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SHULER HEATH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

(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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/07/21 and 09/08/21.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a test for tuberculosis (TB) upon hire. The findings are: Review of Staff A's personnel record revealed: -He was hired on 04/16/21 as a Fill-in Houseparent. -There was no documentation he had received a two-step TB test. Telephone interview with Staff A on 09/08/21 at 9:24am revealed he had not had a TB test since being hired at the facility. Interview with the Administrator on 09/08/21 at 11:33am revealed: -Staff A was told upon hire that he had to have a	D 131		

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D 131	Continued From page 1 TB test. -She had told the Business Office Manager (BOM) to make sure staff employee charts were current. -The BOM is ultimately responsible to ensure TB tests are done for all employees. Telephone interview attempted on 09/08/21 at 3:17pm with the BOM was unsuccessful.	D 131		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on record review and interview the facility Administration failed to complete a Resident Register related to dates and signatures for 1 of 3 residents (Resident #1).	D 248		

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D 248	Continued From page 2 The findings are: Review of Resident #1's current FL-2 dated 03/05/21 revealed: -Diagnoses included diabetes and encephalopathy (a disease is which brain functioning is altered). -"Rest Home" was documented as the current recommended level of care. -Admission date on the FL-2 was dated 12/10/20. Review of Resident #1's record on 09/07/21 revealed: -The Resident Register was signed by Resident #1 but not dated. -The Administrator or Administrator in Charge had not signed or dated the Resident Register for Resident #1. Interview with the Administrator on 09/08/21 at 11:25am revealed: -The Business Office Manager (BOM) is responsible to ensure all admitting paperwork is completed. -She signed the Resident Registers for all residents. -This was an instance where the Resident Register was "accidentally overlooked." -"It just did not get done."	D 248		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 273		

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facility failed to ensure referral and follow-up for 2 of 3 sampled residents who did not have a scheduled appointment made to follow up with the primary care provider after discharging from the local hospital (Resident #2) and one resident who did not have ordered labs or an evaluation by Physical Therapy and Occupational Therapy for treatment (Resident #3).

The findings are:

1. Review of Resident #2's current FL2 dated 09/21/20 revealed diagnoses included schizoaffective disorder, chronic post traumatic stress syndrome, and a communicable disease.

Review of Resident #2's local hospital discharge summary dated 04/28/21 revealed:
-He was discharged with a diagnoses of dehydration and dizziness.
-There was a physician's order to schedule a follow-up within 2 days with the primary care physician (PCP) upon discharge from the hospital.

Review of Resident #2's record revealed there was no documentation related to a follow-up appointment with the PCP.

Interview with the medication aide (MA) on 09/07/21 at 3:35pm revealed residents' referrals and appointments were managed and scheduled by the Business Office Manager (BOM).

Interview with Resident #2 on 09/07/21 at 3:58pm revealed:
-He had weakness and dizziness in April 2021 and was sent to the local hospital where he was admitted.
-His PCP was located at the local veteran's

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hospital.
-He did not know if he had a follow-up appointment or was seen by his PCP after discharging from the local county hospital.
-He had recently been to his PCP's office to have his routine bloodwork drawn.

Interview with the Administrator on 09/08/21 at 4:08pm revealed:
-The referral for a follow-up appointment for Resident #2 was "just missed".
-She was not aware Resident #2 had missed a follow-up appointment with the PCP.
-She was not aware Resident #2 never had an appointment made for a follow-up.
-The BOM was responsible for scheduling referrals and ensuring PCP orders are followed.

Attempted telephone interview with Resident #2's PCP on 09/07/21 at 4:05pm was unsuccessful.

Attempted telephone interview with the BOM on 09/08/21 at 3:17pm was unsuccessful.

2. Review of Resident #3's current FL-2 dated 01/18/21 revealed diagnoses included diabetes, seizures and hypertension.

Review of Resident #3's record revealed:
-A physician order to obtain a urinalysis (UA) with culture and sensitivity (C&S) was ordered 06/16/21.
-A physician order for physical therapy (PT) to evaluate and treat was ordered 06/16/21.
-A physician order for occupational therapy (OT) to evaluate and treat was ordered 06/16/21.
-A new diagnosis of unsteady gait and balance was given by the Primary Care Provider (PCP) on

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06/16/21.
-There had been several falls in the past several weeks.
-There was no documentation a UA with C&S had been completed.
-There was no documentation PT or OT had evaluated or treated Resident #3.

Interview with a medication aide (MA) on 09/08/21 at 9:55am revealed:
-Resident #3's UA and PT/OT information should be in his record.
-She was unable to locate Resident #3's UA or PT/OT information.
-The Business Office Manager (BOM) was responsible for follow-ups for therapy and ensuring the UA was completed.

Interview with Resident #3's Primary Care Provider (PCP) on 09/08/21 revealed:
-The facility had not notified her Resident #3 had not had a UA completed.
-The facility staff did not notify her if UA results are negative.
-The facility staff had not notified her Resident #3 did not have a PT or OT evaluation.
-He had been having frequent falls over the past several weeks.
-PT/OT would have helped him improve his gait and his balance.
-She planed to re-order the PT/OT evaluation.

Interview with the Administrator on 09/08/21 at 4:08pm revealed:
-She was not aware Resident #3 had missed a UA.
-She was not aware Resident #3 never had an appointment made for a PT and OT evaluation.
-The BOM was responsible for scheduling referrals and ensuring PCP orders are followed.

