by the physician for 2 of 7 sampled residents (#6 and #7) who had an order for a mechanical soft diet and a pureed diet. The findings are: 1. Review of Resident #6's current FL-2 dated 10/18/24 revealed: -Diagnoses included vascular dementia and decreased appetite. -There was no diet order listed. Review of Resident #6's signed physician order dated 08/20/24 revealed there was an order for a pureed diet with double portions. Review of the facility's therapeutic diet menu for	D 310	The community educated all staff that all diet orders must be followed according to the menu prepared. There are to be no substitutions unless it meets the requirements of the therapuetic menus and/or by PCP recommendation. Any adjustments will require documentation in the resident file. The DSD, RCC, MCC or designee will be responsible for daily compliance. Date of compliance 12/31/24.	

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the lunch meal service dated 11/13/24 revealed the pureed diet consisted of roast beef, scalloped potatoes, vegetable blend, a roll, and sweet potato pie.

Observation of the lunch meal service on 11/13/24 from 11:58am to 12:25pm revealed:
-Resident #6 was served pureed pot roast, creamed potatoes, pureed green beans, and vanilla pudding.
-Resident #6 was not served bread.

Review of the facility's therapeutic diet menu for the breakfast meal service dated 11/14/24 revealed the pureed diet consisted of hot cereal, eggs, and a biscuit with sausage gravy.

Observation of the breakfast meal service on 11/14/24 between 8:05am and 8:45am revealed.
-Resident #6 was served hot oatmeal and pureed eggs.
-Resident #6 was not served a biscuit with sausage gravy.
-Resident #6 ate 100% of her breakfast.

Interview with a personal care aide (PCA) on 11/15/24 at 9:12am revealed:
-Resident #6 received a pureed diet.
-He had not seen bread on Resident #6's plate.
-He did not think pureed diets could receive bread.

Interview with Resident #6's Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed:
-Resident #6 was on a pureed diet because of dysphagia and to prevent aspiration.
-Resident #6 should be served pureed bread and sausage if she wanted the bread and sausage, and if it was on the therapeutic menu for Resident #6 to have.

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D 310	Continued From page 8 Interview with the cook on 11/15/24 at 8:43am revealed: -Resident #6 received a pureed diet. -Residents who received a pureed diet did not receive bread because it was too thick and would stick to the roof of the mouth. -She had never pureed bread. -She had been told by the Dietary Manager (DM) not to puree bread. -She would cook pre-ordered pureed bread for Resident #6 when it was available in the facility. -Resident #6 did not receive pureed sausage because she received double portions of eggs. -She had been told the sausage was not necessary to puree and serve because Resident #6 already had protein with the eggs that were served. -She knew bread and sausage was on the menu but did not serve the bread and sausage because she was instructed not too. Interview with the DM on 11/15/24 at 8:55am revealed: -The cooks were following the therapeutic menu. -He ordered pureed bread for Resident #6. -The cooks would thaw the pureed bread, heat the bread and serve it. -If the cook did not serve bread, then it may need to be re-ordered. -He had not been told he needed to order more pureed bread. -The sausage could be pureed if it was a patty, but the casing on the sausage links made it hard to puree. -The sausage should have been served; he did not know why it was not served for breakfast. Interview with the Administrator on 11/15/24 at 10:34am revealed:	D 310		

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D 310	Continued From page 9	D 310		

-Resident #6 had an order for a pureed diet.
-Resident #6 could not have bread because it was not the correct consistency.
-A dietician told her residents on pureed diets could not have bread.
-She did not know the pureed therapeutic menu called for bread.
-Resident #6 should have received pureed sausage as was listed on the therapeutic menu.

Attempted telephone interview with Resident #6's Power of Attorney (POA) on 11/14/24 at 2:30pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

Refer to the interview with the Administrator on 11/15/24 at 10:34am.

2. Review of Resident #7's current FL-2 dated 10/08/24 revealed:
-Diagnoses included acid reflux, vitamin D deficiency, and wheezing.
-There was no diet order listed.

Review of Resident #7's signed physician order dated 08/20/24 revealed there was an order for a mechanical soft diet with thickened liquids and double portions.

Review of the facility's therapeutic diet menu for the lunch meal service dated 11/13/24 revealed the mechanical soft diet consisting of ground roast beef, scalloped potatoes, vegetable blend, a roll, and sweet potato pie.

Observation of the lunch meal service on 11/13/24 from 11:58am to 12:25pm revealed:

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D 310	Continued From page 10	D 310		

-Resident #7 was served ground pot roast, creamed potatoes, soft vegetable medley, and vanilla pudding.
-Resident #7 was not served bread.
-Resident #7 ate 100% of the pot roast, vegetable medley, vanilla pudding and 25% of the creamed potatoes.

Review of the facility's therapeutic diet menu for the breakfast meal service dated 11/14/24 revealed the mechanical soft diet consisted of hot cereal, eggs, ground turkey sausage links and wheat toast.

Observation of the breakfast meal service on 11/14/24 between 8:05am and 8:45am revealed.
-Resident #7 was served eggs, chopped sausage, and oatmeal.
-Resident #7 was not served wheat toast.
-Resident #7 ate 100% of the eggs and chopped sausage and 50% of the oatmeal. .

