STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092140	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WRENETTES PLACE	7029 SAN JAN HILL COURT RALEIGH, NC 27610

(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 July 13-14, 2021.	C 000		
C 034	10A NCAC 13G .0302(n) Design and Construction 10A NCAC 13G .0302 Design and Construction (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a current building sanitation report. The findings are: Review of the facility's current building sanitation report revealed: -The most recent report was dated 02/20/19. -There was a demerit score of 5. -Demerits were received in the following area: food service utensils and equipment kept clean and in good repair; and walls and ceilings kept clean and in good repair. Review of the other facility building sanitation report revealed: -There was a report dated 12/11/20 at 8:45am that had documentation that several phone calls were made to the Administrator/Owner. -An email was sent from the Administrator/Owner indicating the facility was still in operation, but she would not set an appointment for inspection. -There was another report dated 12/15/20 that	C 034		

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C 034	Continued From page 1 indicated the facility was not in operation. Telephone interview with the Administrator on 07/13/21 at 5:35pm revealed: -She was responsible for contacting the Department of Environmental Health to conduct an inspection. -She had not scheduled an inspection because she had pending repairs to the women's bathroom floor. -She did not attempt to request a sanitation inspection in 2020 because of the pandemic or 2021. Attempted interview with the Environmental Health Program Supervisor on 07/13/21 at 4:48pm was unsuccessful.	C 034		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure fingerstick blood sugar (FSBS) checks were completed and documented as ordered for 2 of 2 sampled residents with an order for FSBS checks three times a day (Resident #1 and #3).	C 249		

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C 249	Continued From page 2 The findings are: 1. Review of Resident #1's current FL-2 dated 04/29/21 revealed: -Diagnoses included diabetes, low back pain, urinary incontinence, dyslipidemia, schizophrenia, and history of pulmonary embolism. -There was an order for fingerstick blood sugar (FSBS) checks three times a day. Review of Resident #1's care plan dated 04/24/21 revealed there was documentation of FSBS daily under the Licensed Health Professional Support (LHPS) tasks heading and the care plan was signed on 04/29/21 by Resident #1's PCP. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was a printed entry for FSBS test strips use to check FSBS four times daily, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -The four times daily was marked through and once daily was written above it. -The scheduled times of 12:00pm, 4:00pm and 8:00pm were all marked through. -There was documentation of FSBS readings from 05/01/21 to 05/31/21 for 8:00am that ranged from 113 to 154. -There was no documentation of FSBS readings for 12:00pm, 4:00pm and 8:00pm. Review of Resident #1's June 2021 MAR revealed: -There was a printed entry for FSBS test strips use to check FSBS four times daily, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -The four times daily was marked through and once daily was written above it. -The scheduled times of 12:00pm, 4:00pm and 8:00pm were all marked through.	C 249		

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C 249	Continued From page 3 -There was documentation of FSBS readings from 06/01/21 to 06/30/21 for 8:00am that ranged from 105 to 150. -There was no documentation of FSBS readings for 12:00pm, 4:00pm and 8:00pm. Review of Resident #1's July 2021 MAR revealed: -There was a printed entry for FSBS test strips use to check FSBS four times daily, scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -The four times daily was marked through and once daily was written above it. -The scheduled times of 12:00pm, 4:00pm and 8:00pm were all marked through. -There was documentation of FSBS readings from 07/01/21 to 07/13/21 for 8:00am that ranged from 97 to 132. -There was no documentation of FSBS readings for 12:00pm, 4:00pm and 8:00pm. Observation of Resident #1 in the female bathroom on 07/13/21 at 8:54am revealed she stuck her finger and she told staff her FSBS was 102. Observation of Resident #1's glucometer on 07/13/21 at 3:05pm revealed: -There was only one FSBS reading for July 2021 and it was 201. -There were ten FSBS readings for June 2021 that ranged from 99 to 262. -There were ten FSBS readings for May 2021 that ranged from 94 to 382. Interview with Resident #1 on 07/13/21 at 9:35am revealed: -She stuck her own finger to obtain the FSBS in the bathroom. -She told staff her FSBS, but she did not know where they wrote the FSBS reading.	C 249		

