STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 via off-site desk review on June 2-5, 2020, June 8-12, 2020, and June 15-17, 2020.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 1	D 188		

residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the required staffing hours were met to meet the needs of the residents on first, and second shift based on 23 of 42 shifts sampled from 05/24/20 to 06/07/20.

The findings are:

Review of the facility's census report from 05/24/20 to 05/28/20 revealed there was a census of 57, which required thirty-two hours of aide coverage on first and second shift.

Review of staff time cards from 05/24/20 to 05/28/20 revealed:
-On 05/24/20, on first shift, there was a total of 25.5 staff hours with a shortage of 6.4 hours.
-On 05/25/20, on second shift, there was a total of 30.7 staff hours with a shortage of 1.3 hours.
-On 05/25/20, on second shift, there was a total of 28.4 staff hours with a shortage of 3.5 hours.
-On 05/26/20, on first shift, there was a total of 22.9 staff hours with a shortage of 9.0 hours.
-On 05/26/20, on second shift, there was a total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 2	D 188		

of 27.3 staff hours with a shortage of 4.6 hours.
-On 05/27/20, on second shift, there was a total of 22.7 staff hours with a shortage of 9.2 hours.
-On 05/28/20, on first shift, there was a total of 23.5 staff hours with a shortage of 8.4 hours.
-On 05/28/20, on second shift, there was a total of 21.5 staff hours with a shortage of 10.4 hours.

Review of the facility's census report from 05/29/20 to 05/31/20 revealed there was a census of 58, which required thirty-two hours of aide coverage on first and second shift.

Review of staff time cards from 05/29/20 to 05/31/20 revealed:
-On 05/29/20, on first shift, there was a total of 30 staff hours with a shortage of 1.8 hours.
-On 05/29/20, on second shift, there was a total of 23 staff hours with a shortage of 8.9 hours.
-On 05/30/20, on first shift, there was a total of 30 staff hours with a shortage of 1.8 hours.
-On 05/30/20, on second shift, there was a total of 17.9 staff hours with a shortage of 14.0 hours.
-On 05/31/20 on second shift, there was a total of 17.7 staff hours with a shortage of 14.2 hours.

Review of the facility's census report from 06/01/20-06/07/20 revealed there was a AL census of 51-60 residents, which required thirty-two hours of aide coverage on first and second shift.

Review of staff time cards from 06/01/20 to 06/07/20 revealed:
-On 06/01/20, on first shift there was a total of 21.25 staff hours with a shortage of 10.75 hours.
-On 06/01/20, on second shift there was a total of 29.50 staff hours with a shortage of 2.5 hours.
-On 06/02/20, on second shift there was a total of 27.0 staff hours with a shortage of 5.00 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 3	D 188		

-On 06/03/20, on first shift there was a total of 21.00 staff hours with a shortage of 11.00 hours.
-On 06/04/20, on first shift there was a total of 25.25 staff hours with a shortage of 6.75 hours.
-On 06/05/20, on second shift there was a total of 14.50 staff hours with a shortage of 17.50 hours.
-On 06/06/20, on second shift there was a total of 16.75 staff hours with a shortage of 15.25 hours.
-On 06/07/20, on first shift there was a total of 22.00 staff hours with a shortage of 10.00 hours.
-On 06/07/20, on second shift there was a total of 18.00 staff hours with a shortage of 14.00 hours.

Telephone interview with an Assisted Living (AL) resident on 06/15/20 at 10:16 am revealed:
-She resided in the facility for over two years.
-She thought there was a shortage of staff because she saw the same Medication Aide (MA) working more than one shift.
-She also thought the MAs were working several hours in one week because of the number of times she saw MAs working.
-She thought in the spring of 2020 the lower staffing levels were more obvious because of the number of new staff that came and left.
-She received the assistance needed for bathing and dressing.
-However, she had noticed she had to call more than once on second and third shift for her pain medications.
-She believed the PCA responding to her call bell did relay the message to the MA, but thought the MA forgot due to doing other tasks.
-She had seen the housekeeper assisting in dietary and the Activities Director assisting during meal times.

Telephone interview with another resident on 06/12/20 at 2:06 pm revealed:
-There had been a shortage of staff since

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 4	D 188		

September 2019.
-There should be 2 staff working on the hall, but most of the time there was only 1 staff working on the hall.
-The staff responded to her call light between 5-10 minutes when 2 staff were working on the hall.
-It took staff much longer to respond to call lights when there was only 1 staff working on the hall and the length of time depended on the time of the day.

Telephone interview with a personal care aide (PCA) on 06/15/20 at 3:51 pm revealed:
-She worked both on the AL unit and the Special Care Unit (SCU).
-She had noticed a staffing shortage but the staff on duty worked as a team to get all resident care done.
-The census on AL was 57.
-There were usually two MAs and two PCAs.
-To ensure there were enough staff, staff remained from first shift until 7:00 pm and a third shift staff came in at 7:00 pm.
-Some staff were sent to a sister facility, but she did not know why.
-Showers or baths were done on second shift, and she was responsible for three to four showers per shift.
-There had to be a minimum of three staff on the unit for anyone to take a lunch break.
-When staff took a lunch break, another staff assumed the assignment of the person on break.
-If there were not enough PCAs, the MA assumed the assignment of the staff on lunch break.
-She remained over to work third shift about every two to three days.

Telephone interview with a MA on 06/11/20 at 3:09 pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 5	D 188		

-She worked second shift primarily.
-She had worked as a PCA and MA for the AL and SCU.
-Her assignment was based on where she was placed on the assignment sheet.
-The Resident Care Coordinator (RCC) prepared the schedule and assignment sheets.
-The facility was short of staff since September 2019.
-She remained over to assist third shift if she was scheduled off the following day.
-She observed first shift staff remaining over until 7:00 pm and third shift staff coming in at 7:00 pm to assist second shift staff.
-The first weekend of June 2020 she was the only MA until 7:00pm.
-If she needed anything, she could call the RCC as a resource person.
-The RCC, Resident Care Director (RCD), and Administrator have worked on the unit because of the short staffing.
-Staff made two-hour rounds to check residents, determine if the resident's needed incontinent care, locate residents, and determine if any assistance was needed.

Telephone interview with another MA on 06/16/20 at 8:04 am revealed:
-She had worked on the AL unit for over 2 years on second and third shifts.
-The RCC was responsible for doing the assignment sheets and the schedule.
-There was a shortage of staff and there had been a shortage of staff for a "long time".
-The shortage of staff was caused by people who quit soon after being hired.
-The year of 2020 had been particularly difficult year for staffing.
-The second shift staffing should include two MAs and two PCAs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 6 -When she worked on 06/15/20, there were two MAs and two PCAs. -There were some staff who were sent to a sister facility and for the past two months staffing had been short. -To assist with the staffing shortage, she had observed the RCC, RCD and the Administrator come to the floor to assist with resident care. -The Administrator came in to work early in the morning and walked around to ask staff if there were any needs. -The RCD assisted in "general ways" and the RCC worked as a MA. -The MAs also did not just give medications, but they assisted with resident care. -The residents on the AL were able to use there call lights and that also helped staff to know if residents needed anything. -She remained over for first shift on 06/16/20 because first shift was short staffed and needed a MA to work. Telephone interview with the RCC on 06/17/20 at 11:52 am revealed: -She, the RCD, and the Memory Care Director (MCD) made the schedule and the assignment sheets. -The current census on AL was fifty-eight residents. -The AL required four staff on first and second shift, and three staff for third shift. -She knew that staffing was short, and efforts had been made to hire staff. -However, hiring had been difficult because people would not show up to interview or interview and not follow-up. -Also, staff were dismissed that used to work second shift. -Staff were sent to a sister facility to help with staffing due to positive cases of the virus.	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 7	D 188		

-Staff first left on 05/22/20, another on 05/29/20, and 06/04/20.
-These staff were to return to the facility on 06/25/20 after quarantining.
-Sending staff to the sister facility did effect staffing, and she did not know why staff were sent if staffing was already short at the facility.
-She followed the instructions as she was told to do regarding sending staff to the sister facility.
-Her usual work hours were 9:00 am to 7:00 pm and she had recently worked third shift to provide staff coverage.
-There had been no new hires for the AL unit since the beginning of the virus.
-She requested staff to remain over from first shift and/or come in early at 7:00 pm for third shift.
-She also stayed to assist with staffing, and they pulled together as a team to get the resident care completed.
-Some staff changed to twelve hour shifts to try to provide more coverage for staffing.
-She made the RCD and Administrator aware and they filled in to try to solve the staffing shortage.
-Also, she asked as needed staff to pick up extra shifts.
-The Administrator was responsible for staffing on the AL unit.
-No residents or staff had told her of any complaints regarding the staffing shortage.

Telephone interview with the RCD on 06/17/20 at 12:36 pm revealed:
-She and the RCC were responsible for doing the assignment sheets.
-The RCC did the master schedule.
-The AL census was 58 or 59, and staffing coverage was provided based on the resident's needs.
-She knew the facility had a staffing shortage and she discussed the shortage of staff with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 8	D 188		

Administrator.
-A lot of staff went to a sister facility to work, some staff quit, and some staff were let go.
-Efforts were made to hire more staff, but people came to interview and did not follow-up with the paperwork or did not show up for the interview.
-She did not know why the decision was made to send staff to a sister facility if the facility was short staffed.
-Staff left the third or fourth week of May 2020 to work at the sister facility.
-She, the RCC, and the MCD were told to pull together and work as a team to help with the shortage of staff.
-On the first week of June 2020, some of the staff were still at the sister facility and others left to go to the sister facility.
-She and the RCC were there during the first shift and she often remained at work until 9:00 pm to assist with staffing.
-There was no specific plan or instructions provided to staff during the staffing shortage on how resident care would be done.
-Staff just worked together to ensure resident care was completed.
-She placed resident care first prior to her normal duties as the RCD so some of her duties were behind.

