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
	HAL001103	A. BUILDING: _____ B. WING _____	R 03/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on March 23-24, 2021.	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 health care needs were met for 1 of 3 sampled residents (#3) related to the scheduling follow up appointments for Occupational Therapy (OT) and Physical Therapy (PT) after a hospital admission and failure to notify the mental health provider for a medication that was ordered as need but was administered daily. The findings are: 1. Review of Resident #3's current FL-2 dated 01/14/21 revealed diagnoses included Huntington's disease (a condition in which nerve cells in the brain break down over time), adjustment disorder with anxiety, depressed mood, hyperlipidemia, protein calorie malnutrition, Vitamin D deficiency, insomnia, and rhinitis. a. Review of the discharge summary for Resident #3 from the local hospital dated 01/11/21 revealed there was an electronically signed physician's order for referral and treatment for PT and an electronically signed physician's order for referral and treatment for OT.	D 273	The administrator will ensure that all orders are followed as ordered; the administrator will also ensure that all residents charts are reviewed upon discharge from hospital and that any new orders will be implemented as directed. The administrator will update the FL-2 as clients conditions change and new diagnosis are determined. The administrator will discuss new orders with all staff to ensure that all orders are followed to meet the need of the resident.	4/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan C Lee | TITLE: Administrator | (X6) DATE: 4/22/21

Reviewed and accepted - SS- 04/23/21

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D 273	Continued From page 1 Observation of the calendars used for scheduling appointments from January 2021 through March 2021 revealed there were no PT or OT appointments for Resident #3. Interview with Resident #3 on 03/23/21 at 11:18am and 3:11pm revealed: -He could walk but his legs were weak. -He wanted to walk to the store but he could not because of the weakness in his legs. -He fell on his first day back at the facility after being in the hospital. -Staff had to help him with showering. -The Medication Aide/Supervisor-in-Charge (MA/SIC) took him to all his appointments. -He had not missed any appointments. -He had not gone to OT or PT and no one had come to the facility to provide OT or PT for him. -No one had discussed OT or PT with him, but he would be willing to try it if it was offered to him. Telephone interview with Resident #3's family member on 03/24/21 at 10:52am revealed: -She knew Resident #3 was supposed to have OT and PT after his hospital stay in January 2021, but he did not have either. -Resident #3 was supposed to enter a facility that offered inhouse OT and PT but due to the pandemic the facility could not admit him. -She had not been contacted by the facility or the primary care physician (PCP) to set up OT or PT for Resident #3. -She did not think the facility investigated other OT or PT options for Resident #3. Telephone interview with Resident #3's PCP on 03/24/21 at 11:09am revealed: -She did not see the referral for PT and OT in Resident #3's hospital discharge or on his hospital FL-2.	D 273	The administrator will ensure that all orders and needed therapy sessions are written down on the calendar, as well as future appointments to include the doctors name, address, telephone number. The administrator will also communicate all future appointments with the transporation staff to ensure no appointments are missed. The adminstrator will meet with all residents upon discharged from the hospital to discuss treatment plan in an effort to keep residents abreast of services needed. The administrator will also contact the residents family member or guardian to discuss new orders or additional services needed.	04/01/21

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D 273	Continued From page 2 -Normally someone from the hospital set up the PT and OT referrals prior to discharge from the hospital. -She could not say why PT and OT were not set up by the MA/SIC; maybe the MA/SIC was waiting for home health to set up PT and OT for Resident #3. -Resident #3 had Huntington's disease and was still "a little off-balance" so he would benefit from PT and OT. -She could set up in house PT and OT for Resident #3. Interview with the MA/SIC on 03/23/21 at 2:55pm revealed: -Resident #3 had never been to PT or OT. -He never had appointments for PT or OT. -She took Resident #3 to all his appointments. -She and the Administrator were responsible for making appointments for the residents; whoever saw the order made the appointments. -Appointments were put on a calendar. Interview with the Administrator on 03/24/21 at 9:50am revealed: -Resident #3 had never been recommended [referred] to PT or OT. -She had reviewed Resident #3's hospital discharge paperwork. -She did not see the order for PT or OT, and no one ever said anything to her about PT or OT for Resident #3. -Resident #3's PCP was responsible for "getting" PT and OT to come to the facility for the resident. -She and the MA/SIC were responsible for making the appointments for the residents. -She guessed they "both missed this one" so Resident #3 had not had PT or OT. -She, the PCP, and the MA/SIC were supposed to review the hospital discharge information	D 273	The administrator will work with the PCP to ensure that no future orders/services are missed. The administrator will fax all hospital discharge instruction to PCP.	04/01/21