Interview with Resident #7 on 11/14/24 at 9:20am revealed:
-He ate the food he was brought.
-He always had enough food to eat.
-He did not know if he received bread or not.

Interview with Resident #7's Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed:
-Resident #7 was on a mechanical soft diet because of dysphagia.
-Resident #7 should not have a problem with bread, especially if the Dietician had it on the menu.

Interview with the cook on 11/15/24 at 8:43am revealed:
-Resident #7 had a diet order for a mechanical soft diet.

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D 310	Continued From page 11 -Residents who were served mechanically soft diets did not receive bread. -Sometimes the residents could have a slice of loaf bread with the edges cut off. -Biscuits and toast were not soft and could not be served with mechanically soft diets. -Resident #7 did not receive bread for lunch on 11/13/24 or breakfast on 11/14/24. Interview with the Dietary Manager (DM) on 11/15/24 at 8:55am revealed: -Resident #7 had an order for a mechanically soft diet. -Bread was available for residents who had an order for a mechanically soft diet. -Sometimes residents with a mechanically soft diet could manage bread and others could not. -The PCAs told her that Resident #7 could not have bread. -He realized the Dietician had bread on the menu for mechanically soft diets. Interview with the Administrator on 11/15/24 at 10:34am revealed: -A mechanical soft diet should include soft bread or a slice of bread with the crust cut off. -Resident #7 should be given soft bread as listed on the therapeutic diet menu. Refer to the interview with the Administrator on 11/15/24 at 10:34am. _____ Interview with the Administrator on 11/15/24 at 10:34am revealed: -She expected therapeutic diet order to be followed. -The DM had therapeutic menus to follow for all therapeutic diets.	D 310		

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D 358	Continued From page 12	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION. Based on these findings, the Type A2 Violation was not abated. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) who had orders for a bladder muscle relaxant medication and to hold a blood pressure (BP) medication. The findings are: Review of Resident #5's current FL2 dated 10/04/24 revealed diagnoses included schizoaffective disorder, neurocognitive disorder, hyperlipidemia, hypertension, and hypothyroidism. a. Review of Resident #5's after-visit summary from a local hospital dated 10/11/24 revealed: -Resident #5 was admitted on 10/03/24 to the local hospital with diagnoses of urinary retention and being hypertensive with a BP level of 197/58. -There was an order to start tamsulosin (used to	D 358	The community conducted an audit of the residents medictions and orders. A new system has been implemented for recieving all discharge paperwork for residents. The RCC, MCC or designee is responsible to monitor medications daily and to follow up immediately on any missing medications having them delivered STAT to the community. Any refusals will be communicated with the PCP and indicated in the residents chart, with the POA or RP notified. Date of compliance 12/20/24.	

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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relax muscles in the bladder) 0.4mg 1 capsule after dinner.

Review of Resident #5's electronic medication administration record (eMAR) from 10/11/24 through 10/23/24 revealed:
-There was no entry for tamsulosin 0.4mg 1 capsule after dinner.
-There was no documentation tamsulosin was administered for 13 of 13 opportunities from 10/11/24 to 10/23/24.

Review of Resident #5's primary care provider's (PCP) progress notes dated 10/13/24 revealed medication changes for Resident #5 were not referenced by the PCP for starting tamsulosin 0.4mg from the 10/11/24 after-visit summary from the local hospital.

Review of the facility charting notes dated 10/23/24 revealed Resident #5 was sent out to the local hospital due to a low BP of 72/40 and a low pulse of 46.

A request was made on 11/14/24 at 3:05pm for the after-visit summary related to Resident #5's hospital visit on 10/23/24 but was not provided prior to exit.

Telephone interview with a representative from the facility's contracted pharmacy on 11/14/24 at 10:52am revealed:
-Resident #5 did not have an order for tamsulosin 0.4mg 1 tablet after dinner.
-The pharmacy did not receive a new order for tamsulosin on 10/11/24.

Telephone interview with Resident #5's guardian on 11/14/24 at 2:20pm revealed:
-He was aware Resident #5 had an order for

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tamsulosin 0.4mg 1 tablet after dinner on the 10/11/24 after-visit summary from the local hospital due to Resident #5 not voiding urine routinely.
-He was not aware Resident #5 had not been administered tamsulosin as ordered on the after-visit summary.

Interview with a medication aide (MA) on 11/14/24 at 3:10pm revealed:
-She was not aware of the after-visit order to start tamsulosin for Resident #5.
-She was not aware tamsulosin was not on the eMAR and had not been administered to Resident #5.

Interview with a second MA on 11/14/24 at 3:25pm revealed:
-She was not aware of the after-visit order to start tamsulosin for Resident #5 because she was not working when Resident #5 returned to the facility on 10/11/24.
-She was not aware tamsulosin was not on the eMAR and had not been administered to Resident #5.

Interview with Resident #5's PCP on 11/15/24 at 9:00am revealed she expected a possible outcome for Resident #5 to have bladder aggravation with the inability to void if the facility did not administer the tamsulosin as ordered by the medical provider at the local hospital.

Interview with the RCC on 11/15/24 at 9:45am revealed she was not aware the tamsulosin was not being administered to Resident #5 as it must have been overlooked.