Telephone interview with the Administrator on 06/17/20 at 2:31 pm revealed:
-She knew there was a staffing shortage on AL, but she did not know the exact number of hours that the unit was short.
-The clinical staff which consisted of the RCC, MCD and the RCD were responsible for the schedule.
-She was in the process of learning the scheduling process on the facility's computer system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 188	Continued From page 9 -The AL had a current census of 58 or 59 and needed staff based on the census which was twenty-four hours plus a supervisor. -The RCC and RCD had told her daily that more staff were needed, and she had made efforts to hire new staff. -She sent staff to assist at a sister facility because that facility had COVID-19 positive cases and needed assistance with staffing. -She sent staff because she thought at that time, she had enough staff. -Also, some staff were dismissed from employment at the facility and she had made efforts to hire new staff. -The last week of May 2020 staffing was short because some staff went to the sister facility and some staff quit. -The first week of June 2020 staffing was short because other staff went to help the sister facility. -To assist with staffing, the transportation person and the Business Office Manager (BOM) were cross-training, but they were not PCAs. -Also, the Activities Director assisted with staffing and she was a PCA. -She had told staff that they all were to work together to get the resident care done. -She also thought that there might be a time when the facility needed help and by sending staff to assist a sister facility it would be reciprocated if the facility had a need. -She, the RCC and the RCD were expected to assist with staffing on the unit to ensure resident care was done. -She worked on the holiday on 05/25/20 to assist the unit for first shift. -She thought that the current COVID-19 circumstances effected staffing, the hiring process and staff remaining at the facility.	D 188		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 10	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 7 sampled residents related to a fall (#1) and related to multiple refusals of weekly blood pressure as ordered by the primary care provider (PCP) (#7). The findings are: 1. Review of Resident #1's current FL-2 dated 02/26/20 revealed diagnoses included senile degeneration of brain, unspecified dementia with behavioral disturbance, generalized anxiety disorder, and major depressive disorder. Review of Resident #1's electronic progress note dated 04/13/20 at 12:16pm revealed: -The note was entered by the Memory Care Director (MCD). -The hospice agency was informed Resident #1 did not have a primary care provider (PCP). -The facility's contracted PCP agency was no longer providing care to Resident #1. Review of Resident #1's electronic progress note dated 04/14/20 at 3:05pm revealed. -The note was entered by the MCD. -The hospice agency was informed Resident #1 did not have a PCP. -The MCD was waiting for the hospice agency to return her call.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 11 Review of Resident #1's electronic progress note dated 04/15/20 at 1:17pm revealed: -The note was entered by the MCD. -The hospice agency had taken responsibility to become Resident #1's PCP. Review of an electronic Accident/Incident Report dated 05/26/20 at 3:54pm revealed: -The report was entered by the Resident Care Director (RCD). -Resident #1 suffered a fall on 05/25/20 at 7:10pm in the hallway of the special care unit (SCU). -Resident #1 fell when her wheelchair was taken from under her by another resident. -Resident #1 did not exhibit or complain of pain related to the fall; no injuries were noted. -Resident #1's PCP was notified of the fall on 05/25/20 at 9:40pm. Review of a hospice visit note report dated 05/27/20 at 11:05am revealed: -The note was entered by a registered nurse (RN) from the hospice agency. -The area on the note reading "Has patient had a recent fall?" was answered "no." Telephone interviews with the Patient Care Manager from Resident #1's hospice agency on 06/10/20 at 10:02am revealed: -Staff from the facility did not notify the hospice agency of Resident #1's 05/25/20 fall. -The hospice RN's 05/27/20 note did not mention Resident #1 had a recent fall. -The hospice agency would have sent a RN to the facility on the same day, at any hour of the day, even if there was no injury if the agency had been notified of Resident #1's fall. -The hospice agency expected to be notified	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 12 when Resident #1 had a fall so Resident #1 could be assessed by a medical provider. Telephone interview with a representative from the facility's contracted PCP service on 06/10/20 at 10:56 am revealed: -The last date of service for Resident #1 was 03/11/20. -Resident #1 became an inactive patient of the PCP service on 03/25/20. Telephone interview with a physician from the facility's contracted PCP service on 06/10/20 at 4:10pm revealed Resident #1 was not a patient of the PCP service. Telephone interview with a RN from the hospice agency on 06/11/20 at 9:28am revealed the hospice agency should have been called after Resident #1 fell on 05/25/20. Telephone interview with a MA on 06/11/20 at 2:49pm revealed: -She was working on 05/25/20 when Resident #1 fell. -Resident #1 was not sitting all the way back in her wheelchair and was using the handrail to move down the hall in the SCU. -A second resident walked by and pulled Resident #1's wheelchair out from under her and continued to walk down the hall with Resident #1's wheelchair. -If she remembered correctly, the facility's PCP service was Resident #1's PCP. -She left a voice message with the PCP service on 05/25/20. -She did not know if Resident #1 was assessed by the PCP after she fell. Telephone interview with the MCD on 06/17/20 at	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 13	D 273		

7:13am revealed:
-She supervised staff on the SCU.
-She informed staff of who the PCP was for specific residents.
-Resident #1 was no longer being treated by the facility's contracted PCP service.
-On an unknown date, she talked with the hospice RN about the hospice agency becoming Resident #1's PCP.
-The hospice agency was Resident #1's PCP at the time of Resident #1's fall on 05/25/20.
-She did not know which medical provider was notified after Resident #1's fall on 05/25/20.
-The hospice agency should have been called after Resident #1 fell on 05/25/20.
-Resident #1 should have been examined by a medical provider from the hospice agency after her fall on 05/25/20.
-The MA on duty on 05/25/20 was responsible for notifying Resident #1's PCP of Resident #1's fall.
-On an unknown date, the MCD talked with the hospice RN about Resident #1's 05/25/20 fall.

Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed:
-She supervised the MCD.
-The facility's contracted PCP service provided care for most of the residents.
-The PCP information for each resident was in the electronic medication administration record (eMAR) and in the resident's physical record.
-The MCD had talked with someone at the hospice agency about becoming Resident #1's PCP.
-The hospice agency was Resident #1's PCP; she was unsure of the effective date.
-The RCD did not know which medical provider examined Resident #1 after she fell on 05/25/20.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 14	D 273		

06/17/20 at 1:44pm revealed:
-The facility's contracted PCP service was not treating Resident #1.
-The hospice agency was Resident #1's PCP at the time of Resident #1's fall on 05/25/20.
-The hospice agency should have been notified of Resident #1's fall on 05/25/20.
-She did not know which medical provider examined Resident #1 after she fell on 05/25/20.
-The name of the PCP was in the resident record.
-The MCD updated PCP information when needed.
-The Administrator was ultimately responsible for the residents' care.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

2. Review of Resident #7's current FL-2 dated 08/08/19 revealed:
-Diagnoses included memory impairment, neurocognitive disorder, and vitamin D deficiency.
-There was an order for weekly blood pressure.

Review of Resident #7's physician order report signed and dated 11/19/19 revealed there was an order to check blood pressure once weekly and to notify the primary care provider (PCP) if the systolic blood pressure was greater than 180.

Review of Resident #7's physician order report signed and dated 06/08/20 revealed there was an order to check blood pressure once weekly and to notify the PCP if the systolic blood pressure was greater than 180.

Review of Resident #7's electronic progress notes from 04/24/20-05/26/20 revealed there were no entries related to contacting the PCP of weekly blood pressure refusals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 15 Review of a Medication/Treatment Notification dated 06/08/20 at 2:46pm revealed: -The notification was entered by the Memory Care Director (MCD). -Resident #7 refused to have his blood pressure taken on 04/13/20, 04/20/20, 05/25/20, and 06/01/20. -Resident #7's PCP was notified of the refusals on 06/08/20 while the PCP was visiting the facility. Review of a Medication/Treatment Notification dated 06/09/20 at 2:04pm revealed: -The notification was entered by the MCD. -Resident #7 refused to have his blood pressure taken on 05/11/20. -Resident #7's PCP was notified of the refusal on 06/08/20 while the PCP was visiting the facility. Review of Resident #7's electronic medication administration record (eMAR) for April 2020 revealed: -There was an entry for blood pressure weekly on Monday scheduled for 9:00am. -Resident #7's blood pressure was documented on 04/06/20. -Resident #7's blood pressure was not documented on 04/13/20, 04/20/20, and 04/27/20. Review of Resident #7's eMAR for May 2020 revealed: -There was an entry for blood pressure weekly on Monday scheduled for 9:00am. -Resident #7's blood pressure was documented on 05/04/20 and 05/18/20. -Resident #7's blood pressure was not documented on 05/11/20 and 05/25/20.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 16	D 273		

Review of Resident #7's eMAR for June 2020 revealed:
-There was an entry for blood pressure weekly on Monday scheduled for 9:00am.
-Resident #7's blood pressure was not documented on 06/01/20.