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D 273	Continued From page 3 because the more "eyes on it the better" to catch mistakes. b. Review of Resident #3's current FL-2 dated 01/14/21 revealed: -There was an order for clonazepam (a medication used to treat anxiety) 1 mg scheduled once daily at bedtime. -There was an order for melatonin (a supplement used to aid in sleeping due to insomnia) 5 mg scheduled once daily at bedtime. Review of a signed physician's order for Resident #3 dated 01/14/21 revealed there was an order to begin clonazepam 1 mg as needed (PRN) fill on or after 02/10/21. Review of Resident #3's medication administration record (MAR) for January 2021 revealed: -There was an electronic entry for clonazepam 1 mg scheduled once daily at bedtime. -The clonazepam was documented as administered once daily as scheduled at bedtime beginning 01/11/21 and was administered 20 of 20 opportunities. Review of Resident #3's MAR for February 2021 revealed: -There was an electronic entry for clonazepam 1 mg scheduled once daily at bedtime. -The clonazepam was documented as administered once daily for 8 out of 8 opportunities. -There was a handwritten note across the entry dates that read "order changed 02/09/21". -There was a second handwritten entry for clonazepam 1 mg once daily at night PRN; PRN was also written on the date line. -The clonazepam was documented as	D 273		

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D 273	Continued From page 4 administered once daily at bedtime 21 out of 21 opportunities. -There was notation on the back of the MAR that clonazepam was administered once a day at 8:00pm from 02/09/21 to 02/28/21; the reason noted for the administration was anxiety and that the clonazepam was effective each time. Review of Resident #3's MAR for March 2021 revealed: -There was an electronic entry for clonazepam 1 mg at bedtime as needed. -Clonazepam was documented as administered once daily 22 of 22 opportunities. -There was notation on the back of the MAR that clonazepam was administered once a day from 03/01/21 through 03/13/21; the reason noted for each administration was sleep and was effective each time. Review of Resident #3's dispensing records from the facility's contracted pharmacy revealed: -Thirty tablets of clonazepam 1 mg were dispensed on 01/11/21 and 02/09/21. -Seven tablets of clonazepam 1 mg were dispensed on 03/11/21. Telephone interview with Resident #3's Pharmacist on 03/23/21 at 3:58pm revealed: -Thirty tablets of clonazepam 1 mg were dispensed on 01/11/21; the order was to administer daily scheduled at bedtime. -Thirty tablets of clonazepam 1 mg were dispensed on 02/10/21; the order was to administer one tablet take at bedtime as needed. -Seven tablets of clonazepam 1 mg were dispensed on 03/11/21; the order was to administer one tablet at bedtime as needed. -Clonazepam was a controlled substance so a new order was needed each time to refill.	D 273		

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D 273	Continued From page 5 -Clonazepam was used for anxiety, panic disorders and sometimes seizures. Interview with Resident #3 on 03/23/21 at 11:18am revealed: -He only took one medication PRN and that was acetaminophen for headaches. -He took his scheduled medications at night; he did not know what the scheduled medications were. Interview with Resident #3 on 03/24/21 at 8:58am revealed: -He slept good at night and did not wake up in the middle of the night. -He has been in a good mood since he returned from his hospital stay and liked to play games on his tablet by himself. Interview with two residents on 03/24/21 at 9:08am and 10:28am revealed: -Resident #3 used to have "freak out attacks" and yell before he went to the hospital. -Resident #3 had been in a good mood, not yelled and not had any "attacks" since he returned from the hospital. -Resident #3 did not randomly walk into their rooms or knock on the doors at night. -Resident #3 went to bed at night without problems. Telephone interview with Resident #3's mental health provider on 03/23/21 at 4:45pm revealed: -Resident #3 was sent back to the facility with a PRN order for clonazepam; the clonazepam should have never been scheduled. -The Supervisor-in-Charge/Medication Aide (SIC/MA) called on 02/25/21 and tried to get an order to have the clonazepam scheduled for Resident #3.	D 273		

