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D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual and follow-up survey, and a complaint investigation on 09/15/21 and 09/16/21.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .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, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record review and interviews, the	D 254		

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D 254	Continued From page 1 facility failed to ensure 1 of 5 sampled residents (#1) had a care plan that was completed annually. The findings are: Review of Resident #1's current FL2 dated 08/13/21 revealed diagnosis included pulmonary fibrosis and hypertension. Review of the Resident Register for Resident #1 revealed an admission date of 11/01/18. Review of Resident #1's record revealed there was no documented care plan since 05/29/20. Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 12:15pm revealed: -She had mailed a new care plan to Resident #1's physician for review in May 2021. -She had not received the care plan back from the physician and had not followed up on it. -She was responsible for ensuring annual care plans were in the resident records.	D 254		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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	D 358		

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interviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 9 sampled residents (#2, #3) related to not administering two medications used to treat pain associated with an ear infection (#2) and administering the incorrect dose of a medication used to treat hypothyroidism (#3).

The findings are:

Review of the facility's Medication Administration revealed all medications would be prepared and administered consistent with Federal and State guidelines.

1. Review of Resident #2's current FL2 dated 05/04/21 revealed diagnoses included diabetes and depression.

a. Review of a physician's order dated 08/23/21 revealed:
-There was a physician's order for prednisone (used to treat inflammation) 20mg take 1 tablet twice daily.
-There was a note requesting clarification of the physician's order related to the duration of therapy.
-There was documentation to administer the prednisone 20mg take 1 tablet twice daily for three days.

Review of Resident #2's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for prednisone 20mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm from 08/23/21 to 08/27/21.
-There was no documentation prednisone 20mg

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was administered to Resident #2.

Observation of medications on hand on 09/15/21 at 3:15pm revealed there was no prednisone for Resident #2 available on the medication cart.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/21 at 3:45pm revealed:
-There were 20 tablets of prednisone 20mg delivered to the facility on 08/23/21 for Resident #2.
-The pharmacy had delivered the medication before the clarification regarding the duration was received.

Interview with Resident #2 on 09/16/21 at 11:25am revealed:
-She was prescribed the prednisone for chronic ear pain.
-The pain in her ear was caused by a hole in her eardrum.
-She had an infection in her ear and the pain had worsened.
-She had requested something to help with the pain because it was uncomfortable.
-She did not know if she was not administered the prednisone.

Telephone interview with a medication aide (MA) on 09/16/21 at 10:03am revealed:
-The facility's contracted Nurse Practitioner (NP) asked her to write up the order for the prednisone for Resident #2.
-She did not know why the NP had prescribed the prednisone, but she faxed the order to the pharmacy.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/16/21 at 10:50am

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revealed:
-The prednisone was ordered to help with the pain associated with an ear infection.
-Resident #2 would have increased pain from not getting the prednisone.
-All medications should be administered as ordered to the residents.

Interview with the Resident Care Coordinator (RCC) on 09/16/21 at 10:49am revealed:
-She did not know why Resident #2 was not administered the prednisone.
-She or the MAs were responsible for faxing all physician orders to the pharmacy.
-She was responsible for approving the physician orders to appear on the eMARs after the pharmacy entered the order.

b. Review of a physician's order dated 08/23/21 revealed there was a physician's order for Xyzal (used to treat allergies) 5mg take 1 tablet daily for 14 days.

Review of Resident #2's August 2021 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Xyzal 5mg take 1 tablet daily for 14 days scheduled to be administered at 8:00pm.
-There was no documentation Xyzal 5mg was administered to Resident #2.

Observation of medications on hand on 09/15/21 at 3:15pm revealed there was no Xyzal for Resident #2 available on the medication cart.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/15/21 at 3:45pm revealed:
-There were 14 tablets of Xyzal 5mg delivered to

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the facility on 08/23/21 for Resident #2.
-The Xyzal was scheduled to be administered for 14 days started on 08/24/21.

Interview with Resident #2 on 09/16/21 at 11:25am revealed:
-She was prescribed the Xyzal for chronic ear pain.
-The pain in her ear was caused by a hole in her eardrum.
-She had an infection in her ear and the pain had worsened.
-She had requested something to help with the pain because it was uncomfortable.
-She did not know if she was not administered the Xyzal.

Telephone interview with a medication aide (MA) on 09/16/21 at 10:03am revealed:
-The facility's contracted Nurse Practitioner (NP) asked her to write up the order for the Xyzal for Resident #2.
-She did not know why the NP had prescribed the Xyzal, but she faxed the order to the pharmacy.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/16/21 at 10:50am revealed:
-The Xyzal was ordered to help with the pain associated with an ear infection.
-Resident #2 would have increased ear pain and discomfort if she was not administered the Xyzal.
-All medications should be administered as ordered to the residents.