Telephone interview with a medication aide (MA) on 06/08/20 at 1:17pm revealed:
-The MA was responsible for taking blood pressures.
-If residents refused to have their blood pressure taken, they were asked two more times.
-The Memory Care Director (MCD) and the PCP were notified of refusals.
-If blood pressure was ordered weekly and refused, the MA did not attempt to get the resident's blood pressure on another day of the week; the MAs were not instructed to do so.
-The MA was responsible for informing the PCP of refusals.
-She wrote a note in the resident's record whenever she contacted the PCP about refusals.

Telephone interview with Resident #7's PCP on 06/10/20 at 4:10pm revealed:
-She was informed on 06/08/20 of the dates of Resident #7's blood pressure refusals from April 2020-June 2020.
-She expected orders to be followed as written.
-She would have expected to be notified after one or two of Resident #7's blood pressure refusals from April 2020-June 2020.

Telephone interview with the MCD on 06/17/20 at 7:13am revealed:
-She supervised staff on the SCU.
-Whenever a resident refused an order, a report was prepared by the MCD.
-The PCP was supposed to be notified when a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 17	D 273		

resident refused an order.
-Residents were asked two more times after an initial refusal.
-The MA was responsible for notifying the PCP of refusals.
-The MA was responsible for taking Resident #7's blood pressure.
-The MA would not try to get a weekly blood pressure on another day if the entry on the eMAR was scheduled at a specific day at a specific time.
-The MA should notify the PCP on the day of the resident's refusal of a weekly order.

Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed:
-Staff attempted three times before documenting a resident refused an order.
-The MA was responsible for notifying the PCP and the MCD of refusals.
-A note or a report was supposed to be entered in the resident's record.
-She was unaware if the MA attempted to get a weekly blood pressure on another day of the week.

Telephone interview with the Administrator on 06/17/20 at 1:44pm revealed:
-The MA was supposed to complete a refusal form and contact the PCP for instruction when a resident refused an order.
-The PCP should be notified after a resident missed an order twice.
-The Administrator thought Resident #7's PCP would notice the blood pressure refusals when she reviewed Resident #7's record during her visits to the facility.
-The MA was supposed to inform the MCD of refusals.
-The MA or the MCD should have informed the PCP of Resident #7's blood pressure refusals so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 273	Continued From page 18 that she could address the matter with Resident #7 during her visit to the facility -The Administrator was ultimately responsible for the residents' care. Based on record reviews and interviews, it was determined Resident #7 was not interviewable.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders for 3 of 7 sampled residents related to the application of thrombo-embolic deterrent (TED) hose (used to prevent blood clots) (#1), related to fingerstick blood sugars (FSBS) (#2) and related to laboratory findings (#4). The findings are:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 19 1. Review of Resident #1's current FL-2 dated 02/26/20 revealed: -Diagnoses included senile degeneration of brain, unspecified dementia with behavioral disturbance, generalized anxiety disorder, and major depressive disorder. -There was an order for thrombo-embolic deterrent (TED) hose (used to prevent blood clots) apply every morning and remove at bedtime twice a day at 8:00am and 8:00pm. Review of Resident #1's physician order report signed and dated 04/22/20 revealed an order for TED hose apply every morning and remove at bedtime twice a day at 8:00am and 8:00pm. Review of a subsequent primary care provider (PCP) order signed and dated on 05/27/20 revealed Resident's #1's TED hose were discontinued. Review of Resident #1's electronic medication administration record (eMAR) for April 2020 revealed: -There was an entry for TED hose need measurements apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm. -There was documentation Resident #1's TED hose were not put on 21 of 30 opportunities. Review of Resident #1's eMAR for May 2020 revealed: -There was an entry for TED hose need measurements apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm. -There was documentation Resident #1's TED hose were not put on 20 of 27 opportunities. Review of Resident #1's administration compliance report for May 2020 revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 20	D 276		

-There was documentation Resident #1's TED hose were not put on 20 of 27 opportunities.
-There was documentation Resident #1's TED hose were not put on 5 of 27 opportunities because Resident #1 refused the TED hose.
-There was documentation Resident #1's TED hose were not put on 15 of 27 opportunities for various reasons including the TED hose were not in Resident #1's room, the TED hose were reordered, staff were waiting on the pharmacy, and "due to condition."

Telephone interview with a medication aide (MA) on 06/09/20 at 11:35am revealed:
-The Memory Care Director (MCD) was responsible for measuring residents who were ordered TED hose.
-The measurements were faxed to the pharmacy.
-She had put TED hose on Resident #1 when Resident #1 was first admitted to the facility.

Telephone interview with the hospice agency registered nurse (RN) on 06/09/20 at 1:54pm revealed:
-She visited Resident #1 weekly on Wednesdays.
-She never saw Resident #1 wearing TED hose.
-She did not see TED hose in Resident #1's room.
-The TED hose were discontinued on 05/27/20 because Resident #1 did not need them anymore.

Telephone interviews with the Patient Care Manager from Resident #1's hospice agency on 06/10/20 at 9:49am revealed staff did not contact the hospice agency related to Resident #1's TED hose.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/11/20 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 21 9:33am revealed: -The pharmacy sent a form to the facility requesting Resident #1's measurements so the right size TED hose would be dispensed. -The pharmacy did not receive Resident #1's measurements. -The pharmacy did not dispense TED hose for Resident #1. Telephone interview with a second MA on 06/11/20 at 2:49pm revealed: -She had seen Resident #1 wearing TED hose on unknown dates. -The personal care aides (PCA) were responsible for putting on and taking off TED hose. Telephone interview with a third MA on 06/12/20 at 12:36pm revealed: -The MA was responsible for putting on and taking off Resident #1's TED hose. -She had put TED hose on Resident #1 multiple times. -She did not know who supplied Resident #1's TED hose. -"Not in room" meant the TED hose were either lost or in another resident's room. -"Ordered" meant the measurements were retaken. Telephone interview with a fourth MA on 06/15/20 at 4:00pm revealed: -The MA was responsible for putting on and taking off Resident #1's TED hose. -"Not in room" meant staff did not know where the TED hose were located. -"Due to condition" meant there may have been an insurance concern or the order was not right. Telephone interview with the MCD on 06/17/20 at 7:13am revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 22 -She supervised the MAs on the special care unit (SCU). -She or the MA were responsible for obtaining measurements for TED hose. -The facility's contracted pharmacy dispensed Resident #1's TED hose. -The MAs were responsible for putting on and taking off Resident #1's TED hose. -On the eMAR, "not administered due to condition" was documented if a resident was sick or if a medication or treatment was withheld based on ordered parameters. -The hospice PCP saw no need for Resident #1 to have the TED hose and therefore discontinued them. -Resident #1 had multiple pairs of TED hose. -The MCD had put TED hose on Resident #1. -The MAs most likely did not look for the TED hose if the documentation on the eMAR stated "not in room." Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed: -She supervised the MCD. -The MA was responsible for measuring residents for TED hose. -If the MA needed assistance with measuring, the MCD, RCD, or physical therapist would provide assistance. -She did not know who supplied Resident #1's TED hose. -The MAs were responsible for putting on and taking off Resident #1's TED hose. -She had seen Resident #1 wearing TED hose. Telephone interview with the Administrator on 06/17/20 at 1:44pm revealed: -"Due to condition" on the eMAR may have meant the resident was asleep when an order was to have been administered.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 23	D 276		

-No one at the facility measured for TED hose.
-The prescribing provider was responsible for measuring residents for TED hose.
-The supplier of the TED hose or the resident's family member was responsible for measuring for TED hose.
-She did not remember if she ever saw Resident #1 in TED hose.
-The PCP should have been notified by the MCD if the TED hose were not in Resident #1's room.
-She was ultimately responsible for the residents' care.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

2. Review of Resident #2's current FL-2 dated 09/13/19 revealed:
-Diagnoses included hypertension (HTN), gait impairment, diabetes mellitus (DM), schizophrenia, Parkinson's disease, insomnia, anemia and osteoarthritis (OA).
-There was an order for Novolog insulin 100 units (U)/ml (used to treat diabetes mellitus) sliding scale as follows: If fingerstick blood sugar (FSBS) is 60 to 199 give 0 units, and if (FSBS) is greater than 199 give 5 units.
-There was an order to check FSBS before meals and at bedtime.

Review of Resident #2's six- month physician orders dated 05/06/20 revealed:
-There was an order dated 05/06/20 to check FSBS before meals and at bedtime and to notify primary care provider (PCP) if FSBS is greater than 500.
-There was an order dated 05/06/20 to check and record FSBS before meals and at bedtime and inject Novolog insulin 100 units (U)/ml sliding scale as follows: If FSBS is 60 to 199 give 0 units,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 24 and if FSBS is greater than 199 give 5 units. Review of Resident #2's May 2020 eMARs revealed: -There was an entry to check and record FSBS before meals and at bedtime, scheduled for 8:00 am, 12:00 pm, 5:00 pm and 8:00 pm. -There was no documentation of FSBS on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm. -There was documentation on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm. which read, "not administered: due to condition." -The FSBS results ranged from 97 to 346. Telephone interview with a medication aide (MA) on 06/16/20 at 2:37 pm revealed: -Resident #2 had run out of test strips and lancets in May 2020. -He worked on 05/17/20 and 05/25/20 and lancets or test strips were not available for Resident #2. -He also documented "not administered due to condition" on the Compliance Report on the eMAR for May 2020 which meant lancet or test strips were not available to do the FSBS readings for Resident #2. -He had also borrowed lancets or strips from other residents when Resident #2 ran out of test strips or lancets. -He had notified the Resident Care Coordinator (RCC), but he did not recall the date. -He did not know who was responsible for ordering the lancets and test strips.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 25	D 276		

Telephone interview with Resident #2 on 06/12/20 at 11:06 am revealed:
-She was a diabetic and her FSBS checks were done 3 to 4 times per day.
-Staff was responsible for doing her FSBS checks.

