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GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

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D 000	Initial Comments 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		
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 observations, interviews and record reviews, the facility failed to ensure notification of the primary care provider (PCP) for 1 of 5 sampled residents (#5) when the resident verbalized suicidal ideation and when an area of infection had excessive drainage and an odor that required an antibiotic. The findings are: Review of Resident #5's current FL-2 dated 9/29/20 revealed diagnoses included diabetes mellitus type II, hypertension, depression, psoriatic arthritis and hyperlipidemia. Review of Resident #5's electronic progress note dated 10/23/20 at 6:05pm revealed: -The facility psychiatrist was notified by a medication aide (MA) that Resident #5 verbalized suicidal ideation. -Resident #5 was assessed by the Psychiatrist via telephone. -He did not have a plan or means to harm	D 273		

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himself.
-The psychiatrist instructed the MA to have staff check on him every 15 minutes to ensure his safety.
-The psychiatrist instructed staff to provide Resident #5 with plastic utensils for his meals and to collect them after his meals.
-The MA provided an update to the Resident Care Manger (RCM) on 10/23/20.

Telephone interview with a MA on 11/3/20 at 10:36am revealed:
-She contacted Resident #5's psychiatrist on 10/23/20 at 6:05pm to report that he verbalized suicidal ideation.
-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.
-She notified the RCM at the end of her shift.
-She requested that the RCM place Resident #5 on the follow up list for the PCP.
-She did not notify his PCP of his suicidal ideation.
-She provided an update to the 1st shift MA.

Telephone interview with the RCM on 11/4/20 at 12:20pm revealed:
-It was her understanding that the MA on duty notified Resident #5's PCP of his suicidal ideation on 10/23/20.
-She was unaware that the PCP had not been notified by the MA on 10/23/20 about his suicidal ideation.
-She expected the MA to notify his PCP after speaking with the Psychiatrist.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/30/20 at 2:30pm revealed:

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-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.
-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 Resident #5's family member on 11/3/20 at 10:00am revealed:
-She was not notified by the facility that he verbalized suicidal ideation.
-She expected the facility to notify her of his suicidal ideation.

Telephone interview with the Executive Director (ED) on 11/4/20 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.

Review of an electronic progress note from a MA dated 9/26/20 at 10:49pm revealed:
-The MA reported that Resident #5 had been experiencing "a lot" of drainage from his buttock area.
-The drainage area had a bad odor.
-The PCA had to change Resident #5's bed linens two times during her shift due to the amount of drainage.

Telephone interview with a MA on 11/4/20 at 11:06am revealed:
-She worked 2nd shift on 9/26/20.
-She was notified by the 2nd shift PCA on 9/26/20 that Resident #5 had excessive drainage at his buttock area with an odor.
-She did not assess Resident #5 after the PCA

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notified her of the drainage area.
-She documented in the residents' electronic progress note on 9/26/20 at 10:49pm what the PCA reported.
-She documented on the facility daily report form on 9/26/20 that Resident #5 still had drainage on his buttock area.
-She should have assessed the drainage area after the PCA informed her of the increased drainage and odor.
-She should have informed the PCP immediately of the drainage and odor.
-She would be concerned of an infection due to the drainage and odor.
-Had she informed the PCP of the increase in drainage and odor, the PCP would have assessed the area and made recommendations.

Telephone interview with the RCM on 11/4/20 at 12:17pm revealed:
-She expected the MA on duty to notify the PCP of Resident #5's drainage.
-She was unable to remember if she or the MA notified the PCP of Resident #5's drainage.
-She did not think that the PCP had any recommendations for the drainage area.
-The MA should have assessed Resident #5 and documented her findings in the electronic progress notes.

Observation of the facility daily report form revealed:
-There was documentation on the report form on 9/26/20 for the 1st and 2nd shifts that Resident #5 still had drainage on his buttock area.
-There was documentation on the facility daily report form on 9/26/20 on the 3rd shift that the area on his buttock was not draining anymore.
-There was no documentation on the facility daily report form on 9/27/20 or 9/28/20 regarding the

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D 273	Continued From page 4 drainage area, only a check mark. Telephone interview with Resident #5's PCP on 11/4/20 at 1:25pm revealed: -She had not been notified by the facility of excessive drainage and an odor on Resident #5's buttock area. -She had treated an area on his buttock for the drainage on his buttock area approximately 2 weeks prior to 9/26/20. -There was no drainage after he completed the antibiotic treatment. -The facility staff should have notified her of the new onset of 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 -He had completed antibiotic treatment for this wound and improved. -She was concerned that he could have become septic. A second telephone interview with Resident #5's PCP on 11/5/20 at 9:47am revealed: -She assessed the wound on his buttock area on 9/11/20. -She prescribed an antibiotic for Resident #5 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 bit 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 9/11/20. -She assessed the cellulitis on his buttocks on 9/18/20 following his antibiotic treatment and it had improved.	D 273		