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D 273	Continued From page 6 Attempted telephone interview with the BOM on 09/08/21 at 3:17pm was unsuccessful.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided with a non-disposable place setting including a knife. The findings are: Observation of the noon meal on 09/07/21 beginning at 11:59am revealed: -There were eleven place settings on the tables in the dining room. -There were nine residents seated at the tables in the dining room. -Each place setting had a napkin, fork and a spoon, but no knife. -Nine residents were served a salad with turkey pieces, five crackers and two chocolate chip cookies.	D 287		

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D 287	Continued From page 7 -Several residents were observed eating large pieces of lettuce that hung out of their mouths. Interview with the Personal Care Aide (PCA) on 09/07/21 at 2:06pm who served the noon meal revealed: -She did not set the table for lunch. -She knew everyone was supposed to have a knife, fork, and a spoon. -She did not know why there was only a fork and spoon on the tables. Interview with a resident on 09/08/21 at 8:48am who ate the noon meal on 09/07/21 revealed: -He did not receive a knife at the noon meal on 09/07/21. -He did not have difficulty cutting his food but had noticed some of the other residents do when they do not have a knife. -There was not always a knife in the place setting at meal times. Interview with a second resident on 09/08/21 at 8:55am revealed: -Sometimes he could not chew the food he was served. -A knife would be helpful so he could cut his food into smaller pieces. -Sometimes staff would put a knife on the table for meals but not always. Interview with the Administrator on 09/08/21 at 11:33am revealed: -She was not aware staff were not setting a complete place setting at mealtimes. -All residents should have a full place setting that included a knife, fork and spoon at every meal.	D 287		

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D 292	Continued From page 8	D 292		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to document the foods served to residents when substitutions to the menu occurred. The findings are: Review of the facility's lunch menu for 09/07/21 revealed chef salad with turkey, crackers, garlic toast and mixed fruit was to be served. Observation of the noon meal service on 09/07/21 beginning at 11:59am revealed: -A salad with lettuce, tomato and turkey was served. -Five crackers and two chocolate chip cookies were served. Review of the facility's substitution sheets in the kitchen revealed there was no documentation of any food substitution for the noon meal on 09/07/21. Interview with the Personal Care Aide (PCA) on 09/07/21 at 2:06pm revealed: -She did not give the residents what was listed on	D 292		

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D 292	Continued From page 9 the menu for the noon meal on 09/07/21. -She came in at 11:30am and did not have time to make the garlic toast. -There was no fruit available at this facility to be served. -Fruit was kept at another building and she did not have time to get it before the noon meal was served. -The fruit was supposed to be served as dessert, so she gave the residents two chocolate chip cookies instead. -She knew she was supposed to write down any substitutions on the substitutions list, but she had not filled it out yet. Interview with the Administrator on 09/08/21 at 11:33am revealed: -Each House Manager (HM) is given a menu order guide each week. -The HM was supposed to check what is on the menu for the following week and check off what was needed before the food order is put in. -She was not aware substitutions were being made and not documented. -She expected her staff to serve what was on the menu. -Staff should have documented on the substitution list any changes that were made before the meal was served.	D 292		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition	D 306		

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D 306	Continued From page 10 to other beverages. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident at mealtime in addition to other beverages. The findings are: Review of the facility's menu for regular diets revealed water was not listed on the menu. Observation of the noon meal service on 09/07/21 beginning at 11:59am revealed: -There were nine residents present in the dining room for the noon meal. -Two residents were only served water. -Nine residents were only served milk or lemonade. -The seven residents served milk or lemonade were not offered water. Interview with a Personal Care Aide (PCA) on 09/07/21 at 2:06pm revealed: -She poured and delivered beverages for the noon meal. -She gave three residents milk. -All the other residents had lemonade or water. -She did not offer water to every resident. -She was aware all residents were supposed to have water at each meal. -The residents could ask for water if they wanted it. Interviews with three residents on 09/08/21 between 8:21am and 8:55am revealed: -They were offered water at meals occasionally, but not at every meal.	D 306		

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D 306	Continued From page 11 -Staff usually served coffee, milk, tea, or juice. -Two of the three residents were not served or offered water at the noon meal on 09/07/21. Interview with the Administrator on 09/08/21 at 11:33am revealed she was unaware water was not being offered to all residents at each meal.	D 306		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews, and review of the facility's activity calendar, the facility failed to implement an activities program that promoted active involvement by the residents. The findings are: Observation on 09/07/21 at 11:25am during the initial tour of the facility revealed there was an activity calendar posted on the bulletin board in the main hallway dated August 2021. Observation on 09/07/21 from 11:00am through 12:00pm revealed there were no activities	D 315		

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conducted with the 10 residents who were present.

Observation of the September 2021 activities calendar revealed:
-The September 2021 activities calendar was hand delivered by the assistant business office manager to the facility after requesting the current calendar.
-The activity scheduled for 09/07/21 from 10:00am through 12:00pm was documented as visiting the local library and local retail store.

Interview with one resident on 09/07/21 at 11:31am revealed:
-The facility did not offer any activities for him and this caused him to be "depressed".
-He was bored and did not have anything he could do because he used a wheelchair for mobility.

Interview with a second resident on 09/07/21 at 11:37am revealed the facility had not offered activities since COVID-19 started.

Interview with a third resident on 09/07/21 at 12:00pm revealed:
-The facility did not offer any activities.
-He just laid in bed most of the day because there was "nothing to do".

Interview with the medication aide (MA) on 09/07/21 at 2:07pm revealed she did not know if activities were offered for the residents on 09/07/21.

Review of the September 2021 activities calendar revealed an activity of arts and crafts scheduled at 10:00am.

