| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL051073 | A. BUILDING: _____ B. WING _____ | C 08/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE ENCLAVE AT EAGLE POINT | 118 EAGLE POINTE LN CLAYTON, NC 27520 |

| (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 |
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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on 08/24/21-08/25/21. | C 000 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, observation and interviews, the facility failed to ensure medication was administered in accordance with orders by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #2) related to a narcotic anti-anxiety medication and a medication used to treat an enlarged prostate.<br><br>Review of Resident #2's current FL2 dated 10/29/20 revealed:<br>-Diagnoses included unspecified dementia with behavioral disturbances, benign prostrate hyperplasia with lower urinary tract symptoms, urinary tract infection, reported falls, and chronic kidney disease.<br><br>a. Review of Resident #2's subsequent physician's orders revealed there was an order dated 07/28/21 for lorazepam (Ativan) (a narcotic used to treat anxiety) 0.5mg twice a day. | C 330 | | |

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| C 330 | Continued From page 1<br><br>Review of Resident #2's electronic medication administration record (eMAR) for July 2021 revealed:<br>-There was an entry for Ativan 1mg take ½ tablet (0.5mg) two times daily scheduled for administration at 8:00am and 8:00pm.<br>-There was documentation Ativan 0.5mg had been administered from 8:00pm on 07/28/21 through 8:00pm on 07/31/21.<br><br>Review of Resident #2's eMAR for August 2021 on 08/25/21 revealed:<br>-There was an entry for Ativan 1mg take ½ tablet (0.5mg) two times daily scheduled for administration at 8:00am and 8:00pm.<br>-There was documentation Ativan 0.5mg had been administered from 08/01/21-08/13/21.<br>-There was documentation Ativan 0.5mg had not been administered from 08/14/21 through 8:00am on 08/24/21.<br>-There was documentation dated 08/14/21 that Resident #2 was physically unable to take the medication and the medication was not in the medication cart.<br>-There was documentation dated 08/20/21 that Resident #2 was physically unable to take the medication.<br>-There was documentation dated 08/14/21-08/20/21 and 08/21/21-08/24/21 that Resident #2's Ativan 0.5mg was withheld per doctor/registered nurse orders.<br><br>Observation of Resident #2's medication available for administration on 08/24/21 at 5:50pm revealed:<br>-There was a blister pack of 60 half-tablets of Ativan 1mg.<br>-The date on the label on the blister was 08/25/21.<br>-No doses of Ativan had been administered. | C 330 | | |

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| C 330 | Continued From page 2<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/25/21 at 12:31pm revealed:<br>-The pharmacy dispensed medication to the facility on a 30-day cycle.<br>-Controlled substances were not dispensed on a cycle.<br>-Facility staff were responsible for requesting a refill for controlled substances.<br>-Controlled substances required another written order before being dispensed.<br>-The blister pack was to be used for medication administration starting on the date indicated on the Ativan 0.5mg blister pack label.<br><br>Interview with the RCC on 08/24/21 at 7:48pm revealed the hospice provider normally sent orders to the pharmacy.<br><br>Telephone interview with the Clinical Manager at Resident #2's hospice provider's office on 08/25/21 at 9:31am revealed:<br>-The hospice physician ordered Ativan due to Resident #2's anxiety.<br>-The hospice physician did not order Resident #2's Ativan to be withheld from 08/14/21-08/24/21.<br>-Staff had not contacted the hospice provider's office to report Resident #2 had not received the Ativan as ordered from 08/14/21-08/24/21.<br><br>Telephone interview with the House Manager (HM) on 08/25/21 at 1:05pm revealed:<br>-Several of Resident #2's medications were being adjusted or changed in July 2021 and August 2021.<br>-Resident #2 was having "ups and downs."<br>-Resident #2's Ativan had been changed to a different anti-anxiety medication. | C 330 | | |

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| C 330 | Continued From page 3 | C 330 | | |

-Resident #2's Ativan had been withheld because "it was not helping."
-The hospice nurse was supposed to communicate with the Resident Care Coordinator (RCC).

