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FORM APPROVED

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
	HAL001141	A. BUILDING: _____ B. WING _____	R 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 8-9, 2021.	D 000	* Six CPR classes have been scheduled and confirmed for October. Care Staff will be working towards 100% CPR certified * All department managers as well as other department associates are also on the schedule for CPR class	
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed an accredited course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months was completed for 3 of 3 sampled staff (Staff A, B and C). The findings are: Review of staff schedules and personnel records revealed:	D 167	*Completion for care staff to be CPR certified is scheduled for October 31, 2021, and then continue certifiy the remainder of departments One completion of the CPR classes Business Office Manger will be responsible for keeping an audit trail on who is coming up for expiring, getting class set up, as well as making sure staff are attending to keep community in compliance.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Brendle

TITLE: Executive Director

(X6) DATE: 10/08/2021

STATE FORM 6899 CN1O11 If continuation sheet 1 of 39

Reviewed and acknowledged with revisions-10/18/21-SS

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D 167	Continued From page 1 -There were 20 of 21 shifts from 09/02/21 to 09/08/21 that were not covered by CPR certified staff. -The Memory Care Director was the only staff with documentation of CPR certification on 09/08/2021 first shift 8:00am to 4:30pm. Review of Staff A's medication aide(MA) personnel record revealed: -Staff A was hired on 03/01/18. -There was documentation Staff A had completed a CPR course October 2017. -There was no documentation Staff A had completed a current CPR course. Attempted telephone interview with Staff A on 09/09/21 at 5:35pm was unsuccessful. Review of Staff B's medication aide(MA) personnel record revealed: -Staff B was hired on 4/06/16. -There was documentation Staff B had completed a CPR course May 9, 2019. -There was no documentation Staff B had completed a current CPR course. Attempted telephone interview with Staff B on 09/09/21 at 5:40pm was unsuccessful. Review of Staff C's medication aide(MA) personnel record revealed: -Staff B was hired on 06/01/21. -There was no documentation Staff C had completed a current CPR course. -There was no documentation Staff C had ever completed a CPR course. Interview with Staff C on 09/09/21 at 5:45pm revealed: -She was hired on 06/01/2021.	D 167		

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D 167	Continued From page 2 -She completed a CPR course in September 2020, but she never received the certification card. -The Director was supposed to schedule a CPR certification class for staff and she was just going to take the training again. -She had not yet received an email to sign up for a CPR certification class at the facility. The Business Office Manager (BOM) was unavailable for interview on 09/09/21. Interview with the Memory Care Director(MCD) on 09/09/21 at 6:00 pm revealed: -She was hired 09/08/2021. -The Business Office Manager (BOM) was responsible to ensure CPR was completed by staff and he should keep a list of staff who needed CPR and who completed CPR. -The BOM was responsible for scheduling staff to complete CPR certification. -The BOM should have a "tickler" for personnel records for when employees need to complete CPR training. -She had completed CPR training and has the certification card dated March 2021. -Her work hours were 8:00am to 4:30pm Monday through Friday every week. Interview with the Director on 09/09/21 at 5:50pm revealed: -She was hired 09/08/2021. -She did not know that Staff A, B and C did not have documentation of current CPR certification. -She was unable to provide documentation that any staff had current CPR certification. -The weekly staffing schedule was managed through an on-line application and was already in place by the previous Director when she began her first day of work.	D 167		

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D 167	Continued From page 3 -The staffing schedule had "CPR" beside staff who were CPR certified. -She knew there were staff who were not CPR certified, but the existing electronic schedule showed that a CPR certified staff was scheduled each shift. -She thought there would be documentation of CPR certification for those staff with "CPR" by their name. -The BOM and Resident Care Director(RCD) were responsible to ensure staff had current CPR training. -The BOM had a record of staff that had CPR certification and when staff were due to renew their CPR certification, but she did not have access to his record and he was unreachable at that time. -There were two accredited companies that provided CPR training for the staff at the facility. -There was a CPR training class scheduled for staff, but she did not know the date.	D 167		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by:	D 234	* DRC to audit all resident charts to insure that two-step TB tests have been completed on each resident. * Doctor orders requested to perform the two-step TB test * Two-step performed on any identified resident * Completion date for being in compliance is November 12, 2021	

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D 234	Continued From page 4 Based on record reviews and interviews, the facility failed to ensure 2 of 5 residents sampled (#3 and #4) were tested for tuberculosis (TB) disease upon admission. The findings are: 1. Review of Resident #3's current FL-2 dated 05/19/21 revealed diagnoses included vascular dementia, major depressive disorder, atrial fibrillation, idiopathic peripheral autonomic neuropathy, hypothyroidism and hypertension. Review of Resident #3's record revealed: -There was no Resident Register to verify her date of admission to the facility. -There was no documentation of any TB skin tests for Resident #3. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to interview with the Administrator on 09/09/21 at 4:26pm. Refer to attempted interview with the Director of Resident Care (DRC) on 09/09/21 at 8:00am. 2. Review of Resident #4's current FL-2 dated 09/24/20 revealed diagnoses included atrial fibrillation, coronary artery disease, hyperlipidemia, history of coronary vascular accident (CVA) vision loss, and obstructive sleep apnea. Review of Resident #4's Resident Register revealed there was an admission date of 10/01/20.	D 234	Once TB two steps are caught up, going forward the Director of Care will be responsible of making sure that the two steps are placed. All move in going forward will be audited at 30 days to insure that all required move in critera is met.	