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D 315	Continued From page 13 Observation on 09/08/21 at 10:03am revealed there were no activities conducted at the facility. Interview with the MA on 09/08/21 at 2:05pm revealed: -She thought the activity on 09/08/21 was scheduled from 1:00pm through 2:00pm and was board games. -She did not offer any activities to the residents because she had been "behind all day" and was "overwhelmed". Interview with the Administrator on 09/08/21 at 4:08pm revealed: -The activities were scheduled to be conducted at the facility or one of the sister facilities. -The facility did not offer activities daily and residents would have to go to the sister facility offering the activity in order to participate. -The activities calendar did not specify which facility the activities would take place. -The current activities calendar was not posted in the facility because it had not been printed off the computer. -The business office manager (BOM) was responsible for printing the activities calendar and delivering it to the facility. -She did not know why the BOM had not printed the activities calendar and delivered it to the facility. -Staff were responsible for encouraging residents to participate in activities daily. -She did not know why the MA did not inform the residents at the facility of the activities scheduled on 09/07/21 and 09/08/21.	D 315		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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SHULER HEATH CARE/STOREY VILLA	250 PITT STREET KERNERSVILLE, NC 27284

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D 358	Continued From page 14 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, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 4 residents (Resident #4 and #5) observed during the medication pass related to a medication used to treat pain and inflammation (#4) and medications used to treat an irregular heart rate and irritable bowel syndrome with constipation (#5). The findings are: The medication error rate was 13% as evidenced by the observation of 3 errors out of 23 opportunities during the 12:00pm medication pass on 09/07/21 and the 8:00am medication pass on 09/08/21. 1. Review of Resident #4's current FL2 dated 10/13/20 revealed diagnoses included type 2 diabetes, excessive iron stored in the body, decreased mental status, and a communicable disease. Review of Resident #4's physician orders dated 11/20/20 revealed an order for Meloxicam (a medication used to treat pain) 7.5mg twice a day for pain.	D 358		

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Review of Resident #4's physician orders dated 05/07/21 revealed an order to discontinue Meloxicam.

Review of Resident #4's physician's order sheet dated 06/09/21 revealed an order for Meloxicam 7.5mg twice a day for pain.

Observation of the 8:00am medication pass on 09/08/21 revealed:
-The medication aide (MA) prepared Resident #4's medications according to the electronic Medication Administration Record (eMAR) for 8:00am medications.
-The MA placed 8 tablets in the medication cup for Resident #4.
-The 8 tablets were administered to Resident #4 at 8:29am.
-There was no Meloxicam administered to Resident #4 with the 8:00am medication pass.

Review of Resident #4's June 2021 eMAR revealed:
-There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain.
-There was no documentation Meloxicam was administered at 8:00am or 8:00pm from 06/10/21 through 06/30/21.

Review of Resident #4's July 2021 eMAR revealed:
-There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain.
-Meloxicam 7.5mg was documented as not administered from 07/02/21 through 07/10/21 and 07/12/21 through 07/31/21 at 8:00am with reason documented as "withheld per Dr./RN orders" with no physician's order to hold.
-Meloxicam 7.5mg was documented as not administered from 07/01/21 through 07/29/21 and

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D 358	Continued From page 16 on 07/31/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" with no physician's order to hold. Review of Resident #4's August 2021 eMAR revealed: -There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain. -Meloxicam 7.5mg was documented as not administered from 08/01/21 through 08/09/21 and 08/11/21 through 08/30/21 at 8:00am with reason documented as "withheld per Dr./RN orders" with no physician's order to hold. -Meloxicam 7.5mg was documented as not administered from 08/01/21 through 08/31/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" with no physician's order to hold. -The comments section on 08/04/21, 08/05/21, 08/12/21, 08/20/21, 08/25/21, and 08/27/21 documented Meloxicam 7.5mg was held because the primary care provider (PCP) discontinued the medication on 05/07/21. Review of Resident #4's September 2021 eMAR revealed: -There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain. -Meloxicam 7.5mg was documented as not administered from 09/01/21 through 09/05/21 at 8:00am with the reason documented as "withheld per Dr./RN orders" with no physician's order to hold. -Meloxicam 7.5mg was documented as not administered on 09/06/21 and 09/07/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" with no physician's order to hold. Observation of Resident #4's medications on hand on 09/08/21 at 11:40am revealed there was no Meloxicam available for administration.	D 358		

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D 358	Continued From page 17 Interview with the MA on 09/08/21 at 11:40am revealed: -There was no Meloxicam available for administration to Resident #4 on the medication cart. -She sent a medication refill request for Resident #4's Meloxicam to the facility's contracted pharmacy on 09/08/21 after she found it was unavailable for administration during the morning medication pass. -She did not know how long Resident #4's Meloxicam had been unavailable. Interview with the PCP on 09/08/21 at 10:22am revealed: -She reordered Meloxicam 7.5mg take 1 tablet twice daily for pain on 06/09/21. -She had discontinued Resident #4's Meloxicam in May 2021 but had to reorder it due to Resident #4's pain. -She expected the facility to administer Meloxicam to Resident #4 as ordered. -She expected staff to notify her when a resident missed multiple doses of a medication. -The facility staff did not notify her Resident #4 did not receive most doses of his Meloxicam since she had reordered it. Interview with the Administrator on 09/08/21 at 11:53am revealed: -A medication cart audit was completed biweekly by the Business Office Manager (BOM). -The BOM was responsible for reordering missing medications or medications running low on the medication cart. -The facility's contracted pharmacy performed medication cart audits quarterly. -The MA's were responsible for sending a medication refill request to the facility's contracted	D 358		

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pharmacy when a medication ran out.
-She did not know why Resident #4's Meloxicam was missing from the medication cart and was unavailable for administration during the morning medication pass on 09/08/21.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 09/08/21 at 1:40pm revealed:
-Resident #4's Meloxicam 7.5mg 60 tablets was last dispensed on 08/23/21 and scheduled to administer beginning 08/25/21 and would last until 09/25/21 if administered as ordered.
-Resident #4's Meloxicam 7.5mg had been dispensed monthly since it was reordered 06/09/21 and had not been returned to the pharmacy.
-The pharmacy received a refill request this morning (09/08/21) for Resident #4's Meloxicam.

