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| GATES HOUSE | 11 COMMERCE DRIVE GATESVILLE, NC 27938 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 10/28/20 to 11/02/20 and a desk review survey on 11/03/20 to 11/05/20 and a telephone exit on 11/05/20. | D 000 | Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency or corrective action report, the plan of correction is prepared soley as a matter of compliance with state law. | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure notification of the primary care provider (PCP) for 1 of 5 sampled residents (#5) who had verbalized suicidal ideation and when an area of infection had drainage and an odor that required an antibiotic.<br><br>The findings are:<br><br>Review of Resident #5's current FL-2 dated 09/29/20 revealed diagnoses included diabetes mellitus type II, hypertension, depression, psoriatic arthritis and hyperlipidemia.<br><br>Review of Resident #5's electronic psychiatry progress note dated 09/29/20 revealed he was being treated for schizoaffective bipolar type.<br><br>a. Review of Resident #5's electronic progress note dated 10/23/20 at 6:05pm revealed:<br>-The facility Psychiatrist was notified by a medication aide (MA) that Resident #5 verbalized suicidal ideation. | D 273 | It is the policy of Gates House to asssure Health Care as identified in rule area 10A NCAC 13F .0902<br><br>Executive Director will conduct an inservice with all Medication Aides and Care Managers. Inservice will include instructions on contacting primary care physician for all incidents. Medication Aides will contact providing MD or specialist and document instructions given on physician notification form. Care Manager will follow up with primary care about incident and instructions. Documentation will be review in daily stand up meeting, weekly at risk meeting and monthly quality assurance meeting.<br><br>Any resident identified as being at risk for reasons including but not limited to, wound concerns, suicidal ideation will have referrals and daily follow up until concern is resolved. Concerns and resolution will be discussed in daily standup, weekly at risk and monthly quality assurance meetings. | 11/16/20<br><br>11/6/2020 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: L. Fleming 6899 G3LS11 — TITLE: Executive Director — (X6) DATE: 12/29/20



Reviewed and accepted. K-M-Leary, RN 2/1/21

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| D 273 | Continued From page 1<br><br>-Resident #5 was assessed by the Psychiatrist via telephone.<br>-He did not have a plan or means to harm himself.<br>-The Psychiatrist instructed the MA to have staff check on him every 15 minutes to ensure his safety.<br>-The Psychiatrist instructed staff to provide Resident #5 with plastic utensils for his meals and to collect them after his meals.<br>-The MA provided an update to the Resident Care Manger (RCM) on 10/23/20.<br><br>Telephone interview with a MA on 11/03/20 at 10:36am revealed:<br>-She contacted Resident #5's Psychiatrist on 10/23/20 at 6:05pm to report that he verbalized suicidal ideation.<br>-She notified staff working during her shift that the Psychiatrist expected staff to check on him every 15 minutes, provide plastic utensils for his meals and to collect them after his meal.<br>-She notified the RCM at the end of her shift.<br>-She requested that the RCM place Resident #5 on the follow up list for the primary care provider (PCP).<br>-She did not notify his PCP of his suicidal ideation.<br>-She provided an update to the 1st shift MA.<br><br>Telephone interview with the RCM on 11/04/20 at 12:20pm revealed:<br>-It was her understanding that the MA on duty on 10/23/20 notified Resident #5's PCP of his suicidal ideation on 10/23/20.<br>-She was unaware that the PCP had not been notified by the MA on 10/23/20 about his suicidal ideation.<br>-She expected the MA to notify his PCP after speaking with the Psychiatrist. | D 273 | | |

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| D 273 | Continued From page 2 | D 273 | | |

Telephone interview with Resident #5's Psychiatrist on 11/03/20 at 10:15am revealed:
-She assessed Resident #5 by telephone for suicidal ideation, intent and plan.
-She directed staff to check on Resident #5 every 15 minutes to ensure his safety and to provide plastic utensils for his meals and to collect them after his meal.
-She instructed the MA to contact her if Resident #5 expressed suicidal ideation again.

Telephone interview with Resident #5's PCP on 10/30/20 at 2:30pm revealed:
-She was not notified by the facility about Resident #5's suicidal ideation.
-She expected to be notified immediately whenever a resident verbalized suicidal ideation on 10/23/20.
-If she had been informed of Resident #5's suicidal ideation, she would have assessed him.
-She expected the RCM or the MA on duty to inform her of Resident #5's suicidal ideation.

Telephone interview with the Executive Director (ED) on 11/04/20 at 12:46pm revealed:
-She expected the MA or RCM to notify Resident #5's PCP about his suicidal ideation.
-She expected the MA or RCM to notify Resident #5's family member about his suicidal ideation.

b. Review of an electronic progress note from a medication aide (MA) dated 09/26/20 at 10:49pm revealed:
-The MA reported that Resident #5 had been experiencing "a lot" of drainage from his buttocks area.
-The drainage area had a bad odor.
-The personal care aide (PCA) had to change Resident #5's bed linens two times during her

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| D 273 | Continued From page 3<br>shift due to the amount of drainage.<br><br>Telephone interview with a MA on 11/04/20 at 11:06am revealed:<br>-She worked 2nd shift on 09/26/20.<br>-She was notified by the 2nd shift PCA on 09/26/20 that Resident #5 had drainage at his buttocks area with an odor.<br>-She did not check the area on Resident #5's buttocks after the PCA notified her of the drainage area.<br>-She documented in the resident's electronic progress note on 09/26/20 at 10:49pm what the PCA reported.<br>-She documented on the facility's daily report form on 09/26/20 that Resident #5 still had drainage on his buttocks area.<br>-She should have checked the drainage area after the PCA informed her of the increased drainage and odor.<br>-She should have informed the PCP immediately of the drainage and odor.<br>-She did not know why she did not inform the RCC or PCP about the drainage and odor.<br>-It was her responsibility to inform the RCC and PCP about the drainage and odor.<br>-She would be concerned of an infection due to the drainage and odor.<br><br>Telephone interview with the Resident Care Manager (RCM) on 11/04/20 at 12:17pm revealed:<br>-She expected the MA on duty to notify the PCP of Resident #5's drainage.<br>-She was unable to remember if she or the MA notified the PCP of Resident #5's drainage and odor.<br>-The MA should have checked Resident #5 and documented her findings in the electronic progress notes. | D 273 | | |

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| D 273 | Continued From page 4 | D 273 | | |

Telephone interview with Resident #5's PCP on 11/04/20 at 1:25pm revealed:
-She had treated an area on his buttocks for the drainage approximately 2 weeks prior to 09/26/20.
-He had completed antibiotic treatment for this wound and improved.
-There was no drainage to the area after he completed the antibiotic treatment.
-She had not been notified of the drainage and odor on Resident #5's buttocks area.
-The facility staff should have notified her of the increased drainage and odor.
-Had she been notified, she would have cultured the area, excised the area of infection to drain it and prescribed a new antibiotic for treatment.
-She was concerned that he could have become septic since he had new drainage and odor on 09/26/20.
-Septic is a potentially life-threatening condition caused by the body's response to an infection.