Telephone interview with a medical supply technician on 06/15/20 at 4:22 pm revealed:
-There had been a lapse of ordering times between April 2020 and May 2020 for lancets and test strips at the medical supply company.
-The order for April 2020 was placed by the facility on 04/20/20 and delivered to the facility on 04/23/20.
-The order for May 2020 was placed by the facility on 05/26/20 and delivered to the facility on 05/27/20.
-The staff at the facility was responsible for ordering the lancet and test strips.
-The staff at the medical supply sent the order out the next business day.

Telephone interview with Resident #2's PCP on 06/16/20 at 5:33 pm revealed:
-She was not sure if the staff notified her about Resident #2's FSBS checks not being done due to no lancets or test strips at the facility for the resident.
-The staff usually notified her when FSBS checks were not done for Resident #2.
-There would be no outcome if Resident #2's FSBS had not been completed 4 times a day.

Telephone interview with the RCC on 06/17/120 at 2:25 pm revealed:
-The MAs usually notified her if lancets and test strips were running low.
-She did not remember if she was notified if the lancets or test strips were running low in May

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 26	D 276		

2020.
-If lancets or test strips were not available, they were documented on the e-MAR as "not administered due to condition"
-She was responsible for ordering the lancets and test strips from the medical supply store once a month.

Telephone interview with the Administrator on 06/17/20 at 3:24 pm revealed:
-She did not know Resident #2's FSBS checks were not done because lancets or test strips were not available.
-The MA should notify the RCC when 2 boxes of lancets and test strips were left.
-The RCC was responsible for ordering lancet and test strips monthly from the medical supply store.
-There would be no way to know if Resident #2 required sliding scale insulin if they could not obtain FSBS.

3. Review of Resident #4's current FL-2 dated 05/28/20 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure, chronic pain, paroxysmal atrial fibrillation, chronic combine systolic, diastolic heart failure, gastroesophageal reflux disease (GERD) and chronic kidney disease.

Review of Resident #4's physician order dated 04/23/20 revealed an order to repeat hemoglobin and hematocrit in two weeks from the office visit.

Review of Resident #4's laboratory results dated 05/27/20 revealed:
-There was documentation of hemoglobin test result which read hemoglobin down to 7.5 from 8.9 on 05/09/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 27 -There was no documentation of hematocrit test results. Telephone interview with a medication aide (MA) on 06/16/20 at 10:02 am revealed: -The MA did not know about the lab orders dated 04/23/20 for Resident #4. -If the MA had known, she would have notified the Resident Care Coordinator (RCC) about the lab order for Resident #4. -The RCC was responsible for scheduling the lab work. Telephone interview with a second MA on 06/16/19 at 2:37 pm revealed. -The MA did not know about the lab orders dated 04/23/20 for Resident #4. -If the MA had known, he would have notified the RCC about the order for Resident #4. -The RCC was responsible for making sure labs for residents were done. Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/15/20 at 11:36 am and 06/16/20 at 11:31 am was unsuccessful. Telephone interview with the RCC on 06/17/20 at 2:25 pm revealed: -She knew about Resident #4's orders for labs dated 04/23/20. -The labs were not done because Resident #4 was in rehab. -The process was for the MA to notify the RCC. -She was responsible for contacting the transportation staff to get available times to take residents to the lab. -The resident's appointment at the lab was based on the availability of the transportation staff. Telephone interview with the Administrator on	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 276	Continued From page 28 06/17/20 at 3:24 pm revealed: -She did not know the lab work for Resident #4's hematocrit had not been done. -The MA should notify the RCC if a resident required lab work. -The RCC was responsible for contacting the transportation staff to get available times to take the residents' to the lab. -The resident's appointment at the lab was based on the availability of the transportation staff. - If the lab was not drawn, residents would not get the treatment based on the laboratory results.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 344	Continued From page 29	D 344		

facility failed to ensure clarification of physician's orders for 1 of 7 sampled residents (Resident #4) regarding an order for a diuretic.

The findings are:

Review of Resident #4's current FL-2 dated 05/28/20 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), acute respiratory failure, chronic pain, paroxysmal atrial fibrillation, chronic combine systolic, diastolic heart failure, gastroesophageal reflux disease (GERD) and chronic kidney disease.
-There was an order for Bumex (diuretic) 1 mg 1 tablet twice daily for 48 hours.

Review of a physician's discharge order from rehab dated 05/27/20 revealed an order to start Bumex 2 mg twice daily for 2 days and then 1 mg BID.

Review of a physician order dated 06/11/20 revealed an order for Bumex 1 mg daily.

Review of Resident #4's May 2020 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for Bumex tablet 1 mg by mouth X 48 hours, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration from 05/30/20 to 05/31/20 at 8:00 am and 8:00 pm.

Review of Resident #4's June 2020 eMARs revealed:
-There was an entry for Bumex tablet 1 mg by mouth X 48 hours, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 344	Continued From page 30 06/01/20 to 06/01/20 at 8:00 am and 8:00 pm. Telephone interview with Resident #4 on 06/12/20 at 2:06 pm revealed: -She went from 06/02/20 to 06/09/20 without her medication to prevent her legs from swelling. -She had swelling in her legs because her "medication" to prevent swelling was not available. -She took medication in rehab to prevent swelling in her legs, but her discharge orders were not at the facility. -The staff did not have an order for the medication. -She had an appointment with her physician on 06/09/20, and the physician realized the Bumex did not follow the rehab order for Bumex because the resident's Bumex had stopped on 06/01/20. -She just started taking the Bumex again. -She wore a brace to prevent the bone in her knee from going the wrong way when she bent her knee. -She could not wear her brace until the swelling went down in her legs. Telephone interview with a personal care aide (PCA) on 06/15/20 at 10:13 am revealed: -Resident #4 had the swelling in her legs before she went to the hospital. -Resident #4's legs were "kind of swollen" after she came back from the hospital. -Resident #4 took a "water pill" to help with the swelling in her legs. -Resident #4 was not wearing a brace now. Telephone interview with the facility's contracted pharmacist on 06/15/20 at 2:14 pm revealed: -Resident #4's FL-2 was received by the pharmacy on 05/29/20 and 4 tablets of Bumex were dispensed.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 344	Continued From page 31 -The next order for Bumex was received by the pharmacy on 06/09/20 and 30 tablets of Bumex were dispensed. -If Resident #4 did not receive Bumex, her blood pressure could be higher than normal due to more fluid in her system -There would be no long-term side effect from missing the Bumex. Telephone interview with a medication aide (MA) on 06/16/20 at 10:02 am revealed: -She did not know about the Bumex order on the discharge order dated 05/27/20 and the FL-2 dated 05/28/20 not matching for Resident #4. -If she had been working on 05/29/20, she would have notified the physician within an hour of receiving the order. -If there was a difference between the rehab discharge order dated 05/27/20 and the FL-2 order dated 05/28/20, the orders should have been clarified. -The MA or the Resident Care Coordinator (RCC) was responsible for clarifying the orders. Telephone interview with the RCC on 06/17/20 at 2:25 pm revealed: -She did know the discharge order from Rehab dated 05/27/20 did not match the FL-2 dated 05/28/20. -She followed the FL-2 because it was the latest order. -The PCP had a teleconference with Resident #4 on 06/09/20. and she restarted Resident #4's Bumex because the initial order was never processed. Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/15/20 at 11:36 am and 06/16/20 at 11:31 am was unsuccessful.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 344	Continued From page 32 Telephone interview with the Administrator on 06/17/20 at 3:24 pm revealed: -She did not know the discharge orders for Bumex and the FL-2 orders for Bumex for Resident #4 had not been clarified. -Her expectation will be the MA or RCC should have clarify the order within the same day.	D 344		
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 B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure the administration of medication in accordance with the orders of a licensed prescribing practitioner for 3 of 7 sampled residents related to medication for the treatment of pain and anxiety (#1), a resident not receiving sliding scale insulin based on parameters (#2), and medication for the treatment of vitamin D deficiency (#3). The findings are:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 33	D 358		

1. Review of Resident #1's current FL-2 dated 02/26/20 revealed diagnoses included senile degeneration of brain, unspecified dementia with behavioral disturbance, generalized anxiety disorder, and major depressive disorder.

a. Review of Resident #1's FL-2 dated 02/26/20 revealed there was an order for hydrocodone-acetaminophen (a narcotic pain reliever) 5-325mg take ½ tablet three times daily.

Review of Resident #1's physician order report signed and dated 04/22/20 revealed there was an order for hydrocodone-acetaminophen 5-325mg take ½ tablet three times daily.

Review of Resident #1's electronic medication administration record (eMAR) for May 2020 revealed:
-There was an entry for hydrocodone-acetaminophen 5-325mg take ½ tablet three times daily scheduled for administration at 9:00am, 1:00pm, and 9:00pm.
-From 05/22/20-05/26/20, Resident #1 missed 13 doses of hydrocodone-acetaminophen.

Review of Resident #1's medication administration compliance report for May 2020 revealed:
-There were 13 entries related to the missed doses of hydrocodone-acetaminophen 5-325mg from 05/22/20-05/26/20.
-The hydrocodone-acetaminophen was not documented as administered because staff were waiting for delivery from the facility's contracted pharmacy.