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D 273	Continued From page 5 -The redness on the area had decreased to approximately 0.7 inches and there was no drainage or odor. -She did not order home health for wound care on 9/18/20 because the area had greatly improved. -She was not notified by facility staff that he had excessive drainage and an odor at the same wound area on 9/26/20. -She was concerned that the area could have been infected again. -She was concerned that he could have cellulitis again which increased his risk of becoming septic if he did not receive appropriate treatment. -She had concerns that the facility staff did not understand the importance of notifying her about the excessive drainage and odor of the wound. -She could not understand why the facility failed to notify her of the change in Resident #5's wound. -She expected to be notified of any change in any resident to ensure they receive proper care.	D 273		
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.	D 344		

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D 344	Continued From page 6 This Rule is not met as evidenced by: Based on observations, 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. The findings are: Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia with disturbances, psychotic disorder, and back pain. Review of an outpatient visit physician's note for Resident #3's physician's dated 08/27/20 revealed: -Resident #3 was evaluated for "a history of long-standing duration of back pain" and was positive for back pain, arthralgias, and joint pain. -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). -There was no clarification regarding how many tablets were supposed to be administered or what parameters the medication needed to be administered. Review of Resident #3's pharmacy profile dated 08/27/20 revealed: -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. -There was no clarification regarding how many tablets were supposed to be administered or what	D 344		

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parameters the medication needed to be administered.
-Thirty tablets of acetaminophen-codeine 300-30mg were dispensed with no refills on 08/27/20.

Review of Resident #3's primary care provider's (PCP) orders revealed:
-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).
-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).

Review of Resident #3's progress notes for 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.

Interview with a medication aide (MA) on 10/28/20 at 1:14pm revealed:
-Resident #3 was prescribed acetaminophen-codeine when she went to a specialist appointment 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 could not put the medication on Resident #3's electronic medication administration record because the medication order needed to be clarified she thought related to dosage.
-The MCM was supposed clarify the medication order with the prescriber because that was the

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MCM's responsibility.
-She did not call the prescriber of the acetaminophen-codeine to clarify the medication 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 Memory Care Manager 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 was taken to the appointment by another MA but returned without orders from the prescriber for new medication when she brought the narcotic 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 as needed for pain.
-She was supposed to call the prescribing provider the next day, but she did not contact the prescribing provider on 08/28/20.
-She gave the clarification to Resident #3's PCP instead to clarify on 08/28/20 and the PCP wrote the order to clarify the order written for acetaminophen-codeine for Resident #3.

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Second interview with the MCM on 10/30/20 at 4:45pm revealed:
-She did not realize the order written by the PCP for Resident #3's acetaminophen-codeine did not clarify the order because it did not have the strength of the medication noted.
-She had not contacted the PCP or the prescribing provider about the acetaminophen-codeine to get clarification of the order.
-Resident #3's acetaminophen-codeine became missing in early September 2020 and the Resident #3's PCP changed her pain medication to something else.

Interview with the Executive Director on 10/30/20 at 11:22am revealed:
-She did not know there was problem with Resident #3's acetaminophen-codeine order until the medication became missing in September 2020.
-It was the responsibility of the MCM and Resident Care Coordinator (RCC) to clarify medication orders with the physicians.
-If the MCM or the RCC were not available, then the lead MA or supervisor could verify medication orders with the physicians.
-Staff should document their attempts to clarify medication orders in the resident's progress notes.

Telephone interview with Resident #3's PCP on 10/30/20 at 2:15pm revealed:
-She was contacted by the MCM in August 2020 to try to clarify the order for acetaminophen-codeine for Resident #3.
-The MCM had not notified her since she wrote the clarification order that the medication order was not complete.

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D 344	Continued From page 10 -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. -She advised the MCM to check Resident #3's medication list to ensure it was up to date. Telephone interview with a nurse with Resident #3's orthopedic specialist on 11/04/20 at 9:07am revealed: -The facility never contacted their office and requested for clarification of the order for acetaminophen-codeine 300-30mg. -Their office would have clarified the medication order if they had been notified. -The provider had prescribed the medication for Resident #3 to help manage Resident #3's back pain and to prepare for an upcoming procedure. -It was the provider's preference for Resident #3 to have gotten the medication and for the facility to notify their office within 24 hours if there was problem with the medication order.	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: TYPE B VIOLATION	D 358		

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Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the physician for 1 of 5 residents sampled (#3) including a controlled substance for used to treat lower pain and the administration of an inhaler to prevent the exacerbation of shortness of breath.