Interview with the Resident Care Coordinator (RCC) on 09/16/21 at 10:49am revealed:
-She did not know why Resident #2 was not administered the Xyzal.
-She or the MAs were responsible for faxing all

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physician orders to the pharmacy.
-She was responsible for approving the physician orders to appear on the eMARs once the pharmacy entered in the order.

2. Review of Resident #3's current FL2 dated 02/09/21 revealed diagnoses included anxiety, depression, and hypertension.

Observation of the medication pass on 09/15/21 at 11:48am revealed:
-The medication aide (MA) pulled a medication card containing levothyroxine (thyroid hormone supplement used to treat hypothyroidism) 150mcg from the medication cart.
-The MA quickly showed the surveyor the medication label and the surveyor identified the first name of the resident while the MA repeated the name of the resident verbally.
-The medication cup had Resident #3's name written on the side.
-The MA took the medication cup containing the levothyroxine 150mcg and a cup of water into the hallway.
-The MA administered the medication to Resident #3.

Review of Resident #3's Physician Order Sheet dated 03/01/21 revealed a physician's order for levothyroxine 75mcg take 1 tablet daily.

Observation of medication on hand on 09/16/21 at 10:10am revealed:
-There was a bottle of levothyroxine 75mcg available to administer to Resident #3.
-There were 90 tablets of levothyroxine filled at Resident #3's pharmacy on 09/08/21.

Review of Resident #3's electronic Medication Administration Record (eMAR) revealed:

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D 358	Continued From page 7 -There was a computer-generated entry for levothyroxine 75mcg take 1 tablet daily scheduled to be administered at 11:00 am daily. -Levothyroxine 75mcg was documented as administered daily at 11:00am from 09/01/21 to 09/15/21 except for 09/06/21 and 09/07/21. -There was documentation the facility was "waiting on a PA" for levothyroxine 75mcg on 09/06/21 and 09/07/21 and the medication was not administered. Interview with a medication aide (MA) on 09/16/21 at 10:15am revealed: -Resident #3 was ordered levothyroxine 75mcg. -There was another resident in the facility with the same first name that was ordered levothyroxine 150mcg. Telephone interview with a medical assistant from Resident #3's primary care provider's (PCP) office on 09/16/21 at 10:32am revealed: -Resident #3 was prescribed levothyroxine 75mcg. -She talked with Resident #3's PCP regarding the resident being administered the incorrect dose of levothyroxine. -The PCP said it was "a serious error" but was not dangerous to the resident if it was the only occurrence. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/16/21 at 10:50am revealed: -She followed Resident #3 until recently the resident changed providers. -Resident #3 was prescribed levothyroxine 75mcg. -Resident #3 was at an increased risk for palpitations, tremors, and anxiety if she received the incorrect dose of levothyroxine for an	D 358		

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D 358	Continued From page 8 extended period. -All medications should be administered as ordered to the residents. Interview with the Resident Care Coordinator (RCC) on 09/16/21 at 10:49am revealed: -She knew the MA had administered the wrong dose of levothyroxine to Resident #3. -She or the MAs were responsible for faxing all physician orders to the pharmacy. -She was responsible for approving the physician orders to appear on the eMARs once the pharmacy entered in the order.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides (MA) observed residents taking their medications for 3 of 9 sampled residents (#2, #6, and #9) with liquid medications left at the bedside (#6 and #9) and a medication left with the resident in the dining room (#2). . The findings are:	D 366		

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Review of the facility's Medication Administration Policy and Procedure revealed observe the resident consumption of the medication.

1. Review of Resident #9's current FL2 dated 02/01/21 revealed:
-Diagnoses included Alzheimer's Disease.
-There was documentation of intermittent disorientation.
-There was a physician's order for Chlorhexidine (reduces bacteria in the mouth) 0.12% mouth rinse swish and spit 1 capful twice daily.

Observation during the initial tour on 09/15/21 at 10:00am revealed:
-There was a clear 30ml medication cup with 15ml of a blue liquid in it on the counter in Resident #9's room.
-Hand written on the cup was the resident's initials and a time of 8:00am.

Review of Resident #9's electronic Medication Administration Record (eMAR) for 09/15/21 revealed:
-There was an entry for Chlorhexidine 0.12% mouth rinse swish and spit 1 capful twice daily with administration times of 8:00am and 8:00pm.
-There was documentation the Chlorhexidine 0.12% mouth rinse had been administered on 09/15/21 at 8:00am.