Review of Resident #1's May 2020 controlled substance report revealed:
-The last available hydrocodone-acetaminophen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 34 5-325mg dose was administered on 05/22/20 during the 8:00am medication administration time. -There were 84 doses of hydrocodone-acetaminophen 5-325mg documented as received and available for administration on 05/26/20 at 3:09pm by the Memory Care Director (MCD). Review of Resident #1's electronic progress notes revealed there were no entries documented for May 2020 related to contacting Resident #1's primary care provider (PCP) regarding the missed doses of hydrocodone-acetaminophen 325-5mg. Telephone interviews with a medication aide (MA) on 06/08/20 at 12:08pm and 06/12/20 at 12:36pm revealed: -The medication blister pack had a reminder to request a refill of the medication on the eighth day before the medication ran out. -She would send the pharmacy a fax to request a medication refill or she would inform the hospice registered nurse (RN) that medication was needed for Resident #1. -She informed the MCD whenever a medication was not on hand. -She could not remember why she did not give Resident #1 the hydrocodone-acetaminophen 5-325mg in May 2020. -On an unknown date, she told the hospice RN that Resident #1 did not receive the hydrocodone-acetaminophen. -Resident #1's hydrocodone-acetaminophen had to be reordered on 05/22/20. -On an unknown date, she spoke with a representative at the facility's contracted pharmacy about Resident #1's hydrocodone-acetaminophen and was informed about an outstanding balance due.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 35 -She informed the hospice RN and the hospice RN called the pharmacy about the outstanding balance due. -She entered an electronic note whenever she contacted the PCP. Telephone interviews with a second MA on 06/09/20 at 11:35am and 2:40pm revealed: -She always informed the MCD when Resident #1's medication was not available for administration. -She thought the missed hydrocodone-acetaminophen in late May 2020 may have been related to an insurance matter. -The MCD would know more about this matter. Telephone interview with the hospice RN on 06/09/20 at 1:54pm revealed she was not told about Resident #1's missed doses of hydrocodone-acetaminophen in late May 2020. Telephone interview with the Patient Care Manager of the hospice provider on 06/10/20 at 9:49am revealed: -The provider did not receive any calls from staff in May 2020 regarding Resident #1's hydrocodone-acetaminophen order. -The provider would have assisted with obtaining the hydrocodone-acetaminophen on the same day if staff would have informed the agency. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/11/20 at 9:33am revealed: -Hydrocodone-acetaminophen could be dispensed up to five days in advance of when the available medication on hand was to run out. -The hydrocodone-acetaminophen 5-325mg dispensed in April 2020 was enough to last Resident #1 until 05/21/20.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 36 -The pharmacy received an electronic order for hydrocodone-acetaminophen 5-325mg from the hospice physician on 05/26/20. Telephone interview with a nurse practitioner (NP) from the hospice provider on 06/11/20 at 10:21am revealed Resident #1 would have experienced uncontrolled pain and distress as a result of not receiving the hydrocodone-acetaminophen as ordered. Telephone interview with a third MA on 06/11/20 at 2:49pm revealed: -If a medication was not available for a second time when she was supposed to administer it, she would fax a refill request to the pharmacy. -She did not fax a refill request to the pharmacy for Resident #1's hydrocodone-acetaminophen. -Resident #1 may have needed a new order to be written before the hydrocodone-acetaminophen was dispensed in late May 2020. -She did not know how many doses were allowed to be missed before staff were required to notify the primary care provider (PCP). -She did not contact the PCP about Resident #1's hydrocodone-acetaminophen order. -She routinely notified the MCD when she had concerns about a resident's medication. -She did not recall talking to the MCD about Resident #1's hydrocodone-acetaminophen order in May 2020. Telephone interview with a second pharmacist from the facility's contracted pharmacy on 06/15/20 at 4:31pm revealed: -The pharmacy did not receive a refill request for hydrocodone-acetaminophen 5-325mg from the facility in late May 2020. -The pharmacy routinely notified facility staff by phone or fax when a new order was needed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 37	D 358		

before a medication would be dispensed.
-She was unable to access information related to communication with the facility staff or the PCP.
-In late May 2020, there were no refills available from the previous order.
-A new order was required before the hydrocodone-acetaminophen 5-325mg tablets would be dispensed in late May 2020;

Telephone interview with the MCD on 06/17/20 at 7:13am revealed:
-She should have known Resident #1's hydrocodone-acetaminophen was not available for administration after she completed the medication cart audit.
-She must have missed it when she performed the weekly cart audit.
-Resident #1 did not display any changes in behavior as a result of not receiving the hydrocodone-acetaminophen as ordered from 05/22/20-05/26/20.

Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed she was not aware of any reports of Resident #1 displaying any changes in behavior as a result of not receiving the hydrocodone-acetaminophen as ordered from 05/22/20-05/26/20.

Telephone interview with the Administrator on 06/17/20 at 1:44pm revealed she was unaware Resident #1 was not administered 13 doses of hydrocodone-acetaminophen from 05/22/20-05/26/20.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

Refer to the telephone interview with a nurse practitioner (NP) from the hospice provider on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 38 06/11/20 at 10:21am. Refer to the telephone interview with the MCD on 06/17/20 at 7:13am. Refer to the telephone interview with the RCD 06/17/20 at 10:05am. Refer to the telephone interview with the Administrator on 06/17/20 at 1:44pm. Refer to the telephone interview with the Regional registered nurse (RN) on 06/17/20 at 4:25pm. b. Review of Resident #1's FL-2 dated 02/26/20 revealed there was an order for lorazepam (a controlled substance used to treat anxiety) 1mg twice daily. Review of Resident #1's physician order report signed and dated 04/22/20 revealed there was an order for lorazepam 1mg twice daily. Review of Resident #1's electronic medication administration record (eMAR) for May 2020 revealed: -There was an entry for lorazepam 1mg twice daily scheduled for administration at 8:00am and 8:00pm. -From 05/01/20-05/06/20, Resident #1 missed eight doses of lorazepam. -There was documentation lorazepam 1mg was administered on 05/02/20 at 8:00am and 05/05/20 at 8:00am. Review of Resident #1's medication administration compliance report for May 2020 revealed: -There were eight entries from 05/01/20-05/06/20 documented as "waiting on MD approval,"	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 39	D 358		

"waiting on hospice approval," or "due to condition" related to the missed doses of lorazepam.

Review of Resident #1's May 2020 controlled substance report revealed:
-The last available lorazepam 1mg dose was administered on 05/01/20 during the 8:00am medication administration.
-Lorazepam 1mg was administered on 05/02/20 during the 8:00am medication administration; the balance available after the administration was -1.
-One lorazepam 1mg tablet was entered as received on 05/02/20 at 3:11pm by a medication aide (MA); the balance available after the entry was 0.
-Lorazepam 1mg was administered on 05/05/20 during the 8:00 medication administration; the balance available after the administration was -1.
-One lorazepam 1mg tablet was entered as received on 05/05/20 at 2:52pm by the MCD; the balance available after the entry was 0.
-Thirty doses of lorazepam 1mg were entered as received and available for administration on 05/06/20 at 2:42pm by the Memory Care Director (MCD).

Telephone interview with the Memory Care Director (MCD) on 06/17/20 at 7:13am revealed:
-The MA made an error when documenting lorazepam had been administered on 05/02/20 and 05/05/20.
-The controlled substance report was corrected as a result of the MA's errors on 05/02/20 and 05/05/20.

Review of Resident #1's electronic progress notes revealed there were no entries in May 2020 related to contacting Resident #1's primary care provider (PCP) regarding the order for lorazepam

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 40	D 358		

1mg.

Telephone interview with a MA on 06/12/20 at 12:36pm revealed the medication bubble pack had a reminder to request a refill of the medication on the eighth day before the medication ran out.

Telephone interview with the Patient Care Manager at the hospice provider on 06/11/20 at 9:21am revealed:
-Any calls from the facility staff would be directed to her.
-She did not receive any calls in May 2020 from the facility staff related to Resident #1's lorazepam 1mg order.

Telephone interview with the hospice provider registered nurse (RN) on 06/11/20 at 9:28am revealed:
-She was not informed Resident #1's lorazepam 1mg was not available for administration in early May 2020.
-Resident #1 needed the lorazepam 1mg because she would get agitated as a result of her disease process.

Telephone interview with a nurse practitioner (NP) from the hospice provider on 06/11/20 at 10:21am revealed Resident #1 would have demonstrated agitation and distress by crying and yelling as a result of not receiving the lorazepam as ordered.

Telephone interview with a second MA on 06/15/20 at 4:00pm revealed:
-He audited both medication carts in the special care unit (SCU) every Thursday night.
-He made sure the medication available for administration matched the orders on the eMAR.
-If the medication did not match, he gave a note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 41	D 358		

to the MCD.
-If a medication was not available for administration, he called the pharmacy and then entered a note in the resident's record.
-If a medication was documented as not administered "due to condition," it meant there was an insurance concern or the order was incorrect.
-In early May 2020, there was difficulty obtaining Resident #1's lorazepam; a new order was required before the pharmacy would dispense the medication.
-If a medication required a new order before it would be refilled by the pharmacy, he called the PCP to obtain an order; the PCP would send an electronic order to the pharmacy.
-He did not call the PCP about the lorazepam order.
-He talked with the MCD about the lack of lorazepam 1mg "when it first happened."
-He did not know when, but one of the hospice provider RNs made an urgent request for a new order to the hospice physician.
-Resident #1 had no changes in behavior as a result of not receiving the lorazepam as ordered from 05/01/20-05/06/20.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/16/20 at 2:03pm revealed:
-The pharmacy received a refill request for lorazepam 1mg from the facility on 05/05/20.
-The lorazepam 1mg was dispensed on 05/05/20.