Refer to the review of the facility's medication management policy.

Attempted telephone interview with Resident #4's responsible person on 09/08/21 at 11:01am was unsuccessful.

2. a. Review of Resident #5's current FL2 dated 06/30/21 revealed:
-Diagnoses included atrial fibrillation, irritable bowel syndrome with constipation, blood in stool, and schizoaffective disorder.
-There was a medication order for metoprolol (a medication used to control the heart rate) 25mg take 1 tablet daily.

Observation of the 8:00am medication pass on 09/08/21 revealed:
-The medication aide (MA) prepared Resident #5's medications according to the electronic

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Medication Administration Record (eMAR) for 8:00am medications.
-The MA placed 8 tablets and 6 capsules in a medication cup with a dosage of powdered medication in a cup mixed with water.
-The MA administered the 8 tablets, 6 capsules, and powdered medication mixed with water to Resident #5.
-There was no metoprolol administered to Resident #5 with the 8:00am medication pass.

Review of Resident #5's September 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for metoprolol 25mg take 1 tablet by mouth daily.
-There was no documentation metoprolol was administered to Resident #5 on 09/08/21.

Observation of Resident #5's medications on hand on 09/08/21 at 11:40am revealed there was no metoprolol available for administration.

Interview with the MA on 09/08/21 at 11:40am revealed:
-She did not administer metoprolol to Resident #5 with the morning medication pass because she could not find it in the medication cart.
-Resident #5's metoprolol was on cycle fill from the facility's contracted pharmacy and she did not know why it was not dispensed by the pharmacy.
-She did not document metoprolol as not administered on the eMAR because it "slipped" her mind.

Interview with the primary care provider (PCP) on 09/08/21 at 10:22am revealed:
-She ordered metoprolol for Resident #5 to control an irregular heart rhythm.
-She expected the facility to administer

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medications as ordered to Resident #5.
-Resident #5 could not miss additional doses of metoprolol or it could cause him to have an uncontrolled irregular heart rhythm.

Interview with the Administrator on 09/08/21 at 11:53am revealed:
-A medication cart audit was completed biweekly by the Business Office Manager (BOM).
-The BOM was responsible for reordering missing medications or medications running low on the medication cart.
-The facility's contracted pharmacy performs medication cart audits quarterly.
-The MA was responsible for sending a medication refill request to the facility's contracted pharmacy when a medication ran out.
-She did not know why Resident #5's metoprolol was missing from the medication cart and was unavailable for administration during the morning medication pass on 09/08/21.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 09/08/21 at 1:40pm revealed:
-Metoprolol 25mg was last dispensed for Resident #5 on 08/18/21 with a quantity of 28 tablets and was to begin administration on 08/25/21.
-Resident #5's metoprolol should have lasted until 09/22/21 if it was administered as ordered.

Refer to the review of the facility's medication management policy.

b. Review of Resident #5's current FL2 dated 06/30/21 revealed:
-Diagnoses included atrial fibrillation, irritable bowel syndrome with constipation, blood in stool, and schizoaffective disorder.

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-There was a medication order for Linzess (a medication used to treat irritable bowel syndrome) 72mcg take 1 tablet daily.

Observation of the 8:00am medication pass on 09/08/21 revealed:
-The medication aide (MA) prepared Resident #5's medications according to the electronic Medication Administration Record (eMAR) for 8:00am medications.
-The MA placed 8 tablets and 6 capsules in a medication cup with a dosage of powdered medication in a cup mixed with water.
-The MA administered the 8 tablets, 6 capsules, and powdered medication mixed with water to Resident #5.
-There was no Linzess administered to Resident #5 with the 8:00am medication pass.

Review of Resident #5's September 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Linzess 72mcg take 1 capsule by mouth daily.
-Linzess was documented as administered from 09/01/21 through 09/05/21 at 8:00am.
-Linzess was documented as not administered from 09/06/21 through 09/08/21 at 8:00am with reason documented as "out of stock".

Observation of Resident #5's medications on hand on 09/08/21 at 11:40am revealed there was no Linzess available for administration.

Interview with the MA on 09/08/21 at 11:40am revealed:
-She did not administer Linzess to Resident #5 with the morning medication pass because she could not find it in the medication cart.
-Resident #5's Linzess was on cycle fill from the

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facility's contracted pharmacy and she did not know why it was not dispensed by the pharmacy.
-She sent a medication refill request to the facility's contracted pharmacy after she completed the morning medication pass.

Interview with the PCP on 09/08/21 at 10:22am revealed:
-She ordered Linzess for Resident #5 to help with constipation caused by irritable bowel syndrome.
-Resident #5 had a history of bloody stools caused by constipation.
-She was not notified by the facility of the 3 missed doses of Linzess for Resident #5.
-She expected the facility to administer medications as ordered to Resident #5.
-Additional missed doses of Linzess could cause a "flare up" of Resident #5's irritable bowel syndrome and cause bleeding with the passage of stools.