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D 273	Continued From page 6 -He did not feel Resident #3 should have been on clonazepam; his goal long term was to take Resident #3 off the clonazepam. Telephone interview with Resident #3's mental health provider on 03/24/21 at 1:18pm revealed: -Clonazepam was ordered for Resident #3 because of his anxiety; he only needed the medication when he became very agitated or anxious. -Clonazepam was only a short-term treatment and should only have been given when Resident #3 had a "full blown panic attack". -He had never intended for Resident #3's clonazepam to be administered as a scheduled medication. -Clonazepam could mask other problems Resident #3 might have been having if it was administered daily. -No one from the facility had contacted him to let him know Resident #3 was being administered clonazepam daily; only to try to change the clonazepam to scheduled once daily. -The facility staff had requested to have Resident #3's clonazepam changed to a scheduled medication in February 2021 and he had made it very clear then that he did not want Resident #3 to take the clonazepam daily. -Resident #3's other medications should keep him balanced so that he would never need to be administered the clonazepam. -If Resident #3 was administered the clonazepam daily that would mean the resident's other medications were out of balance and he would need to know that so he could adjust the scheduled medications Resident #3 was taking. Interview with the Administrator on 03/23/21 at 8:08am revealed: -Resident #3 had been "good" since his	D 273		

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D 273	Continued From page 7 discharge from the hospital on 01/11/2. -Resident #3 had been sent to the hospital in November 2021 because he was having episodes of yelling, screaming and hallucinations. Telephone interview with the SIC/MA on 03/24/21 at 3:53pm revealed: -Resident #3 did not ask for his clonazepam; she doubted he even knew what it was. -She administered Resident #3 his clonazepam every night so he would sleep. -Resident #3 was up at night if he did not take the clonazepam before bed. -Resident #3 would sit up in the bed or walk the halls or watch television when he could not sleep. -Resident #3 did not bother other residents when he could not sleep. -Resident #3 was not aggressive and was not loud. -Resident #3 had been good and had only been awake at night a few times since he ran out of the last 7 PRN clonazepam tablets that were ordered. -She had called the 800 number for Resident #3's mental health provider when he had run out of the clonazepam tablets; she was trying to get a refill on the clonazepam and trying to get the order changed back to scheduled daily. -She did not notify Resident #3's mental health provider when she administered his medication every night. -Resident #3 had an appointment with the mental health provider on 03/25/21 and she would talk to him then about changing the order for he clonazepam. Interview with the Administrator on 03/24/21 at 10:09am revealed: -Resident #3's clonazepam was ordered by his mental health provider. -She knew Resident #3's clonazepam was	D 273		

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D 273	Continued From page 8 changed to PRN. -Resident #3 was administered his medication every night because he was becoming agitated and moving around instead of sleeping. -Resident #3 was restless and bothered the other residents; the residents had complained to her about Resident #3 going into their rooms and knocking on their doors at night while they tried to sleep. -Resident #3 asked for the clonazepam so he could go to sleep; he did not ask for his clonazepam by name, but he knew what tablets he took and would ask for the tablet to sleep. -The SIC/MA had tried to contact the mental health provider about a month ago to get the order for the clonazepam changed back to a scheduled medication. -The SIC/MA was going to talk to the mental health provider about changing the clonazepam changed back to a scheduled medication at Resident #3's appointment that was scheduled for 03/25/21. -When a PRN was administered for 10-15 days in a row, the facility would contact the provider; they did not document when the mental health provider was notified. -There was not a policy for PRN medications; if there was "it was old and needed to be updated anyway".	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296		