The findings are:

Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia with disturbances, psychotic disorder, back pain, and shortness of breath.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 03/16/16.

a. Review of Resident #3's physician orders dated 08/07/20 revealed:
-There was a medication order for Tramadol 50mg - three times daily and 90 tablets were to be dispensed (Tramadol is a narcotic used to relieve moderate to severe pain).
-Tramadol 50mg was placed on hold on 08/27/20 by Resident #3's PCP due to a new narcotic order from another provider.

Review of a progress note from Resident #3's primary care provider dated 08/06/20 revealed:
-Resident #3 was seen for pain management for lower back pain.
-Resident #3's pain management regimen was Tramadol 50mg three times a day.
-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.
-It was documented Resident #3 "was unable to

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rate" her pain herself "but stated it was a constant nag".
-It was documented there were no changes in Resident #3's pain management regimen and a prescription given to the Memory Care Manager (MCM).

Review of an orthopedic office visit note for Resident #3 dated 08/27/20 revealed:
-Resident #3 presented with low back pain, arthralgia, and joint stiffness.
-She scored her pain at a 10 on a 0-10 pain scale with 10 being the highest level of pain.
-She reported her pain was increased by any prolonged sitting, standing, or walking.
-She was diagnosed with two vertebral compression fractures to her lumbar region.

Review of Resident #3's August 2020 electronic medication administration record (eMAR) revealed: -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 08/01/20 through 08/23/20.
-There was no administration of any scheduled doses of Tramadol on 08/24/20, 08/25/20, 08/26/20, or the morning dose for 08/27/20 for Resident #3.

Review of Resident #3's August 2020 electronic controlled substance log labeled for Tramadol 50mg revealed:
-There were 68 tablets of Tramadol 50mg available for administration on 08/01/20.
-There were 68 doses of Tramadol 50mg was documented as administered from 08/01/20 through 08/23/20.

Review of the facility's August 2020 medication

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administration compliance report for Resident #3 revealed:
-Staff documented Tramadol 50mg was not administered (on hold) for any doses at 8:00am, 2:00pm, and 8:00pm on 08/24/20, 08/25/20, and 08/26/20.
-Staff documented Tramadol 50mg was not administered (on hold) for the 8:00am dose on 08/27/20.

Telephone interview with Resident #3's pharmacy on 11/02/20 at 4:29pm revealed:
-Their pharmacy never received the prescription written 08/07/20 for Tramadol for Resident #3.
-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.
-The pharmacist was concerned that there was hard copy for narcotic that was not accounted for and the resident missed doses of her pain medication because the prescription was not sent to the pharmacy.
-Resident #3 last had a prescription sent to the pharmacy from the facility for Tramadol on 07/19/20.

Interview with a medication aide (MA) on 10/30/20 at 1:20pm revealed:
-Resident #3 was on a scheduled dose of Tramadol because she had back pain.
-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.
-The 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.

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-The MCM kept up with the narcotic 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.
-She did not know that Resident #3 had a prescription written for Tramadol on 08/07/20.
-She documented Resident #3's Tramadol was not administered because the medication was not in the facility.

Telephone interview with a second MA on 11/02/20 at 2:35pm revealed:
-Resident #3 was prescribed scheduled Tramadol because she had back pain.
-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.
-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.
-It was the responsibility of the MCM to get the prescription for Tramadol to the pharmacy so it could be used.

Interview with the Memory Care Manager on 10/30/20 at 10:43am revealed:
-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.
-She did not know why the MAs had documented that the narcotic was on hold.
-She did not realize that Resident #3 had prescription for written for Tramadol on 08/07/20.
-If the resident had the prescription then Resident #3 should not have run of Tramadol for her back pain.

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Second interview with the MCM on 10/30/20 at 4:45pm revealed:
-Resident #3 have a prescription for Tramadol written on 08/07/20.
-She did not know why Resident #3's prescription was not filled, and her Tramadol ran out.
-She was responsible to get the residents' prescription to their pharmacy to be filled once the physician wrote the medication order.

Interview with the Executive Director on 10/30/20 at 11:22am revealed:
-She did not know about the prescription order for Tramadol written for Resident #3 on 08/07/20.
-It was the responsibility of the MCM and Resident Care Coordinator (RCC) to ensure new prescription written were sent to the pharmacy to be filled.
-If Resident #3's prescription had been filled from 08/07/20 then Resident #3 would not have missed any doses of her scheduled Tramadol in late August 2020.

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.

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

Observation of Resident #3's medication on hand on 10/29/20 at 11:47am revealed:
-Resident #3's Symbicort inhaler was in its box and was labeled as dispensed on 08/18/20 for 120 doses.
-Resident #3's Symbicort dosage instruction read take 2 puff every 12 hours.

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-Observation of the dosage gauge of the inhaler revealed there were approximately 75 doses of Symbicort still remaining in the inhaler.

Review of Resident #3's electronic medication administration records (eMARs) revealed:
-Resident #3's Symbicort was documented as administered from 08/18/20 through 08/31/20 at 8:00am and 8:00pm.
-Resident #3's Symbicort was documented as administered from 09/01/20 through 09/30/20 at 8:00am and 8:00pm.
-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.