Interview with the Administrator on 09/08/21 at 11:53am revealed:
-A medication cart audit was completed biweekly by the Business Office Manager (BOM).
-The BOM was responsible for reordering missing medications or medications running low on the medication cart.
-The facility's contracted pharmacy performs medication cart audits quarterly.
-The MA was responsible for sending a medication refill request to the facility's contracted pharmacy when a medication ran out.
-She did not know why Resident #5's Linzess was missing from the medication cart and was unavailable for administration during the morning medication pass on 09/08/21.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 09/08/21 at

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D 358	Continued From page 23 1:40pm revealed: -Linzess 72mcg was last dispensed on 08/13/21 for Resident #5 with a quantity of 30 capsules and should have lasted until 09/13/21. -Resident #5's Linzess was not on a cycle fill and the facility must send a refill request in order for the pharmacy to dispense more of the medication. -The pharmacy received a refill request this morning (09/08/21) for Resident #4's Linzess. Refer to the review of the facility's medication management policy. _____ Review of the facility's medication management policy revealed: -While pulling medications to be administered to residents and you find a resident is out of a medication, contact the pharmacy to get a refill on the medication. -The eMAR must be initialed at the time the medication is administered or not administered with the reason why the medication was not administered. -Check medications 3 times using the 5 rights for medication adminstration before administering medication to the residents.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is	D 363		

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D 363	Continued From page 24 labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept enclosed in a sealed container that identified the name and strength of each medication prepared and the resident's name observed during the 8:00am medication pass. The findings are:	D 363		

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D 363	Continued From page 25 Observation on 09/08/21 at 8:03am revealed: -A medication aide (MA) was sitting on a stool at the medication cart in the main hallway preparing medications for administration for 5 residents with the initials of the residents written on the cup. -The medication cups were uncovered and were not labeled to identify the name and strength of each medication. -A resident was heard yelling from the bathroom "help" and a MA left the medication cart unattended with 5 medication cups containing pills setting on top of the cart to help the resident that fell in the bathroom. -The medication cart was unlocked and unsupervised from 8:10am until 8:30am. Interview with a MA on 09/08/21 at 8:30am revealed: -The process she used for medication administration was to prepare each residents medication and placed them in a medication cup labeled with the resident's initials written on the cup. -Once she had prepared the residents medications, she would administer the medications to the residents. -She did not know medications prepared in advance had to be labeled with the name of the medication, the strength of the medication, and be kept in an enclosed sealed container until the medications were administered. Interview with the Administrator on 09/08/21 at 4:08pm revealed: -The facility's policy for medication preparation and storage was the medications could be prepared in advance when they were stored in a seal container labeled with the resident's name, medication, and strength of the medication. -A MA was expected to never leave medications	D 363		

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D 363	Continued From page 26 unattended or the medication cart unlocked while unattended. -She did not know why the MA left the medications in cups for 5 residents setting on top of the medication cart unattended. -She did not know why the MA left the medication cart unlocked and unattended for 20 minutes. -She expected staff to follow the facility's policies for preparing medications in advance for administration to residents and medication storage. Review of the facility's Medication Policy revealed: -If medications were to be prepared in advance, labels on white cups must match medications in the cup and lids must be placed on the cup. -Always keep the controlled medication cabinet locked. -There was no information regarding leaving medications unsupervised or leaving the medication cart unlocked.	D 363		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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 documenting the resulting effect on the resident;	D 367		

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D 367	Continued From page 27 (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 2 of 4 sampled residents (#1 and #4) related to a medication used to treat diabetes (#1) and a medication used to treat pain (#4). The findings are: Refer to the review of the facility's Medication Administration Policy. 1. Review of Resident #1's current FL-2 dated 01/18/21 revealed diagnoses included diabetes, seizures and hypertension. Review of Resident #1's physician orders dated 06/23/21 revealed an order for Novolog (a medication used to treat diabetes) inject 9 units below the skin with meals and hold if fingerstick blood sugar (FSBS) is less than 100. Review of Resident #1's July 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Novlolg 9 units to be injected below the skin with meals and hod is FSBS is less than 100. -Novolog 9 units was documented as	D 367		

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administered on 07/15/21 at 4:30pm for a FSBS of 72.
-Novolog 9 units was documented as administered on 07/28/21 at 11:30am for a FSBS of 97.

Resident of Resident #1's August 2021 eMAR revealed:
-There was an entry for Novlolg 9 units to be injected below the skin with meals and hod is FSBS is less than 100.
-Novolog 9 units was documented as administered on 08/11/21 at 11:30am for a FSBS of 81.
-Novolog 9 units was documented as administered on 08/25/21 at 7:30am for a FSBS of 95.
-Novolog 9 units was documented as administered on 08/30/21 at 7:30am for a FSBS of 95.
-Novolog 9 units was documented as administered on 08/30/21 at 11:30am for a FSBS of 90.
-Novolog 9 units was documented as administered on 08/31/21 at 7:30am for a FSBS of 67.
-Novolog 9 units was documented as administered on 08/31/21 at 11:30am for a FSBS of 86.

Review of Resident #1's September 2021 eMAR revealed:
-There was an entry for Novlolg 9 units to be injected below the skin with meals and hod is FSBS is less than 100.
-Novolog 9 units was documented as administered on 09/02/21 at 4:30pm for a FSBS of 99.
-Novolog 9 units was documented as administered on 09/06/21 at 7:30am for a FSBS

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of 95.
-Novolog 9 units was documented as administered on 09/06/21 at 11:30am for a FSBS of 97.

