Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049003	A. BUILDING: _____ B. WING _____	R 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE ADULT LIVING CENTER	1372 EUFOLA ROAD STATESVILLE, NC 28677

(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 a follow up survey and a complaint investigation from 09/22/21 through 09/24/21.	D 000	**Plan of Correction** • Staff training on facility policy of Medication Administration to include Complete MAR's and accuracy of MAR documentation and administration. • MAR's reviewed to assure medications are being given and documented correctly. **Monitoring System** • RCC/Director shall randomly audit MAR's weekly x 1 month then monthly thereafter to assure that staff are administering and documenting as needed medications per policy. • Administrator shall monthly follow up to assure that medication audits are being completed and areas found out of compliance are addressed. • Any staff found not following proper procedures shall receive additional training and/or disciplinary action.	10/22/2021
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; (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 medication administration records (MARs) were complete and accurate for 2 of 3 sampled residents (Resident #2 and #3) related to a medication to treat anxiety (#2) and a medication for sleep (#3). The findings are:	D 367		

LSB Reviewed and acknowledged 10/28/21

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D 367	Continued From page 1 1. Review of Resident #2's current FL2 dated 01/26/21 revealed: -Diagnoses included Alzheimer's disease and anxiety disorder. -There was a medication order for lorazepam (a medication used to treat anxiety) 1mg by mouth every 6 hours as needed for anxiety. Observation of Resident #2's medications on hand on 09/22/21 at 2:05pm revealed there was a medication bubble pack containing 21 tablets of lorazepam 1mg. Review of Resident #2's controlled substance count sheets (CSCS) for lorazepam 1mg revealed: -Lorazepam 1mg was dispensed by the facility's contracted pharmacy on 07/14/21 in the amount of 30 tablets. -There was documentation lorazepam 1mg was administered to Resident #2 on 09/09/21 and 09/11/21 at 8:00pm with a remaining balance of 22 tablets. Review of Resident #2's September 2021 medication administration record (MAR) revealed: -There was an entry for lorazepam 1mg take 1 tablet every 6 hours as needed for anxiety. -There was documentation lorazepam 1mg was administered on 09/09/21. -There was no documentation lorazepam 1mg was administered on 09/11/21 or 09/13/21. Telephone interview with a medication aide (MA) on 09/22/21 at 3:35pm revealed: -He did not administer lorazepam 1mg to Resident #2 on 09/22/21 during his 6:00am through 2:00pm shift. -He did not complete a controlled substance	D 367		

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D 367	Continued From page 2 count for the medication cart at the end of his shift because the controlled substance count was completed at shift change, he was the only MA that worked 8-hour shifts, and the Facility Director/MA would complete the controlled substance count with the night shift MA at 6:00pm. -He did not know why Resident #2 had one tablet less of lorazepam available for administration than what was documented. Interview with the Facility Director/MA on 09/22/21 at 3:50pm revealed: -She did not know who administered lorazepam to Resident #2 and did not document the lorazepam as administered. -The facility's policy for medication administration of controlled substances was to document the medication on the resident's medication administration record (MAR) at the time of administration and complete the documentation on the CSCS to keep an accurate record of the controlled substances. Interview with the Administrator on 09/23/21 at 10:48am revealed: -All staff knew the facility's medication administration policy. -The facility's medication administration policy for controlled substances was for the MA to administer the medication to the resident, document the administration on the MAR, and sign the medication out on the CSCS. -If the medication order was administer as needed, the MA was responsible for checking to see if the medication was effective within one hour and documenting the effectiveness. -The reason Resident #2's MAR for lorazepam was not accurate was because a MA failed to document the medication as administered and "I'll	D 367		