Interview with a medication aide (MA) on 10/30/20 at 6:29pm revealed:
-She had not noticed the date on Resident #3's Symbicort until the observation of medication on hand.
-If the medication was given, then Resident #3's Symbicort should be refilled at least once a month.
-When she administered Resident #3's inhaler, she makes sure Resident #3 makes a tight seal with the inhaler before she pumps the inhaler.
-She did not how other MA administered the inhaler to Resident #3.
-She had not noticed that Resident #3 appeared to have increased shortness of breath or complained about being short of breath.

Interview with the Memory Care Manager on 10/30/20 at 4:45pm revealed:
-She did not know that Resident #3's Symbicort had not been reordered since September 2020.
-If Resident #3's Symbicort was being administered properly then it should have finished

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within 30 days.
-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.

Interview with the Executive Director on 10/30/20 at 6:15pm revealed:
-It was her expectation for the MA to administer all medications to the residents as ordered.
-Staff should have noticed that Resident #3's Symbicort had not been reordered since September 2020.
-The Memory Care Manager had been doing medication cart audits weekly for about a month up until about two weeks ago.
-The MAs were supposed to be doing weekly medication cart audits not.
-The dispensing and expiration dates should have been checked on all the medications on the medication cart.

Telephone interview with Resident #3's primary care provider (PCP) on 11/04/20 at 1:25pm revealed:
-Resident #3 had a problem with 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.

____
The facility failed to assure medications were administered as ordered for a resident (#3) including a narcotic used for severe back pain related to vertebral compression fractures and an inhaler to prevent the exacerbation of shortness

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D 358	Continued From page 18 of breath related to COPD. The facility's failure resulted in the resident having no pain medication for a least 11 doses and receiving an inadequate dosage of her inhaler was detrimental to the health, safety and welfare of resident and constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances 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. This Rule is not met as evidenced by: 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 narcotic tablets unaccounted for and no controlled substance log for August 2020 for one resident (#3) and inaccurate controlled substance logs for narcotic administration and disposal for a second resident (#4).	D 392		

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The findings are:

1. Review of Resident #3's current FL-2 dated 06/11/20 revealed diagnoses included dementia with disturbances, psychotic disorder, and back pain.

Review of an outpatient visit physician's note for Resident #3's physician's dated 08/27/20 revealed:
-Resident #3 was evaluated for "a history of long-standing duration of back pain" and was positive for back pain, arthralgias, and joint pain.
-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).

Review of Resident #3's pharmacy profile dated 08/27/20 revealed:
-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.
-Thirty tablets of acetaminophen-codeine 300-30mg were dispensed with no refills on 08/27/20.

Review of Resident #3's controlled substance log for 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 pharmacy.

Review of the facility's controlled substances policy revealed:
-Documentation of the receipt of the controlled substances by the pharmacy will be maintained.

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-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.

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 substances drawer, but she did not count the tablets or put the narcotic in Resident #3's electronic medication administration record (eMAR) because the medication order needed to be clarified.
-The normal process for controlled substances was for the MA to count the medication and enter the medication order on the Resident #3's eMAR.

Interview with the Memory Care Manager on 10/30/20 at 10:43am revealed:

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D 392	Continued From page 21 -Resident #3 had a prescription for acetaminophen-codeine that was picked up from the pharmacy on 08/27/20. -The controlled substance was placed on the medication cart by the MA. -She was not sure if the MA counted the medication when it was received on 08/27/20. -It was the normal process for controlled substances to be counted and put into the system for the resident to have a control log. -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. -Without the medication order clarification, Resident #3 would not have a control for the acetaminophen-codeine. Interview with the Executive Director on 10/30/20 at 11:22am revealed: -Resident #3 did not have a control for her acetaminophen-codeine that was filled in August 2020 because there was a problem with getting her medication order clarified. -She did not know there was problem with Resident #3's acetaminophen-codeine order until the medication became missing in September 2020. -She did not know the MAs were not counting Resident #3's acetaminophen-codeine with the other controlled substances during shift changes. -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. 2. Review of Resident #4's current FL-2 dated 09/29/20 revealed diagnoses included bursitis left shoulder, hyperlipidemia, synovial cysts left knee	D 392		

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Review of Resident #4's physician's orders dated 09/29/20 revealed orders for hydrocodone-acetaminophen 75-325mg 2 tablets three times a day (hydrocodone-acetaminophen is a narcotic used to treat moderate to severe pain.)