Interview with the Administrator on 11/15/24 at 10:35am revealed:

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D 358	Continued From page 15 -She was not aware of the orders for tamsulosin for Resident #5 from the 10/11/24 local hospital after-visit summary. -She did not know Resident #5 missed doses of tamsulosin from 10/11/24 through 10/23/24. Based on interviews and record reviews, it was determined Resident #5 was not interviewable. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 11/14/24 at 10:52am. Refer to the telephone interview with Resident #5's guardian on 11/14/24 at 2:20pm. Refer to the interview with a MA on 11/14/24 at 3:10pm. Refer to the interview with a second MA on 11/14/24 at 3:25pm. Refer to the interview with Resident #5's PCP on 11/15/24 at 9:00am. Refer to the interview with the RCC on 11/15/24 at 9:45am. Refer to the interview with the Administrator on 11/15/24 at 10:35am. b. Review of Resident #5's after-visit summary from a local hospital dated 10/11/24 revealed: -Resident #5 was admitted on 10/03/24 to the local hospital with diagnoses of urinary retention and being hypertensive with a BP level of 197/58 -There was an order to hold lisinopril (used to treat high blood pressure) 40mg 1 tablet daily until a primary care provider (PCP) follow-up.	D 358		

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Review of Resident #5's medication administration record (MAR) from 10/11/24 through 10/23/24 revealed:
-There was an entry for lisinopril 40mg 1 tablet once daily.
-There was documentation lisinopril was administered for 13 of 13 opportunities from 10/11/24 to 10/23/24.
-Lisinopril should have been held and not administered to Resident #5 until the PCP follow-up to provide direction.

Review of the PCP's progress notes dated 10/13/24 revealed medication changes for Resident #5 were not referenced by the PCP to hold lisinopril 40mg from the 10/11/24 after-visit summary from the local hospital.

Review of the facility charting notes dated 10/23/24 revealed Resident #5 was sent out to the local hospital due to a low BP of 72/40 and a low pulse of 46.

A request was made on 11/14/24 at 3:05pm for the after-visit summary related to Resident #5's hospital visit on 10/23/24 but was not provided prior to exit.

Telephone interview with a representative from the facility's contracted pharmacy on 11/14/24 at 10:52am revealed:
-Resident #5 had an active order for lisinopril 40mg 1 tablet once daily.
-The pharmacy last dispensed 30 tablets for lisinopril on 11/05/24.
-The pharmacy did not receive a hold order for lisinopril dated 10/11/24.

Telephone interview with Resident #5's guardian on 11/14/24 at 2:20pm revealed:

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-He was aware Resident #5 had a hold order for lisinopril 40mg 1 tablet once daily on the 10/11/24 after-visit summary from the local hospital.
-He was not aware Resident #5 had been administered lisinopril and not held as ordered from the after-visit summary.

Interview with a MA on 11/14/24 at 3:10pm revealed:
-She was not aware of the after-visit order to hold lisinopril for Resident #5.
-She was aware lisinopril was on the eMAR and had been administered to Resident #5.

Interview with a second MA on 11/14/24 at 3:25pm revealed:
-She was not aware of the after-visit order to hold lisinopril for Resident #5 because she was not working when Resident #5 returned to the facility on 10/11/24.
-She was aware lisinopril was on the eMAR and had been administered to Resident #5.

Interview with Resident #5's PCP on 11/15/24 at 9:00am revealed:
-She was not aware Resident #5 had an order from the 10/11/24 after-visit summary to hold lisinopril.
-She expected a possible outcome for Resident #5 to have low blood pressure with possible confusion, dizziness, and fatigue if the facility continued to not hold lisinopril as ordered by the medical provider at the local hospital.

Interview with the RCC on 11/15/24 at 9:45am revealed she was not aware the lisinopril was being administered to Resident #5 as it must have been overlooked.

Interview with the Administrator on 11/15/24 at

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10:35am revealed she was not aware of the orders to hold lisinopril for Resident #5 from the 10/11/24 local hospital after-visit summary.

Based on interviews and record reviews, it was determined Resident #5 was not interviewable.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 11/14/24 at 10:52am.

Refer to the telephone interview with Resident #5's guardian on 11/14/24 at 2:20pm.

Refer to the interview with a MA on 11/14/24 at 3:10pm.

Refer to the interview with a second MA on 11/14/24 at 3:25pm.

Refer to the interview with Resident #5's PCP on 11/15/24 at 9:00am.

Refer to the interview with the RCC on 11/15/24 at 9:45am.

Refer to the interview with the Administrator on 11/15/24 at 10:35am.

_____

Telephone interview with a representative from the facility's contracted pharmacy on 11/14/24 at 10:52am revealed:
-The facility was responsible to send after-visit summaries and new orders to the pharmacy.
-She had not received the after-visit summary dated 10/11/24 for Resident #5.

Telephone interview with Resident #5's guardian on 11/14/24 at 2:20pm revealed:
-He was aware Resident #5 had been admitted to

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the hospital on 10/03/24 and on 10/23/24.
-Resident #5 had been admitted to the hospital on 10/03/24 for altered mental status, agitation, high BP, and urinary retention.
-Resident #5 had been admitted to the local hospital on 10/23/24 for altered mental status, agitation, low BP, low pulse, and urinary retention.
-He expected the facility to administer Resident #5's medication as ordered by a physician.

