STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL039011	A. BUILDING: _____ B. WING _____	04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS FAMILY CARE HOME	408 MIMOSA STREET OXFORD, NC 27565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 7-8, 2021.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) had an assessment and care plan updated annually. The findings are: 1. Review of Resident #1's current FL-2 dated	C 231		

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06/02/20 revealed diagnosis included type 2 diabetes mellitus, mild mental retardation, schizophrenia, anxiety, depression, hyperlipidemia, hypertension, asthma, and gastroesophageal reflux disease.

Review of Resident #1's most current care plan revealed:
-Resident #1's care plan was completed on 01/20/19 and a reassessment was completed on 01/20/20.
-The physician signed the care plan on 01/20/19
-There was not another care plan completed since 01/20/20.

Refer to interview with the Administrator on 04/08/21 at 2:06pm.

2. Review of Resident #2's current FL-2 dated 10/01/20 revealed diagnoses included type 2 diabetes mellitus, schizophrenia, glaucoma, hypertension, gout, hyperlipidemia, osteoarthritis, vitamin D deficiency, and overactive bladder.

Review of Resident #2's most current care plan revealed:
-Resident #2's care plan was completed on 01/20/19 and a reassessment was completed on 01/20/20.
-Resident #2's physician signed the care plan on 01/22/19.
-There was not another care plan completed since 01/20/20.

Refer to interview with the Administrator on 04/08/21 at 2:06pm.

3. Review of Resident #3's current FL-2 dated 11/15/20 revealed diagnoses included seizure disorder, diabetes mellitus, hypertension,

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C 231	Continued From page 2 hyperlipidemia, Lacunar infarction, coronary artery disease, threat cancer, and traumatic brain injury. Review of Resident #3's most current care plan revealed: -Resident #3's care plan was completed on 01/20/19 and a reassessment was completed on 01/20/20. -Resident #3's physician signed the care plan on 01/22/19. -There was not another care plan completed since 01/20/20. Refer to interview with the Administrator on 04/08/21 at 2:06pm. _____ Interview with the Administrator on 04/08/21 at 2:06pm revealed: -She had not completed new care plans for any of the residents since 2019. -She knew she was supposed to update residents' care plans annually. -She forgot to complete them in 2020. -She was responsible for ensuring resident care plans were updated annually and the physician signed the care plans.	C 231		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks:	C 252		

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C 252	Continued From page 3 (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers, up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as	C 252		

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alternatives to restraints;
(18) oral suctioning;
(19) care of well-established tracheostomy, not to include indo-tracheal suctioning;
(20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph);
(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);
(22) application of prescribed heat therapy;
(23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 3 of 3 sampled residents with LHPS tasks for fingerstick blood sugar (FSBS) (#1, #2, and #3) and ambulation with an assistive device that requires physical assistance (#1 and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated

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C 252	Continued From page 5 06/02/20 revealed diagnosis included type 2 diabetes mellitus, mild mental retardation, schizophrenia, anxiety, depression, hyperlipidemia, hypertension, asthma, and gastroesophageal reflux disease. Observation of Resident #1 on 04/07/21 at 2:45pm revealed she exited the Administrator's vehicle using a cane to ambulate. Observation of Resident #1 on 04/08/21 at 9:08am revealed: -A fingerstick blood sugar (FSBS) was obtained from her right middle finger using a lancet pen prior to the breakfast meal. -Resident #1's FSBS was 148. Review of Resident #1's licensed health professional support (LHPS) evaluations revealed: -There was an LHPS evaluation dated 09/27/19. -The LHPS tasks listed for Resident #1 were FSBS and cane for ambulation. Interview with Resident #1 on 04/07/21 at 3:52pm revealed: -She had lived there since 2015. -She had a FSBS every morning and used the cane beside her bed to ambulate. Interview with Administer on 04/08/21 at 2:06pm revealed: -Resident #1 was diagnosed with diabetes and she obtained a FSBS daily from Resident #1. -Resident #1 had a cane to use for ambulation. Refer to interview with Administer on 04/08/21 at 2:06pm. 2. Review of Resident #2's current FL-2 dated	C 252		