A second telephone interview with Resident #5's PCP on 11/05/20 at 9:47am revealed:
-She assessed the wound on his buttocks area on 09/11/20 and prescribed an antibiotic because the wound had drainage.
-She diagnosed the wound area as cellulitis and had concerns of it becoming more infected.
-It appeared to be an insect bite with two bite marks and redness extended from the bite mark.
-The redness on the area was approximately one inch in diameter.
-She expressed the area of infection on 09/11/20.
-She assessed the cellulitis on his buttocks on 09/18/20 following his antibiotic treatment again and it had improved.
-The redness on the area had decreased to approximately 0.7 inches and there was no

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| D 273 | Continued From page 5<br>drainage or odor.<br>-She did not order home health for wound care on 09/18/20 because the area had greatly improved.<br>-She was concerned that the area could have been infected again.<br>-She was concerned that he could have cellulitis again which increased his risk of becoming septic if he did not receive appropriate treatment.<br>-She had concerns that the facility staff did not understand the importance of notifying her about the excessive drainage and odor of the wound.<br>-She could not understand why the facility failed to notify her of the change in Resident #5's wound.<br>-She expected to be notified of any change in any resident to ensure they received proper care.<br><br>Telephone interview with the Executive Director (ED) on 11/04/20 at 12:46pm revealed she expected the MA or RCM to notify Resident #5's PCP about his wound. | D 273 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(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:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record. | D 344 | It is the policy of Gates House to assure Medication Orders as identified in rule area 10A NCAC 13F .1002(a).<br><br>Care Managers and SIC will utilize the Bucket System as instructed in the facility's policies and procedures. Care Managers will review all new orders and contact prescribing MD for any clarifications within 24 hours of receiving order and document communication and attempts in resident's progress notes. Orders will be reviewed in daily standup, weekly at risk and monthly quality assurance meeting. | 11/06/20 |

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| D 344 | Continued From page 6<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure contact with the prescribing physician for clarification of medication orders for 1 of 5 sampled residents (Resident #3) regarding an order for pain medication.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia, psychotic disorder, and back pain.<br><br>Review of an outpatient orthopedic visit note for Resident #3 dated 08/27/20 revealed:<br>-Resident #3 was evaluated for "a history of long-standing duration of back pain" and was positive for back pain, arthralgias, and joint pain.<br>-There was a new order for acetaminophen-codeine 300-30mg, take 1-2 tablets every 6 hours as needed (Acetaminophen-codeine is a narcotic used to relieve moderate to severe pain).<br>-There was no clarification regarding how many tablets were supposed to be administered or what indications the medication needed to be administered for.<br><br>Review of Resident #3's pharmacy profile dated 08/27/20 revealed:<br>-The medication order for acetaminophen-codeine 300-30mg, take 1-2 tablets every 6 hours as needed, was escribed to the pharmacy on 08/27/20 at 12:07pm.<br>-There was no clarification regarding how many tablets were supposed to be administered or what parameters the medication needed to be administered. | D 344 | Medication aides will perform weekly cart audits, indicating quantity of medication, expiration and open dates. Medication aides will compare current physician orders to medication on hand. Medication aide will report any discreprancies to the Care Manager. Care manager will immediately report discrepancy to pharmacy, prescribing MD and Executive Director. Cart audits will be reviewed during daily standup, weekly at risk and monthly quality assurance meeting. | 11/06/20 |

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| D 344 | Continued From page 7<br>-Thirty tablets of acetaminophen-codeine 300-30mg were dispensed with no refills on 08/27/20.<br><br>Review of Resident #3's primary care provider's (PCP) orders revealed:<br>-Resident went to a doctor's appointment (with another provider) on 08/27/20 who wrote a medication order for acetaminophen-codeine which needed clarification (not specified).<br>-There was a medication order dated 08/28/20 for "acetaminophen-cod#, take one tablet as needed every 6 hours for pain"(the strength was not specified).<br><br>Review of Resident #3's progress notes dated August 2020 and September 2020 revealed there was no documentation of the facility's attempts to clarify the medication order for acetaminophen-codeine 300-30mg with the pharmacy, the prescribing physician, or Resident #3's primary care provider.<br><br>Interview with a medication aide (MA) on 10/28/20 at 1:14pm revealed:<br>-Resident #3 was prescribed acetaminophen-codeine when she went to a specialist appointment for back pain on 08/27/20.<br>-Another MA or the Memory Care Manager (MCM) brought Resident #3's acetaminophen-codeine to her to put in the medication cart.<br>-She could not put the medication on Resident #3's electronic medication administration record because she saw the medication order needed to be clarified.<br>-The MCM was supposed to clarify the medication order with the prescriber because that was the MCM's responsibility.<br>-She did not call the prescriber of the | D 344 | | |

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| D 344 | Continued From page 8 | D 344 | | |

acetaminophen-codeine order to clarify the order; she just locked the medication in the controlled substances drawer in the medication cart.
-The acetaminophen-codeine was not administered to Resident #3 because the resident did not have a clear order.

Interview with the MCM on 10/30/20 at 10:43am revealed:
-Resident #3 had a prescription for acetaminophen-codeine that was sent to her pharmacy by a physician who was treating her back pain on 08/27/20.
-Resident #3 returned without orders from the orthopedist for new medication when she brought the controlled substances from the pharmacy.
-The facility could not give the acetaminophen-codeine to Resident #3 without the medication order from the prescribing physician.
-She tried to call the pharmacy on 08/27/20 to see if the pharmacy would contact the prescribing physician or put the medication on Resident #3's medication profile.
-The pharmacy needed the medication order to be clarified for Resident #3 to be administered either one or two tablets of acetaminophen-codeine 300-30mg every six hours.
-She was supposed to call the prescribing provider the next day, but she did not contact the prescribing provider on 08/28/20.
-Instead, she gave the clarification to Resident #3's PCP to clarify on 08/28/20 and the PCP wrote another order to clarify the order written for acetaminophen-codeine for Resident #3 on 08/27/20.