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D 367	Continued From page 3 take the blame for that". -The MA's should document the medication as administered at the time of administration but "they don't usually do it" until after the MA's reevaluate the effectiveness of the medication. -The MA's did not follow the facility's policy for medication administration because "they are very busy". Telephone interview with a night shift medication aide (MA) on 09/24/21 at 8:37am revealed: -She administered lorazepam 1mg to Resident #2 on 09/13/21 and did not document the administration on the medication administration record (MAR) or the CSCS. -She "missed" documenting medications administered on the MAR and documenting on the CSCS sometimes because "I'm human". -She knew she was supposed to document medications administered on the MAR at the time of administration and on the CSCS but she would "forget sometimes". Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to the review of the facility's Medication Administration Policy. 2. Review of Resident #3's current FL2 dated 05/21/21 revealed: -Diagnoses included vascular dementia, hypertension, and acute kidney failure. -There was a medication order for temazepam (a medication used to treat insomnia) 15mg take 1 capsule daily at bedtime as needed for sleep. Observation of Resident #3's medications on hand on 09/22/21 at 2:30pm revealed there was a	D 367		

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D 367	Continued From page 4 medication bubble pack containing 10 capsules of temazepam 15mg. Review of Resident #3's controlled substance count sheets (CSCS) for temazepam 15mg revealed: -Temazepam 15mg was dispensed by the facility's contracted pharmacy on 09/14/21 in the amount of 15 capsules. -There was documentation temazepam 15mg was administered to Resident #3 on 09/17/21 through 09/20/21 at 8:00pm with a remaining balance of 11 capsules. Review of Resident #3's September 2021 medication administration record (MAR) revealed: -There was an entry for temazepam 15mg take 1 capsule at bedtime as needed for sleep. -Temazepam was documented as administered on 09/03/21-09/05/21, 09/09/11, 09/11/21, 09/14/21, and 09/17/21-09/20/21. -There was no documentation temazepam was administered on 09/21/21. Interview with the Facility Director/MA on 09/22/21 at 3:50pm revealed: -She did not know who administered temazepam to Resident #3 and did not document the temazepam as administered. -Resident #3's temazepam would have been administered at night since the medication was for sleep. -The facility's policy for medication administration of controlled substances was to document the medication on the resident's medication administration record (MAR) at the time of administration and complete the documentation on the CSCS to keep an accurate record of the controlled substances.	D 367		

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D 367	Continued From page 5 Interview with the Administrator on 09/23/21 at 10:48am revealed: -All staff knew the facility's medication administration policy. -The facility's medication administration policy for controlled substances was for the MA to administer the medication to the resident, document the administration on the MAR, and sign the medication out on the CSCS. -If the medication order was administer as needed, the MA was responsible for checking to see if the medication was effective within one hour and documenting the effectiveness. -The reason Resident #3's MAR for temazepam was not accurate was because a MA failed to document the medication as administered and "I'll take the blame for that". -The MA's should document the medication as administered at the time of administration but "they don't usually do it" until after the MA's reevaluate the effectiveness of the medication. -The MA's did not follow the facility's policy for medication administration because "they are very busy". Telephone interview with a night shift medication aide (MA) on 09/24/21 at 8:37am revealed: -She worked third shift on 09/21/21. -She administered temazepam 15mg to Resident #3 on 09/21/21 and did not document the administration on the medication administration record (MAR) or the CSCS. -She "missed" documenting medications administered on the MAR and CSCS sometimes because "I'm human". -She knew she was supposed to document medications administered on the MAR at the time of administration and on the CSCS but she would "forget sometimes".	D 367		

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D 367	Continued From page 6 Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to the review of the facility's Medication Administration Policy. Review of the facility's Medication Administration Policy dated 01/01/12 revealed: -Medication administration was to be documented on the resident's MAR at the time the medication is given by the person administering the dose. -The resident's MAR was initialed by the person administering the medication in the space provided under the date and on the line for that specific medication. Initials on the MAR were verified with a full signature in the space provided. -When as needed medications were administered the date, time, route of administration, complaints or symptoms for which the medication was taken, results achieved from taking the dose and time that results were noted, and signature and initials of the person recording the administration and effects were documented. -The person administering medications reviews the MAR to ascertain that all necessary doses were administered and that all administered doses were documented.	D 367		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.	D 392	**Plan of Correction** • Staff training on facility policy of proper receipt, administration and disposition of controlled substances, to include the facilities policies on counting controlled substances when taking over a medication cart. • MAR's and Count Sheets reviewed to assure controlled medications are being given, counted and documented correctly.	10/22/2021