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D 296	Continued From page 9 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered by the resident's physician for 2 of 3 sampled residents (#1 and #2) who had an order for low sodium diet (#1) and for a dysphagia 3 and low sodium diet (#2). The findings are: Observation of the kitchen on 03/23/21 at 12:03pm revealed: -There was a menu posted in the kitchen -The menu was not dated. -There were 6 therapeutic diets listed on the menu; no concentrated sweets, 1500 calorie, 1800 calorie, 2000 calorie, low fat low cholesterol and no added salt. -The regular menu consisted of 1 to 2 hot dogs on a bun with chili and slaw, potato chips, baked beans, fruit yogurt and a beverage. -The menu for no added salt (NAS) included a roast beef sandwich on wheat bread with lettuce and tomato with lite mayonnaise, coleslaw, baked beans and fruit yogurt with a beverage. Observation of the lunch meal on 03/23/21 at 12:05pm revealed residents were served one to two hot dogs on a bun with chili and slaw, baked beans, canned pears and water. Interview with the Administrator on 03/23/21 at 9:45am revealed all residents had a regular diet order and received a regular diet. 1. Review of Resident #1's current FL-2 dated 02/17/21 revealed:	D 296	The administrator will ensure that all nutrition menus are posted in the facility and that the menu matches the therapeutic diet order by all physcians. The adminstrator will also post a menu in the kitchen area indicating which residents are on special diets. The adminstrator will also ensure that all menus are dated. The administrator has reviewed all residents files to ensure the proper diets are being served to the residents.	4/01/21

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D 296	Continued From page 10 -Diagnoses included: acute congestive heart failure, chronic obstructive pulmonary disease, hyperlipidemia, hypertension, and cerebral ischemia. -There was an order for low sodium heart healthy diet. Observation of the kitchen on 03/23/21 at 12:03pm revealed: -There was a menu posted in the kitchen -The menu was not dated. -There was no menu for a low sodium heart healthy diet. -The regular menu consisted of 1 to 2 hot dogs on a bun with chili and slaw, potato chips, baked beans, fruit yogurt and a beverage. Observation of the lunch meal on 03/23/21 at 12:05pm revealed: -Resident #1 was served one hot dog on a bun with chili and slaw, baked beans, canned pears and water. -Resident #1 ate 100 percent of his meal and requested a second hot dog. -The Administrator served Resident #1 the second requested hot dog on a bun with chili and slaw. -Resident #1 ate 100 percent of the second hot dog. Interview with Resident #1 on 03/24/21 at 9:53am revealed: -He had diabetes and he thought his primary care provider (PCP) wanted him to not eat a lot of sugar. -His PCP told him to not eat a lot of salt, because he had swelling in his ankles and feet prior to his hospitalization. Attempted telephone interview with Resident #1's	D 296		

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D 296	Continued From page 11 primary care provider (PCP) on 03/24/21 at 11:23am was unsuccessful. Telephone interview with the Supervisor in Charge (SIC) on 03/24/21 at 10:34am revealed: -Resident #1 had a regular diet. -She had not reviewed Resident #1's hospital FL-2 dated 02/17/21 for a new diet order, but the Administrator reviewed the paperwork. Interview with the Administrator on 03/24/21 at 1:45pm revealed: -She had reviewed Resident #1's hospital FL-2 dated 02/17/21 and faxed it over to the pharmacy. -She thought he had an order for low salt regular diet. -She knew what to serve Resident #1 based on what she was told over the years by physicians, which was to not add salt to their foods and not place salt on the tables. -She did not know if the hot dogs and canned chili served on 03/23/21 were low sodium or not. Refer to the telephone interview with the SIC on 03/24/21 at 12:10pm. Refer to the interviews with the Administrator on 03/24/21 at 12:00pm and at 1:45pm. 2. Review of Resident #2's current FL-2 dated 03/15/21 revealed: -Diagnoses included malnutrition moderate degree, umbilical hernia, non-intractable vomiting, emphysematous gastritis, abdominal pain, small bowel obstruction, intestinal adhesions, urinary retention, autism spectrum disorder, intellectual disability, and anxiety disorder. -There was a diet order for dysphagia 3 (a dysphagia 3 diet included moist foods in bite sized pieces).	D 296	The administrator had a staff meeting with all staff to discuss special diets.	