Second interview with the MCM on 10/30/20 at 4:45pm revealed:

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| D 344 | Continued From page 9<br>-She did not realize the order written by the PCP on 08/28/20 for Resident #3's acetaminophen-codeine did not clarify the 08/27/20 order because it did not include the strength of the medication.<br>-She had not contacted the PCP or the prescribing provider about the acetaminophen-codeine to get clarification of the order.<br><br>Telephone interview with Resident #3's PCP on 10/30/20 at 2:15pm revealed:<br>-She was contacted by the MCM in August 2020 to try to clarify the order for acetaminophen-codeine for Resident #3.<br>-The MCM had not notified her since she wrote the clarification order (on 08/28/20) that the medication order was not complete.<br>-She questioned the MCM in September 2020 about the order for acetaminophen-codeine for Resident #3 when she did not see it on Resident #3's medication list.<br>-She advised the MCM to check Resident #3's medication list to ensure it was up to date.<br><br>Telephone interview with Resident #3's orthopedic specialist's nurse on 11/04/20 at 9:07am revealed:<br>-The facility never contacted their office to request clarification of the order for acetaminophen-codeine 300-30mg written on 08/27/20.<br>-Their office would have clarified the medication order if they had been notified.<br>-The provider had prescribed the medication for Resident #3 to help manage Resident #3's back pain and to prepare for an upcoming procedure.<br>-It was the provider's preference for Resident #3 to have received the medication and for the facility to notify their office within 24 hours if there | D 344 | | |

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| D 344 | Continued From page 10<br>was problem with the medication order.<br><br>Interview with the Executive Director on 10/30/20 at 11:22am revealed:<br>-She did not know there was problem with Resident #3's acetaminophen-codeine order until September 2020.<br>-It was the responsibility of the MCM and Resident Care Coordinator (RCC) to clarify medication orders with the providers.<br>-If the MCM or the RCC were not available, then the lead MA or supervisor could verify medication orders with the providers.<br>-Staff should document their attempts to clarify medication orders in the resident's progress notes. | D 344 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by the physician for 1 of 5 residents sampled (#3) including a controlled substance used to treat lower back | D 358 | It is the policy of Gates House to assure Medication Administration as identified in rule area 10A NCAC 13F .1004(a).<br><br>Medication aides will perform weekly cart audits, indicating quantity of medication, expiration and open dates. Medication aides will compare current physician orders to medication on hand. Medication aide will report any discrepancies to the Care Manager. Care manager will immediately report discrepancy to pharmacy, prescribing MD and Executive Director. Cart Audits will be discussed in daily standup, weekly at risk, and monthly quality assurance meeting. | 11/06/20 |

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| D 358 | Continued From page 11<br>pain and the administration of an inhaler to prevent the exacerbation of shortness of breath.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia with disturbances, psychotic disorder, back pain, chronic obstructive pulmonary disease, and shortness of breath.<br><br>a. Review of Resident #3's physician orders dated 08/07/20 revealed:<br>-There was a medication order for Tramadol 50mg - three times daily and 90 tablets were to be dispensed (Tramadol is a controlled substance used to relieve moderate to severe pain).<br>-Tramadol 50mg was placed on hold on 08/27/20 by Resident #3's PCP due to a new controlled substance order from another provider.<br><br>Review of a progress note from Resident #3's primary care provider dated 08/06/20 revealed:<br>-Resident #3 was seen for pain management for lower back pain.<br>-Resident #3's pain management regimen was Tramadol 50mg three times a day.<br>-Resident #3's pain level was documented at 3 on a 0-10 pain scale with 0 being no pain and 10 being the highest level of pain.<br>-Resident #3 "was unable to rate" her pain herself "but stated it was a constant nag".<br>-It was documented there were no changes in Resident #3's pain management regimen and a prescription was given to the Memory Care Manager (MCM).<br><br>Review of an orthopedic office visit note for Resident #3 dated 08/27/20 revealed:<br>-Resident #3 presented with low back pain, | D 358 | Medications not administered as ordered will have medication error report completed, including notification to the responsible party and physician within 72 hours, by the discovering person. Med error reports will be discussed in daily standup, weekly at risk, and monthly quality assurance meeting.<br><br>Medication aides will be observed by a RN or RPh passing medications. Medication aides will have quarterly observation following inital med pass. Executive Director will maintain observations in administrator office. Any Medication Aide not in compliance with medication administration regulation and facility policy and procedures will be removed from the cart until competency and compliance is demonstrated.<br><br>Medication aides assigned to the medication carts are responsible for the medications scheduled during that time. If a med is found not to be available, medication aide will contact the pharmacy and document on the P-Card. Care manager will follow up with pharmacy and notify primary care and Executive Director. Medication compliance report will be reviewed in daily standup, weekly at risk and monthly quality assurance meetings. | 11/06/20<br><br>12/15/20<br><br>11/06/20 |

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| D 358 | Continued From page 12<br><br>arthralgia, and joint stiffness.<br>-She scored her pain at a 10 on a 0-10 pain scale with 10 being the highest level of pain.<br>-She reported her pain was increased by any prolonged sitting, standing, or walking.<br>-She was diagnosed with two vertebral compression fractures to her lumbar region.<br><br>Review of Resident #3's August 2020 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Tramadol 50mg take one tablet three times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm and documented as administered from 08/01/20 through 08/23/20 and at 8:00pm on 08/24/20.<br>-Tramadol was not documented as administered on at 8:00am and 2:00pm on 08/24/20, 08/25/20, and 08/26/20 and not documented at 8:00pm on 08/25/20 for Resident #3.<br><br>Review of the facility's August 2020 medication administration compliance report for Resident #3 revealed:<br>-Staff documented Tramadol 50mg was not administered (on hold) for doses at 8:00am and 2:00pm on 08/24/20.<br>-Staff documented Tramadol 50mg was not administered (on hold) for doses at 8:00am, 2:00pm, and 8:00pm on 08/25/20 and 08/26/20.<br>-Staff documented Tramadol 50mg was not administered (on hold) for the 8:00am dose on 08/27/20.<br><br>Review of Resident #3's August 2020 electronic controlled substance log labeled for Tramadol 50mg revealed:<br>-There were 88 tablets of Tramadol 50mg available for administration on 08/01/20.<br>-There were 68 doses of Tramadol 50mg | D 358 | LHPS will perform inservice and check off with all medication aides on properly administering oral medications.<br><br>All resident's oral medication will be reviewed and quantity measured during weekly cart audits and reordered in timely manner. Cart audit will be reviewed in daily stand up, weekly at risk and monthly quality assurance meetings. | 12/18/20<br><br>11/06/20 |

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| D 358 | Continued From page 13<br>documented as administered from 08/01/20 through 08/23/20.<br><br>Telephone interview with the pharmacist at Resident #3's pharmacy on 11/02/20 at 4:29pm revealed:<br>-Their pharmacy never received the prescription written 08/07/20 for Tramadol for Resident #3.<br>-The facility usually faxed over a copy of the prescription when the facility received it from the provider and then brought the hard copy to the pharmacy when they came to pick up the medication.<br>-The pharmacist was concerned that there was no hard copy for controlled substances to account for the missed doses of Resident #3's pain medication because the prescription was not sent to the pharmacy from the facility.<br>-Resident #3 last had a prescription sent to the pharmacy from the facility for Tramadol on 07/19/20.<br><br>Interview with a medication aide (MA) on 10/30/20 at 1:20pm revealed:<br>-Resident #3 was on a scheduled dose of Tramadol because she had back pain.<br>-She documented not administering Resident #3's Tramadol on 08/24/20, 08/26/20, and 08/27/20 because there was no Tramadol on the medication cart for Resident #3.<br>-The Memory Care Manager (MCM) was aware Resident #3's Tramadol was out on 08/24/20 and the MCM was supposed to follow-up with the Resident #3's PCP for a new prescription for Tramadol.<br>-The MCM kept up with the controlled substance prescriptions and kept the original copies in her office until it was time for staff to pick-up Resident #3's pain medication from the pharmacy.<br>-She did not know that Resident #3 had a | D 358 | | |