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D 392	Continued From page 7 This Rule is not met as evidenced by: Based on obseervations, interviews and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 2 of 3 sampled residents (Resident #2 and #3) who had orders for controlled substances. The findings are: 1. Review of Resident #2's current FL2 dated 01/26/21 revealed: -Diagnoses included Alzheimer's disease and anxiety disorder. -There was a medication order for lorazepam (a medication used to treat anxiety) 1mg by mouth every 6 hours as needed for anxiety. Observation of Resident #2's medications on hand on 09/22/21 at 2:05pm revealed there was a medication bubble pack containing 21 tablets of lorazepam 1mg. Review of Resident #2's controlled substance count sheets (CSCS) for lorazepam 1mg revealed: -Lorazepam 1mg was dispensed by the facility's contracted pharmacy on 07/14/21 in the amount of 30 tablets. -There was documentation lorazepam 1mg was administered to Resident #2 on eight days with a remaining balance of 22 tablets. Telephone interview with a medication aide (MA) on 09/22/21 at 3:35pm revealed: -He did not administer lorazepam 1mg to	D 392	**Monitoring System** • RCC/Director shall randomly audit MAR's, Controlled Substance Count Sheets weekly x 1 month then monthly thereafter to assure that staff are administering, counting controlled substances and documenting controlled substance counts. • Random Unannounced review of controlled substance counts during staff changing over to ensure staff are following policy for counting and documenting count weekly x 1 month then monthly thereafter. • Administrator shall monthly follow up to assure that controlled substance audits are being completed and areas found out of compliance are addressed. • Any staff found not following proper procedures shall receive additional training and/or disciplinary action.	

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D 392	Continued From page 8 Resident #2 on 09/22/21 during his 6:00am through 2:00pm shift. -He did not complete a controlled substance count for the medication cart at the end of his shift because the controlled substance count was completed at shift change, he was the only MA that worked 8-hour shifts, and the Facility Director/MA would complete the controlled substance count with the night shift MA at 6:00pm. -He did not know why Resident #2 had one tablet less of lorazepam available for administration than what was documented on the CSCS. Interview with the Facility Director/MA on 09/22/21 at 3:50pm revealed: -She did not know who administered lorazepam to Resident #2 and did not document the lorazepam as administered. -She did not complete a controlled substance count when taking over the medication cart at 2:00pm because "I didn't have time". -The facility's policy for medication administration of controlled substances was to document the medication on the resident's medication administration record (MAR) at the time of administration and complete the documentation on the CSCS to keep an accurate record of the controlled substances. -The facility's process for shift change for the MA's included to complete a medication count of the controlled substances and compare it to the CSCS to ensure accuracy of the controlled substances. Telephone interview with the facility's contracted pharmacy on 09/23/21 at 10:24am revealed Resident #2's lorazepam 1mg was dispensed on 08/27/21 in the amount of 30 tablets.	D 392		