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D 296	Continued From page 12 Review of Resident #2's hospital discharge summary dated 03/15/21 revealed there was an order for a low sodium heart healthy diet. Observation of the kitchen on 03/23/21 at 12:03pm revealed: -There was a menu posted in the kitchen -The menu was not dated. -There was no menu for dysphagia 3, or low sodium heart healthy diet. -The regular menu consisted of 1 to 2 hot dogs on a bun with chili and slaw, potato chips, baked beans, fruit yogurt and a beverage. Observation of the lunch meal on 03/23/21 at 12:05pm revealed: -Resident #2 was served one chopped hot dog on a bun with chili and slaw, baked beans, canned pears and water. -Resident #2 ate 100 percent of his meal. Telephone interview with the Supervisor-in-Charge (SIC) on 03/24/21 at 12:10pm revealed: -She followed the regular menu when she prepared and served meals because none of the residents were on any special [therapeutic] diets. -Resident #2 was not on a special diet but she usually chopped up Resident #2's food for him because he did not have teeth. Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable. Telephone interview with Resident #2's primary care provider (PCP) on 03/24/21 at 11:26am revealed: -Resident #2 had a history of ileus and this was	D 296		

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D 296	Continued From page 13	D 296		

the reason for his recent surgery in March 2021.
-He needed a regular diet that was chopped or soft.
-She had not seen Resident #2's hospital FL-2 diet order of dysphagia 3 and she was not familiar with a dysphagia 3 diet.
-No staff had requested a new diet order for Resident #2.
-She had not noted the diet on Resident #2's hospital discharge summary, but he would benefit from a low sodium diet because his blood pressure was increasing.
-She would have ordered a soft low sodium diet for Resident #2 because he would benefit.
-She had not written a new diet order for Resident #2.

Telephone interview with the SIC on 03/24/21 at 10:34am revealed:
-She had reviewed Resident #2's hospital FL-2 and discharge summary and thought Resident #2's diet orders were soft foods until he could tolerate a regular diet.
-She told the Administrator Resident #2's diet order was soft foods .
-She did not know Resident #2's diet order was dysphagia 3 on the FL-2.
-When the PCP ordered a "special diet", staff were told by the PCP.
-She was not told by Resident #2's PCP that he had a special diet.
-Resident #2's PCP had not written a special diet order for him.

Interview with the Administrator on 03/24/21 at 1:45pm revealed:
-She had reviewed Resident #2's hospital discharge summary and she thought it indicated Resident #2 should have a regular diet.
-She did not know what a dysphagia 3 diet should

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D 296	Continued From page 14 include for foods. -She did know Resident #2 had one diet on his FL-2 and another on the hospital discharge summary. -If she had known, she would have told his PCP on 03/23/21. -She chopped Resident #2's food since admission because he had abdominal problems and did not digest food easily. Refer to the telephone interview with the SIC on 03/24/21 at 12:10pm. Refer to the interview with the Administrator on 03/24/21 at 12:00pm and at 1:45pm revealed . _____ Telephone interview with the Supervisor-in-Charge (SIC) on 03/24/21 at 12:10pm revealed she followed the regular menu when she prepared and served meals because none of the residents were on any special [therapeutic] diets. Interviews with the Administrator on 03/24/21 at 12:00pm and at 1:45pm revealed: -None of the residents were on a special [therapeutic] diet. -All the residents were on a regular and no added salt (NAS)diet because that was the house diet. -NAS meant no salt on the tables. -She and the SIC followed the menu posted in the kitchen. -She was responsible for ensuring residents received the diet as ordered by their PCP.	D 296		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 15 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medication administration records were accurate for 1 of 3 sampled residents (#1) to include an injectable medication to treat high blood sugar. The findings are: Review of Resident #1's current FL-2 dated 02/17/21 revealed: -Diagnoses included acute congestive heart failure, chronic obstructive pulmonary disease, hyperlipidemia, hypertension, and cerebral ischemia. -There was a medication order for Victoza	D 367	The administrator has reviewed all resident records to ensure that all orders are correct. The administrator has updated all residents FL-2 to reflect current orders; The administrator has scheduled mandatory staff training to discuss all medication concerns.	04/01/21