Telephone interview with the Director of Operations of Resident #2's hospice provider on 08/25/21 at 1:21pm and 2:46pm revealed:
-There was an order for Resident #2 dated 07/28/21 for Ativan 0.5mg twice a day.
-There was an order dated 08/04/21 for another anti-anxiety narcotic.
-There was no documentation Resident #2 was not receiving the Ativan as ordered.

Telephone interview with a Supervisor-in-Charge (SIC) on 08/25/21 at 3:12pm revealed:
-She was "under the impression" there was an order to withhold Resident #2's Ativan.
-The HM told her Resident #2's Ativan had been discontinued but had not been removed from the eMAR.
-She did not know if Resident #2's Ativan had been returned to the pharmacy.
-She did not talk with the RCC about Resident #2's Ativan order.
-She routinely spoke with the HM.

Telephone interview with a second SIC on 08/25/21 at 3:50pm revealed:
-There was a red dot on the eMAR entry for Resident #2's Ativan 0.5mg.
-The red dot meant there was a note about the medication.
-She clicked on the red dot and saw that Resident #2's Ativan had previously been withheld.
-She continued to withhold Resident #2's Ativan.
-She did not remember if Resident #2's Ativan was in the medication cart.

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| C 330 | Continued From page 4 | C 330 | | |

-She did not talk with anyone about withholding Resident #2's Ativan.

Telephone interview with the RCC on 08/25/21 at 4:30pm revealed:
-The HM told her there was an order to withhold Resident #2's Ativan 0.5mg.
-She did not see a written order to withhold Resident #2's Ativan.

Telephone interview with the Administrator on 08/25/21 at 5:20pm revealed:
-The HM should be informed by the SIC when a resident missed three doses of an ordered medication.
-The HM was responsible for informing the RCC when a resident missed three doses of an ordered medication.
-The RCC was responsible for notifying the PCP or hospice provider when a resident missed three doses of an ordered medication.
-There was a "breakdown" in communication among the HM, the hospice nurse, and the RCC related to the administration of Resident #2's Ativan 0.5mg.

Based on record review and observations, it was determined Resident #2 was not interviewable.

Refer to the telephone interview with the HM on 08/24/21 at 4:15pm.

Refer to the telephone interview with the Clinical Manager at Resident #2's hospice provider's office on 08/25/21 at 9:31am.

Refer to the telephone interviews with the HM on 08/25/21 at 1:05pm and 3:22pm.

Refer to the telephone interview with the Director

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| C 330 | Continued From page 5<br>of Operations at Resident #2's hospice provider's office on 08/25/21 at 2:46pm.<br><br>Refer to the telephone interview with the RCC on 08/25/21 at 4:30pm.<br><br>Refer to the telephone interview with the Administrator on 08/25/21 at 5:20pm.<br><br>b. Review of Resident #2's current FL2 dated 10/29/20 revealed there was an order for tamsulosin (Flomax) (used to treat an enlarged prostate) 0.4mg daily take 30minutes after breakfast.<br><br>Review of Resident #2's subsequent physician's orders revealed there was an order dated 06/28/21 to discontinue Flomax 0.4mg daily.<br><br>Review of Resident #2's electronic medication administration record (eMAR) for June 2021 revealed:<br>-There was an entry for Flomax 0.4mg take one capsule in the morning 30 minutes after breakfast scheduled for administration at 8:00am.<br>-There was documentation Flomax 0.4mg had been administered at 8:00am the entire month of June 2021.<br><br>Review of Resident #2's eMAR for July 2021 revealed:<br>-There was an entry for Flomax 0.4mg take one capsule in the morning 30 minutes after breakfast scheduled for administration at 8:00am.<br>-There was documentation Flomax had been administered at 8:00am on 07/01/21 and from 07/13/21-07/31/21.<br>-There was documentation Flomax had not been administered on 07/02/21-07/12/21.<br>-There was documentation dated 07/02/21 and | C 330 | | |

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| C 330 | Continued From page 6 | C 330 | | |

07/05/21 that Flomax was withheld per doctor/registered nurse orders.
-There was documentation dated 07/03/21-07/04/21 and 07/06/21-07/12/21 that Flomax was not given because the medication had not been delivered from the pharmacy.