Review Resident #4's physician order dated 08/14/20 and 10/07/20 revealed hydrocodone-acetaminophen 75-325mg 2 tablets three times a day

Review of Resident #4's September 2020 electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone-acetaminophen 75-325mg 2 tablets three times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There were 89 of 90 doses of hydrocodone-acetaminophen 75-325mg documented as administered from 09/01/20 - 09/30/20.
-One dose of hydrocodone-acetaminophen 75-325mg was documented as not administered at 8:00am on 09/23/20 due to the resident refusing.
-One dose of hydrocodone-acetaminophen 75-325mg was documented as administered at 8:00pm on 09/23/20.
-One dose of hydrocodone-acetaminophen 75-325mg was documented as administered at 8:00pm on 09/25/20.

Review of Resident #4's October 2020 eMAR revealed:
-There was an entry for hydrocodone-acetaminophen 75-325mg 2 tablets

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three times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm.
-There were 54 of 68 doses of hydrocodone-acetaminophen 75-325mg documented as administered from 10/01/20 - 10/28/20.
-There was an entry for hydrocodone-acetaminophen 75-325mg 2 tablets three times a day with scheduled administration times of 8:00am, 2:00pm, and 8:00pm on 10/17/20.
-One dose of hydrocodone-acetaminophen 75-325mg was documented as not administered at 2:00pm on 10/24/20 with no documentation as to why not given.

Review of controlled substance (CS) logs for Resident #4's hydrocodone-acetaminophen 75-325mg tablets for September 2020 revealed:
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as administered on 09/23/20 at 7:20pm.
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as dropped medication on 09/23/20 at 10:47pm.
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as administered on 09/25/20 at 8:03pm.
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as wasted with reasoning documented as other on 09/26/20 at 7:36am.

Review of controlled substance (CS) logs for Resident #4's hydrocodone-acetaminophen 75-325mg tablets for October 2020 revealed:
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as administered on 10/17/20 at 8:00pm.
-Hydrocodone-acetaminophen 75-325mg 1 tablet was documented as wasted with the reasoning

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on other on 10/18/20 at 7:02am.
-Hydrocodone-acetaminophen 75-325mg 2 tablet was documented as administered on 10/24/20 at 8:51am
-Hydrocodone-acetaminophen 75-325mg 2 tablet was documented as wasted, dropped medication on 10/24/20 at 3:13pm.
-There was no documentation of Hydrocodone-acetaminophen 75-325mg being administered between 8:51am and 3:13pm.

Review of Resident #4's pharmacy dispensing records for hydrocodone-acetaminophen 75-325mg revealed:
-There were 180 hydrocodone-acetaminophen 75-325mg tablets dispensed on 09/01/20.
-There were 180 hydrocodone-acetaminophen 75-325mg tablets dispensed on 10/09/20.

Interview with a Medication Aide (MA) on 11/02/20 at 3:46pm revealed:
-She sent Resident #4 out of the facility to the hospital around 12:38 pm on 10/24/20.
-She had popped the medication for administration to Resident #4's 2:00pm scheduled dose.
-She sent Resident #4 to the hospital before Resident #4's 2:00pm scheduled dose of hydrocodone-acetaminophen 75-325mg was given.
-She had to put in wasted on the CS log because she had not pulled the hydrocodone-acetaminophen 75-325mg.
-She had never taken the hydrocodone-acetaminophen 75-325mg out of the package.
-She called the Resident Care Coordinator (RCC) and informed them as to what happen and needing to document in the system as wasted to correct the count.

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-She had not given Resident #4 her 2:00pm dose of medication because Resident #4 was out of the facility by 1:00pm.
-She had clicked all Resident #4's medications as not administered in the system except the hydrocodone-acetaminophen 75-325mg, she had accidently marked it as administered.
-When then medications marked as administered in the system you had to enter the number of tables given for the count to be correct.
-She had accidently document administering hydrocodone-acetaminophen 75-325mg 1 tablet.

Interview with the RCC on 11/02/20 at 4:30pm revealed:
-MA's should document in Matrix how many medications are being wasted and why the medication is being wasted.
-MA's should contact the RCC when medication was wasted.
-MA's were expected to check and recheck the number entered prior to clicking administered in the system.

Interview with the Executive Director (ED) in 11/02/20 at 4:15pm revealed:
-MA's should document in Matrix how many medications are being wasted and why the medication is being wasted.
-MA's should contact the Care Mangers when medication was wasted.
-Care Mangers were responsible for control substance log audits.
-Care Mangers were to complete control substance log audits weekly.
-There is no way to track errors in the system.
-She expected all medication orders to be given as ordered.

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D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for 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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff working while displaying COVID-19 symptoms, residents not maintaining a social	D 601		

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distance of six feet apart, residents not wearing masks, and staff failing identifying a resident (#4) who was on isolation or wear the required personal protective equipment with providing care to the resident.

The findings are:

1. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities last updated 04/30/20 revealed:
-Residents should wear a cloth face covering or face mask whenever they leave their room in the facility.
-Face masks should not be worn under the nose or mouth.
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.
-If personnel are ill, have them keep their face mask on and leave the workplace.
-All personnel should practice social distancing (remain at least six feet apart) when in common areas.
-Implement social distancing among residents (remain at least six feet apart).

