

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/09/2025
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681
---	--

(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 Home Licensure Section completed an annual survey from January 8 through January 9, 2025.	D 000		
D 618	<p>10A NCAC 13F .1802 (a) Reporting & Notification of a Suspected or C</p> <p>10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK</p> <p>(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to report a confirmed influenza (flu) outbreak as established by the local health department (LHD) that began on 12/31/24 in which two residents were hospitalized due to testing positive for influenza (Resident #4 and Resident #5).</p> <p>The findings are:</p> <p>Observation upon initial entry to the facility on 01/08/25 at 8:30am revealed signage on the outside door which read, "Attention! Beyond this point masks are required due to the recent sickness outbreak!"</p> <p>Interview with a Medication Aide (MA) upon</p>	D 618	<p>Administrator reported the 1/9/25 cases of Flu to the Alexander County Health Dept. All future communicable diseases will be reported within 24 hours or sooner. In the event that the Administrator is unable to report confirmed communicable diseases to the health Dept., the owner or designee will do so immediately.</p> <p><i>Sherry Jackson</i> Administrator 2/11/25</p>	

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Reviewed and acknowledged by MH 02/17/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681
---	--

(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 618	<p>Continued From page 1</p> <p>arrival at the facility on 01/08/25 8:30am revealed: -There was a census of 16. - Three residents had tested positive for the flu and were asked to stay in their rooms. -One resident (Resident #5) was hospitalized on 01/03/25 after testing positive for the flu and not counted as part of the census.</p> <p>Observation during the initial facility tour on 01/08/25 from 9:30am to 10:00am revealed: -The three residents who had tested positive for the flu were in their rooms with the door shut. -Residents in common areas were wearing masks.</p> <p>Review of the facilities Disease Control Manual revealed a memo from the NC Department of Health and Human Services (NCDHHS) Division of Health Service Regulation (DHSR) dated 11/21/22 revealed: -The Adult Care Home Administrator or his/her designee must report all suspected communicable disease outbreaks to the Local Health Department (LHD). -A suspected communicable disease outbreak is defined as any illnesses among residents with same identifiable infectious cause (e.g. evidence of the same virus found on laboratory testing). -Reports must be made by phone within 24 hours of the time when the outbreak is reasonably suspected to exist.</p> <p>1. Review of Resident #5's current FL-2 dated 01/06/25 revealed a diagnoses of diabetes mellitus, heart failure, chronic obstructive pulmonary disease (COPD), high blood pressure, arthritis, and chronic back pain.</p> <p>Review of Resident #5's Resident Register revealed an admission date of 07/25/24.</p>	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(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 618	Continued From page 2 Review of Resident #5's pharmacy review on 10/15/24 revealed a recommendation for a flu and covid vaccine. Review of the facilities list of Covid-19 and Influenza vaccinations revealed Resident #5 received a Covid-19 and flu vaccination on 10/23/24. Review of the facilities list of residents who had tested positive for the flu revealed Resident #5's had tested positive on 01/06/25. Review of Resident #5's hospital discharge summary dated 01/08/25 revealed: -Resident #5 was admitted to the hospital on 01/03/25 due to a cough, shortness of breath and weakness. -She denied chest pain, dizziness, headache, diarrhea or vomiting. -Her admitting diagnosis was influenza, and acute hypoxic respiratory failure. -She was started on Tamiflu (a medication to treat the flu) and given intravenous fluids and supplemental oxygen. -Resident #5 was discharged on 01/08/25 back to the facility with a discharge diagnosis of Influenza and acute hypoxic respiratory failure. -She had orders to take acetaminophen-hydrocodone (a medication used to treat pain)325mg-5mg take 1 tablet three times daily, cipro (a medication used to treat bacterial infections)500 mg 1 tablet every 12 hours, oseltamivir (a medication used to treat viruses also called Tamiflu) 30mg 1 tablet every 12 hours. -She should follow up with her physician in three to five days. Interview with Resident #5 on 01/09/25 at	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025	
NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(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 618	<p>Continued From page 3</p> <p>12:50pm in the hallway revealed she felt much better.</p> <p>Refer to interview with the medication aide (MA) on 01/08/25 at 11:10am</p> <p>Refer to interview with the personal care assistant (PCA) on 01/09/25 at 3:15pm.</p> <p>Refer to interview with the Activities Director on 01/09/25 at 3:15pm.</p> <p>Refer to telephone interview with the Administrator on 01/08/25 at 5:23pm.</p> <p>Refer to telephone interview with a Registered Nurse (RN) from the LHD on 01/09/25 10:20am.</p> <p>Refer to interview the Administrator on 01/09/25 at 2:10pm.</p> <p>Refer to telephone interview with the facility's contracted primary care provider (PCP) on 01/09/25 at 3:50pm.</p> <p>2. Review of Resident #4's current FL-2 dated 06/20/24 revealed a diagnosis of oxygen dependent, diabetes mellitus, chronic obstructive pulmonary disease (COPD), anemia, depressive disorder, high blood pressure.</p> <p>Review of Resident #4's Resident Register revealed an admission date of 07/04/24.</p> <p>Review of Resident #4's pharmacy review on 10/15/24 revealed a recommendation for a flu and covid vaccine.</p> <p>Review of the facilities list of Covid-19 and flu vaccinations revealed Resident #4 received a</p>	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(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 618	Continued From page 4 Covid-19 and flu vaccination on 10/26/24. Review of the facilities list of residents who had tested positive for the flu revealed Resident #4 had tested positive on 01/03/25. Review of an accident/incident report dated 01/08/25 revealed: -Resident #4 had called for help and was found in her bedroom sitting on the floor. -Resident reported she had fallen on her buttock when trying to get out of her chair. -Resident was disoriented. -Resident was sent out to the Emergency Department (ED) for an evaluation. Review of Resident #4's ED discharge summary revealed: -Resident #4 tested positive for influenza A. -Received a prescription for Tamiflu 75 mg twice daily. Observation and interview with Resident #4 on 01/09/25 at 1:30pm revealed: -She was lying in her bed and wearing oxygen. -She said she was very tired but getting better. -She thought she had pneumonia and the flu. Refer to interview with the MA on 01/08/25 at 11:10am Refer to interview with the PCA on 01/09/25 at 3:15pm. Refer to interview with the Activities Director on 01/09/25 at 3:15pm. Refer to telephone interview with the Administrator on 01/08/25 at 5:23pm.	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681
---	--