Interview with a medication aide (MA) on 09/07/21 at 3:37pm revealed:
-She was not sure what happened on the eMAR for 07/15/21 and 09/02/21.
-Although her initials were on the eMAR she did not administer Novolog to Resident #1 on 07/15/21 or 09/02/21.
-She knew Resident #1 had an order to hold his Novolog if his blood sugar was less than 100.
-Sometimes, if she forgot to log out of the computer, it would automatically document a medication was administered at the scheduled time when she had not actually given the medication.
-She has had to shut the computer down and then re-start it to get it back to normal.

Interview with a second MA on 09/07/21 at 5:20pm revealed:
-She remembered Residnet #1's FSBS was higher than 97 on 97/28/21 becaused he had eaten sugary foods that day.
-She entered Resident #1's blood sugar incorrectly.
-She did not know how to go back in the computer and correct it.

Interview with a third MA on 09/08/21 at 9:24am revealed:
-He has never given Resident #1 insulin if his blood sugar was less than 100.
-He was unsure how to show that he had held the insulin for Resident #1 on the computer when his blood sugar was less than 100.
-He documented on the eMAR to show the result

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of Resident #1's blood sugar.
-He incorrectly documented he had administered Novolog 9 units when he had not on 8/25/21, twice on 08/30/31, twice on 08/31/31 and twice on 09/06/21.
-He had not asked anyone to show him on the computer how to document that the insulin was being held for blood sugar less than 100.

Interview with the Administrator on 09/08/21 at 09/08/21 at 11:33am revealed:
-She was not aware staff were documenting medication they were not actually giving.
-Staff should have asked for assistance how to correct mistakes on the computer.

2. Review of Resident #4's current FL2 dated 10/13/20 revealed diagnoses included type 2 diabetes, excessive iron stored in the body, decreased mental status, and a communicable disease.

Review of Resident #4's physician orders dated 05/07/21 revealed an order to discontinue Meloxicam (a medication used to treat pain).

Review of Resident #4's physician's order sheet dated 06/09/21 revealed an order for Meloxicam 7.5mg twice a day for pain.

Observation of the 8:00am medication pass on 09/08/21 revealed there was no Meloxicam administered to Resident #4 with the 8:00am medication pass.

Review of Resident #4's June 2021 eMAR revealed:
-There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain.
-Meloxicam was documented as not administered

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from 06/01/21 through 06/07/21 at 8:00am and 8:00pm with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam.
-There was no documentation Meloxicam was administered on 06/08/21 at 8:00pm.
-There was no documentation Meloxicam was administered at 8:00am or 8:00pm from 06/09/21 through 06/30/21.

Review of Resident #4's July 2021 eMAR revealed:
-There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain.
-Meloxicam 7.5mg was documented as not administered from 07/02/21 through 07/10/21 and 07/12/21 through 07/31/21 at 8:00am with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam.
-Meloxicam 7.5mg was documented as not administered from 07/01/21 through 07/29/21 and on 07/31/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam.

Review of Resident #4's August 2021 eMAR revealed:
-There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain.
-Meloxicam 7.5mg was documented as not administered from 08/01/21 through 08/09/21 and 08/11/21 through 08/30/21 at 8:00am with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam.
-Meloxicam 7.5mg was documented as not administered from 08/01/21 through 08/31/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam.
-The comments section on 08/04/21, 08/05/21,

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D 367	Continued From page 32 08/12/21, 08/20/21, 08/25/21, and 08/27/21 documented Meloxicam 7.5mg was held because the primary care provider (PCP) discontinued the medication on 05/07/21 but the Meloxicam had been reordered on 06/09/21. Review of Resident #4's September 2021 eMAR revealed: -There was an entry for Meloxicam 7.5mg take 1 tablet by mouth twice a day for pain. -Meloxicam 7.5mg was documented as not administered from 09/01/21 through 09/05/21 at 8:00am with the reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam. -Meloxicam 7.5mg was documented as not administered on 09/06/21 and 09/07/21 at 8:00pm with reason documented as "withheld per Dr./RN orders" and there was no physician's order to hold Meloxicam. Observation of Resident #4's medications on hand on 09/08/21 at 11:40am revealed there was no Meloxicam available for administration. Interview with the Administrator on 09/08/21 at 11:53am revealed: -She did not know why the MA's documented on the eMAR that the Meloxicm for Resident #4 had been held per "Dr./RN orders" when there were no orders to hold Resident #4's Meloxicam. -The MA's were expected to document on the eMAR's accurately. Refer to the review of the facility's Medication Administration Policy. _____ Review of the facility's Medication Administration Policy revealed: -While preparing medications for administration	D 367		

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D 367	Continued From page 33 and a resident's medication was not available, document on the eMAR record accordingly. -When a medication was not administered, it was to be documented as not administered with the reason for not administering.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interview, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who was not observed to wash or sanitize her hands, touched medications with bare hands, and used her fingernail to pull medication from bubble packages while preparing and after administering oral medications to residents. The findings are: Observation of a MA on 09/08/21 from 8:10am through 8:58am revealed: -The MA was sitting at the medication cart puncturing bubble packages with her fingernail and removing medications with her fingernail on the left index finger and placing the medications in a medicine cup when a resident yelled for help from the bathroom.	D 371		