Interview with a MA on 11/14/24 at 3:10pm revealed:
-The MAs, the Resident Care Coordinator (RCC), and the Special Care Coordinator (SCC) were responsible to review the after-visit summaries when residents returned from a hospital visit.
-The MAs, the RCC, and the SCC were responsible to fax new orders received from medical providers and the hospital to the pharmacy.

Interview with a second MA on 11/14/24 at 3:25pm revealed:
-The MAs, the RCC, and the SCC were responsible to review the after-visit summaries when residents returned from a hospital visit.
The -MAs, the RCC, and the SCC were responsible to fax new orders received from medical providers and the hospital to the pharmacy.

Interview with Resident #5's PCP on 11/15/24 at 9:00am revealed:
-She was not aware of Resident #5's 10/11/24 after-visit summary from the local hospital when she visited Resident #5 on 10/13/24.
-She expected the facility to communicate with her for Resident #5's medication changes from other medical providers and from after-visit summaries from the local hospital.

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D 358	Continued From page 20 Interview with the RCC on 11/15/24 at 9:45am revealed: -She, the SCC, and the MAs were responsible to review the after-visit summaries when residents returned from a hospital visit. -She, the SCC, and the MAs were responsible to fax new orders from medical providers and the hospital to the pharmacy. -She was not aware the pharmacy had not received the after-visit summary dated 10/11/24 for Resident #5 with the medication changes. -She had faxed the Resident #5's 10/11/24 after-visit summary to the pharmacy on 10/11/24 but did not follow up with the pharmacy to make sure the fax was received from someone at the pharmacy. -She was not aware the PCP had not received the after-visit summary from 10/11/24 for Resident #5 with medication changes. -The MAs were responsible to place the after-visit summaries in the PCP's folder at the facility for the PCP to review on an upcoming visit. -She and the SCC were responsible to audit the eMARs weekly to ensure medications were administered as order by the physician. Interview with the Administrator on 11/15/24 at 10:35am revealed: -She expected the MAs, the RCC, and the SCC to review the after-visit summary's when residents returned from a hospital visit. -She expected the RCC and the SCC to audit the eMARS on a weekly basis to avoid medications not being administered to residents. -She expected MAs to administer Resident #5's medications as ordered by the physician. _____ The facility failed to ensure medications were administered as ordered for 1 of 5 residents (#5)	D 358		

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D 358	Continued From page 21 who did not receive a bladder muscle relaxant medication which could result in an increase in symptoms of urinary retention due to the inability to void urine, and received a held blood pressure medication which could result in a decrease of blood pressure with confusion and fatigue and was sent back to the hospital with a low blood pressure. This failure was detrimental to the health and safety and welfare of the residents and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/24 for this violation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	D 367	The community conducted and audit of all residents that are on sliding scale and immediately corrected the issue in the MAR. The RCC, MCC, or designee is responsbile for daily review of all medications and responsible for follow up with the PCP, the pharmacy and POA. All documentation will be made. If there are any refusals, the PCP will be notified and all recommendations will be followed. Date of compliance 12/31/24.	

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D 367	Continued From page 22 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 2 of 5 sampled residents (#2 and #3) regarding sliding scale insulin (#2 and #3) and a supplement (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 01/01/24 revealed diagnoses included diabetes mellitus type 2, hyperlipidemia, hypertension, mental impairment, and psychotic disorder. a. Review of Resident #2's signed physician orders dated 09/17/24 revealed: -There was an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime. -There was an order for Novolog Flexpen 100 units/ml (a fast-acting insulin used to treat high blood sugar levels) sliding scale insulin before meals for FSBS readings as follows: 70 to 150 give 0 units; 151 to 200 give 1 unit; 201 to 250 give 2 units; 251 to 300 give 3 units; 301 to 350 give 4 units; 351 to 400 give 6 units. Review of Resident #2's September 2024 electronic medication administration record (eMAR) from 09/22/24 to 09/30/24 revealed: -There was an entry for Novolog Flexpen 100 units/ml per SSI before meals for FSBS readings of 70 to 150 give 0 units; 151 to 200 give 1 unit; 201 to 250 give 2 units; 251 to 300 give 3 units; 301 to 350 give 4 units; 351 to 400 give 6 units with a scheduled administration time of 7:30am,	D 367		

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11:30am and 4:30pm.
-FSBS readings ranged from 53 to 588.
-The eMAR had a space for documentation of the initials of the staff member obtaining the FSBS, the site of administration and the FSBS reading.
-There was no space for documentation of the amount of Novolog SSI administered.
-There was no documentation of the amount of Novolog administered for 25 of 25 opportunities from 09/22/24 to 09/30/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for Novolog Flexpen 100 units/ml per SSI before meals for FSBS readings of
70 to 150 give 0 units; 151 to 200 give 1 unit; 201 to 250 give 2 units; 251 to 300 give 3 units; 301 to 350 give 4 units; 351 to 400 give 6 units with a scheduled administration time of 7:30am, 11:30am and 4:30pm.
-FSBS readings ranged from 75 to 571.
-The eMAR had a space for documentation of the initials of the staff member obtaining the FSBS, the site of administration and the FSBS reading.
-There was no space for documentation of the amount of Novolog SSI administered.
-There was no documentation of the amount of Novolog administered for 87 of 87 opportunities from 10/01/24 to 10/31/24.