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| D 358 | Continued From page 14<br>prescription written for Tramadol on 08/07/20.<br><br>Telephone interview with a second MA on 11/02/20 at 2:35pm revealed:<br>-Resident #3 was prescribed scheduled Tramadol because she had back pain.<br>-She documented Resident #3's Tramadol as not administered (on hold) on 08/25/20 because Resident #3 did not have any Tramadol on the medication cart.<br>-She was not sure why Resident #3 ran out of the scheduled Tramadol on 08/23/20 or if there any previous written prescription for additional Tramadol written for Resident #3 in August 2020.<br>-It was the responsibility of the MCM to get the prescription for Tramadol to the pharmacy so it could be dispensed.<br>-The MAs usually told the MCM within the last week of doses when a resident's controlled substances needed to be refilled.<br><br>Interview with the MCM on 10/30/20 at 10:43am revealed:<br>-Resident #3's Tramadol was not administered in late August before Resident #3 saw the orthopedic specialist because the resident had been refusing the medication.<br>-She thought the MAs told her Resident #3 was refusing her Tramadol.<br>-She did not know why the MAs had documented that the controlled substance was on hold.<br>-She did not realize that Resident #3 had a prescription written for Tramadol on 08/07/20.<br>-If the resident had the prescription written on 08/07/20, then Resident #3 should not have run of Tramadol for her back pain.<br>-She would have sent the prescription to Resident #3's pharmacy if she had known about the prescription written on 08/07/20.<br>-She normally kept the hard copies of the | D 358 | | |

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| D 358 | Continued From page 15<br><br>prescriptions for the residents' controlled substances in her office after the primary care provider wrote them until the prescriptions needed to be filled at the pharmacy.<br><br>Second interview with the MCM on 10/30/20 at 4:45pm revealed:<br>-Resident #3 had a prescription for Tramadol written on 08/07/20.<br>-She did not know why Resident #3's prescription was not filled, and her Tramadol ran out.<br>-She was responsible to get the residents' prescription to their pharmacy to be filled once the physician wrote the medication order.<br>-The MAs usually told her when a resident needed to have their controlled substances refilled when there was at least week of dose remaining.<br><br>Interview with the Executive Director on 10/30/20 at 11:22am revealed:<br>-She did not know about the prescription order for Tramadol written for Resident #3 on 08/07/20.<br>-It was the responsibility of the MCM and Resident Care Coordinator (RCC) to ensure new prescriptions were sent to the pharmacy to be filled.<br>-If Resident #3's prescription had been filled from 08/07/20, the resident would not have missed any doses of her scheduled Tramadol in late August 2020.<br><br>Interview with Resident #3 on 10/28/20 at 11:05am revealed:<br>-She was alert and with occasional disorientation.<br>-She complained of lower back pain that "felt like it was cutting, and it was aggravating".<br>-Sometimes, she could not get out bed because of her back pain.<br>-She could not say how long she had problems | D 358 | | |

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| D 358 | Continued From page 16 | D 358 | | |

with the pain in her lower back.
-She could not rate her back pain on a 0-10 pain scale.
-She thought staff gave her pain medications at night, "but they (staff) were usually good about having medication" for her back pain.

b. Review of Resident #3's current FL-2 dated 06/11/20 revealed a medication order for Symbicort inhaler 80/4.5mcg - 2 puffs every 12 hours for shortness of breath.

Telephone interview with Resident #3's primary care provider (PCP) on 11/04/20 at 1:25pm revealed:
-Resident #3 had shortness of breath and a history of chronic obstructive pulmonary disease (COPD).
-She needed her Symbicort to be administered ordered.
-If Resident #3 was not being administered her inhaler as ordered then it could cause an exacerbation of her shortness of breath especially when the change in weather and season that could aggravate Resident #3's COPD.

Observation of Resident #3 on 10/28/20 at 11:18am revealed:
-Resident #3 ambulated slowing down the hallway in the Special Care Unit (SCU) from her room.
-Resident #3's breathing was fast, and she stopped several times to rest while going toward the nurse's station.

Review of Resident #3's pharmacy dispensing record revealed the resident's Symbicort inhaler was last dispensed on 08/18/20 for a 30-day supply.

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| D 358 | Continued From page 17<br><br>Observation of Resident #3's medication on hand on 10/29/20 at 11:47am revealed:<br>-Resident #3's Symbicort inhaler was in its box and was labeled as dispensed on 08/18/20 for 120 doses.<br>-Resident #3's Symbicort dosage instruction read take 2 puff every 12 hours.<br>-Observation of the dosage meter of the inhaler revealed there were approximately 75 doses of Symbicort still remaining in the inhaler.<br><br>Review of Resident #3's electronic medication administration records (eMARs) revealed:<br>-Resident #3's Symbicort was documented as administered from 08/18/20 through 08/31/20 at 8:00am and 8:00pm for a total of 56 doses.<br>-Resident #3's Symbicort was documented as administered from 09/01/20 through 09/30/20 at 8:00am and 8:00pm for a total of 120 doses.<br>-Resident #3's Symbicort was documented as administered from 10/01/20 through 10/27/20 at 8:00am and 8:00pm and administered at 8:00am on 10/28/20 for a total of 110 doses.<br><br>Interview with a medication aide (MA) on 10/30/20 at 6:29pm revealed:<br>-She had not noticed the date on Resident #3's Symbicort until the observation of medication on hand.<br>-If the medication was given, then Resident #3's Symbicort should be refilled at least once a month.<br>-When she administered Resident #3's inhaler, she made sure Resident #3 made a tight seal with the inhaler before she pumps the inhaler.<br>-She did not know how other MAs administered the inhaler to Resident #3.<br>-She had not noticed that Resident #3 appeared to have increased shortness of breath or complained about being short of breath. | D 358 | | |

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| D 358 | Continued From page 18<br><br>Interview with the Memory Care Manager (MCM) on 10/30/20 at 4:45pm revealed:<br>-She did not know that Resident #3's Symbicort had not been reordered since September 2020.<br>-If Resident #3's Symbicort was being administered properly, then it should have finished within 30 days and should have been refilled by the pharmacy.<br>-She had completed an audit on the medication cart about two weeks ago, but she did not check the dosage meter on Resident #3's inhaler.<br><br>Interview with the Executive Director on 10/30/20 at 6:15pm revealed:<br>-It was her expectation for the MA to administer all medications to the residents as ordered.<br>-Staff should have noticed that Resident #3's Symbicort had not been reordered after September 2020.<br>-The MCM had been doing medication cart audits weekly for about a month up until about two weeks ago and the MAs were supposed to be doing weekly medication cart audits.<br>-The dispensing and expiration dates should have been checked on all the medications on the medication cart.<br><br>The facility failed to administer medications as ordered to Resident #3, who had history of chronic back pain and COPD. The resident missed doses of Tramadol (used for severe back pain) for pain related to vertebral compression fractures. The resident was not administered her Symbicort inhaler as ordered to prevent the exacerbation of shortness of breath and COPD exacerbation. The facility's failure resulted in the resident having no pain medication for a least 8 doses and not receiving her inhaler which placed the resident at risk of exacerbation of shortness | D 358 | | |