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D 367	Continued From page 16 18mg/3ml inject 1.2 mg into the skin daily. Review of Resident #1's January 2021 medication administration record (MAR) revealed: -There was an entry for Victoza 18 mg inject 1.2 mg subcutaneous daily, scheduled at 8:00am. -There was documentation of administration of Victoza 1.2 mg daily from 01/01/21 to 01/31/21 at 8:00am. Review of Resident #1's February 2021 and March 2021 MARs revealed -There was no entry for Victoza 18 mg inject 1.2 mg daily. -Resident #1 was hospitalized from 02/10/21 to 02/17/21. Observation of Resident #1's medications on hand on 03/24/21 at 9:00am revealed: -There was a box of Victoza with one unopened pen and one opened pen of Victoza not dated. -There was a medication label on the box indicated Victoza was dispensed on 01/27/21. Telephone interview with Resident #1's pharmacist on 03/24/21 at 11:08am revealed: -Resident #1 had an active order dated 02/17/21 for Victoza inject 1.2 mg daily. -Victoza was dispensed in a box of three pens per box. -Resident #1 had two boxes of Victoza dispensed on 02/17/21. -Each pen provided 15 doses of Victoza. Based on record reviews, observations, and interviews, Resident #1 had sufficient amount of Victoza available for administration. Interview with Resident #1 on 03/24/21 at 9:53am revealed:	D 367	The administrator contacted the pharmacist to discuss how to prevent future errors; pharmacist agreed to review all orders and print new MAR anytime a new order as has been added or discontinued. The administrator wil ensure that all medication opened is dated and that each resident had sufficient amount of medication.	

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D 367	Continued From page 17 -He took pills and an injection to treat his diabetes. -He did not remember the name of the medications, but he received the injection in his stomach every morning. Interview with the Administrator on 03/24/21 at revealed: -She or the other MA administered Victoza to Resident #1 every morning. -She reviewed Resident #1's hospital FL-2 in February when he returned from the hospital. -She worked hard to ensure all of Resident #1's medications were entered on his MARs. -She thought she had not missed any of his medications on his February and March 2021 MARs. -She did not realize Resident #1's Victoza was not entered on his February and March 2021 MARs. -She was responsible for ensuring the MARs were accurate.	D 367	The administrator will ensure that all orders are checked by all staff to prevent future errors; the administrator has scheduled mandatory training for all staff. The administrator has created a tracking log to track all medication orders in an effort to prevent future errors.	4/1/21
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of	D 451	The administrator will notify the county department of social services of any accidents or incidents. The administrator will also enusre that all accidents or incidents are documented. In an effort to prevent future errors administrator scheduled mandatory training to discuss documentation and communication concerns.	4/01/21

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D 451	Continued From page 18 social services (DSS) of incidents resulting in injury requiring emergency medical evaluation and medical treatment at a hospital for 1 of 2 residents sampled (#3). The findings are: Review of Resident #3's current FL-2 dated 01/14/21 revealed diagnoses included Huntington's disease, adjustment disorder with anxiety, depressed mood, hyperlipidemia, protein calorie malnutrition, Vitamin D deficiency, insomnia, and rhinitis. Review of Resident #3's resident health service record dated 01/12/21 revealed there was a laceration above the left eyebrow that was closed with Dermabond. Review of an incident reported dated 01/12/21 revealed Resident #3 fell getting out of bed, cut his eye and was taken to the hospital by a facility staff. Review of an after-visit summary from the emergency department (ED) at the local hospital dated 01/12/21 revealed Resident #3 was seen for and diagnosed with a facial laceration. Telephone interview with the local county Adult Home Specialist (AHS) on 03/15/21 at 2:02pm revealed that she had not received any incident reports from the facility in "a while" and had none for 2021. Interview with the Supervisor-in-Charge/Medication Aide (SIC/MA) on 03/23/21 at 2:55pm revealed: -Resident #3 fell getting out of the bed on 01/12/21 and was taken to the emergency room.	D 451		