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D 392	Continued From page 9 Interview with the Administrator on 09/23/21 at 10:48am revealed: -All staff knew the facility's medication administration policy. -The facility's medication administration policy for controlled substances was for the MA to administer the medication to the resident, document the administration on the MAR, and sign the medication out on the CSCS. -If the medication order was administer as needed, the MA was responsible for checking to see if the medication was effective within one hour and documenting the effectiveness. -The reason Resident #2's CSCS for lorazepam was not accurate was because a MA failed to document the medication as administered and "I'll take the blame for that". -The MA's should document the medication as administered at the time of administration but "they don't usually do it" until after the MA's reevaluate the effectiveness of the medication. -The MA's did not follow the facility's policy for medication administration because "they are very busy". -The MA who worked from 6:00am through 2:00pm on 09/22/21 did not complete a shift to shift controlled substance count on the medication cart because "it was time for him to leave". Telephone interview with a night shift medication aide (MA) on 09/24/21 at 8:37am revealed: -She administered lorazepam 1mg to Resident #2 on 09/13/21 and did not document the administration on the medication administration record (MAR) or the CSCS. -She "missed" documenting medications administered on the MAR and documenting on the CSCS sometimes because "I'm human". -She knew she was supposed to document	D 392		

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D 392	Continued From page 10 medications administered on the MAR at the time of administration and on the CSCS but she "forgets sometimes". Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current FL2 dated 05/21/21 revealed: -Diagnoses included vascular dementia, hypertension, and acute kidney failure. -There was a medication order for temazepam (a medication used to treat insomnia) 15mg take 1 capsule daily at bedtime as needed for sleep. Observation of Resident #3's medications on hand on 09/22/21 at 2:30pm revealed there was a medication bubble pack containing 10 capsules of temazepam 15mg. Review of Resident #3's controlled substance count sheets (CSCS) for temazepam 15mg revealed: -Temazepam 15mg was dispensed by the facility's contracted pharmacy on 09/14/21 in the amount of 15 capsules. -There was documentation temazepam 15mg was administered to Resident #3 on four days with a remaining balance of 11 capsules. Interview with the Facility Director/MA on 09/22/21 at 3:50pm revealed: -She did not know who administered temazepam to Resident #3 and did not document the temazepam as administered. -Resident #3's temazepam would have been administered at night since the medication was for sleep. -She did not complete a controlled substance	D 392		

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D 392	Continued From page 11	D 392		

count when taking over the medication cart at 2:00pm because "I didn't have time".
-The facility's policy for medication administration of controlled substances was to document the medication on the resident's medication administration record (MAR) at the time of administration and complete the documentation on the CSCS to keep an accurate record of the controlled substances.
-The facility's process for shift change for the MA's included to complete a medication count of the controlled substances and compare it to the CSCS to ensure accuracy of the controlled substances.

Telephone interview with the facility's contracted pharmacy on 09/23/21 at 10:24am revealed Resident #3's temazepam 15mg was dispensed on 09/14/21 in the amount of 15 capsules.

Interview with the Administrator on 09/23/21 at 10:48am revealed:
-All staff knew the facility's medication administration policy.
-The facility's medication administration policy for controlled substances was for the MA to administer the medication to the resident, document the administration on the MAR, and sign the medication out on the CSCS.
-If the medication order was administer as needed, the MA was responsible for checking to see if the medication was effective within one hour and documenting the effectiveness.
-The reason Resident #3's CSCS for temazepam was not accurate was because a MA failed to document the medication as administered and "I'll take the blame for that".
-The MA's should document the medication as administered at the time of administration but "they don't usually do it" until after the MA's

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D 392	Continued From page 12 reevaluate the effectiveness of the medication. -The MA's did not follow the facility's policy for medication administration because "they are very busy". -The MA who worked from 6:00am through 2:00pm on 09/22/21 did not complete a shift to shift controlled substance count on the medication cart because "it was time for him to leave". Telephone interview with a night shift medication aide (MA) on 09/24/21 at 8:37am revealed: -She worked third shift on 09/21/21. -She administered temazepam to Resident #3 on 09/21/21 and did not document the administration on the medication administration record (MAR) or the CSCS. -She "missed" documenting medications administered on the MAR and documenting on the CSCS sometimes because "I'm human". -She knew she was supposed to document medications administered on the MAR at the time of administration and on the CSCS but she "forgets sometimes". Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 392		
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	D 612	**Plan of Correction** • The Administrator and the Director shall review and make necessary revisions of COVID-19 Infection Control procedures, to include screening procedures, to ensure procedures are in compliance with published guidance or directives specific to COVID-19 outbreaks that have been issued by NCDHHS or the local health department.	10/22/2021

