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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 29, 2021.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimal of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 4 of 4 fixtures at two sinks and two showers used by the residents. The findings are: Review of the facility's water temperature log revealed: -There were water temperatures documented for 2020 and 2021. -The water temperature log did not indicate which water fixtures were used to test the temperatures documented. -There were water temperatures documented for 06/06/20, 07/01/20, 08/01/20, 09/03/20, 10/03/20, 11/02/20, and 12/02/20 of 101 degrees Fahrenheit (F). -There were water temperatures documented for 01/01/21, 04/01/21, 05/01/21, 06/01/21, and	C 105		

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C 105	Continued From page 1 07/01/21 of 101 degrees F. -There were water temperatures documented for 02/01/21, and 03/01/21 of 100 degrees F. Observation of the hot water temperatures in the hallway resident bathroom on 07/29/21 at 8:58am revealed the water temperature at the sink fixture was 95.2 degrees F and the shower fixture was 94.3 degrees F. Observation of the hot water temperatures in the private resident bathroom on 07/29/21 at 9:02am revealed the water temperature at the sink fixture was 93.7 degrees F and the shower fixture was 98.1 degrees F. Observation on 07/29/21 at 10:11am revealed there was a small non- digital water thermometer available to test the hot water temperatures with a range from 0 degrees F to 220 degrees F. Observation of the hot water temperatures in the hallway resident bathroom with the Administrator on 07/29/21 at 10:11am revealed the hot water temperature at the sink fixture was 97.2 degrees F and the shower fixture was 97.2 degrees F. Interview with the Administrator on 07/29/21 at 10:25am revealed she would go outside and access the hot water heater to adjust the hot water heater temperature. Observation of the hot water temperatures in the hallway resident bathroom on 07/29/21 at 2:20pm revealed the water temperature at the sink fixture was 131.2 degrees F and the shower fixture was 128.8 degrees F. Interview with the Administrator on 07/29/21 at 2:21pm revealed she would adjust the hot water	C 105		

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heater temperature again.

Observation of the hot water temperatures in the hallway resident bathroom on 07/29/21 at 5:07pm revealed the water temperature at the sink fixture was 128.7 degrees F.

Interview with a resident on 07/29/21 at 9:03am revealed:
-She had observed the water was too cold.
-She did not use the hallway bathroom along with the other residents, but she used her private bathroom.
-She bathed herself and turned on the hot water minutes before she showered to try to warm the water.
-She had told the Administrator about the hot water temperature.
-The water had not been hot since her admission 18 months ago.

Interview with another resident on 07/29/21 at 9:08am revealed:
-She used the hallway bathroom and she did not need any assistance with activities of daily living (ADL).
-She had not noticed that the water temperature was too hot.

Interview with the Supervisor-in-Charge (SIC) on 07/29/21 at 3:05pm revealed:
-The Administrator checked the hot water temperatures monthly.
-She checked the hot water temperatures if she was scheduled to work on the first day of the month.
-She used a water thermometer that was stored in the kitchen on a clipboard with the water temperature log.
-She thought the hot water temperature range for

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C 105	Continued From page 3 the facility should be between 110 degrees F. -She notified the Administrator if the hot water temperature was below or above 110 degrees F. Interview with the Administrator on 07/29/21 at 3:57pm revealed: -Hot water temperatures were tested monthly. -If the hot water temperature was between 100 degrees F and 116 degrees F. -She expected staff to notify her if the hot water temperature was not between 100 degrees F and 116 degrees F and adjust the hot water heater temperature. -She did not know the water temperatures were lower than 100 degrees F, but she thought the hot water temperature was low due to 6 residents showering, and laundry. -The hot water heater was fueled by gas not electricity and she adjusted the hot water temperature twice. -She was responsible for ensuring the facility hot water temperatures remained between the range of 100 degrees F and 116 degrees F.	C 105		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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	C 342		

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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 the accuracy of medication administration records for 1 of 3 sampled residents (#3), including a medication used to prevent seizures, a medication to treat gastro-esophageal reflux disease (GERD) and an ophthalmic medication used for dry eye relief.