Review of Resident #2's eMAR for August 2021 on 08/24/21 revealed:
-There was an entry for Flomax 0.4mg take one capsule in the morning 30 minutes after breakfast scheduled for administration at 8:00am.
-There was documentation Flomax had been administered at 8:00am from 08/01/21-08/24/21.

Observation of Resident #2's medication available for administration on 08/24/21 at 5:50pm revealed:
-There was a blister pack containing 17 capsules of Flomax 0.4mg.
-The label on the blister pack was dated 07/26/21 and indicated 30 capsules had been dispensed from the pharmacy.
-There was a second blister pack containing 30 capsules of Flomax 0.4mg.
-The label on the blister pack was dated 08/25/21 and indicated 30 tablets had been dispensed from the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/25/21 at 12:31pm revealed:
-The pharmacy did not receive a discontinue order for Resident #2's Flomax 0.4mg in June 2021 or July 2021.
-An order to discontinue Flomax 0.4mg was sent to the pharmacy on 08/24/21.

Refer to the telephone interview with the HM on 08/24/21 at 4:15pm.

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| C 330 | Continued From page 7<br><br>Telephone interview with the Clinical Manager at Resident #2's hospice provider's office on 08/25/21 at 9:31am revealed an order dated 06/28/21 written by the hospice physician to discontinue Resident #2's Flomax 0.4mg had been sent to the facility.<br><br>Interview with the RCC on 08/24/21 at 7:48pm revealed:<br>-She located the 06/28/21 order discontinuing Resident #2's Flomax in her email inbox.<br>-The hospice provider normally sent orders to the pharmacy.<br><br>Telephone interview with the RCC on 08/25/21 at 4:30pm revealed the Flomax error was due to "not enough communication" between her and the hospice provider<br><br>Telephone interview with the Administrator on 08/25/21 at 5:20pm revealed:<br>-He did not want medication errors to occur.<br>-There needed to be better communication with the pharmacy.<br>-The order discontinuing Resident #2's Flomax was missed because of a lack of communication with the hospice provider.<br><br>Based on record review and observations, it was determined Resident #2 was not interviewable.<br><br>Refer to the telephone interview with the HM on 08/24/21 at 4:15pm.<br><br>Refer to the telephone interview with the Clinical Manager at Resident #2's hospice provider's office on 08/25/21 at 9:31am.<br><br>Refer to the telephone interviews with the HM on | C 330 | | |

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| C 330 | Continued From page 8<br>08/25/21 at 1:05pm and 3:22pm.<br><br>Refer to the telephone interview with the Director of Operations at Resident #2's hospice provider's office on 08/25/21 at 2:46pm.<br><br>Refer to the telephone interview with the RCC on 08/25/21 at 4:30pm.<br><br>Refer to the telephone interview with the Administrator on 08/25/21 at 5:20pm.<br><br>_____<br>Telephone interview with the HM on 08/24/21 at 4:15pm revealed:<br>-The hospice nurse audited Resident #2's eMAR "a couple weeks ago."<br>-The hospice physician routinely faxed orders to the RCC and the RCC was responsible for faxing orders to the pharmacy.<br><br>Telephone interview with the Clinical Manager at Resident #2's hospice provider's office on 08/25/21 at 9:31am revealed:<br>-The hospice physician was Resident #2's attending physician, effective 06/06/21.<br>-The hospice physician's orders were routinely sent to the facility and facility staff was responsible for faxing the order to the pharmacy.<br>-The hospice nurse was going to review Resident #2's medications on the next visit to the facility.<br><br>Telephone interviews with the HM on 08/25/21 at 1:05pm and 3:22pm revealed:<br>-There were "so many hands" in Resident #2's orders.<br>-The RCC was responsible for reviewing the eMARs.<br>-The facility's eMAR system was new.<br>-She was "under the impression" the pharmacy had the ability to remotely review the eMARs. | C 330 | | |