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HERITAGE PLACE ADULT LIVING CENTER	1372 EUFOLA ROAD STATESVILLE, NC 28677

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D 612	Continued From page 13 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: TYPE A2 VIOLATION Based on observation, interviews and record reviews the facility failed to ensure recommendations and guidance established by the Centers for Disease Control and Prevention (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of visitors, residents and staff for COVID-19 signs and symptoms. The findings are: Review of the CDC's 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 breathing, fatigue, headache, body aches, loss of smell or taste, sore throat, congestion or runny nose, nausea, vomiting or diarrhea). -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -A strong infection and prevention program is	D 612	• Implementation of a COVID-19 daily screening questionnaire that shall be completed by staff and visitors. • Anyone showing signs and symptoms or who have been exposed to COVID-19 shall refrain from being in the facility per the local health departments guidance. • Immediate training with staff on daily COVID-19 screening procedures for entering the facility. • Immediate training with staff on daily COVID-19 screening procedures for residents. • Training on the Signs and Symptoms of COVID-19. • Training on reporting and the procedures to take for staff, visitors and/or residents exhibiting signs and symptoms of COVID-19 and/or exposure to COVID-19. • The Director and/or SIC shall review daily staff COVID-19 screening logs to ensure all staff on duty have completed the screening logs and that the policy and procedures were followed for anyone showing signs and symptoms of COVID-19. • The Resident Care Coordinator/ SIC shall review daily resident COVID-19 screenings to ensure residents have been screened and procedures were followed for anyone showing signs and symptoms of COVID-19. • Residents and/or Staff who have signs and symptoms of COVID-19 and/or exposure to COVID-19 shall be tested for COVID-19 and quarantined per the local health departments guidance. • The Administrator/designee shall monitor all COVID-19 procedures to ensure the facility is in compliance with NCDHHS guidance and the facilities Infection Control Policies and Procedures. The administrator shall ensure documentation is maintained for the monitoring.	

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D 612	Continued From page 14 critical to protect both residents and healthcare personal. Review of the NCDHHS Long Term Care Infection Control Assessment and Response Tool for Local Health Department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever and signs and symptoms of COVID-19. Review of the NCDHHS guidelines dated 05/05/21 revealed: -Everyone who enters a healthcare facility shall be screened for signs and symptoms of COVID-19 by temperature checks, screening questions and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperatures are checked. Review of the facility's Guidance for Infection Control and Prevention Concerning Coronavirus Disease dated 03/18/2020 revealed: -The facility will monitor the CDC website for up to date resources and information. -The facility will work closely with NCDHHS, the local health department and the CDC, and follow their guidance. -The facility will monitor residents and employees for fever or respiratory symptoms. -Staff who have signs and symptoms of a respiratory illness should not report to work. Review of COVID-19 Staff Procedures for Admission into the Facility revealed: -A paper documenting the procedures was attached to the front of the screening log book. -Staff were to wait outside and call the facility to have their temperature taken before entry.	D 612		

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D 612	Continued From page 15 -Staff were to use hand sanitizer and wear proper Personal Protective Equipment (PPE); mask and gloves required, before entering the facility. -If staff were exposed to COVID-19 they were not allowed to enter the facility. -Record staff name and temperature in the log. Observation of the facility entrance on 09/22/21 from 9:05am to 9:13am revealed: -There was signage on the locked door identifying the presence of COVID-19 in the facility. -A male staff unlocked the door, asked the surveyors who they were and requested the surveyors remain in the foyer. -The male staff did not screen the surveyors upon entry into the facility's foyer by asking COVID-19 screening questions or check temperature. -The facility director came to the foyer, requested the surveyors follow her into the office but did not screen the surveyors for COVID-19 symptoms or take their temperatures. Review of the facility's temperature log sheet on 09/22/21 at 10:47am revealed: -Two of the five facility's staff had signed in on the temperature screening log. -Two of the facility's contracted Hospice staff had signed in on the temperature screening log. -There were no COVID-19 screening questions accompanying the temperature screening log. Interview with the facility director on 09/22/21 at 9:14am revealed: -Eighteen of the 24 residents that lived at the facility were positive for COVID-19. -Three residents were currently at the hospital due to COVID-19. -One resident who had been at the hospital had died from COVID-19. -The facility had multiple staff out of work due to	D 612		