Review of Resident #2's November 2024 eMAR from 11/01/24 to 11/14/24 revealed:
-There was an entry for Novolog Flexpen 100 units/ml per SSI before meals for FSBS readings of
70 to 150 give 0 units; 151 to 200 give 1 unit; 201 to 250 give 2 units; 251 to 300 give 3 units; 301 to 350 give 4 units; 351 to 400 give 6 units with a scheduled administration time of 7:30am,

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 367	Continued From page 24 11:30am and 4:30pm. -FSBS readings ranged from 77 to 586. -The eMAR had a space for documentation of the initials of the staff member obtaining the FSBS, the site of administration and the FSBS reading. -There was no space for documentation of the amount of Novolog SSI administered. -There was no documentation of the amount of Novolog administered for 33 of 33 opportunities from 11/01/24 to 11/12/24. Observation of medications available for administration for Resident #2 on 11/13/24 at 2:20pm revealed there was one full Novolog Flexpen insulin 100/ml and one with 20 units remaining and available for administration that was dispensed on 11/01/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/14/24 at 10:27am revealed: -The pharmacy had an order for Novolog Flexpen 100 units/ml per SSI before meals for FSBS readings of 70 to 150 give 0 units; 151 to 200 give 1 unit; 201 to 250 give 2 units; 251 to 300 give 3 units; 301 to 350 give 4 units; 351 to 400 give 6 units. -She did not know why there was no space to document the amount of insulin administered to Resident #2. -There was no documentation the facility had contacted the pharmacy regarding Resident #2's eMAR not having a space to document the amount of SSI administered to Resident #2 when her blood sugars were greater than 150. -The facility staff had the ability to add a space on the eMAR to document the number of units administered to Resident #2 when her blood sugars were greater than 150..	D 367		

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 367	Continued From page 25 Interview with a medication aide (MA) on 11/14/24 at 1:01pm revealed: -Resident #2's FSBS was checked before meals and at bedtime and was administered additional Novolog insulin based on the sliding scale that was ordered. -She had administered extra units of Novolog to Resident #2. -She did not document the number of units of Novolog insulin she administered. -She had noticed there was nowhere to document the number of units administered during the SSI administration. -She had not mentioned to the Special Care Coordinator (SCC) there was nowhere to document the number of units of insulin administered. Interview with a second MA on 11/14/24 at 2:22 revealed: -There was no space on the eMAR to document the amount of insulin administered when with a SSI order. -She could place the amount of insulin administered in the notes, but she did not. -She had not told management that there was no were to document the amount of SSI administered to Resident #2. Interview with the Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed: -She expected the facility staff to administer Resident #2's SSI and document how many units of insulin were administered. -She would not be able to tell if Resident #2 received the correct amount of insulin if it was not documented. Interview with the SCC on 11/14/24 at 2:05pm revealed:	D 367		

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D 367	Continued From page 26 -The MAs should be documenting on the eMAR the units of insulin administered to Resident #2. -There would be no way to know how many units of insulin was administered if the units were not documented. -She had not been notified there was no space on the eMAR to document the units of insulin administered to Resident #2. -The MA could document the units of insulin administered in the notes since there was no place on the eMAR to document. -She expected the MAs to document the units of insulin administered to Resident #2. Interview with the Administrator on 11/15/24 at 10:34am revealed: -The MA should have notified the SCC there was nowhere to document the amount of insulin administered to Resident #2. -The MA could have documented the amount of insulin administered in the notes section of the eMAR or in the progress notes. -She had not been informed there was not were to document the amount of insulin administered until this morning. b. Review of Resident #2's signed physician orders dated 09/17/24 revealed there was an order for sodium chloride 1gm (used as an electrolyte replenisher) on Monday, Wednesday, and Friday. Review of Resident #2's September 2024 eMAR from 09/22/24 to 09/30/24 revealed: -There was an entry for sodium chloride 1gm on Monday, Wednesday, and Friday. -There was documentation sodium chloride 1gm was administered every Tuesday, Thursday, Saturday, and Sunday.	D 367		

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Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for sodium chloride 1gm on Monday, Wednesday, and Friday.
-There was documentation sodium chloride 1gm was administered every Tuesday, Thursday, Saturday, and Sunday.

Review of Resident #2's November 2024 eMAR from 11/01/24 to 11/14/24 revealed:
-There was an entry for sodium chloride 1gm on Monday, Wednesday, and Friday.
-There was documentation sodium chloride 1gm was administered every Tuesday, Thursday, Saturday, and Sunday.

Observation of medications available for administration for Resident #2 on 11/13/24 at 2:20pm revealed

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/14/24 at 10:27am revealed:
-The pharmacy had an order for sodium chloride 1gm every Monday, Wednesday, and Friday.
-Tuesday, Thursday, Saturday, and Sunday should not pop up when a medication was ordered Monday, Wednesday, and Friday if the order was entered into the eMAR correctly.
-The facility staff had the ability to change which days of the week pop up on the MAR for the medications to be administered.