Interview with Resident #9 on 09/15/21 at 10:00am revealed the liquid medication was her mouth rinse and she would take it "later".

Refer to the interview with a medication aide (MA) on 09/15/21 at 3:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) 09/15/21 at 3:40pm.

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D 366	Continued From page 10 2. Review of Resident #2's current FL2 dated 05/04/21 revealed: -Diagnoses included diabetes and depression. -There was a physician's order for Miralax (used to treat constipation) powder mix 1 capful in 8 ounces of beverage of choice and take daily. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Miralax powder mix 1 capful in 8 oz of beverage of choice and take every day for constipation scheduled to be administered daily at 8:00am. -Miralax was documented as administered daily at 8:00am from 09/01/21 to 09/16/21. Observation in the dining room during the morning medication pass on 09/16/21 at 8:10am revealed: -Resident #2 was sitting at a table in the dining room. -The medication aide (MA) prepared Resident #2's medications at the medication cart in the hallway outside of the dining room. -The MA popped 13 tablets into a clear, medication cup. -The MA mixed a capful of Miralax into a cup of water. -The MA carried the medication cup and cup of water containing Miralax to Resident #2 in the dining room. -The MA handed the medication cup containing tablets to Resident #2 and sat the cup of water containing the Miralax onto the tablet. -The MA stood by Resident #2 and watched her take the medication cup containing 13 tablets. -The MA walked away from Resident #2 leaving the cup of water containing Miralax on the tablet.	D 366		

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D 366	Continued From page 11 Interview with Resident #2 on 09/15/21 at 9:45am revealed: -The MAs usually leave her medications with her to take when she wants to. -The MAs did not have to worry about her taking her medications so they would leave the medications with her. Interview with a MA on 09/16/21 at 8:20am revealed: -She did not watch Resident #2 take the Miralax because it sometimes took her a while to drink the entire cupful. -She needed to make sure she got the medications administered to the other residents and did not have time to wait on Resident #2 to take the Miralax. -She was supposed to watch the residents take their medications. Refer to the interview with a medication aide (MA) on 09/15/21 at 3:30pm. Refer to the interview with the Resident Care Coordinator (RCC) 09/15/21 at 3:40pm. 3. Review of Resident #6's current FL2 dated 07/05/21 revealed: -Diagnoses included cerebrovascular disease, debility, dementia, and poor balance. -There was a physician's order for Miralax (used to treat constipation) powder mix 1 capful in 8 oz of beverage of choice and take daily as needed. Review of Resident #6's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Miralax powder mix 1 capful in 8 oz of beverage	D 366		

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of choice and take every day as needed with no scheduled administration time.
-Miralax was documented as administered on 09/05/21 at 9:11am.

Observation in Resident #6's room on 09/15/21 at 9:57am revealed there was a small medication cup containing a white powder on a small table beside Resident #6's recliner.

Interview with Resident #6's on 09/15/21 at 9:57am revealed:
-The white powder was a laxative she used for constipation.
-The medication aide (MA) gave it to her to take when she needed it.
-She kept it in her room and mixed it with her water or a drink throughout the day.

Interview with a MA on 09/15/21 at 3:15pm revealed she did not know why Resident #6 had Miralax left in a medication cup in her room.

Refer to the interview with a medication aide (MA) on 09/15/21 at 3:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) 09/15/21 at 3:40pm.

_____

Interview with a Medication Aide (MA) on 09/15/21 at 3:30pm revealed:
-She had been trained to observe the residents taking their medications.
-She did not know why the medications had been left in the residents' rooms.

Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 3:40pm revealed:
-The medication aides (MAs) were trained to observe the residents take their medications.

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D 366	Continued From page 13 -The MAs should not have left medications in the residents' rooms.	D 366		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 3 of 9 sampled residents (#2, #7, and #8) had orders to self-administer medications related to medications kept in residents' rooms including vitamins, an anti inflammatory, nasal spray, and eye drops (#7), an anti inflammatory gel and eye drops (#8), and a multivitamin, fish oil, and iron supplement (#2). The findings are: Review of the facility's Self Administration of Medications Policy and Procedure revealed the physician writes an order for self administration	D 375		

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including specific medications to be self administered.

1. Review of Resident #7's current FL2 dated 05/13/20 revealed:
-Diagnoses included Alzheimer's Disease and vascular dementia.
-There was documentation of intermittent disorientation.
-Medication orders included fluticasone propionate (treats seasonal allergies) 50mcg 1 spray in each nostril twice daily and women's one a day (multivitamin) daily.