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D 612	Continued From page 16 positive COVID-19 tests. -She was the director but was the acting Resident Care Coordinator (RCC) because the RCC was out of work due to COVID-19. -Staff vaccination rate was very low but 23 of 24 residents were vaccinated. Telephone interview with a medication aide (MA) on 09/23/21 at 4:56pm revealed one resident died last week after being transferred to the hospital with COVID-19. Observation at the end of the main hallway outside room 17 on 09/22/21 at 9:48am revealed there was a resident lying in a recliner chair surrounded by screens of plastic attached to metal frames surrounding the chair. Interview with a personal care aide (PCA) on 09/22/21 at 9:48am revealed the resident sitting in the recliner chair in the main hallway surrounded by plastic screens had tested positive for COVID-19. Interview with a resident on 09/22/21 at 9:55am revealed: -She tested positive for COVID-19 a few days prior. -Many staff were out of work due to positive COVID-19 test results. -"Some" staff worked when they had symptoms of COVID-19 and did not feel well. Interview with a resident on 09/22/21 at 10:01am revealed: -She had recently tested positive for COVID-19 but had no symptoms of the virus. -The facility staff rarely checked her temperature. Interview with the Administrator on 09/22/21 at	D 612		

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D 612	Continued From page 17 10:02am revealed: -The facility had the first case of COVID-19 about 3 weeks ago when an employee tested positive. -The employee worked in the facility for 2 days without knowing she had been exposed to COVID-19 and once it was identified the positivity rate escalated. -When the pandemic started last year, a sophisticated air exchange system was installed that prevented the virus from being air-borne in the facility. -He closely monitored the security cameras installed in the facility and that was also how he knew the virus was transmitted by touch, since it could not be air-borne. -The only recommendation the LHD gave to the facility was COVID-19 positive staff had to remain out of work for 10 days and could only return to work after the 10 days if they had been fever-free for 24 hours and were not having any signs or symptoms of COVID-19. -The facility disinfected high touch areas twice daily, stopped visitation and screened all people that entered the building for COVID-19 to prevent the spread of the virus. -The MA who let the surveyors in the building earlier in the day was intimidated when he realized who was at the facility and he forgot the screen them for COVID-19. -He replied "okay" and shrugged his shoulders when he was informed the facility director did not screen the surveyors. -He rapid tested himself for COVID-19 every morning before he entered the facility because having a fever was just one indicator of having the virus and he wanted to be sure he did not have it. Interview with the facility director on 09/22/21 at 10:58am revealed:	D 612		

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D 612	Continued From page 18 -Staff knew they needed to screen themselves for symptoms of COVID-19, take their temperature and sign the screening log before they started work. -She did not have time to supervise staff and confirm that staff were following the screening procedures. -Staff should not come to work if they were exhibiting symptoms of COVID-19. Interview with the facility's contracted Hospice nurse on 09/22/21 at 12:05pm revealed: -She checked her own temperature and wrote it down on the facility's temperature log when she arrived at the facility. -The facility staff did not check her temperature or ask her the COVID-19 screening questions upon entrance into the facility. Second interview with the MA on 09/22/21 at 3:35pm revealed he checked the resident's temperatures daily but would only record a temperature if the resident had a fever. Interview with the Administrator on 09/22/21 at 4:00pm revealed: -Staff screened themselves for symptoms of COVID-19, took their temperatures and signed the screening log before each shift. -The facility director was responsible for monitoring the screening log. -He and the facility director could see on the security cameras if staff were properly screening themselves before they started work each shift. Observation upon entrance into the facility on 09/23/21 at 8:30am revealed a temperature was checked of the survey team but no COVID-19 screening questions were asked.	D 612		