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| D 358 | Continued From page 19<br>of breath and COPD exacerbation and this was detrimental to the health, safety and welfare of resident and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/20 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020. | D 358 | | |
| D 392 | 10A NCAC 13F .1008(a) Controlled Substances<br><br>10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 5 residents (#3 and #4) sampled who had 30 controlled substance tablets unaccounted for and no controlled substance log for August 2020 for one resident (#3) an inaccurate controlled substance logs for controlled substance administration and disposal for a second resident (#4).<br><br>The findings are: | D 392 | It is the policy of Gates House to assure Controlled Substance as identified in rule area 10A NCAC 13F .1008(a).<br><br>Medications, including controlled substance, received from outside pharmacies will be logged in by qualified medication staff on duty. The documentation will be made on the receipt of medications from outside pharmacies form, documenting the resident's name, date, dispensing pharmacy, medication name, strength and quantity of medication received. Medication should then be placed on cart in controlled substance box and added to the electronic Narcotic count by qualified medication staff. Medication from outside pharmacies will be placed on Pharmacies receiving form and kept in a binder in the Care Manager's office. | 11/06/20 |

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| D 392 | Continued From page 20<br><br>1. Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia, psychotic disorder, and back pain.<br><br>Review of an outpatient orthopedic visit note for Resident #3 dated 08/27/20 revealed:<br>-Resident #3 was evaluated for a history of long-standing duration of back pain and was positive for back pain, arthralgias, and joint pain.<br>-There was a new order for acetaminophen-codeine 300-30mg, take 1-2 tablets every 6 hours as needed (Acetaminophen-codeine is a controlled substance used to relieve moderate to severe pain).<br><br>Review of Resident #3's pharmacy profile dated 08/27/20 revealed:<br>-The medication order for acetaminophen-codeine 300-30mg, take 1-2 tablets every 6 hours as needed, was escribed to the pharmacy on 08/27/20 at 12:07pm.<br>-Thirty tablets of acetaminophen-codeine 300-30mg were dispensed with no refills on 08/27/20.<br><br>Telephone interview with the pharmacist at Resident #3's pharmacy on 11/02/20 at 4:29pm revealed:<br>-Thirty tablets of acetaminophen-codeine 300-30mg were dispensed on 08/27/20 for Resident #3.<br>-No acetaminophen-codeine had been returned to the pharmacy for Resident #3.<br><br>Review of Resident #3's controlled substance log dated August 2020 and September 2020 revealed there was no entry of the Resident #3's acetaminophen-codeine 300-30mg, 30 tablets dispensed on 08/27/20 upon receipt from the | D 392 | When wasting a controlled substance, qualified medication staff should document name and strength of medication, quantity being wasted, method of wasting, reason for wasting and two signatures. Documentation will be kept in disposal log. Care manager will review log and follow up if necessary.<br><br>Medication aides will perform narcotic count at shift change, if any discreprancies found, cart exchange will be held off and care manager will be notify immediately. Care Manager will notify Executive Director and discrepany will be reviewed immediately. Primary care and pharmacy will be notify by the care manager if necessary. Discrepancies will be reviewed during daily standup, weekly at risk, and monthly quality assurance meeting. 11/6/20<br><br>Care manager will conduct random Narcotic counts weekly for 30 days, then bi-monthly for 60 days thereafter. Any discrepancies will be reviewed immediately with Executive Director and pharmacy and prescribing MD will be notified. Narcotic count will ne reviewed in daily standup, weekly at risk and monthly quality assurance meeting 12/18/20 | |

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pharmacy.

Review of the facility's controlled substances policy revealed:
-Documentation of the receipt of the controlled substances by the pharmacy will be maintained.
-Documentation of controlled substances will be maintained by the facility and will be available for review with the resident's record.

Review of the facility's final Health Care Personnel Investigative Report dated 09/16/20 revealed:
-Acetaminophen-codeine 300-30mg tablets were placed in the medication cart for Resident #3 on 08/27/20.
-"Quantity was not in place in the system for the medication aides (MAs) to complete the count of medication."
-The MAs were not counting the acetaminophen-codeine 300-30 tablets along with their other controlled substances.
-The MA realized the medication was no longer on the medication cart on 09/08/20.

Observation of Resident #3's medication on hand on 10/29/20 at 11:47am revealed there was no acetaminophen-codeine available for Resident #3.

Interview with a MA on 10/28/20 at 1:14pm revealed:
-Resident #3 was prescribed acetaminophen-codeine for back pain on 08/27/20.
-Another MA or the Memory Care Manager (MCM) brought Resident #3's acetaminophen-codeine to her to put in the medication cart.
-She put the medication in the controlled

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| D 392 | Continued From page 22<br><br>substances drawer, but she did not count the tablets or put the controlled substance in Resident #3's electronic medication administration record (eMAR) because the medication order needed to be clarified.<br>-The normal process for controlled substances was for the MA to count the medication and enter the medication order and document the count on the Resident #3's eMAR.<br><br>Interview with the MCM on 10/30/20 at 10:43am revealed:<br>-Resident #3 had a prescription for acetaminophen-codeine that was picked up from the pharmacy on 08/27/20.<br>-The controlled substance was placed on the medication cart by the MA.<br>-She was not sure if the MA counted the medication when it was received on 08/27/20.<br>-The normal process for controlled substances were counted and put into the system for the resident to have a control log by the MAs.<br>-The facility had a problem with Resident #3's medication order for acetaminophen-codeine and the medication needed to be clarified before it could be put in Resident #3's eMAR profile.<br>-Without the medication order clarification, Resident #3 would not have a control log for the acetaminophen-codeine.<br><br>Interview with the Executive Director on 10/30/20 at 11:22am revealed:<br>-Resident #3 did not have a control log for her acetaminophen-codeine that was filled in August 2020 because there was a problem with getting her medication order clarified.<br>-She did not know there was problem with Resident #3's acetaminophen-codeine order until the medication "became missing" in September 2020. | D 392 | | |