Review of the CDC guidelines for the prevention and spread of the coronavirus disease in LTC facilities last updated 06/25/20 revealed:
-For a resident returning from a hospital admission, 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.
-Staff should wear an N95 or higher-level

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D 601	Continued From page 28 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. -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. Review of the facility's infection/ COVID-19 guidelines revealed: -Any employee with symptoms of COVID-19 should report to their immediate supervisor as soon as possible. -The supervisor will request the employee to go home and the supervisor will report the event to the Executive Director. -The employee showing symptoms of COVID-19 will be excluded from work for at least 24 hours after they no longer have a fever. a. Review of the facility's COVID-19 Screen Log for Staff D revealed: -Staff D was screened by another employee on 09/20/20 at 6:53pm. -Staff D reported having shortness of breath and muscle pain. Review of the Staff D's time card on revealed Staff D worked on 09/20/20 from 7:30pm to 7:00am on 09/21//20. Attempted telephone interview with Staff D on 11/04/20 at 9:35am was unsuccessful. Telephone interview with a MA on 11/02/04 at 2:00pm revealed: -She worked on the morning of 09/20/20 and arrived shortly before her 7am shift.	D 601		

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-She was trained on completing pre-screening for staff and visitors.
-She did not complete a pre-screening for Staff D on 09/20/20.
-She did not allow any staff to continue to work if they had any signs or symptoms of COVID-19.
-She had reported immediately to the ED of all staff who displayed or reported any signs or symptoms of COVID-19.
-Staff were screened by another staff and self-pre-screening was not allowed.

Telephone interview with the ED on 11/04/20 at 12:20pm revealed:
-Staff were not allowed to work if they displayed any signs or symptoms of COVID-19.
-She was not aware Staff D worked with reported signs COVID-19 symptoms.
-Staff D tested positive for COVID-19 on 07/29/20 and remained on quarantine for the required 14 days and returned to work on 08/17/20.
-Staff who tested positive for COVID-19 were quarantined for 14 days and had to submit a negative COVID-19 test result after their quarantine to be eligible to return to work.

Attempted telephone interview with the Divisional Vice President of Operations on 1104/20 at 1:58pm was unsuccessful.

Refer to telephone interview with the ED on 11/04/20 at 12:20pm.

b. Review of the facility's COVID-19 Screen Log for Staff G revealed Staff G completed a self-pre-screening on 09/24/20 at 8:19pm and reported having a cough.

Review of Staff G's time card revealed Staff G had worked on 09/24/20 from 8:13pm to

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11:07pm.

Telephone interview with Staff G on 11/04/20 at 9:40am revealed:
-She worked on 09/24/20 with a cough symptom.
-She informed the ED of having coughing symptoms.
-She had consulted with her PCP who instructed her to take a "fluid pill" to ease the coughing.
-She did not provide any documentation from the PCP's order to have her to take the "fluid pill" to ease her cough.
-The ED knew of Staff G's medical condition and allowed her to work.
-The ED gave Staff G permission to remain at work.
-Staff G had completed COVID-19 testing on 08/31/20 and 11/04/20.
-She was not positive for COVID-19.
-She did not complete her own COVID-19 pre-screening on 09/24/20.
-Staff were not allowed to complete their own COVID-19 pre-screenings.
-She was trained on completing pre-screenings for other staff and visitors.
-She knew the policy of staff not being allowed to work if the staff had a high temperature or any signs of COVID-19 symptoms.

-Telephone interview with the ED on 11/04/20 at 12:20pm revealed:
-Staff were not allowed to work if they displayed any signs or symptoms of COVID-19.
-Staff who had known medical conditions were not allowed to work if they reported or displayed any signs or symptoms of COVID-19.
-She was not aware of Staff G working with reported signs COVID-19 symptoms.
-She had not given permission Staff G to remain at work with COVID-19 symptoms.

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-Staff who had reported COVID-19 symptoms were to quarantine for 10 days, complete a COVID-19 test and submit a negative result and could not have any symptoms and be cleared of taking related medications 24-hours prior to reporting back to work.
-It was the expectation of the ED that staff would not allow another staff or visitor who had displayed or reported any COVID-19 symptoms into the facility and immediately informed her or a supervisor.

Attempted telephone interview with the Divisional Vice President of Operations on 11/04/20 at 1:58pm was unsuccessful.

Refer to telephone interview with the ED on 11/04/20 at 12:20pm.