Interview with a medication aide (MA) on 11/14/24 at 1:01pm revealed:
-She administered Resident #2's sodium chloride on Monday, Wednesday, and Fridays as ordered.
-She administered Resident #2 sodium chloride yesterday, on Wednesday.
-She did not administer sodium chloride to

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Resident #2 today, Thursday.
-She had not noticed the initials of the MAs were being documented on the days the medication was not given.
She administered the medication based on the order in the eMAR, which was Monday, Wednesday, and Friday.

Interview with the Primary Care Provider (PCP) on 11/15/24 at 10:20am revealed:
-She reviewed Resident #2's eMAR to verify medications were administered as ordered.
-If the eMAR was not accurate, she would think the medication was not being administered as ordered.

Interview with the Special Care Coordinator (SCC) on 11/14/24 at 2:05pm revealed:
-She did not know the incorrect days popped up on the eMAR to administer medication to Resident #2.
-The MAs had not informed her that the incorrect days popped up on the eMAR.
-The pharmacy could have been called to correct this issue if she had known about it.

Interview with the Administrator on 11/15/24 at 10:34am revealed:
-Resident #2's eMARs should be correct.
-Resident #2's PCP reviewed the eMARs to adjust medications as needed.
-The eMARs should be accurate when the PCP reviewed the eMARS because new medication orders could be written based on what the PCP sees on the eMAR.

2. Review of Resident #3's current FL2 dated 10/21/24 revealed:
-Diagnoses included type 2 diabetes mellitus, hyperlipidemia, chronic pain, and generalized

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muscle weakness.
-There was an order for Lispro flex pen (a fast-acting insulin used to treat high blood sugar levels)100 unit/ml check fingerstick blood sugar (FSBS) and inject SSI four times daily.

Review of Resident #3's physician's orders dated 04/10/24 revealed an order for Lispro flex pen 100unit/ml check FSBS and inject four times daily per SSI parameters: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, 401 and greater give 12 units.

Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/22/24 through 09/30/24 revealed:
-There was an entry for Lispro 100units/ml flex pen check FSBS and inject four times daily per SSI parameters: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, 401 and greater give 12 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-FSBS's ranged from 97 to 238.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS values, but no space for documenting the amount of Lispro administered
-There was no documentation of the amount of Lispro administered for 36 of 36 opportunities 09/22/24 to 09/30/24 for Resident #3.
-Examples of Resident #3's FSBS values documented on the September 2024 eMAR notes but not documentation for the amount of Lispro administered were as follows:
-On 09/22/24, FSBS was 238 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR.

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D 367	Continued From page 30 -On 09/25/24, FSBS was 206 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 09/27/24, FSBS was 186 and 2 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 09/29/24, FSBS was 189 and 2 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. Review of Resident #3's October 2024 eMAR revealed: -There was an entry for Lispro 100units/ml flex pen check FSBS and inject four times daily per SSI parameters: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, 401 and greater give 12 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm. -FSBS's ranged from 96 to 271. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS value, but no space for documenting the amount of Lispro administered -There was no documentation of the amount of Lispro administered for 124 of 124 opportunities from 10/01/24 to 10/31/24. -Examples of Resident #3's FSBS values documented on the October 2024 eMAR notes but not documentation for the amount of Lispro administered were as follows: -On 10/07/24, FSBS was 245 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 10/14/24, FSBS was 232 and 4 units of Lispro should have been administered but no	D 367		

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D 367	Continued From page 31 Lispro insulin was documented as administered on the eMAR. -On 10/22/24, FSBS was 235 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 10/30/24, FSBS was 271 and 6 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. Review of Resident #3's November 2024 eMAR from 11/01/24 through 11/12/24 revealed: -There was an entry for Lispro 100units/ml flex pen check FSBS and inject four times daily per SSI parameters: 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, 401 and greater give 12 units scheduled for administration at 7:30am, 11:30am, 4:30pm, and 8:00pm. -FSBS's ranged from 83 to 271. -The eMAR had a space for documentation of the staff obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS value, but no space for documenting the amount of Lispro administered -There was no documentation of the amount of Lispro administered for 48 of 48 opportunities 11/01/24 to 11/12/24. -Examples of Resident #3's FSBS values documented on the November 2024 eMAR notes but not documentation for the amount of Lispro administered were as follows: -On 11/02/24, FSBS was 222 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 11/04/24, FSBS was 273 and 6 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR.	D 367		

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D 367	Continued From page 32 -On 11/06/24, FSBS was 231 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. -On 11/11/24, FSBS was 216 and 4 units of Lispro should have been administered but no Lispro insulin was documented as administered on the eMAR. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/14/24 at 10:52am revealed: -She had worked with the facility to ensure the eMAR was updated with Resident #3's sliding scale parameters, but the facility was responsible to review and update the eMAR for the amounts of insulin administered. -She was not aware of why the orders were set up the way they were in the eMARs, leaving out a space to document insulin amount and site on the residents' eMARs with SSI orders. -There was no documentation the facility had contacted the pharmacy regarding Resident #3's eMAR not properly documenting the administration of Lispro SSI. -She would have worked with the facility to correct the problem. Observation of medications available for administration for Resident #3 on 11/14/24 at 1:40pm revealed Lispro insulin was available for administration and was dispensed on 10/15/24. Interview with Resident #3 on 11/14/24 at 2:05pm revealed: -The medication aides (MA) completed his FSBS frequently every day and sometimes his insulin changes. -He was not sure how much insulin he received, but he usually received the insulin every day.	D 367		