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D 451	Continued From page 19 Telephone interview with SIC/MA on 03/24/21 at 10:44am revealed: -An incident report was completed whenever there was an incident. -She came to work one day in 2020 and staff told her Resident #3 had fallen. -She did not witness his fall, but she did an incident report. -She wrote the incident on a form that the Administrator gave to her. -The form was not titled incident report. -She notified Resident #3's family member, but she did not notify Resident #3's physician or the local Department of Social Services (DSS). Interview with the Administrator on 03/24/21 at 10:23am revealed: -Resident #3 fell the day he got out of the hospital. -The SIC/MA took him to the hospital. -She thought she had sent a copy of the incident report to the local DSS via fax the day after the incident. -The facility fax machine did not print out a confirmation the fax was received. -She did not call to confirm the county DSS received the incident report so she had no way of knowing if they received the incident report. -She was responsible for sending the incident reports to the DSS.	D 451		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an	D 612		

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D 612	Continued From page 20 emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 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 as related to staff failing to use personal protective equipment (PPE). The findings are: Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 05/29/20 revealed: -Personnel should always wear a face mask at all times while they are in the facility. -COVID-19 was transmitted through droplet, therefore the mouth and nose are to be completely covered when wearing a face mask to prevent contamination and transmission of COVID-19. -Designate one or more facility employees to ensure all residents and staff have been	D 612	The administrator will ensure that the infection preventionand control program is followed as directed. The adminstrator had a mandatory staff training on CDC quidelines/infection disease. All staff are are required to wear mask at all times; all staff has been properly educated on wearing of a mask. The administrator also met will all residents to discuss COVID-19 and standard precautions. The administrator will continue to screen any one enter the facility and ensure that infection control policies are being followed. The adminstrator will conduct random checks to prevent future issues.	4/1/21

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D 612	Continued From page 21 screened at least daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue, headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. Review of the NC Department of Health and Human Services Guidance for Smaller Residential Settings and long-term care (LTC) facilities dated 06/26/20 revealed: -All workers in LTC facilities, including family care homes, must wear face coverings while in the facility and those face coverings must be surgical masks as long as surgical mask supplies are available. -Staff should be screened daily for signs and symptoms of COVID-19. Observation on 03/23/21 at 9:30am at the facility rear doorway revealed: -There was a sign posted on the entrance doors that instructed visitors to wear a face mask. -The Administrator came to the door, greeted the surveyors and said she would need to take our temperatures before entering the facility. -The Administrator was not wearing a face mask. -There were surgical face masks available at the screening station. Interview with a resident on 03/23/21 at 10:45am revealed: -He had seen the Administrator wearing a face mask when she was preparing to leave the facility. -She wore it sometimes but not all the time. -He did not remember the last time he saw her wearing a face mask. Observation on 03/24/21 at 8:40am revealed the	D 612		

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D 612	Continued From page 22 Administrator was not wearing a face mask. Interview with another resident on 03/24/21 at 9:53am revealed: -He saw the Administrator wearing a face mask when the Administrator left to go out of the facility. -She did not take him to physician appointments. -The Administrator was not wearing a face mask on 03/23/21 nor on 03/24/21. Interview with a third resident on 03/24/21 at 10:20am revealed: -The Administrator did not always wear a face mask. -He did not know she was supposed to wear a face mask, because they all lived in the same facility. -He thought that since he, the other residents, and the Administrator lived like a family, the Administrator did not always have to wear her face mask. Telephone interview with the Supervisor in Charge (SIC) on 03/24/21 at 10:40am revealed: -She always wore a face mask while at the facility. -The Administrator provided face masks to use in the facility. -She had not received any training about COVID-19, but a manual was made by the licensed health professional support (LHPS) registered nurse (RN). -She thought there were documents in the manual about wearing face masks. -She thought there was guidance in the manual about the CDC guidelines concerning wearing face masks. -She had overheard the LHPS RN encouraging the Administrator to wear a face mask. -She last saw the Administrator wear a face mask	D 612		