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Telephone interview with the ED on 11/04/20 at 12:20pm revealed:
-Staff who reported or displayed any signs or symptoms of COVID-19 should be reported immediately to the ED if on site or the Resident Care Manager, Memory Care Manager or the Supervisor.
-Staff were not allowed to complete their own pre-screening.
-All screenings were completed on a tablet and an alert or warning signs was provided to the staff completing the screening that the staff or visitor were not allowed to enter the facility.
-All the staff were trained to complete pre-screening of staff and visitors and the tablet did not require a security code to sign in or out on the tablet.
-High temperatures, reports of symptoms and reports of pending COVID-19 test results were warning signs of COVID-19.
-The facility's COVID-19 Screening Log was an

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electronic monitoring system used by the corporate office and she had to request a print out of the staff screenings because the staff screenings were archived at their corporate office and she did not have direct access to the monitoring system.

c. 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.

Review of Resident #4's record revealed a hospital discharge date of 10/27/20.

Observation of the assisted living side of the facility on 10/28/20 at 2:20pm revealed:
-Resident #4's room door was open.
-There was no signage posted on Resident #4's room door indicating isolation precautions.
-The medication aide (MA) entered Resident #4's room to administer medication with a mask and a face shield on.
-The MA exited Resident #4's room, hand sanitized and proceeded to administer medication to two other resident that were not COVID-19 positive and was not on isolation.

Interview with a MA on 10/28/20 at 2:19pm revealed:
-Resident #4 had just returned from the hospital on 10/27/20.
-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

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hospital, emergency department, or doctor's office were required to quarantine in their rooms for ten days when returning to the facility.
-There was no signage posted outside the resident's door to indicate quarantine.
-The resident was placed in the hot box communications and the information related to who was on quarantine was passed verbally from shift to shit via report.
-Resident were required to isolate in their rooms with the door closed.
-Staff were to wear personal protective equipment including mask, face shields and gloves when providing care to these residents.
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.
-The staff member lowered the mask of one resident 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.
-The staff member brought a fifth resident into the sitting area with the other four residents and placed the fifth resident approximately within two feet of the other residents at approximately 11:41am.
-The fifth resident was wearing a mask over her mouth and nose.
-The staff member was observed pacing back and forth in the area of the five residents within three feet of the residents with no social distancing practiced.

Observation of the SCU on 10/28/20 from 1:00pm to 1:40pm revealed:
-There were six residents in the sitting area and

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all the residents were sitting one to three feet apart.
-Two of the residents were not wearing masks and were sitting less than two feet apart.
-There were additional four residents sitting in wheelchairs sitting approximately two feet apart from each other.
-One of those residents was not wearing a mask, the second resident wore their mask under their chin, and the third and fourth/ resident wore their masks under their noses.
-A personal care aide (PCA) escorted a resident down the hallway; the resident was not wearing a mask; and seated the resident in the sitting room next to the resident (less one foot apart) who was not wearing a mask.
-A receptionist was observed assisting another unmasked resident to for window visit with a family member.
-The PCA moved a second resident who was not wearing a mask from the dining room down the hallway to the resident's bedroom.
-The PCA nor the receptionist offered to any of the unmasked residents masks to wear to prevent the spread of infection or encourage social distancing with any of the residents.

Interview with a PCA on 10/28/20 at 11:42am revealed:
-It was hard to keep residents social distanced or to get residents to wear their masks.
-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.
-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.
-It was hard to get the residents to social

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distances.
-Some residents wandered, and staff tried to keep up with them to make sure they did not touch anything or anyone.
-The residents lined up wheelchairs without social distancing were being monitored by staff for safety.
-She had not thought about the social distancing of the residents in the sitting area.

Observation of the SCU on 10/29/20 at 9:41am revealed:
-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.
-No staff offered the resident a mask to wear.

Second observation of the SCU on 10/29/20 at 9:57am revealed a female resident walked down the hallway from her room, passed the nurse's station with staff present, and the resident was not wearing, nor did staff offer the resident a mask.

Third observation of the SCU on 10/29/20 at 11:32am revealed:
-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.
-A medication aide (MA) brought a second resident and sat her less than one front apart from the first resident.
-The second resident was not wearing a mask.
-Staff did not offer a mask to either of the residents.

Fourth observation of the SCU on 10/29/20 at 3:18pm revealed:

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-There were fourteen residents in the sitting area of the SCU who were sitting two to three feet apart.
-Eight of these residents were not wearing masks and three other residents wore their masks under their chin.
-None of the staff present offered the residents masks or encouraged residents to social distance.

Fifth observation of the SCU on 10/28/20 at 11:13am revealed staff walked pass a resident sitting in a wheelchair in the hallway with no mask on.

Sixth observation 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.

Seventh observation of the SCU revealed staff was rolling a resident with no mask on down the hallway towards the TV room.

Eighth observation 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 residents that did not have a mask on.

Nineth observation of the SCU on 10/29/20 at 9:49am revealed:
-Staff talking to a resident standing less than six feet apart.
-Staff had on a face shield and a mask.
-Staff removed mask from covering mouth and nose to talk to the resident.