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D 612	Continued From page 19 Interview with a MA on 09/23/21 at 9:54am revealed: -He was the MA who answered the door on 09/22/21 and his "heart dropped" and he "panicked" when he realized state surveyors were at the door. -The facility was not allowing visitors, so he went to the facility director to tell her who was at the door and ask if he was allowed to let them enter. -He did not screen the surveyors for COVID-19 because the facility director took over at that point. -He usually screened all visitors that entered the facility, but visitation stopped when the COVID-19 outbreak started on 08/31/21. Telephone interview with a facility employee on 09/24/21 at 8:37am revealed: -The facility tested staff once or twice a week for COVID-19 but "not every week" and only if they had any symptoms of COVID-19. -She requested the facility director test her for COVID-19 on 08/31/21 because she had been near a family member who was sick. -Her COVID-19 test on 08/31/21 was positive and she did not return to work until 09/10/21. -For more than a year, when staff reported to work, they were required to take their temperature and document in a log which was kept near the time clock. -She did not always take her temperature and sign the log because she "forgot sometimes". -She knew she should not report to work if she had a cough or any symptoms of COVID-19. Review of the resident and staff COVID-19 screening log revealed: -The COVID-19 Staff Procedures for Admission into the Facility was attached to the front of the screening log.	D 612		

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D 612	Continued From page 20 -The screening log was on a counter by the employee timeclock along with hand sanitizer, a box of gloves, a box of masks and a digital thermometer. -There was documentation residents' temperatures were taken 30 of 31 days in July 2021. - There was documentation residents' temperatures were taken 28 of 31 days in August 2021. - There was documentation residents' temperatures were taken 09/01/21 through 09/03/21 and 09/05/21. -There was no documentation residents' temperatures were taken from 09/06/21 through 09/23/21. -There was documentation staff consistently screened for COVID-19, took their temperature and signed the screening log in July 2021, August 2021 and from 09/01/21 through 09/07/21. -There was documentation only the 2 same staff took their temperatures and signed the screening log each day on 09/11/21 and 09/12/21. -There was documentation 2 of 5 staff took their temperatures and signed the screening log on 09/13/21. -There was documentation 2 of 6 staff took their temperatures and signed the screening log on 09/14/21. -There was documentation 2 of 6 staff took their temperatures and signed the screening log on 09/15/21. -There was documentation 2 of 7 staff took their temperatures and signed the screening log on 09/16/21. -There was documentation 4 of 10 staff took their temperatures and signed the screening log on 09/17/21. -There was documentation 3 of 8 staff took their temperatures and signed the screening log on	D 612		

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D 612	Continued From page 21 09/18/21. -There was documentation 1 of 7 staff took their temperature and signed the screening log on 09/19/21. -There was documentation 3 of 7 staff took their temperatures and signed the screening log on 09/20/21. -There was documentation 1 of 7 staff took their temperature and signed the screening log on 09/21/21. -There was documentation 4 of 7 staff took their temperatures and signed the screening log on 09/22/21. -There was no documentation the employee who tested positive for COVID-19 on 08/31/21 took her temperature or signed the screening log when she worked on 09/13/21 through 09/17/21, 09/19/21, 09/21/21 or 09/22/21. Interview with the facility director on 09/23/21 at 10:22am revealed: -Staff took and documented the residents' temperatures daily until 09/04/21 when the facility started regular COVID-19 testing. -Temperatures were no longer taken if a resident had a positive COVID-19 test. -Temperatures were only taken if a resident complained of not feeling well or were exhibiting symptoms. -Temperatures taken were not recorded unless it was elevated. -She did not need to take daily temperatures on residents because she knew them so well and could look at them and see if they had a temperature. Interview with the Administrator on 09/23/21 at 11:37am and 12:40pm revealed: -He did not document in the screening log because he took a rapid COVID-19 test at home	D 612		