Telephone interview with the MCD on 06/17/20 at 7:13am revealed:
-On the eMAR, "not administered due to condition" was documented if a resident was sick or if a medication or treatment was withheld based on ordered parameters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 42	D 358		

-She was not informed by the MA that Resident #1's lorazepam 1mg was not available for administration.
-She sent a text message to the hospice RN on 05/05/20 letting her know that lorazepam 1mg was not available for administration.
-Resident #1 had no changes in behavior as a result of not receiving the lorazepam as ordered from 05/01/20-05/06/20.

Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed:
-She could not recall anything related to Resident #1's lorazepam order in late May 2020.
-The MCD would have more information about Resident #1's lorazepam order.
-She was not aware of any reports of Resident #1 displaying any changes in behavior as a result of not receiving the lorazepam as ordered from 05/01/20-05/06/20.

Telephone interview with the Administrator on 06/17/20 at 1:44pm revealed:
-Resident #1's lack of lorazepam 1mg available for administration in early May 2020 may have been related to an insurance matter, but she was not sure.
-The MCD should have called the PCP to resolve the situation related to Resident #1's lorazepam order.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

Refer to the telephone interview with a nurse practitioner (NP) from the hospice provider on 06/11/20 at 10:21am.

Refer to the telephone interview with the MCD on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 43 06/17/20 at 7:13am. Refer to the telephone interview with the RCD 06/17/20 at 10:05am. Refer to the telephone interview with the Administrator on 06/17/20 at 1:44pm. Refer to the telephone interview with the Regional registered nurse (RN) on 06/17/20 at 4:25pm. _____ Telephone interview with a nurse practitioner (NP) from the hospice provider on 06/11/20 at 10:21am revealed: -Administering scheduled medication as ordered to a resident diagnosed with dementia was crucial because residents diagnosed with dementia could not request supplemental medication if it was needed. -The MA was not able to assess if a resident required a dose of supplemental medication if it was needed. Telephone interview with the MCD on 06/17/20 at 7:13am revealed: -She audited the electronic medicaton administration record (eMAR) on Thursday nights. -She compared the orders with the entries on the eMAR and with the medication available for administration. -She made sure all ordered medication was available on the medication cart. -There was a reminder on the medication blister pack for staff to request a refill when there were eight doses remaining. -The MA was responsible for faxing a refill request to the pharmacy. -The MA could tell if a medication refill had been requested by checking for notes in the resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 44 record or by checking for a fax verification in the fax notebook. -If a medication was not available on the medication cart, she made sure there was an order for it and requested the medication from the pharmacy. -The pharmacy would deliver the requested medication on the night the medication was requested. -The pharmacy informed staff if a new order was needed. -The MA would let her know when a new order was needed and she would notify the provider to obtain an order. Telephone interview with the Resident Care Director (RCD) on 06/17/20 at 10:05am revealed: -If a medication was not available for administration, the MA was supposed to notify the pharmacy and the MCD. -When a new order was needed before a medication would be dispensed by the pharmacy, the MCD notified the PCP to obtain an order. -The medication blister pack had a reminder to request a refill when 8-10 doses of a medication remained. -The MA was supposed to remove the sticker from the blister pack and fax it to the pharmacy to request the refill. -The fax confirmation was supposed to be given to the MCD. -Staff could see if a medication refill had been requested by observing that the sticker was no longer on the blister pack or by calling the pharmacy to verify a refill had been requested. -The MCD was responsible for performing weekly cart and eMAR audits. -The eMAR was checked by the MCD as new orders were added to the eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 45	D 358		

-The MCD notified her most of the time when there were concerns about residents' medication.
-The MCD was directly responsible for medication administration on the SCU.

Telephone interview with the Administrator on 06/17/20 at 1:44pm revealed:
-There was a reminder on the medication blister pack to request a refill when there were 8-10 doses remaining.
-The MA was responsible for requesting refills from the pharmacy.
-If the sticker had been removed from the medication blister pack it meant a refill had been requested.
-The MA was responsible for notifying the MCD or the DRC if a medication was not available on the medication cart.
-If a medication was not available on the medication cart, the MCD was responsible for contacting the PCP and getting an updated order.
-The MA should notify the PCP when two doses of a medication have been missed.
-The MCD performed weekly eMAR and medication cart audits.

Telephone interview with the Regional registered nurse (RN) on 06/17/20 at 4:25pm revealed the MA was supposed to notify the pharmacy and the MCD when medication was not available for administration.

2. Review of Resident #3's current FL-2 dated 02/21/20 revealed diagnoses included acute upper gastrointestinal bleeding, hyperkalemia, hypertension, and advanced Alzheimer's dementia.

Review of Resident #3's physician's order dated 03/18/20 revealed an order for Vitamin D3 50,000

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 46	D 358		

units once weekly for eight weeks. (Vitamin D is a vitamin supplement).

Review of Resident #3's March 2020, April 2020, and May 2020 Medication Administration Record (eMAR) revealed there was no computer-generated entry for Vitamin D3 50000 units weekly and no documentation of administration.

Telephone interview with a medication aide (MA) on 06/04/20 at 1:47pm revealed there were no Vitamin D3 50,000 units available to be administered for Resident #3.

Telephone interview with a Pharmacy Technician with the facility's contracted pharmacy on 06/04/20 at 4:30pm revealed:
-Four tablets of Vitamin D3 50,000 units were dispensed on 03/18/20 with directions to be administered weekly for 8-weeks and would have lasted for 4-weeks.
-There was no other dispensing for Vitamin D3 50,000 units for Resident #3.
-Vitamin D3 50,000 units were not cycle filled and would need to be reordered for the remaining four doses.

Telephone interview with a medication aide (MA) on 06/09/20 at 11:27am revealed:
-She only administered medications that were scheduled on the eMAR.
-She only pulled the medications scheduled to be administered.
-She did not recall if Resident #3 had Vitamin D3 50,000 units scheduled to be administered weekly.
-If Resident #3's Vitamin D3 50,000 units were on the eMAR she administered the medication but if it was not listed on the eMAR she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 47	D 358		

administer the medication.
-The Memory Care Director (MCD) was responsible for medication cart audits and she did not know the process.

Telephone interview with the MCD on 06/05/20 at 12:07pm revealed:
-The pharmacy entered new medication orders into the eMAR system.
-She sent Resident #3's order for Vitamin D3 50,000 units weekly to the pharmacy on 03/18/20.
-She would have been responsible to make sure the order was on the eMAR; she did not recall if she had checked or not.
-If there was a medication on the cart that was not on the eMAR she expected the MA to tell her.
-She did not recall being told anything about Resident #3's Vitamin D3 50,000 units not being listed on the eMAR.
-Medication could not be administered if it was not on the eMAR.
-Cart audits were completed by the third shift MA weekly.
-Cart audits were completed using the physician's orders from that day.
-Notes related to any discrepancies between medications on hand and eMARs were made on the physician's orders and given to her.

Telephone interview with a third shift MA on 06/09/20 at 3:33pm revealed:
-He used the active physician's orders to complete cart audits.
-If there was medication on the medication cart that was not on the current order, he would remove the medication from the medication cart, make a note on the physician's orders and provide the information to the MCD.
-He did not recall if Resident #3 had Vitamin D3 50,000 units on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 48 Second telephone interview with the MCD on 06/10/20 at 2:52pm revealed: -The pharmacy staff entered orders into the eMAR system. -She was responsible for making sure the Vitamin D3 50,000 weekly for 8-weeks order had been entered in the eMAR and she did not realize the order had not been transcribed onto the eMAR. -When the medication was delivered to the facility, the MA should have contacted the pharmacy and notified her the medication order had not been transcribed onto the eMAR.. -She did not recall anyone telling her the order for Vitamin D3 50,000 units was not on the eMAR. -The medication was not returned to the pharmacy during "that time period" due to the COVID-19 virus. -The Vitamin D3 would have been wasted because medications were not sent back to the pharmacy due to the COVID-19 virus; they did not have a record of wasted medication. Telephone interview with Resident #3's primary care provider (PCP) on 06/10/20 at 4:16pm revealed: -Vitamin D3 was ordered for Resident #3 as a preventive medication for the COVID 19 virus. -She expected medication to be administered as ordered. -She was not concerned Resident #3 did not receive Vitamin D3 50,000 for 8-weeks. Review of three weekly cart audits for Resident #3 from 03/23/20-04/23/20 revealed no notation of Vitamin D3 50,000 units available on the medication cart. Telephone interview with the Resident Care Director (RCD) on 06/12/20 at 8:31am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 49 -She was not aware Resident #3 did not receive her Vitamin D3 50,000 units as ordered. -Orders written by the PCP were faxed to the pharmacy by the MCD. -The MCD was responsible for making sure the medication was added into the eMAR by pharmacy staff. -If the medication was not added into the eMAR, the MCD could add the order onto the eMAR and notify the pharmacy. -When the medication was delivered to the facility, it was checked in by the MA on duty, and verified there was a current order for the medication and the medication delivered matched the order. -If the medication was not on the medication cart the MA should have called the pharmacy and verified there was an order and had the pharmacy staff or the care manager add the medication order into the eMAR. -Medication cart audits were being done but were behind because of the change in responsibilities with the current Covid-19 crisis, including covering shifts when staff were out, assisting with meals in residents rooms, washing clothes for residents whose family usually did the laundry, making sure residents had increased socialization due to no visitors being allowed into the facility, and special events such as birthdays were recognized, among many other tasks. -She was concerned the MAs needed additional training and education to make sure they knew the process. Telephone interview with the Administrator on 06/12/20 at 9:13am revealed: -She was not aware Resident #3 did not receive her Vitamin D3 50,000 units as ordered. -The MCD and MAs were ultimately responsible for medication administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 50 Based on interview and record review, it was determined Resident #3 was not interviewable. 3. Review of Resident #2's current FL-2 dated 09/13/19 revealed: -Diagnoses included hypertension (HTN), gait impairment, diabetes mellitus (DM), schizophrenia, Parkinson's disease, insomnia, anemia and osteoarthritis (OA). -There was an order for Novolog insulin 100 units (U)/ml (used to treat diabetes mellitus) sliding scale as follows: If fingerstick blood sugar (FSBS) was 60 to 199 give 0 units, and if FSBS was greater than 199 give 5 units. -There was an order to check FSBS before meals and at bedtime. Review of Resident #2's six- month physician orders dated 05/06/20 revealed: -An order dated 05/06/20 to check FSBS before meals and at bedtime and to notify primary care provider (PCP) if FSBS was greater than 500. -There was an order dated 05/06/20 to check and record FSBS before meals and at bedtime and inject Novolog 100 units (U)/ml sliding scale (SSI) as follows: If FSBS was 60 to 199 give 0 units, and if FSBS was greater than 199 give 5 units. Review of Resident #2's May 2020 Electronic Medication Administration Records (eMARs) revealed: -There was an entry to check and record FSBS before meals and at bedtime, scheduled for 8:00 am, 12:00 pm, 5:00 pm and 8:00 pm. -There was no documentation of FSBS on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 51	D 358		