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D 367	Continued From page 33 -He denied any current symptoms related to headaches or dizziness. Interview with a MA on 11/14/24 at 1:50pm revealed: -Resident #3 had an order for FSBS checks for four times every day with sliding scale parameters and her FSBS were always 96-230 in the past 2-3 months. -She was aware the eMAR system did not have a space on Resident #3's FSBS order entry to document the amount of insulin administered and but she had not brought this to the Resident Care Coordinator's (RCC) attention. -She was not able to enter the amounts of insulin administered to Resident #3 into the eMAR. -She was not aware of any additional methods to document the amount of insulin units administered to Resident #3. -The RCC was responsible for auditing the eMARS. Interview with a second MA on 11/14/24 at 3:10pm revealed: -The RCC and the SCRC audited the residents' eMAR for documentation of FSBS and amount of insulin administered. -Resident #3 had an order for FSBS checks for four times every day and her FSBS were always 82-270's, and she had to give him insulin when she had worked as a MA. -The eMAR did not have a space on Resident #3's FSBS order entry to document the amount of insulin administered when she was trained, but she had not brought this to the RCC's attention. Telephone interview with Resident #3's primary care provider (PCP) on 11/15/24 at 9:00am revealed: -She expected the facility staff to administer	D 367		

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Resident #3's Lispro per the sliding scale and document how many units of insulin were administered.
-She would not be able to tell if Resident #3 received the correct amount of insulin if it was not documented.

Interview with the RCC on 11/15/24 at 9:45am revealed:
-The medication aides (MAs) documented the administration of medications on the eMAR routinely.
-She and the Special Care Coordinator (SCC) audited the residents' eMARs weekly for documentation and accuracy, but she had not noticed that Resident #3's FSBS order entry did not have a space to document the amount of Lispro SSI administered.
-No staff had followed up with her regarding the eMAR system not having a space to document the amount of insulin administered to Resident #3 and it must have been overlooked.
-There was no other documentation she could provide to monitor the amounts of Lispro SSI administered to Resident #3.
-She expected all MAs to document the amount of insulin units administered in the eMAR for all residents moving forward.

Interview with the Administrator on 11/15/24 at 10:35am revealed:
-She was not aware Resident #3's amount of Lispro insulin administered was not being documented by the MAs.
-The MAs should have let the RCC and SCC know about the missing documentation areas for SSI.
-She expected the RCC and the SCC to audit the eMARS on a weekly basis.
-She expected the number of units of insulin

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D 367	Continued From page 35 administered to be documented correctly by the MAs.	D 367		
D 423	10A NCAC 13F .1104 (e) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (e) All or any portion of a resident's personal funds shall be available to the resident or their authorized representative upon request during the facility's established business days and hours except as provided in Rule .1105 of this Section. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure residents' personal funds were available during regular established business office hours for 4 of 4 sampled residents (Resident #1, #3, #10 and #11). The findings are: 1. Review of Resident #1's current FL2 dated 4/10/24 revealed diagnoses included stiff man syndrome (a neurological disorder that cause muscle stiffness and spasms), Parkinson's disease and adult failure to thrive.	D 423	The residents trust fund will be available to access on the 10th of the month unless it falls on a weekend or a holiday in which it will be the next business day. The resident bank days are listed in the community for all residents to see. The BOM, ED or designee will be responsibe to maintain the resident trust fund and documentation. Date of compliance 12/31/24.	