Observation during the initial tour on 09/15/21 at 9:34am revealed:
-There was a 7 day plastic medication box on the counter in Resident #7's room.
-There were two red capsules, one orange tablet, and one white tablet in six of the compartments of the medication box.

Observation of Resident #7's bathroom on 09/16/21 at 8:05am revealed there was a bottle of multivitamins, a bottle labeled naproxen sodium (anti inflammatory) 220mg, a bottle labeled fluticasone propionate 50mcg, and a bottle labeled Systane lubricant eye drops on a shelf.

Review of Resident #7's record revealed there was not a physician's order to self administer medications.

Interview with Resident #7 on 09/15/21 at 9:34am revealed:
-The medication box was "just vitamins" that she took everyday.
-She was not prescribed any medications by a physician.
-She was not sure where the medication box

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came from.

Interview with Resident #7 on 09/16/21 at 8:06am revealed she did not know what the medications in the bathroom were for or who put them there.

Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 3:40pm revealed:
-She did not know why Resident #7 had the medications in her room.
-She thought Resident #7 might have had them in her purse upon admission.

Interview with a medication aide (MA) on 09/15/21 at 3:30pm revealed:
-She did not know the medications were in the residents' rooms.
-Maybe a family member had brought the medications to the residents.
-Family members were informed that medications required a physician's order and were to be kept in the medication cart.

Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 3:40pm revealed:
-Sometimes residents' family members brought medications to the residents.
-Family members were informed that medications required a physician's order and were to be kept in the medication cart.

2. Review of Resident #8's current FL2 dated 10/19/20 revealed:
-Diagnoses included osteoarthritis and chronic kidney disease.
-There was no documentation as to level of orientation.

Observation during the initial tour on 09/15/21 at 9:42am revealed there was an opened 1.76 oz

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tube of diclofenac sodium 1% (anti inflammatory pain medication) topical gel and an opened box of Refresh lubricant eye drops on the bedside table.

Review of Resident #8's physician orders revealed there was no order for the diclofenac sodium 1% gel or the Refresh eye drops.

Review of Resident #8's revealed there was not a physician's order to self administer medications.

Interview with Resident #8 on 09/15/21 at 9:42am revealed a family member had brought the medications in to him and he used the diclofenac sodium 1% gel on his knees.

Interview with a medication aide (MA) on 09/15/21 at 3:30pm revealed:
-She did not know the medications were in the residents' rooms.
-Maybe a family member had brought the medications to the residents.
-Family members were informed that medications required a physician's order and were to be kept in the medication cart.

Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 3:40pm revealed:
-Sometimes residents' family members brought medications to the residents.
-Family members were informed that medications required a physician's order and were to be kept in the medication cart.

3. Review of Resident #2's current FL2 dated 05/04/21 revealed diagnoses included diabetes and depression.

Observation during the initial tour on 09/15/21 at 9:45am revealed there was a bottle of fish oil

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D 375	Continued From page 17 1200mg (supplement used to support the heart, brain, and eyes), once daily multivitamin (vitamin supplement), and iron 325mg (iron supplement) on the nightstand by Resident #2's bed. Review of Resident #2's record revealed there was no physician orders for fish oil, once daily multivitamin, or iron. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed: -There was no computer-generated entry for fish oil 1200mg, once daily multivitamin, or iron 325mg. -There was no documentation fish oil 1200mg, once daily multivitamin, or iron 325mg. Interview with Resident #2 on 09/15/21 at 9:45am revealed: -The facility staff knew she had the medications in her room. -The facility staff were "okay" with her having the medications in her room -She took one tablet of each of the supplements every day. Interview with a medication aide (MA) on 09/15/21 at 3:15pm revealed: -She did not know Resident #2 had medications in her room. -She did not know Resident #2 was taking the fish oil, multivitamin, and iron supplement. Interview with a medication aide (MA) on 09/15/21 at 3:30pm revealed: -She did not know the medications were in the residents' rooms. -Maybe a family member had brought the medications to the residents.	D 375		

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D 375	Continued From page 18 -Family members were informed that medications required a physician's order and were to be kept in the medication cart. Interview with the Resident Care Coordinator (RCC) on 09/15/21 at 3:40pm revealed: -Sometimes residents' family members brought medications to the residents. -Family members were informed that medications required a physician's order and were to be kept in the medication cart. Interview with the RCC on 09/16/21 at 12:00pm revealed she did not know the medication was in Resident #2's room. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 09/16/21 at 10:53am revealed all medications should be stored in the medication cart and administered by a MA.	D 375		
D 610	10A NCAC 13F .1801 (a) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to implement an infection prevention and control program consistent with the May 05, 2021	D 610		

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North Carolina Department of Health and Human Services (NCDHHS) published guidelines on infection prevention and control related to not allowing visitation at the facility during the COVID-19 global pandemic.