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C 249	Continued From page 4 -She did her FSBS daily in the morning. Telephone interview with the Administrator on 07/13/21 at 5:40pm revealed: -Resident #1 obtained her own FSBS and then told the Administrator the FSBS reading. -She did not look at the glucometer to verify the FSBS reading reported by Resident #1. -She thought Resident #1's FSBS was ordered daily. -Resident #1 had a previous order for FSBS three times a day, but Resident #1's primary care provider (PCP) changed the order. -She thought the new order was in Resident #1's chart on Resident #1's care plan. -She thought Resident #1's care plan could be used as an order because the PCP signed it. -She did not know why Resident #1's glucometer FSBS readings did not match the documentation on Resident #1's May 2021, June 2021, and July 2021 MARs. Attempted telephone interview with Resident #1's primary care provider (PCP) 07/13/21 at 1:45pm was unsuccessful. Refer to the telephone interview with the Administrator on 07/13/21 at 5:40pm. 2. Review of Resident #3's current FL-2 dated 07/01/21 revealed: -Diagnoses included diabetes, schizoaffective bipolar type, essential hypertension and hyperlipidemia. -There was an order for fingerstick blood sugar checks three times a day. Review of Resident #3's previous physician orders revealed there was an order dated 02/09/21 for FSBS three times a day.	C 249		

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C 249	Continued From page 5 Review of Resident #3's May 2021 medication administration record (MAR) revealed: -There was a handwritten entry for FSBS checks, scheduled for 8:00am. -There was documentation of FSBS readings from 05/01/21 to 05/31/21 for 8:00am and the FSBS readings ranged from 100 to 155. -There was another handwritten entry for FSBS checks, scheduled for 2:00pm. -There was documentation of FSBS readings from 05/01/21 to 05/31/21 for 2:00pm and the FSBS readings ranged from 126 to 219. -There was a third handwritten entry for FSBS checks, scheduled for 7:00pm. -There was no documentation of FSBS readings from 05/01/21 to 05/31/21 for 7:00pm. Review of Resident #3's June 2021 MAR revealed: -There was a handwritten entry for FSBS checks, scheduled for 8:00am. -There was documentation of FSBS readings from 06/01/21 to 06/30/21 for 8:00am and the FSBS readings ranged from 119 to 152. -There was another handwritten entry for FSBS checks, scheduled for 2:00pm. -There was documentation of FSBS readings from 06/01/21 to 06/30/21 for 2:00pm and the FSBS readings ranged from 122 to 215. -There was a third handwritten entry for FSBS checks, scheduled for 7:00pm. -There was documentation of FSBS readings from 06/01/21 to 06/30/21 for 7:00pm and the FSBS readings ranged from 122 to 177. Review of Resident #3's July 2021 MAR revealed: -There was a handwritten entry for FSBS checks, scheduled for 8:00am. -There was documentation of FSBS readings	C 249		

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C 249	Continued From page 6	C 249		

from 07/01/21 to 07/13/21 for 8:00am.
-There was another handwritten entry for FSBS checks, scheduled for 2:00pm.
-There was documentation of FSBS readings from 07/01/21 to 07/12/21 for 2:00pm.
-There was a third handwritten entry for FSBS checks, scheduled for 7:00pm.
-There was no documentation of FSBS readings from 07/01/21 to 07/12/21 for 7:00pm.

Observation of Resident #3's glucometer on 07/13/21 at 3:30pm revealed:
-There were FSBS readings for two days for May 2021 that ranged from 270 to 290.
-There were FSBS readings for three days for June 2021 that ranged from 227 to 291.
-There were FSBS readings for six days for July 2021 that ranged from 88 to 355.

Interview with Resident #3 on 07/13/21 at 3:40pm revealed:
-She had her FSBS checked prior to breakfast and 2 hours after lunch and dinner.
-She did not have her 2:00pm FSBS completed on 07/13/21, but the Administrator administered medications to her.