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D 371	Continued From page 34 -The MA left the medication cart and helped the resident who fell in the bathroom out of the floor, into a wheelchair then walked to the dining room and used the community phone with bare hands to call for an ambulance. -The MA did not wash her hands or use hand sanitizer when she returned to the medication cart. -There was no hand sanitizer available on the medication cart. -The MA used her bare hands to remove medications from the bubble pack using her fingernails to puncture the package and remove each pill. -The MA's fingernails appeared artificial, long, and had nail polish on them. -The MA pulled each pill from the bubble package using the fingernail of her left index finger and held each pill between her index finger and thumb before dropping the pills into a medication cup. -The MA touched a pitcher of water on top of the medication cart with bare hands and poured water into a cup for a resident. -The MA poured the medication into her bare hand and pushed each pill with the fingernail of her right index finger to count the number of pills in the cup. -The MA administered 8 tablets of medication to the another resident. -The MA touched the mouse of the computer with her bare hand and documented in the electronic Medication Administration Record (eMAR) the medications as administered. -The MA opened another drawer on the medication cart and removed bubble packages of medications for a second resident. -The MA did not sanitize or wash her hands or apply gloves and proceeded to puncture the bubble packages for the second resident with her fingernail and removed each pill with the	D 371		

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D 371	Continued From page 35 fingernail of her left index finger and held it between her index finger and thumb to place the medication in a medication cup. -The MA opened the bottom drawer on the medication cart and removed a bottle containing powdered medication to be mixed with water. -The MA poured the powdered medication into a cup and poured water from a pitcher that was setting on top of the medication cart with bare hands. -The MA poured the second resident's medications into her hand and pushed each pill with the fingernail of her right index finger to count the number of pills in the cup. -The MA administered 14 pills and the powdered medication mixed with water to the second resident. -The MA touched the mouse of the computer with bare hands and documented in the eMAR the medications as administered. -The MA did not sanitize or wash her hands or apply gloves and proceeded to puncture bubble packages of medications for a third resident with her fingernail. Interview with the MA on 09/08/21 at 8:58am revealed: -She was supposed to wash or sanitize her hands before preparing and administering medications between each resident. -She did not wash or sanitize her hands because her hands were clean. Interview with the Administrator on 09/08/21 at 4:08pm revealed: -The facility's policy for medication administration included the MA washed hands, applied gloves, prepared and administered medications, removed gloves, and either washed hands or applied hand sanitizer between each resident.	D 371		

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D 371	Continued From page 36 -If a MA was interrupted and had to leave the medication cart to do another task, the MA was expected to remove their gloves and rewash their hands before resuming the medication pass. -The MA administering medications to the residents had received infection control training at the facility within the last year. -She did not know why the MA did not wash or sanitize her hands or apply gloves while preparing or administering medications to the residents. Review of the facility's medication management policy revealed: -While preparing medications for administration and a resident's medication was not available document on the eMAR record accordingly. -Contact the pharmacy to see if the medication has been reordered. -Medications were to be documented as administered at the time of administration. -When a medication was not administered, it was to be documented as not administered with the reason for not administering. _____ The facility failed to ensure infection control measures were implemented when preparing and administering medications to residents as evidenced by the medication aide not washing or sanitizing her hands after touching multiple surfaces and helping a resident off the bathroom floor then proceeding to remove pills from bubble packages using her unwashed and unsanitized hands to open the bubble package, using her left index fingernail to pull the pills from the package, placing them into a medication cup to be administered to residents. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D 371		

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D 371	Continued From page 37 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2021.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under supervision of staff in charge of medication administration. The findings are: Observation of the medication pass on 09/08/21 at 8:03am revealed: -The medication aide (MA) prepared 5 different resident's medications in medication cups and had the cups setting on top of the medication cart in the main hallway. -The MA was sitting at the medication cart pulling medications from bubble packages when a resident yelled for help from the bathroom.	D 378		

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D 378	Continued From page 38 -The MA left the medication cart unlocked with the medication cups setting on top of the cart to assist the resident out of the bathroom floor. -The medication cups containing medications for 5 residents was left unattended until the MA returned to the medication cart at 8:30am. Interview with the MA on 09/08/21 at 8:30am revealed: -She knew she was not supposed to leave medications sitting on top of the medication cart unattended. -She knew she was supposed to lock the medication cart when leaving the cart unattended. -She would prepare the medications for multiple residents by placing the medications in a medication cup labeled with each resident's initials. -She would administer the medications to each resident after she had prepared the medications. -She left the medications in cups sitting on top of the medication cart unattended because a resident fell in the bathroom. Interview with the Administrator on 09/08/21 at 4:08pm revealed: -Medications should never be left sitting out unattended and the medication cart should be locked when unattended. -She did not know why the MA left 5 resident's medications in medication cups setting on top of the medication cart unattended. -She did not know why the MA left the medication cart unlocked for almost 30 minutes while it was parked in the main hallway. -She expected staff to follow the facility's procedures for medication administration. Review of the facility's Medication Administration Policy revealed there was no policy on leaving the	D 378		

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D 378	Continued From page 39 medication cart unlocked or medications being left unattended.	D 378		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 11 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of visitors, staff, and residents and wearing the required personal protective equipment (PPE). The findings are: Review of the Centers for Disease Control and	D 612		

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D 612	Continued From page 40 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. -Staff should continue to wear face mask in long term facilities regardless of vaccination status. 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 COVID-19 policy revealed: -Key entry points into the facility will be identified and limited to the number needed to respond to needed healthcare services. Entry points include front entrance of the community with a visitor check. -All persons including residents, visitors, non-employees ... entering the facility will be screened for signs and symptoms, diagnosis, and exposure of COVID-19. -A face mask was to be worn covering the nose and mouth while in the facility. -Use of signage to indicate 6 feet physical distancing. -All employees will be screened for COVID-19 before each workday and each shift by self-screening conducted before reporting to work and completed onsite screening form. Observation upon entrance to the facility on	D 612		