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-She was not able to enter orders on the eMARs.
-When orders were changed, the eMAR and the medication available in the medication cart should match.
-Orders were sent from the hospice physician to the RCC.
-The RCC and the hospice nurse were responsible for reviewing the eMARs and the medications in the medication cart.

Telephone interview with the Director of Operations at Resident #2's hospice provider's office on 08/25/21 at 2:46pm revealed:
-She expected Resident #2's medication to be administered as ordered.
-She expected to be informed by staff if there were "difficulties" with a medication.

Telephone interview with the RCC on 08/25/21 at 4:30pm revealed:
-The hospice provider faxed orders to her and the pharmacy.
-She did not fax orders to the pharmacy.
-The pharmacy entered the orders on the eMARs.
-The HM and the hospice nurse were responsible for reviewing the eMARs monthly and when new orders were written.
-The HM knew she was responsible for reviewing the eMARs.
-The SICs did not enter orders on the eMAR; she rarely entered orders on the eMAR.
-When eMARs were reviewed, staff was supposed to verify the orders were in the resident's record.
-If orders were not in the resident's record, staff were expected to inform her.
-The SIC was to initially report a discrepancy to the HM.
-If the HM could not "troubleshoot" the problem or the problem was "too big," the HM would let her

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| C 330 | Continued From page 10<br>know.<br>-The HM was responsible for reviewing medication that was delivered from the pharmacy.<br>-She expected medications to be "administered perfectly."<br><br>Telephone interview with the Administrator on 08/25/21 at 5:20pm revealed:<br>-The RCC received orders from the healthcare providers and placed them in the residents' records.<br>-The RCC informed staff of changes to medication orders.<br>-The HM was responsible for reconciling the eMARs with the current orders.<br>-The RCC double-checked behind the HM.<br>-He expected medication orders to be followed.<br>-He expected to be able to locate written orders in the residents' record. | C 330 | | |
| C 612 | 10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM<br>(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease<br>threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published<br>guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or<br>emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific<br>guidance or directives shall be implemented by the facility. | C 612 | | |

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control and Prevention (CDC) during the global coronavirus (COVID-19) pandemic were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents as related to visitor screening and the use of facemasks by facility staff.

The findings are:

1. Observation upon entry to the facility on 08/24/21 at 8:44am revealed:
-There was a screening area in the entry hall with COVID-19 screening questionnaires, a thermometer, a box of surgical facemasks, and hand sanitizer.

Observation on 08/24/21 at 12:12pm revealed a healthcare provider (HCP) entered the facility and was not screened by staff, nor did she self-screen.

Review of the CDC interim infection prevention and control recommendations for healthcare personnel during the COVID-19 pandemic dated 02/23/21 revealed everyone entering a facility was to be assessed for symptoms of COVID-19