The findings are:

1. Review of Resident #3's current FL-2 dated 06/21/21 revealed diagnosis included epileptic seizures.

a. Review of Resident #3's current FL-2 dated 06/21/21 revealed there was an order for levetiracetam 500mg (used to treat seizures) take one tablet twice daily.

Review of Resident #3's May 2021 printed medication administration records (MAR) revealed:
-There was an entry for levetiracetam 500mg one tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of

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levetiracetam from 05/01/21 to 05/31/21 at 8:00am.
-There was no documentation of administration of levetiracetam from 05/01/21 to 05/31/21 at 8:00pm.

Review of Resident #3's June 2021 printed MAR revealed:
-There was an entry for levetiracetam 500mg one tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of levetiracetam from 06/01/21 to 06/30/21 at 8:00am.
-There was no documentation of administration of levetiracetam from 06/01/21 to 06/30/21 at 8:00pm.

Observation of Resident #3's medications on hand on 07/29/21 at 2:32pm revealed:
-There was one bubble packet of levetiracetam 500mg tablets.
-There were 29 tablets remaining in the packet and available for administration.
-Resident #3's levetiracetam was dispensed on 07/15/21.

Interview with Resident #3 on 07/29/21 at 5:07pm revealed:
-She saw the picture of the levetiracetam tablets, and she verified that she had not missed any doses.
-She took levetiracetam in the morning and before bed.

Telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm revealed:
-There was an order dated 02/01/21 for levetiracetam 500mg one tablet twice daily.
-Levetiracetam was dispensed with the cycle fill

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on the 15th of each month.
-Depending upon the number of days in the month, 30 or 31 tablets were dispensed each month.

Interview with the Supervisor in Charge (SIC) on 07/29/21 at 3:05pm revealed:
-She did not know Resident #3's levetiracetam was not documented as administered at 8:00pm on the May 2021 and June 2021 MARs.
-She administered it to Resident #3,but she did not know why she never documented the 8:00pm dose for May 2021 and June 2021.

Refer to telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm.

Refer to interview with the Administrator on 07/29/21 at 3:57pm.

b. Review of Resident #3's current FL-2 dated 06/21/21 revealed there was an order for omeprazole 20mg (used to treat gastro-esophageal reflux disease) take one tablet twice daily.

Review of Resident #3's May 2021 printed medication administration records (MAR) revealed:
-There was an entry for omeprazole 20mg one tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of omeprazole from 05/01/21 to 05/31/21 at 8:00am.
-There was no documentation of administration of omeprazole from 05/01/21 to 05/31/21 at 8:00pm.

Review of Resident #3's June 2021 printed MAR revealed:
-There was an entry for omeprazole 20mg one

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tablet twice daily, scheduled for 8:00am and 8:00pm.
-There was documentation of administration of omeprazole from 06/01/21 to 06/30/21 at 8:00am.
-There was no documentation of administration of omeprazole from 06/01/21 to 06/30/21 at 8:00pm.

Observation of Resident #3's medications on hand on 07/29/21 at 2:32pm revealed:
-There was one bubble packet of omeprazole 20mg capsules.
-There were 31 capsules remaining in the packet and available for administration.
-Resident #3's omeprazole was dispensed on 07/15/21.

Interview with Resident #3 on 07/29/21 at 5:07pm revealed:
-She saw the picture of the omeprazole capsules.
-She took omeprazole two times a day in the morning and before bed.

Telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm revealed:
-There was an order dated 02/01/21 for omeprazole 20mg one capsule twice daily.
-Resident #3's omeprazole was dispensed with the cycle fill on the 15th day of the month.

Interview with the Supervisor in Charge (SIC) on 07/29/21 at 3:05pm revealed:
-She did not know that she had not documented administering Resident #3's 8:00pm dose of omeprazole on the May 2021 and June 2021 MARs.
-She administered omeprazole to Resident #3,but she did not know why she never documented the 8:00pm dose for May 2021 and June 2021.