Tenth observation of the SCU on 10/29/20 at 9:39 am revealed:

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-A resident with no mask on was sitting directly across from the nurse's station.
-There were two staff sitting at the nurse's station.
-Staff did not redirect the resident to wear a mask.

Eleventh observation of the SCU on 10/29/20 at 9:52am revealed the same resident was still sitting across from the nurse's station with no mask on.
-The same staff was sitting at the nurse's station and did not redirect the resident to wear a mask.

Twelfth observation of the SCU on 10/29/20 at 9:55am revealed:
-There were 3 residents in the dining room with one staff present.
-One of the residents that was wearing a mask went around the dining room and hugged other residents that were not wearing a mask because they were eating.
-Staff that was present did not redirect the residents.

Interview with a MA on 10/29/20 at 3:15pm revealed:
-Staff "did the best they could to keep masks on the residents in the SCU".
-"It was hard to do" because most of the residents could not remember to keep the mask on or over their face and nose.
-It was difficult to keep the residents in the SCU socially distanced, since they could not remember to do so and sometimes wandered.

Telephone interview with a second MA on 11/2/20 at 4:41pm revealed:
-There was a problem with getting the residents in the SCU to social distance and to wear masks due to COVID-19.

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-The residents do not understand the concept that of the precautions that are needed to be taken because of the pandemic.
-Some residents are easy to redirect to social distance and to remind to put on their masks and other residents are not.
-Even the residents in the wheelchair will move themselves when we are trying to maintain social distancing.
-The staff did try to maintain social distancing and encourage all residents in the SCU to wear their masks.

Telephone interview with a third MA who worked in the SCU 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 due to COVID-19.
-The residents do not understand the concept that of the precautions that are needed to be taken because of the pandemic.
-Some residents are easy to redirect to social distance and to remind to put on their masks and other residents are not.
-Even the residents in the wheelchair will move themselves when we are 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 residents, but they had a difficult time keeping

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D 601	Continued From page 39 them socially distanced. -The two residents in the television area should have been at least six feet apart and wearing masks. -She expected staff to ensure residents were always wearing masks. -She expected staff to reinforce the importance of social distancing and wearing masks to residents. Interview with the Executive Director (ED) on 10/29/20 at 4:15pm revealed: -All staff were expected to wear a mask while in the facility. -All residents were to wear a mask when outside of their rooms except when they are eating in the dining room. -Residents were to social distance when out of their rooms. -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. -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. d. Observation of a resident on the assisted living (AL) unit on 10/29/20 at 10:00am revealed: -He used the telephone located at the nursing station to speak with someone. -The telephone cord was placed over the top of the nursing station counter so the resident could use the telephone. -Once he completed his telephone call, he handed the telephone receiver back to the medication aide (MA).	D 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL037001	A. BUILDING: ______ B. WING ______	11/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

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D 601	Continued From page 40	D 601		

-The MA placed the telephone receiver on the counter next to the telephone base and looked for alcohol wipes to sanitize the phone.
-After approximately five minutes she returned and placed the telephone receiver back on the telephone base without sanitizing it.

Interview with the MA on 10/29/20 at 10:29am revealed:
-She should have sanitized the telephone after the resident returned the phone to her per the facilities COVID-19 Infection Control Policy.
-She acknowledged that it was her fault that she forgot to sanitize the telephone.
-She did eventually sanitize the telephone receiver and the telephone base.

Interview with the Executive Director (ED) on 10/29/20 at 3:35pm revealed:
-The MA should have sanitized the telephone at the nursing station after it was used by the resident.
-The MA should have followed the COVID-19 Infection Control Policy for the facility.

____

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 (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic and to ensure all staff with signs symptoms of COVID-19 were not allowed to work in which constituted possible exposure of COVID-19 to residents, failure to properly use PPE, social distancing, isolation and proper cleaning of telephones used by residents. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a TYPE B VIOLATION.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 601	Continued From page 41	D 601		

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020.

D914 G.S. 131D-21(4) Declaration of Residents' Rights — D914

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 observations, interviews, and record reviews the facility failed to ensure residents were free of neglect and harm as related to residents' rights regarding the facility adhering to infection control guidelines during the Coronavirus pandemic and assuring pain medication was administored as ordered to Resident #3 with a history of chronic pain.

The findings are:

1. Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 42 infection as related to staff working while displaying COVID-19 symptoms, residents not maintaining a social distance of six feet apart, residents not wearing masks, and staff failing identifying a resident (#4) who was on isolation or wear the required personal protective equipment with providing care to the resident. [Refer to Tag D601 10A NCAC 13F .1801 Infection Prevention and Control (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the physician for 1 of 5 residents sampled (#3) including a controlled substance for used to treat lower 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 Adminstration (Type B Violation).]	D914		