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D 423	Continued From page 36 Review of Resident #1's personal funds ledger from October 2024 to November 2024 revealed: -In October 2024, there was a beginning balance of $31.00 and an ending balance of $21.00 with a 10/10/24 deposit of $90.00 and on 10/10/24 a withdrawal of $100.00. -In November 2024, there was a beginning balance of $21.00 with a 11/11/24 deposit of $64.00 and a withdrawal on 11/11/24 of $75.00. -There was an ending balance of $10.00 on 11/15/24. Interview with Resident #1 on 11/15/24 at 8:30am revealed: -There was a sign posted on the Business Office Manager's (BOM)/Assistant Administrator's office door for resident bank hours Monday through Friday from 11am to 2pm. -He received his personal funds on 10/10/24 and 11/12/24. -He went to the front office when an announcement was made for residents to come to the front office to collect resident funds around the 10th of the month. -The rest of the month, there was no one to give out money on a regular basis during bank hours. -The Administrator and BOM were the only ones who had access to funds and they were not there every day, Monday thru Friday. -The Administrator and BOM were at the facility 1 or 2 days during the week for 2-3 hours around 10:00am-11:00am and then they were not there again until the next week. -He used his personal funds to have his family members buy body wash, snacks or food items he liked, and some clothing. Refer to the telephone interview with the BOM/Assistant Administrator on 11/15/24 at	D 423		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 423	Continued From page 37 10:20am. Refer to the interview with the Administrator on 11/15/24 at 10:35am. 2. Review of Resident #3's current FL2 dated 10/24/24 revealed diagnoses included gout, osteoarthritis, diabetes mellitus, chronic pain, and insomnia. Review of Resident #3's personal funds ledger from October 2024 to November 2024 revealed: -In October 2024, there was a beginning balance of $0.00 and an ending balance of $0.00 with a 10/10/24 deposit of $90.00 and 10/10/24 withdrawal of $90.00. -In November 2024, there was a beginning balance of $0.00 with a 11/11/24 deposit of $90.00 and a withdrawal on 11/11/24 of $90.00. -There was an ending balance of $0.00 on 11/15/24. Interview with Resident #3 on 11/15/24 at 9:30am revealed: -Residents' bank hours were Monday through Friday from 11am to 2pm. -He received his personal funds on 10/10/24 and 11/12/24. -He went to the front office when an announcement was made for residents to come to the front office to collect resident funds around the 10th of the month. -He used his personal funds to shop for clothes and buy snacks every month. Refer to the telephone interview with the BOM/Assistant Administrator on 11/15/24 at 10:20am. Refer to the interview with the Administrator on	D 423		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 423	Continued From page 38 11/15/24 at 10:35am. 3. Review of Resident #10's current FL2 dated 11/04/24 revealed diagnoses included dementia, bipolar disorder and benign prostatic hyperplasia. Review of Resident #10's personal funds ledger from October 2024 to November 2024 revealed: -In October 2024, there was a beginning balance of $90.00 and an ending balance of $90.00 with a 10/10/24 deposit of $90.00 and on 10/10/24 a withdrawal of $180.00. -In November 2024, there was a beginning balance of $0.00 with a 11/11/24 deposit of $90.00 and a withdrawal on 11/11/24 of $90.00. -There was an ending balance of $0.00 on 11/15/24. Interview with Resident #10 on 11/15/24 at 8:45am revealed: -Residents' bank hours were Monday through Friday from 11am to 2pm. -He received his personal funds on 10/10/24 and 11/12/24. -He went to the front office when an announcement was made for residents to come to the front office to collect resident funds around the 10th of the month. -After the 10th or 11th of each month, he could not get out money on a regular basis during bank hours because the Administrator and BOM were not there every day. -The Administrator and BOM were at the facility 2 or 3 days during the week for 2-3 hours around 10:00am-11:00am. -He used his personal funds to shop and buy lunch when he volunteered at his church. Refer to the telephone interview with the BOM/Assistant Administrator on 11/15/24 at	D 423		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 423	Continued From page 39 10:20am. Refer to the interview with the Administrator on 11/15/24 at 10:35am. 4. Review of Resident #11's current FL2 dated 01/14/24 revealed diagnoses included chronic kidney disease and diabetes type 2. Review of Resident #11's personal funds ledger from October 2024 to November 2024 revealed: -In October 2024, there was a beginning balance of $260.00 and an ending balance of $30.00 with a 10/10/24 deposit of $90.00 and 2 withdrawals on 10/18/24 and 10/31/24 of $100.00 each. -In November 2024, there was a beginning balance of $30.00 with a 11/11/24 deposit of $90.00 and a withdrawal on 11/11/24 of $90.00. -There was an ending balance of $30.00 on 11/15/24. Interview with Resident #11 on 11/13/24 at 9:08am revealed: -She had received resident funds on 10/10/24 and Tuesday of this week (11/12/24) due to a bank holiday 11/11/24. -The residents' bank hours were posted to be Monday through Friday 11:00am-2:00pm. -The Administrator or Business Office Manager (BOM) had residents line up at the front office after the funds were deposited around the 10th of each month and dispersed money to those residents. -If she did not get her funds as soon as it was deposited, she would not be able to get it after the 10th of the month. -The Administrator and BOM were not in the office every day during the posted bank hours and they were the only ones who gave out resident funds.	D 423		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 423	Continued From page 40 -She used her resident funds to purchase snacks, puzzle books and craft items. Refer to the telephone interview with the BOM/Assistant Administrator on 11/15/24 at 10:20am. Refer to the interview with the Administrator on 11/15/24 at 10:35am. _____ Telephone interview with the Assistant Administrator/BOM on 11/15/24 at 10:20am revealed: -Resident bank hours were Monday through Friday form 10:00am-2:00pm as posted on his door. -He and the Administrator were responsible for dispersing resident funds during resident bank hours and the receptionist had been training to help give out residents' funds. -He was at the facility's office every weekday and available to give residents their funds. -On the rare occasion he would not be in the office, the Administrator or receptionist were available to give residents their funds. Interview with the receptionist on 11/15/24 at 10:40am revealed: -She witnessed resident funds dispersments with the Administrator or BOM around the 10th of each month. -She did not have access to the money to disperse funds herself if the Administrator or BOM were not in the office. -The Administrator and BOM were in the office "sporadically" after the 10th of each month for residents to get their money. Interview with the Administrator on 11/15/24 at 10:35am revealed:	D 423		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	R-C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 423	Continued From page 41 -She and the BOM were responsible for dispersing resident funds Monday thru Friday 11:00am-2:00pm. -She or the BOM were in the office every day and available to give residents their money. -Bank deposits were available for residents on the 10th of each month and residents could get their funds anytime during the residents' bank hours.	D 423		