(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 618	<p>Continued From page 5</p> <p>Refer to telephone interview with a RN from the LHD on 01/09/25 10:20am.</p> <p>Refer to interview the Administrator on 01/09/25 at 2:10pm.</p> <p>Refer to telephone interview with the facilities contracted PCP on 01/09/25 at 3:50pm.</p> <p>_____</p> <p>Telephone Interview with the Administrator on 01/08/25 at 5:23pm revealed: -She had not called the LHD to report the outbreak of the flu. -She was unaware she needed to report a flu outbreak.</p> <p>Interview with a medication aide (MA) on 01/08/25 at 11:10am revealed: -She started in August 2024 as an MA. -She had infectious disease training completed by a Registered Nurse (RN) from the facilities contracted pharmacy when she started. -She had training again in October 2024 from the same RN on colds, flu, COVID and respiratory syncytial virus (RSV) a virus that infects the respiratory tract and what her role was if the facility had any residents with these. -She knew she had to isolate the resident who was coughing or had a temperature and let the Administrator know immediately and staff was to wear masks. -She stated there were residents who refused to wear masks, so she tried to keep them in their room until there were no more signs and symptoms. -She said the facilities contracted PCP was made aware of the residents with signs and symptoms of colds and flu and she would order them a flu test and follow up with the residents weekly.</p>	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681
---	--

(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 618	<p>Continued From page 6</p> <p>Interview with a PCA on 01/09/25 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -She started in October 2024 as a PCA. -She had training in Infection Control in October 2024 from a nurse from the facility's pharmacy. -She knew she had to isolate the residents who had a cold, coughing or sneezing and made the MA or Administrator aware immediately. -She said she could not make the residents wear a mask but could remind them and encourage them to stay in their room until their symptoms were gone. -She made the MA aware of anyone with symptoms immediately. <p>Interview with the Activities Director on 01/09/25 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -He started in October 2024 as the Activity Director and PCA. -He had training in Infection Control in October 2024 with other staff members from a nurse from the facility's pharmacy. -He knew he had to isolate the residents who had a cold, coughing or sneezing and made the MA or Administrator aware immediately. -He could not make the residents wear a mask but could remind them and encourage them to stay in their room until their symptoms were gone. -He was not doing group activities due to the flu outbreak but was doing individual tasks with the residents such as playing chess and uno. -He made the MA or Administrator aware of anyone with symptoms immediately. <p>Telephone interview with a RN from the LHD on 01/09/25 10:20am revealed:</p> <ul style="list-style-type: none"> -The Communicable Disease Nurse who handles communicable disease reports was not available. -Facilities were expected to report by phone 	D 618		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681		
(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 618	<p>Continued From page 7</p> <p>within 24 hours suspected communicable diseases of same or similar symptoms when an outbreak was more than one resident. -She was just notified today on 01/09/25 of the flu outbreak from the facility. -LHD reports outbreaks of communicable diseases. -They would send out a representative from environmental health department (environmental health is under the LHD) to the facility for a consultation if the facility would like an assistance.</p> <p>Interview with the Administrator on 01/09/25 at 2:10pm revealed: -She was responsible for reporting an outbreak to the local Health Department (LHD) -She knew outbreaks such as Covid-19, Nora Virus, bed bugs, tuberculous needed to be reported to the LHD but was not aware that an outbreak of flu needed to be reported. -Five residents tested positive for the flu which began on 12/31/24 and the last positive test for the flu was on 01/06/25. -Two staff had tested positive for the flu, but no staff were currently sick as of today 01/09/25. -She reported immediately to the PCP the residents' symptoms of fever and cough and initiated Covid-19 and flu tests. -Residents that were positive for flu received a prescription for Tamiflu. -Residents that did test positive for the flu were asked to stay in their rooms. -Residents not affected with the flu were asked to wear a mask in the common areas. -They completed and continued to provide extra cleaning of high touch areas such as doorknobs, handrails, and shared bathrooms. -Residents were seen weekly by the PCP.</p>	D 618		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: hal002008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAITH ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3032 N C HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681
---	--

(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 618	<p>Continued From page 8</p> <p>Telephone interview with the PCP on 01/09/25 at 3:50pm revealed:</p> <ul style="list-style-type: none"> -She was notified immediately when the residents started to feel ill. -She was visiting the residents weekly at the facility to monitor residents. -She had no concerns about the care and treatment the residents were getting at the facility. 	D 618	<p style="text-align: right;"><i>Sherry Jackson</i> 2/14/25 Administrator Sherry Jackson</p>	
-------	---	-------	--	--