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D 612	Continued From page 22 each day before he came to the facility. -The staff screening log was not accurate because staff sometimes forgot to document. -Staff knew better than to report to work if they had symptoms of COVID-19. -He knew by viewing his camera monitoring system if staff followed the facility's policies and procedures for infection prevention and control and how COVID-19 spread in the facility but would not "tell" how COVID-19 spread in the building and if staff had followed the facility's policies and procedures for infection prevention and control. -The facility only checked residents' temperatures if the resident's skin was "red" or "blotchy" and looked like they had a fever. -Temperatures were not the only indicator of being positive for COVID-19. -On 08/31/21 he and the facility director were standing in the hall near the time clock when they heard an employee cough while reporting to work, so he asked her about the cough and sent her to get a COVID-19 test, which ended up being positive. -The employee who tested positive for COVID-19 on 08/31/21 had worked 12 hour shifts on 08/29/21 and 08/30/21. Interview with the facility's contracted Hospice nurse on 09/23/21 at 11:55am revealed she used to fill out the COVID-19 screening questionnaire provided by the facility at the beginning of the COVID-19 pandemic but was then told by the Administrator to just report any symptoms of COVID-19 and to self-check a temperature upon entrance into the facility. Telephone interview with the director at the LHD on 09/23/21 at 2:01pm revealed: -She had a telephone conversation with the	D 612		

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D 612	Continued From page 23 Administrator on 09/08/21and he assured her that he was doing everything possible to mitigate the spread of the virus including temperature checks on residents and screening staff and visitors. -She told him staff who tested positive for COVID-19 needed to stay out of work for 10 days and could return if they had been fever free for 24 hours and were not exhibiting any symptoms of COVID-19. -She told him to have staff tested every 3-7 days until there were no positive tests for 14 days. -She thought he knew what to do to prevent the spread of the virus but she was not confident he made sure staff followed guidance and policies. The facility failed to follow recommendations and guidance from the Centers for Disease Control and Prevention, North Carolina Department of Health and Human Services and their own facility policies regarding screening visitors, staff and residents for temperature and symptoms during the global coronavirus (COVID-19) pandemic. This failure resulted in 22 residents and multiple staff contracting coronavirus, four residents being transported to the hospital due to complications of coronavirus, and one resident death. This failure resulted in substantial risk that death or serious physical harm would occur and constitutes a Type A2 Violation. The facility failed to provide a plan of protection in accordance with G.S. 131D-34 by 09/24/21. THE CORRECTION DATE FOR THIS A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2021.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 24 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 observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and regulations as related to infection prevention. The findings are: Based on observation, interview and record review the facility failed to ensure recommendations and guidance established by the Centers for Disease Control and Prevention (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of visitors, residents and staff for COVID-19 signs and symptoms. [Refer to Tag 612 10A NCAC 13F .1801c Infection Prevention (Type A2 Violation)].	D912	**Plan of Correction** • Staff training on Residents Rights. • (SEE POC FOR D612) **Monitoring System** • Activities director shall randomly interview of residents monthly to ensure that they are receiving care and services which are adequate, and in compliance with federal and state laws and rules and regulations. • Director shall review interviews of residents monthly to ensure residents rights are not being violated. • The Administrator/designee shall monitor all COVID-19 procedures to ensure the facility is in compliance with NCDHHS guidance and the facilities Infection Control Policies and Procedures, and that Resident Rights are being monitored. The administrator shall ensure documentation is maintained for the monitoring. • (SEE MONITORING SYSTEMS FOR D612)	10/22/2021

10-27-2021