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| D 392 | Continued From page 23<br>-She did not know the MAs were not counting Resident #3's acetaminophen-codeine with the other controlled substances during shift changes.<br>-The MA should have counted Resident #3's acetaminophen-codeine and placed the medication on hold in the system until the medication order was clarified.<br><br>2. Review of Resident #4's current FL-2 dated 09/29/20 revealed diagnoses included bursitis left shoulder, hyperlipidemia, synovial cysts left knee and lordosis.<br><br>Review of Resident #4's physician's orders dated 09/29/20 revealed orders for hydrocodone-acetaminophen 7.5-325mg 2 tablets three times a day (hydrocodone-acetaminophen is a controlled substance used to treat moderate to severe pain.)<br><br>Review of Resident #4's physician order dated 08/14/20 and 10/07/20 revealed hydrocodone-acetaminophen 7.5-325mg 2 tablets three times a day.<br><br>Review of Resident #4's September 2020 electronic medication administration record (eMAR) revealed:<br>-There was an entry for hydrocodone-acetaminophen 7.5-325mg 2 tablets three times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.<br>-There were 178 of 180 tablets of hydrocodone-acetaminophen 7.5-325mg documented as administered from 09/01/20 - 09/30/20.<br>-One dose of hydrocodone-acetaminophen 7.5-325mg was documented as not administered at 8:00am on 09/23/20 due to the resident refusing. | D 392 | | |

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| D 392 | Continued From page 24<br>-One dose of hydrocodone-acetaminophen 7.5-325mg was documented as administered at 8:00pm on 09/23/20.<br>-One dose of hydrocodone-acetaminophen 7.5-325mg was documented as administered at 8:00pm on 09/25/20.<br><br>Review of controlled substance (CS) logs for Resident #4's hydrocodone-acetaminophen 7.5-325mg tablets dated 09/01/20 through 09/31/20 revealed:<br>-There was documentation of Hydrocodone-acetaminophen 7.5-325mg balance was 58 tablets on 09/01/20.<br>-There was documentation of Hydrocodone-acetaminophen 7.5-325mg 180 tablets was received on 09/02/20 and increased the balance to 234 tablets on 09/02/20.<br>-There was documentation of Hydrocodone-acetaminophen 7.5-325mg balance was 60 tablets on 09/30/20.<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as administered on 09/23/20 at 7:20pm.<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as dropped medication on 09/23/20 at 10:47pm.<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as administered on 09/25/20 at 8:03pm.<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as wasted with reason documented as "other" on 09/26/20 at 7:36am.<br><br>Review of Resident #4's October 2020 eMAR revealed:<br>-There was an entry for hydrocodone-acetaminophen 7.5-325mg 2 tablets three times a day with scheduled administration times of 8:00am, 2:00pm and 8:00pm. | D 392 | | |

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| D 392 | Continued From page 25<br>-There were 108 of 124 tablets of hydrocodone-acetaminophen 7.5-325mg documented as administered from 10/01/20 - 10/28/20.<br>-There was an entry for hydrocodone-acetaminophen 7.5-325mg 2 tablets three times a day with scheduled administration times of 8:00am, 2:00pm and 8:00pm on 10/17/20.<br>-One dose of hydrocodone-acetaminophen 7.5-325mg was documented as not administered at 2:00pm on 10/24/20 with no documentation as to why not administered.<br><br>Review of controlled substance (CS) logs for Resident #4's hydrocodone-acetaminophen 7.5-325mg tablets for 10/01/20 through 10/31/20 revealed:<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as administered on 10/17/20 at 8:00pm.<br>-Hydrocodone-acetaminophen 7.5-325mg 1 tablet was documented as "wasted" with the reason "other" on 10/18/20 at 7:02am.<br>-Hydrocodone-acetaminophen 7.5-325mg 2 tablets were documented as administered on 10/24/20 at 8:51am<br>-Hydrocodone-acetaminophen 7.5-325mg 2 tablets were documented as wasted, dropped medication on 10/24/20 at 3:13pm.<br>-There was no documentation of Hydrocodone-acetaminophen 7.5-325mg being administered between 8:51am and 3:13pm on 10/24/20.<br><br>Review of Resident #4's pharmacy dispensing records for hydrocodone-acetaminophen 7.5-325mg revealed:<br>-There were 180 hydrocodone-acetaminophen 7.5-325mg tablets dispensed on 09/01/20. | D 392 | | |

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| D 392 | Continued From page 26<br>-There were 180 hydrocodone-acetaminophen 7.5-325mg tablets dispensed on 10/09/20.<br><br>Interview with a Medication Aide (MA) on 11/02/20 at 3:46pm revealed:<br>-She sent Resident #4 out of the facility to the hospital around 12:38 pm on 10/24/20.<br>-She had popped the medication for administration to Resident #4's 2:00pm scheduled dose.<br>-She sent Resident #4 to the hospital before Resident #4's 2:00pm scheduled dose of hydrocodone-acetaminophen 7.5-325mg was given.<br>-She had to put in wasted on the CS log because she had not removed the hydrocodone-acetaminophen 7.5-325mg from the bubble packaging.<br>-She had never taken the hydrocodone-acetaminophen 7.5-325mg out of the package.<br>-She called the Resident Care Coordinator (RCC) and informed the RCC as to what happen and needing to document in the system as wasted to correct the count.<br>-She had not given Resident #4 her 2:00pm dose of hydrocodone-acetaminophen 7.5-325mg 2 tablets because Resident #4 was out of the facility by 1:00pm.<br>-She had clicked all Resident #4's medications as not administered in the system except the hydrocodone-acetaminophen 7.5-325mg, she had accidently marked it as administered.<br>-When the medications marked as administered in the system she had to enter the number of tables given for the count to be correct.<br>-She had accidently document administering hydrocodone-acetaminophen 7.5-325mg 1 tablet.<br><br>Interview with the RCC on 11/02/20 at 4:30pm | D 392 | | |

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| D 392 | Continued From page 27<br>revealed:<br>-MAs should document on the electronic control substance log how many medications were being wasted and why the medication was being wasted.<br>-MAs should have contacted the RCC when medication was wasted.<br>-MAs were expected to check and recheck the number entered prior to clicking administered in the system.<br><br>Interview with the Executive Director (ED) in 11/02/20 at 4:15pm revealed:<br>-MAs should document in on the electronic control substance log how many medications were being wasted and why the medication was being wasted.<br>-MAs should have contacted the RCC or the Memory Care Manager (MCM) when medication was wasted.<br>-The RCC and MCM were responsible for control substance log audits.<br>- The RCC and MCM were to complete control substance log audits weekly.<br>-There was no way to track errors in the system.<br>-She expected the CS log to be completed accurately. | D 392 | | |
| D 601 | 10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program<br><br>10A NCAC 13F .1801 Infection Prevention and Control Program<br>(a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and<br>implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for | D 601 | It is the policy of Gates House to assure Infection Prevention and Control as identified in the rule area 10A NCAC 13F .1801 (a)(b). | |