Telephone interview with the Administrator on 07/13/21 at 5:40pm revealed:
-She and the medication aide (MA) checked Resident #3's FSBS three times a day.
-She did not check Resident #3's FSBS on 07/13/21 at 2:00pm because she was busy doing other tasks.
-She did not know Resident #3's glucometer FSBS readings did not match the documentation on Resident #3's May 2021, June 2021 and July 2021 MARs.
-She did not know why Resident #3's glucometer FSBS readings were not obtained as ordered.

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C 249	Continued From page 7 -She thought another glucometer was used to obtain Resident #3's FSBS, but she could not locate that glucometer in the medication storage area. Attempted telephone interview with Resident #2's primary care provider (PCP) 07/13/21 at 1:45pm was unsuccessful. Refer to the telephone interview with the Administrator on 07/13/21 at 5:40pm. _____ Telephone interview with the Administrator on 07/13/21 at 5:40pm revealed she was responsible for ensuring FSBS were obtained as ordered by the resident's PCP.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the	C 254		

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C 254	Continued From page 8	C 254		

resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule 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 2 of 2 sampled residents (#2) with LHPS tasks for fingerstick blood sugars (FSBS).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/29/21 revealed:
-Diagnoses included diabetes, low back pain, urinary incontinence, dyslipidemia, schizophrenia, and history of pulmonary embolism.
-There was an order for fingerstick blood sugar (FSBS) checks three times a day.

Review of Resident #1's licensed health professional support (LHPS) evaluations revealed there was one LHPS evaluation dated 03/12/20.

Observation of Resident #1's bathroom on 07/13/21 at 8:54am revealed Resident #1 stuck her finger for a FSBS.

Interview with Resident #1 on 07/13/21 at 9:37am revealed:
-She obtained her FSBS daily and told staff the FSBS reading.
-She had her own glucometer.

Refer to the telephone interview with the Administrator on 07/13/21 at 5:30pm.

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C 254	Continued From page 9 2. Review of Resident #3's current FL-2 dated 07/01/21 revealed: -Diagnoses included diabetes, schizoaffective bipolar type, essential hypertension and hyperlipidemia. -There was an order for fingerstick blood sugar (FSBS) checks three times a day. Review of Resident #3's licensed health professional support (LHPS) evaluations revealed there was one LHPS evaluation dated 03/12/20. Observation of Resident #3's glucometer on 07/13/21 at revealed there were FSBS readings for the month of May 2021, June 2021 and July 2021. Interview with Resident #3 on 07/13/21 at 3:40pm revealed she had her FSBS at breakfast, two hours after lunch and two hours after dinner. Refer to the telephone interview with the Administrator on 07/13/21 at 5:30pm. _____ Telephone interview with the Administrator on 07/13/21 at 5:30pm revealed: -There were three residents with FSBS ordered by their primary care provider. -She thought the pharmacy did the LHPS evaluations quarterly. -She did not have a LHPS nurse and no LHPS evaluations were completed in 2021 due to the pandemic. -She was responsible for ensuring the LHPS evaluations were completed for residents.	C 254		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330		

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C 330	Continued From page 10 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 2 of 3 sampled residents(#1 and #3) related to a medication used to treat constipation (#1) and a topical medication used to treat skin conditions (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 04/29/21 revealed: -Diagnoses included diabetes, low back pain, urinary incontinence, dyslipidemia, schizophrenia, and history of pulmonary embolism. -There was an order for Miralax powder mix (used to treat constipation) one capful in suitable liquid twice daily. Review of Resident #1's May 2021 printed medication administration record (MAR) revealed: -There was an entry for Miralax powder mix one capful in a suitable liquid and drink twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Miralax from 05/01/21 to 05/31/21 at 8:00am and 8:00pm.	C 330		