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C 252	Continued From page 6 10/01/20 revealed: -Diagnoses included type 2 diabetes mellitus, schizophrenia, glaucoma, hypertension, gout, hyperlipidemia, osteoarthritis, vitamin D deficiency, and overactive bladder. -There was an order for weekly fingerstick blood sugar (FSBS) monitoring. Review of Resident #2's January, February, March, and April 2021 medication administration records (MARs) revealed there were weekly blood sugars documented on the back of Resident #2's MARS. Review of Resident #2's licensed health professional support (LHPS) evaluations revealed there were no LHPS evaluations. Interview with Resident #2 on 04/07/21 at 4:00pm revealed the Administrator stuck her finger to obtain blood for a FSBS. Interview with Administer on 04/08/21 at 2:06pm revealed she obtained a FSBS from Resident #2 weekly. Refer to interview with Administer on 04/08/21 at 2:06pm. 3. Review of Resident #3's current FL-2 dated 11/15/20 revealed: -Diagnoses included seizure disorder, diabetes mellitus, hypertension, hyperlipidemia, Lacunar infarction, coronary artery disease, threat cancer, and traumatic brain injury. -There was an order for weekly finger stick blood sugar (FSBS) monitoring. Review of Resident #3's vital signs logs revealed: -There were FSBS documented from December	C 252		

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C 252	Continued From page 7 2020 to April 2021. -The FSBS were documented daily. Review of Resident #3's licensed health professional support (LHPS) evaluations revealed there were no LHPS evaluations. Observation of Resident #3 on 04/07/21 at 2:45pm revealed he exited the Administrator's vehicle with the use of a cane. Observation of Resident #3 on 04/08/21 at 9:20am revealed: -The Administrator stuck Resident #3's finger with a lancet pen and obtained blood for a FSBS. -Resident #3's FSBS was 132. -Resident #3 had a cane leaning against the wall near his bed. Interview with Resident #3 on 04/07/21 at 3:49pm revealed: -The Administrator checked his FSBS but he did not know how often. -He used the cane that was in his room to ambulate with sometimes but not always. Interview with Administer on 04/08/21 at 2:06pm revealed: -Resident #3's FSBS were obtained daily, because he had sliding scale insulin. -Resident #3 used a cane for ambulating. Refer to interview with Administer on 04/08/21 at 2:06pm. _____ Interview with the Administrator on 04/08/21 at 2:06pm revealed: -She did not have a nurse to complete the LHPS evaluations for the residents' LHPS tasks. -The last time she had a LHPS nurse was in	C 252		

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C 252	Continued From page 8 2019. -The former LHPS nurse was called in December 2019 when she did not come back to the facility to complete the quarterly LHPS evaluations. -The former LHPS nurse did not answer the phone. -She was given a list of LHPS nurses by the pharmacist who completed the quarterly pharmacy reviews, but when she called some of the nurses there was no answer. -She had not sought out a new LHPS nurse since December 2019. -She was responsible for ensuring residents' LHPS evaluations were completed by a licensed professional quarterly.	C 252		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents related to a medication used to control involuntary body movements (#1). The findings are:	C 330		

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C 330	Continued From page 9 Review of Resident #1's current FL-2 dated 06/02/20 revealed: -Diagnoses included type 2 diabetes mellitus, mild mental retardation, schizophrenia, anxiety, depression, hyperlipidemia, hypertension, asthma, and gastroesophageal reflux disease. -There was a medication order for Austedo 9 mg (used to decrease involuntary movements) twice daily. Review of Resident #1's subsequent mental health provider orders revealed: -There was an order dated 09/18/20 for Austedo 125mg twice daily. -There was an order dated 09/29/20 to discontinue Austedo 9 mg twice daily and start Austedo 125mg twice daily. -There was an order dated 11/06/20 to continue Austedo 12 mg twice daily. -There was an order dated 01/27/21 to discontinue Austedo 12 mg twice daily. -There was a titration order dated 01/27/21 to start Austedo 9 mg three times daily for one to two weeks then discontinue 9 mg three times per day and change to Austedo 9 mg two tablets (18mg) twice daily. -There was an order dated 04/01/21 to discontinue Austedo 9 mg two tablets twice daily and start Austedo 125mg two tablets twice daily. Review of Resident #1's six-month physician orders dated 02/11/21 revealed: -There was a discontinue written beside the entry for Austedo 12 mg twice daily and the entry was struck through with a line. -There was an order for Austedo 9 mg two tablets twice daily with a start date of 02/03/21. Review of Resident #1's February 2021	C 330		