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| D 601 | Continued From page 28<br><br>Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection as related to residents not social distancing at least six feet, staff failure to wear required personal protective equipment (PPE) while providing care to a resident who had been placed in quarantine after a hospital stay, and staff failure to properly disinfect a telephone after resident use.<br><br>The findings are:<br><br>Review of the CDC guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities last updated 11/04/20 revealed:<br>-Residents should wear a face covering or face | D 601 | All residents including those with cognitive impairments, will be encouraged to wear masks and to social distance. SIC is responsible for monitoring compliance with social distancing and mask wearing, during their assigned shift. Executive Director or Care Manager will make round daily to ensure compliance.<br><br>All staff are responsible for encouraging social distancing and mask wearing during their assigned shift.<br><br>Executive Director will provide an in-service on infection control measures including proper donning of PPE, encouraging residents to wear masks, and disinfecting high touch areas including but not limited to telephones.<br><br>Facility will rearrange furniture in common area to assist in social distancing until infection control guidelines change.<br><br>Noncompliance with social distancing and mask wearing will be reviewed daily during standup meetings, weekly during At Risk meeting and monthly at Quality Assurance meeting. Care managers are responsible for physician and family notification for residents identified not to be compliant with infection control regulations and facility policy and procedures. Documentation of notification will be made on Infection Control Event Report. COVID Observations will be updated as needed. | 11/06/20<br><br>11/06/20<br><br>11/06/20<br><br>11/06/20<br><br>12/20/20 |

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| D 601 | Continued From page 29<br>mask whenever outside their room.<br>-Face masks should be worn covering the nose and mouth.<br>-Health care personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves.<br>-Health care personnel should perform hand hygiene by using alcohol-based hand sanitizer with 60-95% alcohol or wash their hands with soap and water for at least 20 seconds.<br>-All personnel should practice social distancing (remain at least six feet apart) when in common areas.<br>-Health care personnel should implement social distancing among residents (remain at least six feet apart).<br><br>Review of the CDC guidelines for the prevention and spread of the coronavirus disease in LTC facilities last updated 11/20/20 revealed:<br>-For a resident returning for readmission to the facility, provision may include the resident being placed in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19.<br>-Staff should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.<br>-Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.<br><br>Review of the NC DHHS guidelines for the core principles of COVID-19 infection prevention for | D 601 | Any resident placed on quarantine will be identified using a star on the residents door. Resident's door will remain closed with star in the center with quarantine end date in the middle. Executive Director will inservice all staff about facilities quarantine procedure. Topics include donning and doffing of PPE when entering and exiting identified room. | 11/06/20 |

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| D 601 | Continued From page 30<br><br>larger residential settings, with seven or more beds, last updated on 10/16/20 revealed:<br>-Hand hygiene should be practiced (use of alcohol-based hand sanitizer is preferred).<br>-Residents must wear a face covering or mask when not in their room.<br>-Social distancing, of at least six feet, should be maintain between residents.<br>-Frequently touched surfaces should be cleaned often.<br>-Staff should use the appropriate personal protective equipment (PPE) when providing resident care.<br><br>1. Review of Resident #4's current FL-2 dated 09/29/20 revealed diagnoses included bursitis left shoulder, hyperlipidemia, synovial cysts left knee and lordosis.<br><br>Review of Resident #4's progress note dated 10/27/20 revealed a hospital discharge date of 10/27/20.<br><br>Observation of the assisted living side of the facility on 10/28/20 at 2:20pm revealed:<br>-Resident #4's room door was open.<br>-The medication aide (MA) entered Resident #4's room to administer medications while wearing a mask and a face shield.<br>-The MA did not wear gloves nor a gown while administering medication to Resident #4.<br>-The MA exited Resident #4's room, sanitized her hands with hand sanitizer and proceeded to administer medication to two other residents identified as COVID-19 negative and were not on isolation.<br>-The MA did not close Resident #4's room door when exiting the room.<br><br>Interview with a MA on 10/28/20 at 2:19pm | D 601 | | |

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| D 601 | Continued From page 31 | D 601 | | |

revealed:
-All residents that left the facility to go to the hospital were put on ten-day quarantine after returning to the facility.
-She knew Resident #4 had just returned from the hospital on 10/27/20.
-She was informed of Resident #4's quarantine status when arriving for her shift.
-She knew Resident #4 was on ten-day quarantine due to returning from outside the facility.

Interview with the Executive Director (ED) on 10/29/20 at 4:15pm revealed:
-Resident #4 was on quarantine due to returning from the hospital on 10/27/20.
-All residents that left the facility to go to the hospital, emergency department, or doctor's office were required to quarantine in their rooms for ten days when returning to the facility.
-The resident was placed in the hot box communications and the information related to who was on quarantine was passed verbally from shift to shift via report.
-Residents were required to isolate in their rooms with the door closed.
-Staff were to wear personal protective equipment including mask, face shields, gowns and gloves when providing care to these residents.
-The MA should have worn mask, gloves, gown and face shield when administering medication to Resident #4.

2. Observation of the sitting area of the Special Care Unit (SCU) on 10/28/20 from 11:31am to 11:41am revealed:
-There were four residents and a staff member in the sitting area who were all sitting or standing within two to three feet of each other; all were wearing masks.

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| D 601 | Continued From page 32<br>-Three of the residents were sitting in chairs adjacent to each other and the fourth resident was in her wheelchair across from them with the staff member walking amongst the residents.<br>-The staff member lowered the mask of one of the four residents, under the resident's chin, to clean her face, and did not place the mask back over her nose and mouth.<br>-The staff did not have on gloves and did not sanitize nor wash hands after touching the resident's face.<br>-The staff member brought a fifth resident into the sitting area with the other four residents and sat the fifth resident in an adjacent chair approximately two feet of three previously seated residents.<br>-The fifth resident was wearing a mask over her mouth and nose.<br>-The staff member was observed pacing back and forth in the area of the five residents within three feet of the residents and social distancing was not encouraged by the staff.<br><br>Observation of the SCU on 10/28/20 from 1:00pm to 1:40pm revealed:<br>-There were six residents in the sitting area and all the residents were sitting one to three feet apart.<br>-Two of the residents were not wearing masks and were sitting in adjacent chairs less than two feet apart.<br>-There were an additional four residents sitting in wheelchairs sitting adjacent to each other approximately two feet apart from each other in front of the television.<br>-One of those residents was not wearing a mask, the second resident wore their mask under their chin, and the third and fourth residents wore their masks under their noses.<br>-A personal care aide (PCA) escorted a resident | D 601 | | |