-There was documentation on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm which read, "not administered: due to condition."
-It could not be determined if Novolog SSI should have been administered on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm without the FSBS results.
-The FSBS results ranged from 97 to 346.

Telephone interview with a medication aide (MA) on 06/16/20 at 2:37 pm revealed:
-Resident #2 had run out of test strips and lancets in May 2020.
-He worked on 05/17/20 and 05/25/20 and lancets or test strips were not available.
-He documented "not administered due to condition" on the Compliance Report on the eMAR for May 2020 which meant lancets or test strips were not available to do the blood sugar reading for Resident #2.
-He had notified the Resident Care Coordinator (RCC), but he did not recall the date.
-He did not know who was responsible for ordering the lancets and test strips.

Telephone interview with the facility's contracted pharmacist on 06/15/20 at 2:14 pm revealed:
-There would be no way to know if Resident #2 required sliding scale insulin because the staff could not obtain FSBS checks without the availability of lancets or test strips.
-It could not be determined if Novolog SSI should have been administered on 05/17/20 at 12:00 pm, on 05/22/20 at 12:00 pm, on 05/23/20 at 5:00 pm and 8:00 pm, on 05/24/20 at 12:00 pm, 5:00 pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 52	D 358		

and 8:00 pm, on 05/25/20 at 8:00 am and 12:00 pm without the FSBS results.
-There would be no long-term side effects for Resident #2 from missing the sliding scale insulin.

Telephone interview with Resident #2's primary care provider (PCP) on 06/16/20 at 5:33 pm revealed
-She was not sure if the staff notified her about Resident #2's FSBS checks not being done due to no lancets or test strips available for Resident #2.
-The staff usually notified her when blood sugar checks were not done for Resident #2.
-There would be no way to know if Resident #2 required SSI when the FSBS was not obtained.
-There would be no outcome if Resident #2 missed her FSBS checks.

Telephone interview with the RCC on 06/17/120 at 2:25 pm revealed:
-The MAs usually notified her if lancets and test strips were running low.
-She did not remember if she was notified of the lancets or test strips were running out in May 2020.
-If lancets or test strips were not available, it would be documented on the e-MAR as "not administered due to condition"
-She was responsible for ordering the lancets and test strips from the medical supply store once a month.
-Effective 06/17/20, she would go out to the local medical supply and buy lancet and test strips if lancet and test strips are low or not available.
-The system in place was that lancets or test strips were ordered once a month.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 358	Continued From page 53 06/17/20 at 3:24 pm revealed: -She did not know Resident #2's FSBS were not done because lancets or test strips were not available. -The MA should notify the RCC when 2 boxes of lancets and test strips were left. -The RCC was responsible for ordering lancets and test strips monthly from the medical supply store. -The RCC could also go to the local medical supply store and buy lancets or test strips for the residents. -There would be no way to know if Resident #2 required sliding scale insulin. The facility failed to administer medications as ordered by the licensed provider resulting in a hospice resident diagnosed with dementia not receiving 13 sequential doses of a narcotic pain medication and 10 sequential doses of an anti-anxiety medication (#1); and a resident not receiving sliding scale insulin based on parameters (#2). The facility's failure was detrimental to the health and welfare of the residents and constitutes a Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/17/20 for this violation.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 54 training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the Special Care Unit (SCU) with a census of 43 to 45 were met for 28 of 42 shifts sampled from 05/24/20 to 06/07/20. The findings are: Review of the facility's current license effective January 1, 2020 revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of sixty beds. Review of the facility's Resident Bed List Report dated 05/24/20 and 05/25/20 revealed there was a SCU census of 45 residents, which required 45 staff hours on first and second shift and 36 staff hours on third shift. Review of the individual employee time cards from 05/24/20 to 05/25/20 revealed: -On 05/24/20, there was a total of 37.66 staff hours provided on first shift with a shortage of 7.34 hours. -On 05/24/20, there was a total of 35.52 staff hours provided on second shift with a shortage of 9.48 hours. -On 05/25/20, there was a total of 40.07 staff hours provided on first shift with a shortage of 4.93 hours.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 55 -On 05/25/20, there was a total of 31.57 staff hours provided on third shift with a shortage of 4.43 hours. Review of the facility's Resident Bed List Report dated 05/26/20, 05/27/20, 05/28/20, and 05/29/20 revealed there was a SCU census of 44 residents, which required 44 staff hours on first and second shift, and 35 staff hours on third shift. Review of the individual employee time cards from 05/26/20 to 05/29/20 revealed: -On 05/26/20, there was a total of 38.31 staff hours provided on first shift with a shortage of 5.69 hours. -On 05/26/20, there was a total of 42.33 staff hours provided on second shift with a shortage of 1.67 hours. -On 05/26/20, there was a total of 32.57 staff hours provided on third shift with a shortage of 2.63 hours. -On 05/28/20, there was a total of 42.26 staff hours provided on first shift with a shortage of 1.74 hours. -On 05/28/20, there was a total of 42.765 staff hours provided on second shift with a shortage of 1.23 hours. -On 05/29/20, there was a total of 32.11 staff hours provided on third shift with a shortage of 3.09 hours. Review of the facility's Resident Bed List Report dated 05/30/20 and 05/31/20 revealed there was a SCU census of 43 residents, which required 43 staff hours on first and second shift, and 34 staff hours on third shift. Review of the individual employee time cards from 05/30/20 to 05/31/20 revealed: -On 05/30/20, there was a total of 30.19 staff	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 56	D 465		

hours provided on first shift with a shortage of 4.06 hours.
-On 05/31/20, there was a total of 35.73 staff hours provided on first shift with a shortage of 7.27 hours.
-On 05/31/20, there was a total of 40.19 staff hours provided on second shift with a shortage of 2.81 hours.
-On 05/31/20, there was a total of 31.13 staff hours provided on third shift with a shortage of 3.27 hours.

Review of the Resident Bed List Report dated 06/01/20 revealed there was a SCU census of 43 residents, which required 43 staff hours on first and second shift, and 34.4 hours on third shift.

Review of the individual employee time cards dated 06/01/20 revealed:
-There were 32.54 staff hours provided on first shift leaving the shift short 10.46 staff hours.
-There were 41.37 staff hours provided on second shift leaving the shift short 1.63 staff hours.

Review of the Resident Bed List Report dated 06/02/20 revealed there was a SCU census of 43 residents, which required 43 staff hours on first and second shift, and 34.4 hours on third shift.

Review of the individual employee time cards dated 06/02/20 revealed:
-There were 30.34 staff hours provided on second shift leaving the shift short 12.66 staff hours.
-There were 28.3 staff hours provided on third shift leaving the shift short 6.1 staff hours.

Review of the Resident Bed List Report dated 06/03/20 revealed there was a SCU census of 43

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 57	D 465		

residents, which required 43 staff hours on first and second shift, and 34.4 hours on third shift.

Review of the individual employee time cards dated 06/03/20 revealed:
-There were 32.39 staff hours provided on first shift leaving the shift short 11.61 staff hours.
-There were 33.98 staff hours provided on second shift leaving the shift short 9.02 staff hours.

Review of the Resident Bed List Report dated 06/04/20 revealed there was a SCU census of 44 residents, which required 44 staff hours on first and second shift, and 35.2 hours on third shift.

Review of the individual employee time cards dated 06/04/20 revealed:
-There were 41.26 staff hours provided on second shift leaving the shift short 2.74 staff hours.
-There were 22.30 staff hours provided on third shift leaving the shift short 12.9 staff hours.