The findings are:

Review of the NCDHHS Guidance for Visitation, Quarantine and Communal Activities in Post-Acute Care Facilities in Response to COVID-19 Vaccination revealed:
-"Outdoor visitation continues to be preferred even when the resident and visitor are fully vaccinated against COVID-19 as this space allows increased space and airflow".
-"Facilities should allow responsive indoor visitation a all times for all residents, regardless of vaccination status of the resident or visitor, unless certain scenarios exist, including unvaccinated residents if the COVID-19 county positivity rate is >10% AND <70% of residents in the facility are fully vaccinated".
-Compassionate care visits should be allowed at all times, regardless of vaccination status, the county's COVID-19 positivity rate, or an outbreak.

Observation of the facility's main entrance door on 09/15/21 at 9:00am revealed:
-The door was locked.
-A sign was taped to the door documenting "As of August 17 due to the increase in COVID cases there will be no visitations allowed, inside or outside. Our residents health is of our utmost importance. Thank you for understanding".

Review of a note posted on the medication room's door on 09/16/21 at 7:49am revealed:
-The note was signed by the Administrator and documented it was effective 08/06/21.

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-The note was titled visitation.
-The note documented "Due to the recent spike in COVID-19 cases we are suspending all indoor visitation no matter of vaccination status. Visitation will still be allowed outdoors at all the facilities, but a mask is required".

Interview with the Activity Director on 09/15/21 at 10:23am revealed:
-When the county COVID-19 cases increased the Administrator changed the visitation policy at the facility.
-Until 08/17/21, visits were being allowed outside as long as visitors and residents wore a mask.
-Until 08/07/21 the facility allowed compassionate care visits but the facility currently did not have any resident who was seriously ill or in need of that level of visit.
-Visitation was changed on 08/17/21 to visits through the window, on the telephone or on the computer only.
-There was a sign posted on the front door to inform visitors of the change.
-Families were supportive of the change because they were cautious and concerned.

Interview with a family member on 09/15/21 at 4:45pm revealed:
-A family member lived at the facility and they visited at least weekly.
-All the family members were vaccinated.
-The family member asked the surveyor how the facility was allowed to refuse compassionate care visits for the family member that resided at the facility.
-The resident was in her 90's, had dementia and did not understand why they visits were conducted through the window.
-Face-to-face visits were only allowed if the family took the resident to a medical appointment.

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-The family member requested a visit with the resident after the sign was posted on the front door but was denied entrance.
-The facility was contacted several times and a return call from the Resident Care Coordinator (RCC) or the Administrator was requested, but calls were never returned.

Interview with a second family member on 09/16/21 at 12:45pm revealed:
-Earlier this summer he was allowed to visit but could not come inside the building; he had to take the resident out.
-Management from the facilty told him about a month ago that visits were no longer allowed due to the surge in COVID-19 cases in the county.

Interview with a resident on 09/15/21 at 3:00pm revealed:
-She really missed her family members.
-She hoped she would be able to see them again soon.
-She did not know if the facility allowed visits or not but her family always called before they came for a visit.

Interview with a second resident on 09/16/21 at 9:36am revealed:
-Her family used to visit regularly but it was stopped and now she was only able to stand at the window and wave.
-She did not like only being able to see her family at the window because it was hard to visit that way.
-She did not understand why visitation was changed.
-She enjoyed it in the past when her family was able to come inside and visit.

Interview with the RCC on 09/16/21 at 9:14am

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D 610	Continued From page 22 revealed: -All residents were vaccinated, except one who was unable to have it. -Most of the staff were vaccinated. -The facility received the May 05, 2021 NCDHHS visitation guidelines. -The Administrator changed the visitation policy when the counties COVID-19 cases increased in August 2021. -Initially inside visits were eliminated but outside visits were allowed as long as everyone wore a mask. -After an outbreak of COVID-19 at a sister facility, all face-to-face visitation was eliminated but visits through the window, on the telephone and on the computer were allowed. -The local health department did not give the facility any guidance on visitation. Interview with the local health department on 09/16/21 at 11:32am revealed they were in weekly contact with the facility's RCC but no guidance was given in regards to visitation.	D 610		