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| C 612 | Continued From page 12<br>or exposure to others with suspected or confirmed COVID-19 infection.<br><br>Review of the CDC interim infection prevention and control recommendations to prevent COVID-19 spread in long-term care facilities dated 03/29/21 revealed healthcare personnel entering a facility were to be assessed for symptoms of COVID-19 or close contact outside the facility to others with COVID-19 infection.<br><br>Review of the CDC updated healthcare infection prevention and control recommendations in response to the COVID-19 vaccination dated 04/27/21 revealed visitors were to be screened for symptoms of and exposure to COVID-19 regardless of their vaccination status.<br><br>Interview with the House Manager (HM) on 08/24/21 at 12:30pm revealed:<br>-Visitors to the facility were to have their temperatures taken, complete the screening questionnaire, and wear a facemask while they were at the facility.<br>-Healthcare providers routinely completed a self-screen for COVID-19.<br>-Staff on duty was responsible for screening people who came into the facility.<br>-She thought the HCP had completed a self-screen.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/24/21 at 12:36pm revealed:<br>-Staff on duty was responsible for screening anyone who came into the facility.<br>-She thought the HCP had screened herself.<br><br>Interview with the HCP on 08/24/21 at 1:18pm revealed:<br>-No one screened her when she entered the | C 612 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL051073 | A. BUILDING: _____ B. WING _____ | C 08/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ENCLAVE AT EAGLE POINT | 118 EAGLE POINTE LN CLAYTON, NC 27520 |

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facility.
-She had forgotten to screen herself when she entered the facility.

Telephone interview with the Resident Care Coordinator (RCC) on 08/25/21 at 10:30am revealed:
-HCP were supposed to self-screen, verbally respond to screening questions, enter their temperature in the log and sign the log as verification they read the questionnaire.
-Staff received training on COVID-19 screening one year ago "when COVID first started."
-The entry to the facility was routinely locked and staff was responsible for letting visitors into the facility and "catching them" so they would be screened.
-The door was not locked at the time the HCP entered the facility.

Telephone interview with the Administrator on 08/25/21 at 5:20pm revealed:
-Staff was responsible for taking the temperatures of visitors to the facility.
-Visitors were supposed to complete the COVID-19 screening questionnaire.
-There were parameters related to temperature and approval for entering the facility.
-The SIC on duty was responsible for screening everyone who came into the facility; the SIC was aware of this responsibility.
-The entry to the facility was usually locked so staff would have to let visitors into the facility.
-The entry to the facility was unlocked when the HCP arrived at the facility.

2. Observations on 08/24/21 from 9:57am-12:30pm revealed:
-The House Manager (HM) entered the facility and had her facemask positioned below her

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ENCLAVE AT EAGLE POINT | 118 EAGLE POINTE LN CLAYTON, NC 27520 |

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| C 612 | Continued From page 14 | C 612 | | |

nose.
-The HM continually had her mask positioned below her nose or below her chin while in the facility.

Review of the Centers for Disease Control and Prevention (CDC) updated healthcare infection prevention and control recommendations in response to the coronavirus (COVID-19) vaccination dated 04/27/21 revealed healthcare personnel should continue to wear source control (facemasks) while at work.

Interview with the HM on 08/24/21 at 12:30pm revealed:
-Staff were supposed to self-screen, wear a facemask, and wash their hands after entering the facility.
-She was "wrong" by not wearing the facemask to cover her nose and mouth.

Telephone interview with the Resident Care Coordinator (RCC) on 08/25/21 at 10:30am revealed:
-Staff were expected to wear facemasks covering their nose and mouth whenever "doing something" with the residents, when they were around other staff, or when they were cooking.
-Fully vaccinated staff could remove their facemasks when they were alone in the facility office.
-Unvaccinated staff were always required to wear facemasks .
-The HM should have been wearing her facemask appropriately.
-She told the HM to wear the facemask properly earlier in the day.
-Training on proper facemask usage was provided in March 2020.
-Signage on facemask usage was displayed at

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|---|---|---|---|---|
| C 612 | Continued From page 15<br>the facility.<br><br>Telephone interview with the Administrator on 08/25/21 at 5:20pm revealed:<br>-Staff were expected to wear facemasks in the appropriate way.<br>-He would have a conversation with staff about proper use of facemasks.<br>-Training on COVID-19 precautions was provided in March 2020 and was routinely discussed in monthly staff meetings.<br>-The HM was present for the training and the monthly staff meetings.<br>-Staff meetings were held last the Thursday of each month.<br>-The last staff meeting had taken place in July 2021. | C 612 | | |