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hand-written medication administration record (MAR) revealed:
-There was an entry for Austedo 12 mg one tablet twice daily, scheduled at 8:00am and 8:00pm.
-There was documentation of administration of Austedo 12 mg from 02/01/21 to 02/02/21 at 8:00am and 8:00pm.
-There was and entry for Austedo 9 mg take two tablets twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of Austedo 9 mg from 02/03/21 to 02/28/21 at 8:00am and 8:00pm.
-There was no documentation of Austedo 9 mg three times daily.

Review of Resident #1's March 2021 printed MAR revealed:
-There was an entry for Austedo 9 mg twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of Austedo 9 mg from 03/01/21 to 03/11/21 at 8:00am and 8:00pm.
-There was a note written beside staff initials indicating "direction changed on 03/12/21".
-There was an entry for Austedo 9 mg three times daily, scheduled for 8:00am, 1:00pm and 8:00pm.
-There was documentation of administration of Austedo 9 mg from 03/12/21 at 8:00pm, from 03/13/21 to 03/31/21 at 8:00am, 1:00pm and 8:00pm.

Review of Resident #1's April 2021 printed MAR revealed:
-There was a hand-written entry for Austedo 9 mg three times daily, scheduled for 8:00am, 1:00pm, and 8:00pm.
-There was documentation of administration of Austedo 9 mg from 04/01/21 to 04/04/21 at 8:00am, 1:00pm and 8:00pm and 04/05/21 at

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C 330	Continued From page 11 8:00am. -There was no documentation of administration of Austedo 9 mg on 04/05/21 at 1:00pm and 8:00pm and from 04/06/21 to 04/07/21 at 8:00am, 1:00pm and 8:00pm. -There was a printed entry for Austedo 9 mg twice daily with a line struck through it. -Written beside the entry was "direction changed 03/12/21. -There was no entry for Austedo 12 mg two tablets twice daily. Based on observations, record reviews, and interviews, Resident #1's Austedo was not titrated as ordered by the mental health provider on 01/27/21 and Austedo 9 mg three times daily was administered beyond the two weeks period ordered by Resident #1's mental health provider. Observation of Resident #1's medications on hand on 04/08/21 at 12:15pm revealed: -There was one full bottle of 120 tablets of Austedo 12 mg available to administer to Resident #1 dispensed on 04/01/21. -There were no empty bottles of Austedo 9 mg. Telephone interview with a representative from Resident #1's facility contracted pharmacy on 04/08/21 at 12:44pm revealed: -They did not provide Austedo for Resident #1 but the order was placed on her MARs monthly. -There was an electronic prescription sent from Resident #1's mental health provider dated 12/18/20 for Austedo 9 mg twice daily. Telephone interview with a representative from Resident #1's mail order pharmacy on 04/08/21 at 1:32pm revealed: -There was no order in the computer system for Resident #1 for Austedo 9 mg three times daily.	C 330		

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C 330	Continued From page 12 -There was an order dated 03/12/21 for Austedo 12 mg twice daily. -There were 120 tablets of Austedo dispensed for Resident #1 on 04/01/21 and mailed to the facility. -Austedo was a new medication used to treat tardive dyskinesia and was better than Cogentin. -Austedo had to be titrated to the resident who used the medication and was dependent upon the resident's symptoms. Interview with the Administrator on 04/08/21 at 3:45pm revealed: -Resident #1 received her Austedo from another pharmacy because the facility contracted pharmacy was not able to provide the medication. -Resident #1's mental health provider prescribed Austedo for her. -Resident #1 was receiving Austedo 9 mg three times a day and her Austedo 12 mg tablets arrived in the mail on 04/06/21. -She began administering Austedo 12 mg to Resident #1 on 04/06/21. -She did not know the Austedo 12 mg was not on Resident #1's April MAR. -She no longer had the empty bottle of Austedo 9 mg, but Resident #1 ran out of the tablets in April 2021. -She kept giving Resident #1 Austedo 9 mg until the Austedo 12 mg arrived at the facility. -She began administering the Austedo 12 mg dose that was ordered once the tablets were received at the facility. -She knew the order was changed from Austedo 9 mg to Austedo 12 mg but did not have the Austedo 12 mg tablets to administer to Resident #1. -She thought she was administering the ordered dose of Austedo to Resident #1 in February and March 2021.	C 330		