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C 330	Continued From page 11 Review of Resident #1's June 2021 printed MAR revealed: -There was an entry for Miralax powder mix one capful in a suitable liquid and drink twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Miralax from 06/01/21 to 06/30/21 at 8:00am and 8:00pm. Review of Resident #1's July 2021 printed MAR revealed: -There was an entry for Miralax powder mix one capful in a suitable liquid and drink twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Miralax from 07/01/21 to 07/12/21 at 8:00am and 8:00pm and 07/13/21 at 8:00am. Observation of Resident #1's medications in the facility on 07/13/21 at 2:58pm revealed: -There was one 510-grams bottle of Miralax dispensed on 07/ 07/20 containing one-half of Miralax powder. -There were two 510-grams bottles of Miralax dispensed on 12/21/20 both containing one-half of Miralax powder. Review of Resident #1's Miralax bottle label revealed there was documentation underneath the number of ounces within the bottle that indicated the bottle contained 30 once daily doses. Telephone interview with a pharmacist at Resident #1's facility contracted pharmacy on 07/13/21 at 3:52pm revealed: -Resident #1's Miralax was dispensed two bottles per dispensing. -Each bottle of Miralax lasted for 30 days.	C 330		

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C 330	Continued From page 12 -Resident #1's order was for Miralax one capful twice daily. -The last date Miralax was dispensed for Resident #1 was on 01/18/21. Interview with Resident #1 on 07/13/21 at 8:23am revealed: -The Administrator and a male medication aide (MA) gave her medication. -She took medications in the morning and at night before bed. Telephone interview with the Administrator on 07/13/21 at 5:40pm revealed: -She attempted to review the resident's records weekly and that included a review of the FL-2, care plan and the MARs. -She reviewed the new MARs when they were delivered from the pharmacy. -She did not review the previous months MARs at the end of the month. -Resident #1 took Miralax twice a day. -She administered Miralax to Resident #1 by placing a capful in a small cup of water and Resident #1 took it with her other medications. -She did not know how long one 510 gram bottle of Miralax lasted. -She thought each bottle lasted a "long time". -She knew Resident #1 had three bottles of Miralax available for administration. -She did not know that one bottle would last for 30 days. -She did not know why Resident #1 still had Miralax bottles from July 2020 and December 2020. -Resident #1 had many bottles once and other residents also took Miralax. -She thought she might have used another resident's Miralax to administer to Resident #1.	C 330		

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Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/13/21 at 1:45pm was unsuccessful.

Refer to interview with the Administrator on 07/13/21 at 5:40pm.

2. Review of Resident #3's current FL-2 dated 07/01/21 revealed:
-Diagnoses included diabetes, schizoaffective bipolar type, essential hypertension and hyperlipidemia.
-There was a medication order for ammonium lactate cream (used to treat dry skin conditions) apply topical cream twice daily to dry feet.

Review of Resident #3's primary care provider orders dated 02/09/21 revealed there was an order for ammonium lactate 12% cream apply to feet twice daily.

Review of Resident #3's May 2021 printed medication administration record (MAR) revealed:
-There was an entry for ammonium lactate cream apply topically to feet twice daily, scheduled for 8:00 am and 8:00pm.
-There was documentation of administration of ammonium lactate cream from 05/01/21 to 05/31/21 at 8:00am and 8:00pm.

Review of Resident #3's June 2021 printed medication administration record (MAR) revealed:
-There was an entry for ammonium lactate cream apply topically to feet twice daily, scheduled for 8:00 am and 8:00pm.
-There was documentation of administration of ammonium lactate cream from 06/01/21 to 06/30/21 at 8:00am and 8:00pm.

Review of Resident #3's July 2021 printed

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C 330	Continued From page 14	C 330		

medication administration record (MAR) revealed:
-There was an entry for ammonium lactate cream apply topically to feet twice daily, scheduled for 8:00 am and 8:00pm.
-There was documentation of administration of ammonium lactate cream from 07/01/21 to 07/12/21 at 8:00am and 8:00pm.