Review of the Resident Bed List Report dated 06/05/20 revealed there was a SCU census of 44 residents, which required 44 staff hours on first and second shift, and 35.2 hours on third shift.

Review of the individual employee time cards dated 06/05/20 revealed:
-There were 35.96 staff hours provided on first shift leaving the shift short 8.04 staff hours.
-There were 28.46 staff hours provided on second shift leaving the shift short 15.54 staff hours.
-There were 16.50 staff hours provided on third shift leaving the shift short 18.7 staff hours.

Review of the Resident Bed List Report dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 58	D 465		

06/06/20 revealed there was a SCU census of 44 residents, which required 44 staff hours on first and second shift, and 35.2 hours on third shift.

Review of the individual employee time cards dated 06/0620 revealed:
-There were 28.19 staff hours provided on first shift leaving the shift short 15.1 staff hours.
-There were 31.27 staff hours provided on second shift leaving the shift short 12.73 staff hours.

Review of the Resident Bed List Report dated 06/07/20 revealed there was a SCU census of 44 residents, which required 44 staff hours on first and second shift, and 35.2 hours on third shift.

Review of the individual employee time cards dated 06/0720 revealed there were 16.34 staff hours provided on first shift leaving the shift short 27.66 staff hours.

Telephone interview with a personal care aide (PCA) on 06/16/20 at 6:18 am revealed:
-She had noticed a staff shortage since late May 2020.
-She had remained on duty to work first shift and worked where ever there was a need.
-She had worked the third shift on 06/15/20 with one medication aide (MA) and two other PCAs.
-When the third shift was short, the MA assumed the assignment of a hallway that a PCA would have assumed or the PCAs on the shift split the unassigned hallway.
-If a second shift staff was able to remain on duty, that person would work third shift.
-She did not know of any other ways staffing was covered to assist with resident care.
-She thought third shift was short 70% of the time since late May 2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 59	D 465		

-Some staff were "loaned out" to a sister facility, after management asked for volunteers.
-Staff worked as a team to get all the resident care done.

Telephone interview with a MA on 06/11/20 at 3:25 pm revealed:
-She worked on second shift as a PCA or MA based on the assignment sheet.
-She worked on both the Assisted Living (AL) unit or SCU depending on where the need for staff was located.
-Staffing on the SCU had been short for the past two to three months due to staff quitting,
-The second shift should have two MAs and three to four PCAs on duty.
-Third shift should have one MA and four PCAs on duty.
-For the past two to three months, staffing was at a "normal level" 30% of the time.
-When there were three PCAs, the MA took one of the four assigned hallways.
-When staff had to take breaks, the remaining staff assumed the assignment of the person on lunch break.
-Staff were working hard to get all the resident care done.
-Some staff were sent to a sister facility to assist them, but she did not know why.
-To assist with the staffing shortage, the Resident Care Director (RCD) and Administrator had assisted with resident care such as during meal times or providing supervision for the residents.

Telephone interview with a second medication aide (MA) on 06/11/20 at 2:49pm revealed:
-She worked second shift.
-There were four halls in the special care unit (SCU).
-She considered the SCU to be fully staffed when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 60	D 465		

there were two MAs and 4 PCAs on a shift.
-The SCU often was not fully staffed.
-The SCU was short-staffed as recent as 06/10/20.
-The RCD assisted with administering medication in the SCU on 06/10/20.
-There were three PCAs working on the SCU on 06/10/20.
-The SCU was fully staffed one day on the weekend of 06/06/20-06/07/20.

Telephone interview with a third MA on 06/15/20 at 4:33 pm revealed:
-She had noticed a staff shortage on the SCU.
-There were supposed to be two MAs and four PCAs on first shift.
-Often now there was one MA and two or three PCAs on the first shift.
-She was able to ask the Memory Care Director (MCD) for assistance if needed and the MCD was aware of the staff shortage.
-Lately the MCD worked third shift to assist with staffing.
-She and other staff worked together to get the resident care completed.
-Some staff were sent to a sister facility to assist them with staffing two to three weeks ago.
-To ensure residents were checked every two hours during lunch breaks, she took an assigned hallway or a PCA assumed half of the hallway.

Telephone interview with the MCD on 06/17/20 at 7:13 am revealed:
-She, the RCC, and the RCD made the schedule for staff.
-There were no staff assigned specifically to the SCU.
-For first shift, there should be a total of five staff for the current census of forty-five and eight staff if the census was a full capacity of 60 on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 61 SCU. -For second shift on the SCU, there should be five to six staff, but staffing depended on the census. -There should be no less than five staff on the second shift for the SCU. -For third shift, there should be four to five staff for the SCU. -She knew that one staff equaled eight residents for staffing purposes. -Staffing was always a challenge, due to call outs and no calls, no shows. -She worked first and third shift to assist with staffing on the SCU. -The RCC and RCD also worked on both units, but the RCD primarily worked on the SCU. -The RCD remained over until 9:00 pm some evenings. -She forgets to clock in with the time clock sometimes and the time clock on the ground floor malfunctioned the first week of June 2020. -She counted her hours into the staffing for four hours on first shift for the SCU, but she did work in her office. -When she worked third shift, she counted her hours for the entire shift. -On third shift, she did work in her office after the residents were medicated and settled into their beds. -Sometimes staff remained over from first shift until 7:00 pm and third shift staff came in at 7:00 pm to assist staffing on second shift. -She understood that five staff equaled forty hours of staffing and a census of 45 required more hours of staffing. -Staff were supposed to notify her during second and third shift and weekends if staff called out. -Staff did not always notify her when there was a call out and tried to solve the staffing shortage themselves by splitting the work among staff who	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 62	D 465		

were present on the shift.
-Staff also moved from AL to SCU on third shift because AL only needed two staff for third shift.
-If staff notified her, she would have tried to call in staff to assist or come in to work the shift herself.
-She worked on 05/25/20 on day shift, because the management had a meeting and discussed who would work the holiday.
-Staff were sent to a sister facility because that facility had a need and staff were sent to help.
-Staff were sent the last week of May 2020 and were returning on 06/22/20.
-She did not think staffing was short if she, the RCD, and the Administrator "chipped in" to help.
-The facility was in the process of hiring more PCAs and MAs.
-Staffing was the responsibility of the RCC, RCD and herself.
-She did not know the specific hours that the SCU was short and the only thing that changed the first week of June 2020 was that additional staff went to the sister facility to work.
-She requested staff to remain over from first shift or come in early for third shift to help.
-She did not know of any other specific circumstances for the weeks of 05/24/20 to 06/07/20 that caused short staffing on the SCU.

Telephone interview with the RCD on 06/17/20 at 12:36 pm revealed:
-She and the RCC were responsible for doing the assignment sheets.
-The RCC did the master schedule.
-The census on the SCU was between 43 and 44 and they staffed the unit based on the census.
-She knew the facility had a staffing shortage.
-A lot of staff went to a sister facility to work, some staff quit, and some staff were let go.
-Efforts were made to hire more staff.
-She did not know why the decision was made to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 63	D 465		

send staff to a sister facility if the facility was short staffed.
-Staff left the third or fourth week of May 2020 to work at the sister facility.
-She, the RCC, and the MCD were told to pull together and work as a team to help with the shortage of staff.
-During the first week of June 2020, some of the staff were still at the sister facility and others left to go to the sister facility.
-She discussed the shortage of staff with the Administrator.
-She and the RCC were there during the first shift and she often remained at work until 9:00 pm to assist with staffing.
-The MCD worked third shift to assist with staffing coverage.
-There were no specific plan or instructions provided to staff during the staffing shortage on how resident care would be done.
-Staff just worked together to ensure resident care was completed.
-She placed resident care first prior to her normal duties as the RCD so some of her duties were behind.

Telephone interview with the Administrator on 06/17/20 at 2:31 pm revealed:
-She knew there was a staffing shortage on the SCU, but she did not know the exact number of hours that the unit was short.
-The clinical staff which consisted of the RCC, MCD and the RCD were responsible for the schedule.
-She was in the process of learning the scheduling process on the facility's computer system.
-The SCU had a current census of 43 or 44 and needed staff based on the census.
-Staff had told her daily that more staff were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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 465	Continued From page 64 needed, and she had made efforts to hire new staff. -She sent staff to assist at a sister facility. -She sent staff because she thought she had enough staff. -Some staff were dismissed from employment at the facility and she had made efforts to hire new staff. -The last week of May 2020 staffing was short because some staff went to the sister facility and some staff quit. -The first week of June 2020 staffing was short because other staff went to help the sister facility. -To assist with staffing, the transportation person and the Business Office Manager (BOM) were cross-training, but they were not PCAs. -The Activities Director (AD) was assisting with staffing and she was a PCA. -She had told staff that they all were to work together to get the resident care done. -She, the MCD and the RCD were expected to assist with staffing on the unit to ensure resident care was done. -She worked on the holiday on 05/25/20 to assist the unit for first shift.	D 465		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure each resident was free of neglect related to medication administration. The findings are:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092181	A. BUILDING: _____ B. WING _____	R-C 06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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
D914	Continued From page 65 Based on record reviews and interviews, the facility failed to ensure the administration of medication in accordance with the orders of a licensed prescribing practitioner for 3 of 7 sampled residents related to medication for the treatment of pain and anxiety (#1), a resident not receiving sliding scale insulin based on parameters (#2), and medication for the treatment of vitamin D deficiency (#3). [Refer to Tag D358, 10A NCAC 13F .1004 (a) Medication Administration (Unabated B Violation)]	D914		