Refer to telephone interview with Resident #3's

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C 342	Continued From page 8 pharmacist on 07/29/21 at 1:55pm. Refer to interview with the Administrator on 07/29/21 at 3:57pm. c. Review of Resident #3's current FL-2 dated 06/21/21 revealed there was an order for Restasis 0.05% (used to treat chronic dry eye) instill one drop in both eyes twice daily. Review of Resident #3's May 2021 printed medication administration records (MAR) revealed: -There was an entry for Restasis 0.05% instill one drop in both eyes twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Restasis from 05/01/21 to 05/31/21 at 8:00am. -There was no documentation of administration of Restasis from 05/01/21 to 05/31/21 at 8:00pm. Review of Resident #3's June 2021 MAR revealed: -There was an entry for Restasis 0.05% instill one drop in both eyes twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Restasis from 06/01/21 to 06/30/21 at 8:00am. -There was no documentation of administration of Restasis from 06/01/21 to 06/30/21 at 8:00pm. Observation of Resident #3's medications on hand on 07/29/21 at 2:32pm revealed: -There was one box of Restasis drop vials. -There were 31 vials remaining in the box and available for administration. -Resident #3's Restasis was dispensed on 07/01/21. Interview with Resident #3 on 07/29/21 at 5:07pm	C 342		

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revealed:
-She had eye drops placed in each eye twice daily.
-She had not missed any doses of the eye drops.

Telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm revealed:
-There was an order dated 03/02/21 for Restasis one drop in each eye twice daily.
-The facility had to call for refills of Resident #3's Restasis.
-The last refill of Resident #3's Restasis was 07/01/21.
-Each box contained 30 doses and each individual vial contained one dose.

Interview with the Supervisor in Charge (SIC) on 07/29/21 at 3:05pm revealed:
-She administered Restasis to Resident #3.
-Each vial was used once and contained enough medication for one drop in each eye.
-She did not know why she never documented the 8:00pm dose for May 2021 and June 2021.

Refer to telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm.

Refer to interview with the Administrator on 07/29/21 at 3:57pm.

_____

Telephone interview with Resident #3's pharmacist on 07/29/21 at 1:55pm revealed:
-The pharmacy provided MARs to the facility.
-The MARs were delivered on the 26 th or 27 th of each month.

Telephone interview with the Administrator on 07/29/21 at 3:57pm revealed:
-The pharmacy provided MARs for the facility.
-She and the SIC reviewed the new MARs each

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C 342	Continued From page 10 month. -She used the pill packs to review the new MARs. -She tried to review the previous months MARs to identify missed documentation and errors. -She did not know the MAs were not documenting some medications at 8:00pm. -She thought Resident #3 was administered all her medications at 8:00pm and the MAs did not document thoroughly. -The MAs and SIC were responsible for ensuring residents' MARs were accurate.	C 342		
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 the facility.	C 612		

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C 612	Continued From page 11 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 and residents. 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 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)	C 612		

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C 612	Continued From page 12 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 07/29/21 from 8:49am revealed: -She came to the front door of the facility without a face mask. -She shut the door and returned to the door with a face mask that was looped over one ear but not covering her nose and mouth. -She placed the face mask on once she telephoned the Administrator. -One resident was sitting in the living room area without a face mask. Observation of the Administrator on 07/29/21 at 9:05am revealed she did not have a face mask on when she came into the facility. Observation of the Administrator in the hallway of the facility on 07/29/21 at 12:35pm revealed she did not have her face mask covering her nose. Observation of another staff in the facility on 07/29/21 at 9:43pm revealed she wore a face mask below her nose and mouth. Observation of the facility on 07/29/21 at 4:35 pm revealed: -There was a screening station in the living room on a table. -There was a plastic bag of face masks on the table. -There was one case of surgical face masks with 50 face masks per box in a storage closet. Interview with a resident on 07/29/21 at 5:20pm revealed: -Staff wore masks when they went outside of the	C 612		