Observation of Resident #3's medications on hand on 07/14/21 at 3:28pm revealed:
-There was one box containing two 140-gram tubes of ammonium lactate dispensed on 07/17/19.
-One tube of ammonium lactate was opened and ¾ full of medication.
-The second tube of ammonium lactate was unopened.

Telephone interview with a pharmacist at Resident #3's pharmacy on 07/14/21 at 3:58pm revealed:
-Resident #3's ammonium lactate cream was ordered 07/10/18.
-Ammonium lactate 280 grams cream was dispensed on 07/17/19 for Resident #3.
-There were no other dispense dates for Resident #3's ammonium lactate.

Interview with the Administrator on 07/14/21 at 4:30pm revealed:
-She did not know Resident #3 was not administered ammonium lactate cream as ordered by Resident #3's primary care provider (PCP).
-She administered medications to Resident #3 and she had applied ammonium lactate to Resident #3's feet.
-She thought the reason there was ammonium lactate cream remaining from 2019 was because it was not administered to Resident #3.

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C 330	Continued From page 15 -She knew Resident #3's ammonium lactate was documented as administered on Resident #3's May 2021, June 2021, and July 2021 MARs. -Resident #3 had the two tubes of ammonium lactate dated 07/17/19 but she did not have any other tubes of ammonium lactate dispensed from another date. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/13/21 at 1:45pm was unsuccessful. Refer to the telephone interview with the Administrator on 07/13/21 at 5:40pm was unsuccessful. _____ Telephone interview with the Administrator on 07/13/21 at 5:40pm revealed she was responsible for ensuring the resident's medications were administered as ordered by their PCP.	C 330		
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 guidance or directives shall be implemented by	C 612		

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C 612	Continued From page 16 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 use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection and screening of staff. The findings are: 1. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed: -Personnel should wear a face mask while in the facility and for protection during resident care encounters. -Personnel who worked in areas with minimal to no community transmission of the coronavirus should use a well-fitting face mask for source control. Review of the CDC Updated Healthcare Infection Prevention and Control Recommendations in	C 612		

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C 612	Continued From page 17 Response to COVID-19 Vaccination dated 04/27/21 revealed recommendations for use of personal protective equipment (PPE) by personnel was unchanged. Review of the North Carolina Department of Health and Human Services (NC DHHS) Guidance for Best Practices for Infection Prevention in Long Term Care Facilities (LTCFs) dated 02/10/21 revealed LTCFs should follow the CDC guidance for appropriate selection and use of PPE. Observation of the staff upon entrance into facility on 07/13/21 from 8:00am to 7:23pm revealed: -She came to the front door of the facility without a face mask. -She returned to the kitchen and began preparing the resident's breakfast without a face mask. -She sat with residents in the living room area without a face mask. -She served breakfast, lunch, and dinner without a face mask. Observation of the Administrator on 07/13/21 at 8:25am revealed she did not have a face mask on when she came into the facility. Observation of the Administrator upon her return to the facility on 07/13/21 at 11:15am revealed she did not have a face mask on upon entering the facility again. Observation of the Administrator entering the facility for the third occasion on 07/13/21 at 1:43pm revealed she did not wear a face mask. Observation of the facility on 07/13/21 at 2:40 pm revealed: -There was a screening station in the living room	C 612		

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C 612	Continued From page 18 on an end table. -There was an opened box of face masks on the end table. -There were two cases of surgical face masks with 50 face masks per box in a locked space upstairs. -There were two cases of disposable gloves in a locked space upstairs. -There were three cases of disposable gowns in a locked space upstairs. Interview with a resident on 07/13/21 at 8:41am revealed: -Staff wore masks when they went outside of the facility transporting residents to medical appointments or to get take-out food. -Staff did not wear a face mask inside the facility. Interview with a second resident on 07/13/21 at 2:37pm revealed staff wore face masks when they came into the facility sometimes and staff wore a face mask when they took the residents to a drive-thru restaurant. Interview with the personal care aide (PCA) on 07/13/21 at 4:03pm revealed: -She had worked at the facility since December 2020. -She worked Tuesday to Monday as live in staff and she was relieved by another staff. -For COVID-19, she and the residents washed their hands constantly, used hand sanitizer, no visitors were allowed in the house except healthcare professionals, and social distancing. -The residents did not leave the facility except to go shopping. -She had not received any formal training concerning COVID-19. -She was given a notebook to read and review concerning COVID-19.	C 612		