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	HAL034107	A. BUILDING: _____ B. WING _____	R-C 09/08/2021

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D 612	Continued From page 41 09/07/21 at 11:45am revealed: -The facility staff did not complete COVID-19 screening or check temperatures of the survey team. -There was a small table at the entrance of the main living room that contained a sign stating "please check in for COVID screening before visiting residents", a box of face mask, bottle of hand sanitizer, a clipboard with a visitors log labeled with name and screening questions, and a thermometer laying on top of the clipboard. -The visitors log was blank. -The medication aide (MA) entered the building at the same time as the survey team and applied a face mask upon entrance. Interview with a MA on 09/07/21 at 2:07pm revealed: -All staff were required to wear a face mask when around residents. -There was a clipboard in the living room with a log to document a visitor's name, temperature, and COVID-19 screening questions. -The log was also for residents leaving and entering the facility. -The MA on duty was responsible for screening visitors for COVID-19, checked temperatures, and recorded them onto the visitor's log. -She "took over" as the MA at 11:30am when the other MA "got sick" and had to leave. -She did not know why screening was not completed for the survey team upon entrance at the facility. -Staff were supposed to record their temperatures on a log along with the COVID-19 screening questions. -She was responsible for checking her own temperature and self-screening for COVID-19 upon entrance at the facility when reporting for work duty.	D 612		

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D 612	Continued From page 42 -She checked her own temperature but did not record it onto a log because she did not report for her shift until 11:30. -She would sometimes remove her face mask when showering residents because "it gets hot" in the bathroom. Interview with a second MA on 09/07/21 at 3:35pm revealed: -There was no longer a log kept with resident's temperatures or COVID-19 screening questions. -Residents were not screened for COVID-19 or temperatures were not checked anymore because all the residents had been fully vaccinated for COVID-19. Observation upon entrance to the facility on 09/08/21 at 8:00am revealed the facility staff did not complete COVID-19 screening or check temperatures of the survey team. Observation of a MA on 09/08/21 at 8:13am revealed: -The MA was not wearing a face mask. -The MA helped a resident who had fallen off the bathroom floor while neither the MA or resident was wearing a face mask. Observation of a MA on 09/08/21 at 8:18am revealed she was standing in the main hallway not wearing a face mask approximately 2 feet from two staff members from a sister facility. Observation of a MA on 09/08/21 at 8:30am revealed she was still not wearing a face mask. Interview with a MA on 09/08/21 at 8:30am revealed she "usually" wore a face mask but was not wearing one because she became distracted when a resident fell.	D 612		

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D 612	Continued From page 43 Observation of a MA on 09/08/21 at 9:30am revealed she was not wearing a face mask in 2 residents room while changing the linens on one resident's bed while the other resident was lying in his bed. Interview with the primary care provider (PCP) on 09/08/21 at 10:22am revealed: -She visited the facility weekly -She had never been screened for COVID-19 or temperature checked by the facility staff. -It was important for the facility staff to follow CDC guidelines and wear face mask to protect the residents from contracting COVID-19. Observation on 09/08/21 at 11:03am revealed: -A staff member from a sister facility entered the facility with her face mask pulled down below the chin exposing her mouth a nose and walked down the main hallway. -A MA exited a resident's room and walked down the hallway with her face mask pulled down exposing her nose and mouth. -The staff from a sister facility was not screened and did not complete a self-screening or temperature check upon entrance into the facility. Observation in the main hallway on 09/08/21 at 12:02pm revealed: -A MA was standing at the medication cart with her face mask pulled down below her chin exposing her mouth and nose. -A resident was sitting in a wheelchair in the hallway approximately 6 feet from the medication cart. Interview with the Administrator on 09/08/21 at 4:08pm revealed: -Staff were not expected to screen visitors upon	D 612		

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D 612	Continued From page 44 entrance into the facility anymore because there was a sign posted in the living room stating, "please check in for COVID screening before visiting residents" and she expected visitors to self screen for COVID-19. -Staff were expected to wear a face mask while at the medication cart or around any residents. -Residents were not screened and temperatures were not checked by facility staff anymore because the residents had been vaccinated. -She was unable to provide a temperature log of residents because the facility no longer kept a temperature log. -The facility staff checked their own temperatures and self-screened but did not document it anywhere. -The facility's policy was not followed because she borrowed and adopted the policy from another facility.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are:	D912		

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D912	Continued From page 45 Based on observations and interview, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who was not observed to wash or sanitize her hands, touched medications with bare hands, and used her fingernail to pull medication from bubble packages while preparing and after administering oral medications to residents. [Refer to Tag D371 NCAC 13F .1004(n) Medication Administration (Type B Violation)].	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had completed the state approved annual infection control training. The findings are:	D934		

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D934	Continued From page 46 Review of Staff C's personnel record revealed: -Staff C was hired 01/10/19. -There was documentation Staff C's last state approved infection control training was completed on 09/19/19. -There was no documentation of completion of the state approved Infection control training since 09/19/18 available for review in Staff C's personnel record. An attempted telephone interview with Staff C on 09/08/21 at 3:17pm was unsuccessful. Interview with the Administrator on 09/08/21 at 3:42pm revealed: -She sent out a group message to every employee when a mandatory training was scheduled. -She was not aware Staff C had not completed the annual infection control training. -Staff C was responsible to ensure all staff completed their required training.	D934		