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C 612	Continued From page 13 facility transporting residents to appointments. -Staff did not always wear a face mask inside the facility. Interview with a second resident on 07/29/21 at 5:07pm revealed: -She knew the SIC was not wearing a face mask when she answered the front door on 07/29/21. -She thought the SIC was busy doing tasks for the facility and simply forgot to put the face mask on properly. Interview with the Supervisor in Charge (SIC) on 07/29/21 at 3:05pm revealed: -She had worked at the facility for two years. -She worked Monday through Wednesday 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. -She had received training concerning COVID-19 from a nurse over the telephone. -The nurse reviewed the signs and symptoms of COVID-19, and what to do if all the residents needed COVID-19 testing. -The training occurred in the spring of 2020. -There was a facility COVID-19 policy. -She wore a face mask everywhere she went, and she changed it daily. -She wore a face mask at the grocery store, church, and at work. -She thought the CDC guidelines were that a face mask was to be worn in the facility.. -She did not have a face mask on when she opened the door because she forgot to put it on. -She had a face mask in her pocket when she opened the front door this morning. -She had not read the CDC guidelines concerning the wearing of face masks.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL098032	A. BUILDING: _____ B. WING _____	07/29/2021

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C 612	Continued From page 14 -She did not see the other staff with her face mask below her nose and mouth while working in the facility. Interview with the Administrator on 07/29/21 at 3:57pm revealed: -She had a COVID-19 policy in the COVID-19 notebook. -She had signage on the front door concerning COVID-19 and she did not know who took the signs down. -Staff were expected to wear a face masks in the facility. -The other staff who came to assist the SIC on 007/29/21 had her face mask down because she had a respiratory illness. -She also had respiratory illness and took face mask breaks by removing the face mask from her nose and mouth. -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 07/29/21 at 1:29pm was 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.	C 612		

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C 612	Continued From page 15 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. Observation of the facility on 07/29/21 at 8:48am revealed: -Staff provided screening upon entrance into the facility. -There was a screening station in the living room on a table. -There was a thermal scan thermometer available for use on the table. Review of three residents' May 2021, June 2021, and July 2021 medication administration records (MARs) revealed there was no documentation of any temperatures. Interview with the Supervisor in Charge (SIC) on 07/29/21 at 8:55am revealed there were 5 residents residing in the facility. Review of residents' temperatures in a spiral notebook revealed: -There were temperatures documented from 04/03/21 to 07/11/21, but not daily. -There were temperatures documented for 5 residents on 04/03/21, 04/09/21, 04/11/21, 04/18/21, 04/25/21, 05/02/21, 05/08/21, 05/16/21, 05/23/21, 05/30/21, 06/06/21, 06/13/21, 06/18/21, 06/20/21, 07/02/21, 07/04/21 and 07/11/21. -There was no documentation for the time the temperatures were obtained. Interview with a resident on 07/29/21 at 5:20pm	C 612		

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C 612	Continued From page 16	C 612		

revealed staff took her temperature sporadically and no one had asked her questions concerning COVID-19 symptoms.

Interview with another resident on 07/29/21 at 5:07pm revealed:
-Her temperature was checked when she left and returned to the facility.
-No one asked him any questions about COVID-19 symptoms.

Interview with the Supervisor in Charge (SIC) on 07/29/21 at 3:05pm revealed:
-She obtained the resident's temperatures and documented the resident's temperatures in a spiral notebook kept in the medication cart.
-She screened herself on the first day back at work by taking her temperature, and she documented her temperature in the notebook.
-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.
-She did not know the CDC guidelines related to screening of the residents and staff.
-She had not obtained the resident's temperatures from 07/26/21 to 07/29/21.

Interview with the Administrator on 07/29/21 at 5:45pm revealed:
-Visitors were still screened and their temperatures were checked.
-She thought if a person was vaccinated the screening process had changed.
-She called the local health department frequently, but when she asked questions she did not specify if it pertained to long term care or public guidelines.
-She expected staff to screen themselves when they left and returned to the facility.
-She did not require the staff to document their

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C 612	Continued From page 17 temperatures unless they had a fever. -Residents were screened when they left and returned to the facility by taking their temperatures -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 07/29/21 at 1:29pm was unsuccessful.	C 612		