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| D 601 | Continued From page 33<br>down the hallway; the resident was not wearing a mask; and seated the resident in the sitting room next to another resident (less one foot apart) who was not wearing a mask.<br><br>Interview with a PCA on 10/28/20 at 11:42am revealed:<br>-It was hard to keep residents social distanced or to get residents to wear their masks.<br>-Most of the residents removed their masks as soon as the staff put the masks on the residents or could not remember to wear their masks over their mouths and noses.<br>-Some residents were easy to remind to wear their masks and would put on their masks when the staff asked, or residents refused; staff would not force the residents to wear masks.<br>-Some residents wandered, and staff tried to keep up with them to make sure they did not touch anything or anyone.<br>-The residents lined up wheelchairs without social distancing were being monitored by staff for safety.<br>-She had not thought about the social distancing of the residents in the sitting area.<br><br>Observations of the SCU on 10/29/20 at 11:32am revealed:<br>-There was one resident who was not wearing a mask sitting across from the nurse's station with several staff and several residents passing in the hallway within two feet in front of her.<br>-A MA brought a second resident and sat her less than one foot apart from the first resident.<br>-The second resident was not wearing a mask.<br>-Staff did not offer a mask to either of the residents.<br><br>Observations of the SCU on 10/29/20 at 3:18pm revealed: | D 601 | | |

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| GATES HOUSE | 11 COMMERCE DRIVE GATESVILLE, NC 27938 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 601 | Continued From page 34<br>-There were fourteen residents in the sitting area of the SCU who were sitting two to three feet apart.<br>-Eight of these residents were not wearing masks and three other residents wore their masks under their chin.<br>-None of the staff present offered the residents masks or encouraged residents to social distance.<br><br>Observations of the SCU on 10/28/20 at 1:28pm revealed staff directed a resident to go sit in the TV room with other residents and the resident did not have on a mask, the mask was in the resident's hand.<br><br>Observations of the SCU on 10/28/20 at 1:36pm revealed staff directing a resident with no mask on to go sit in the TV room directly beside another resident that did not have a mask on.<br><br>Observations of the SCU on 10/29/20 at 9:49am revealed:<br>-A staff member was talking to a resident standing less than six feet apart.<br>-She had on a face shield and a mask.<br>-She removed her mask from covering her mouth and nose to talk to the resident.<br><br>Interview with a MA on 10/29/20 at 3:15pm revealed:<br>-Staff did the best they could to keep masks on the residents in the SCU.<br>-It was hard to do because most of the residents could not remember to keep the mask on or over their face and nose.<br>-It was difficult to keep the residents in the SCU socially distanced, since they could not remember to do so and sometimes wandered.<br>-The staff had rearranged the furniture in the | D 601 | | |

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| | HAL037001 | A. BUILDING: _____ B. WING _____ | 11/05/2020 |

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| D 601 | Continued From page 35 | D 601 | | |

residents' sitting areas for social distancing on 10/28/20, but moved the furniture back earlier on 10/29/20 because it posed a fall risk to the residents because the residents were use to the chairs being in certain places.

Telephone interview with the LHD Infection Control Nurse on 11/02/20 at 11:14am revealed she had provided guidance verbally by telephone to the Executive Director in late July 2020 or early August 2020 regarding the need for residents and all staff to wear masks and to social distance when it was reported the facility had a resident who was positive for COVID-19.

Telephone interview with a second MA on 11/02/20 at 4:41pm revealed:
-There was a problem with getting the residents in the SCU to social distance and to wear masks.
-The residents did not understand the concept of the precautions that were needed to be taken because of the pandemic.
-Some residents were easy to redirect to social distance and to remind to put on their masks and other residents were not.
-Even the residents in the wheelchairs would move themselves when staff were trying to maintain social distancing.
-The staff did try to maintain social distancing and encourage all residents in the SCU to wear their masks.

Interview with the Memory Care Manager on 10/29/20 at 4:05pm revealed:
-Residents were expected to wear masks, but they removed them frequently.
-She and staff attempted to enforce social distancing of residents, but they would often move.
-She had seen staff attempt to social distance

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| D 601 | Continued From page 36<br><br>residents, but they had a difficult time keeping them socially distanced.<br>-The two residents in the television area should have been at least six feet apart and wearing masks.<br>-She expected staff to reinforce the importance of social distancing and wearing masks to residents.<br><br>Interview with the Executive Director (ED) on 10/29/20 at 4:15pm revealed:<br>-All staff were expected to wear a mask while in the facility.<br>-All residents were to wear a mask when outside of their rooms except when they are eating in the dining room.<br>-Residents were to social distance when out of their rooms.<br>-Staff had been trained on the correct usage of personal protective equipment (PPE) including donning and doffing, cleaning and disinfecting commonly touch surfaces, maintaining social distance and isolation on 03/05/20.<br>-She expected staff to redirect the residents to wear their mask, wear their mask correctly and to social distance on both the assisted living side and the SCU of the facility.<br><br>3. Observation of a resident on the assisted living (AL) unit on 10/29/20 at 10:00am revealed:<br>-He used the telephone located at the nursing station to speak with someone.<br>-The telephone cord was placed over the top of the nursing station counter so the resident could use the telephone.<br>-Once he completed his telephone call, he handed the telephone receiver back to the medication aide (MA).<br>-The MA placed the telephone receiver on the counter next to the telephone base and looked for alcohol wipes to sanitize the phone. | D 601 | | |

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| D 601 | Continued From page 37<br>-After approximately five minutes she returned and placed the telephone receiver back on the telephone base without sanitizing it.<br><br>Interview with the MA on 10/29/20 at 10:29am revealed:<br>-She should have sanitized the telephone after the resident returned the phone to her per the facility's COVID-19 Infection Control Policy.<br>-She acknowledged she forgot to sanitize the telephone.<br>-She did eventually sanitize the telephone receiver and the telephone base.<br><br>Interview with the Executive Director (ED) on 10/29/20 at 3:35pm revealed:<br>-The MA should have sanitized the telephone at the nursing station after it was used by the resident.<br>-The MA should have followed the COVID-19 Infection Control Policy for the facility.<br><br>The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (DHHS) for infection prevention and transmission during the COVID-19 pandemic and to ensure social distancing, proper cleaning of telephones used by residents, isolation of a resident who went out to the hospital and staff failure to wear proper PPE including a gown and gloves when caring for a resident who had been placed on quarantine after a hospital stay. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a TYPE B VIOLATION.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for | D 601 | | |

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| D 601 | Continued From page 38<br>this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020. | D 601 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by: Based on record review, observation, and interview of staff and residents, the facility failed to assure provision of adequate and appropriate care and services to residents regarding medication administration and infection prevention and control.<br><br>The findings are:<br><br>1.Based on observations, interviews and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection as related to residents not social distancing at least six feet, staff failure to wear | D912 | It is the policy of Gates House to assure Resident Rights as identified in the rule area G.S. 131D-21(2)<br><br>All employees will review and sign an updated Declaration of Resident's Rights form. Documentation will be kept in individual staff files. | 12/18/20 |

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| D912 | Continued From page 39<br><br>required personal protective equipment (PPE) while providing care to a resident who had been placed in quarantine after a hospital stay, and staff failure to properly disinfect a telephone after resident use. [Refer to Tag D601 10A NCAC 13F .1801 Infection Prevention and Control (Type B Violation).]<br><br>2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by the physician for 1 of 5 residents sampled (#3) including a controlled substance used to treat lower back pain and the administration of an inhaler to prevent the exacerbation of shortness of breath. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] | D912 | | |