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D 612	Continued From page 23 in February 2021. -She had reviewed the COVID-19 CDC guidelines that recommend staff should wear a face mask at all times while in facilities. Interview with the Administrator on 03/24/21 at 1:45pm revealed: -All staff and 10 residents were given the COVID-19 vaccine in January 2021 or February 2021. -She placed the documentation of the COVID-19 vaccination in the individual resident and staff records. -There were face masks available at each screening station at the front door and rear entrance door. -Staff went to the facility contracted pharmacy to complete infection control training last year and she thought there was information about COVID-19 included in the training. -The other medication aide (MA) wore facemasks, when near residents and while doing personal care. -She lived in the home and did not want to wear face masks while inside. -She was not aware she should wear face masks while on duty at the facility. -She did not know staff were able to remove a face mask while in the staff bedroom area. -Another staff bought grocery supplies and took residents to their appointments, the pharmacy delivered, and she only left the facility to attend a personal physician's appointment. -She wore a face mask while on duty in the facility for two to three days after she had an outside appointment. -However, once she was in the facility for ten days she no longer wore a face mask. -She did have a medical illness that affected her lungs and she became anxious when wearing a	D 612		

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D 612	Continued From page 24 face mask. -She had not read the recommendations given by the CDC regard face mask guidelines for infection control of COVID-19. -She was responsible for ensuring all staff were following the guidelines of the CDC and NC DHHS for infection control including wearing face masks in the facility.	D 612		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program	D935	The adminstrator has placed a copy of the missing medication training each staff member book; The administrator has created at staff training log to help with tracking process; the administrator has audited all staf charts to ensure that all charts are within compliance. The administator will continue to ensure that only authorize personal manage medication. The administrator has ensured that all staff records are complete it include a hiring date; the administrator has ensured that all MA a medication clinical skills competency validation in their chart to to include: 5/10/15 hour medication training. The adminstrator will conduct mandatory training and will monitor the process.	4/1/21

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D935	Continued From page 25 developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled staff (A and B) who administered medications had completed the medication clinical skills competency validation prior to administering medications. The findings are: 1. Review of Staff A's personnel record revealed: -There was no hire date for Staff A who was the Administrator, but she opened the facility in 2005. -Staff A did not have a medication clinical skills checklist. -Staff A passed the medication aide test 08/31/00. Review of a resident's January, February, and March 2021 medication administration records (MARs) revealed there was documentation of administration of medications by Staff A. Interview with a resident on 03/23/21 at 11:00am revealed the Administrator administered medications to him. Interview with the Administrator on 03/24/21 at	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001103	A. BUILDING: _____ B. WING _____	R 03/24/2021

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D935	Continued From page 26 1:45pm revealed: -She did not know her medication clinical skills checklist was not in her staff record. -She had one in her record in the past and had more than one completed in the past. -She administered medications to the residents. Refer to the interview with the Administrator on 03/24/21 at 1:45pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 01/14/09 for the position of supervisor in charge (SIC) -Staff B did not have a medication clinical skills checklist in the record. -Staff B passed the medication aide test on 10/28/16 and completed the 15-hour medication aide course on 07/20/19. -Staff B completed the 5-hour medication aide course on 10/28/16. Review of a resident's January, February, and March 2021 medication administration records (MARs) revealed there was no documentation of administration of medications by Staff B. Interview with a resident on 03/24/21 at 9:53am revealed Staff B gave him medications in the past, and the last time was in December 2020. Attempted telephone interview with Staff B on 03/24/21 at 10:33am was unsuccessful. Interview with the Administrator on 03/24/21 at 1:45pm revealed: -She did not know Staff B did not have a medication clinical skills checklist in her staff record. -She could not say if she had a medication clinical skills checklist completed in the past.	D935		

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D935	Continued From page 27 -Staff B had not worked at the facility since 2020. Refer to the interview with the Administrator on 03/24/21 at 1:45pm. Interview with the Administrator on 03/24/21 at 1:45pm revealed: -New staff records were completed by the LHPS Registered Nurse (RN) in February 2021 and she reviewed them in February 2021. -She noticed that documents were missing from her staff record and asked the LHPS RN about the missing documents in February 2021. -She could not recall which documents she noticed were missing at the time of her review. -She was responsible for ensuring staff records contained the required documentation. -She was responsible for ensuring MAs had completed the medication clinical skills checklist.	D935		