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C 330	Continued From page 13 -She knew Resident #1's mental health provider had discontinued Austedo 9 mg twice daily in September 2020. -She was not able to locate Resident #1's mental health provider for Austedo 9 mg three times daily and the provider had to send the orders to her. -She could not receive the orders from Resident #1's mental health provider on 04/08/21 because she was not in the office and she did not have any paper for the fax machine. -She was not able to receive emailed documents because her email was malfunctioning. -She did not know she should have stopped administering Austedo 9 mg three times a day after two weeks. -She was responsible for ensuring medications were given as ordered by the PCP. Attempted telephone interview with Resident #1's mental health provider on 04/08/21 at 1:25pm was unsuccessful.	C 330		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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 observations, record reviews, and interviews, the facility failed ensure the record of controlled substances were maintained and reconciled accurately with the documented	C 367		

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receipt and administration of controlled substances for 1 of 1 sampled residents (#2) with an order for an anti-anxiety medication.

The findings are:

Review of Resident #2's current FL-2 dated 10/01/20 revealed:
-Diagnoses included type 2 diabetes mellitus, schizophrenia, glaucoma, hypertension, gout, hyperlipidemia, osteoarthritis, vitamin D deficiency, and overactive bladder.
-There was an order for clonazepam 0.5mg (used to treat anxiety and used as a sleep aide) 1 to 2 tablets daily as needed for anxiety.

Review of Resident #2's clonazepam-controlled substance log revealed:
-The log started with a balance of 30 tablets and the date of the log was 03/04/20.
-There were two doses documented as administered on the controlled substance log.
-One dose was administered on 03/05/20 and the balance was 29 tablets.
-The second dose was administered on 12/31/20 and the balance was 28 tablets.

Review of Resident #2's March 2020 medication administration record (MAR) revealed:
-There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed.
-There was documentation of administration of clonazepam 0.5mg on 03/05/20.
-There was documentation on the back of the MAR that one tablet of clonazepam was administered on 03/05/20.

Review or Resident #2's April, May, June, July, August, September, October and November 2020 MAR revealed:

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C 367	Continued From page 15 -There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed. -There was no documentation of administration of clonazepam 0.5mg. Review of Resident #2's December 2020 MAR revealed: -There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed. -There was documentation of administration of clonazepam 0.5mg on 12/31/20. -There was documentation on the back of the MAR that one tablet of clonazepam was administered on 12/31/20. Review or Resident #2's January 2021 MAR revealed: -There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed. -There was documentation of administration of clonazepam 0.5mg on 01/30/21. -There was documentation on the back of the MAR that two tablets of clonazepam were administered on 01/30/21. Review of Resident #2's February 2021 MAR revealed: -There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed. -There was documentation of administration of clonazepam 0.5mg on 02/01/21 and 02/02/21. -There was documentation on the back of the MAR that two tablets of clonazepam were administered on 02/01/21 and 02/02/21. Review of Resident #2's March 2021 MAR revealed: -There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed. -There was documentation of administration of	C 367		

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clonazepam 0.5mg on 03/15/21, 03/23/21, 03/25/21 and 03/27/21.
-There was documentation on the back of the MAR that one tablet of clonazepam was administered on 03/15/21, 03/23/21, 03/25/21 and 03/27/21.

Review or Resident #2's April 2021 MAR revealed:
-There was an entry for clonazepam 0.5mg 1 or 2 tablets daily as needed.
-There was no documentation of administration of clonazepam 0.5mg.

Observation of Resident #2's medications on hand on 04/08/21 at 11:35am revealed there were 13 tablets of clonazepam 0.5mg dispensed on 03/04/20.

Telephone interview with Resident #2's facility contracted pharmacy on 04/08/21 at 12:44pm revealed:
-Resident #2 had an order dated 03/04/20 for clonazepam 0.5mg one to two tablets daily as needed for anxiety.
-There were 30 tablets dispensed for Resident #2 on 03/04/20 and this was the only dispensing for this medication.