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C 612	Continued From page 19 -She thought the CDC guidelines were that all visitors had to wear a face mask. -She did not know staff in the facility had to wear a face mask. -She had not read the CDC guidelines concerning the wearing of face masks. -The Administrator had not told her to wear a face mask while working in the facility. Telephone interview with the Administrator on 07/13/21 at 5:45pm revealed: -She followed whatever the Governor said to do. -She had a COVID-19 policy in the notebook in the end table in the living room. -She had signage on the front door concerning COVID-19 but took them down and placed the signs on the medication room door. -She had staff read a document on COVID-19 and sign. -She placed the signed training papers in the COVID-19 book. -Staff wore face masks in the facility until July 2021 when "they" stated everything was opened up. -She received an email from a seniors organization and the email stated everything was opened up. -She stopped wearing a face mask on 07/01/21 and she was fully vaccinated. -She had read part of the CDC guidelines for healthcare personnel dated 04/28/21. -She did not know the current CDC guidelines for long term care facilities concerning wearing a face mask in the facility. -She was responsible for following the CDC guidelines related to the use of face masks. Attempted telephone interview with the local county health department (LHD) Registered Nurse (RN) on 07/13/21 at 4:52pm was	C 612		

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C 612	Continued From page 20 unsuccessful. 2. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed all residents and staff should screen 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 COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Review of the facility's visitor screening logs revealed: -There was a screening tool used for visitors that included a space to document temperatures. -The visitor screening tool did not include questions concerning COVID-19 exposure. -There were completed visitor screening logs for previous visitors to the facility. Observation of the facility on 07/13/21 at 8:00am revealed: -Staff provided screening upon entrance into the facility. -There was a screening station in the living room on an end table. -There was a thermal scan thermometer available for use on the end table. Review of three residents' May 2021, June 2021,	C 612		

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C 612	Continued From page 21 and July 2021 medication administration records (MARs) revealed there was no documentation of any temperatures. Review of the facility wall calendar revealed there were temperatures documented for each resident daily from 07/01/21 to 07/12/21. Interview with a resident on 07/13/21 at 8:56am revealed staff took her temperature daily and no one had asked her questions concerning COVID-19 symptoms. Interview with another resident on 07/13/21 at 2:37pm revealed: -He had his temperature checked daily. -No one asked him any questions about COVID-19 symptoms. Interview with the personal care aide (PCA) on 07/13/21 at 4:03pm revealed: -She obtained the resident's temperatures and documented the resident's temperatures on the wall calendar in the dining room. -She screened herself on the first day back at work by taking her temperature, and she documented her temperature in the notebook on the end table in the living room. -She was given a policy to read about COVID-19. -She did not ask the residents about COVID-19 symptoms but observed them for symptoms. -No resident had complained that they did not feel well. Telephone interview with the Administrator on 07/13/21 at 5:45pm revealed: -The facility had a COVID-19 screening list to document the visitor's temperatures. -Staff were screened by her when they came back on duty.	C 612		

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C 612	Continued From page 22 -Residents were screened daily by taking their temperatures and the temperatures were documented on a wall calendar in the dining room. -She took all the staff screening sheets home. -She took her temperature when she entered the facility, but she did not document her temperature. -She did not know staff were supposed to screen daily. -She did not know the CDC guidelines related to staff and resident screening. -She was responsible for following the guidelines of the CDC for screening of staff and residents by taking temperatures daily and documenting the results on the screening log. -She was responsible for ensuring all staff were following the guidelines of the CDC 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 07/13/21 at 4:52pm was unsuccessful.	C 612		