Based on observations, record reviews, and interviews, there were 5 clonazepam 0.5 mg tablets administered to Resident #2 without any documentation of administration on her MARs or on the controlled substance log.

Telephone interview with Resident #2's primary care provider (PCP) on 04/08/21 at 4:35pm revealed:
-Resident #2 was last seen by her PCP on 10/01/20.

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C 367	Continued From page 17 -Resident #2 had clonazepam 0.5mg 1 to 2 tablets daily as needed ordered to treat her nervousness. -Resident #2 had also a history of schizophrenia. Interview with the Administrator on 04/08/21 at 3:45pm revealed: -She did not know there were 5 tablets of Resident #2's clonazepam that were not documented as administered. -She did not use the controlled substance log and documented administering Resident #2's clonazepam on her MARs. -No one else gave medications in the facility. -She gave Resident #2 clonazepam and did not document the administration of the clonazepam on Resident #2's MARs or the controlled substance log. -She was responsible for ensuring the controlled substance logs matched the balance of controlled substance available to administer for a resident.	C 367		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an 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	C 612		

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C 612	Continued From page 18 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 the screening of residents, staff and visitors. 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 designate one or more facility employees to ensure all residents and staff have been 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 staff should be	C 612		

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C 612	Continued From page 19 screened daily for signs and symptoms of COVID-19. Review of the facility's infection control policy revealed: -There was no date and the title of the document was infection control procedure. -There were instructions for when to use gloves, masks, gowns, and eye protection. -There were instructions for hand washing. Based on record reviews and interviews the facility did not have a COVID-19 policy. Observation of the Administrator on 04/07/21 at 2:55pm revealed: -She came to the front entrance door of the facility wearing a face mask and took a thermal scan temperature. -The first thermometer did not work and the Administrator obtained a new infrared thermometer from the storage area to use. -She did not document the temperature on any screening tool or ask about any COVID-19 symptom after entrance was allowed. Observation of the Administrator on 04/08/21 at 9:49am revealed: -She took the temperatures of two fire inspectors who entered the facility, but she did not document the temperatures. -She did not ask the fire inspectors any questions concerning COVID-19 symptoms. Observation of the facility on 04/08/21 at 12:00pm revealed: -The environmental health inspector entered the facility and the Administrator did not take his temperature nor did she ask any questions concerning COVID-19 symptoms.	C 612		

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C 612	Continued From page 20 Based on record reviews and interviews, the facility did not have any staff, visitor or resident screening logs for COVID-19 screening. Interview with a resident on 04/07/21 at 3:49pm revealed his temperature was checked at the physician's office and the Administrator checked his temperature sometimes. Interview with another resident on 04/07/21 at 3:52pm revealed the Administrator checked her blood pressure and blood sugar, but not her temperature. Interview with the Administrator on 04/08/21 at 4:45pm revealed: -She was the only staff and her family lived in the facility. -She did go out to the grocery store or to a resident's physician's appointment. -She did not take their temperatures daily, and they did not have symptoms of COVID-19. -She did not check the residents' temperatures daily, and she did not document any residents' temperatures on their MARs. -She had received the COVID-19 vaccine, and the residents received the vaccine. -The local Health Department (LHD) offered the facility training concerning COVID-19 precautions and guidance concerning the COVID-19 vaccine via zoom on 01/07/21. -COVID-19 infection control and prevention training included washing their hands, disinfecting surfaces, and ensuring the residents did not have temperatures greater than 100 or 101. -The LHD nurse provided slides from the presentation via email. -The facility did not have a COVID-19 screening log to document the visitors' or staff's	C 612		

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C 612	Continued From page 21 temperatures or COVID-19 symptoms. -She had not completed the daily screening for staff, residents or visitors. -She thought since everyone had received the vaccine that she did not have to complete screenings of staff and residents. -She had planned to create a visitor screening document after the global pandemic began but did not. -She did not know why she had not created the screening document for visitors. -She was responsible for ensuring all staff were following the guidelines of the CDC and LHD for infection control by providing daily temperature screenings for residents and staff in the facility. Attempted telephone interview with the local county health department (LHD) Registered Nurse (RN) on 04/07/21 at 2:33pm was unsuccessful.	C 612		