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D 234	Continued From page 5 Review of Resident #4's record revealed there was no documentation of any tuberculosis (TB) skin test. Interview with Resident #4 on 09/09/21 at 3:56pm revealed: -He had not received a TB skin test prior to his admission. -He was in the military and he had received TB skin test annually during his military career. -His TB skin tests were negative during his military career. -He had not received a TB skin test after his admission. Refer to interview with the Administrator on 09/09/21 at 4:26pm. Refer to attempted interview with the Director of Resident Care (DRC) on 09/09/21 at 8:00am. Interview with the Administrator on 09/09/21 at 4:26pm revealed: -New admissions were expected to have a TB skin test upon admission. -She expected an appointment was made upon admission for the second TB skin test to be completed within two weeks. -The Director of Resident Care (DRC) would be responsible for assuring residents' TB skin tests were completed. -The DRC was on vacation on 09/09/21. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful.	D 234		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 6 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 5 sampled residents (#5) with a diet order for controlled carbohydrates (CCHO) diet with mechanical soft texture. The findings are: Review of Resident #5's current FL2 dated 05/10/21 revealed: -Diagnoses included aphasia, dysphagia, muscle weakness, essential hypertension, atrial fibrillation, leukemia, and constipation. -There was no diet order documented for Resident #5. Review of Resident #5's diet order dated 06/22/20 revealed Resident #5 was to be served a controlled carbohydrates (CCHO) with mechanical soft texture. Review of the facility's therapeutic diet menus revealed: -There was a menu for a CCHO diet. -There was a separate menu for a mechanical soft diet. -The lunch menu for 09/08/21 was divided as	D 310	* Audit completed on doctor's orders vs what is showing in Point Click Care and in dietary. * Audit for signature and date to make sure the order is in the year window for compliance * Request and implement any diet order that doesn't match clinical and dietary, or out of date * Inservice clinical and dietary departments on diet orders and complying to them * Completion date by October 15, 2021 * Going forward the DRC will audit the diets and have meeting with the Dietary Manager to ensure that both departments have the same diet order in use. * The DRC wil go over any changed diets at our Weekly Risk meeting for all departments to be aware of. *Going forward the Director of Resident Care will be responsible for making sure that all diet orders are updated yearly or as needed by residents doctor and shared with dietary so that both clinical and dietary match on all diet orders.	

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D 310	Continued From page 7 primary and secondary menus. -The primary lunch menu for 09/08/21 for a mechanical soft diet was ground soup du jour, saltines, ground roast pork with tarragon mustard sauce, couscous, sautéed yellow squash, dinner roll, margarine, red velvet cake, hot beverage of choice, and milk. -The secondary lunch menu for 09/08/21 for a mechanical soft diet was ground roast beef, beef gravy, mashed potatoes, seasonal garden blend vegetable, and soft garden vegetable salad. Observation of Resident #5's lunch meal on 09/08/21 at 12:25pm revealed Resident #5 was served roast beef sandwich with lettuce and tomato, iced tea, and a slice of chocolate cake. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed Resident #5 had a regular diet and she observed Resident #5 receiving a regular diet during meal times. Interview with the dietary manager (DM) on 09/09/21 at 5:33pm revealed: -When she prepared meals for Resident #5, and she used the CCHO menu. -Resident #5 completed a menu selection and chose the food items she wanted for meals. -Resident #5 told staff what she wanted to eat and that was what she provided to Resident #5. -She knew Resident #5 had a mechanical soft diet order. -The facility did offer a mechanical soft menu. -She knew Resident #5 had choked in the past and had a swallowing test. -She had not told the medication aides, Director of Resident Care (DRC), or the former Administrator that Resident #5 refused to eat certain foods when prepared based on the mechanical soft menu.	D 310		

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D 310	Continued From page 8 -She had not told a MA, the DRC or the former Administrator because she did not know that she was supposed to tell anyone. -She served Resident #5 the foods she requested. Interview with Administrator on 09/09/21 at 4:26pm revealed: -She did not know Resident #5's diet order. -She did not know Resident #5 received a roast beef sandwich for the lunch meal service on 09/08/21, but she knew residents in the Assisted Living (AL) unit chose their food selections from a menu. -She was concerned about Resident #5 having a mechanical soft diet and receiving regular texture foods. -The DRC was responsible for ensuring the DM received diet orders. -The DM was responsible for serving diets as ordered by the physician. Attempted interview with Resident #5 on 09/09/21 at 10:36am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358	* Chart to mar audit to be performed by MT and DRC for order compliance *Orders are to be reviewed by MT and entered into Point Click Care * DRC is to then approve orders in Point Click Care	

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D 358	Continued From page 9 and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents(#3) related to a medication used to prevent blood clots, two vitamin supplements, a medication used to treat Alzheimer's disease, and a medication used to treat dysrhythmia. The findings are: 1. Review of Resident #3's current FL-2 dated 05/19/21 revealed diagnoses included vascular dementia, major depressive disorder, atrial fibrillation, idiopathic peripheral autonomic neuropathy, hypothyroidism and hypertension. a. Review of Resident #3's physician orders dated 06/17/21 revealed there was a medication order for Cardizem ER 180mg (used to treat atrial fibrillation) one tablet daily. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Cardizem ER 180mg take one tablet daily, scheduled for 9:00am. -There was documentation of administration of Cardizem ER 180mg from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 8:00am. -There was no documentation of administration of Cardizem ER on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. -There were 7 doses of Cardizem ER not	D 358	*Report for missed meds to be run each morning for accurancy *Med techs need re-education on how to put orders into point click care, making sure medications are in house, following through with giving medications, as well as documentation * Completion date to have the training completed will be October 22, 2021 *Completion date for daily auditing will be ongoing Correction date-11/15/21-SS amended on 10/18/21	

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D 358	Continued From page 10 documented as administered. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for Cardizem ER 180mg take one tablet daily, scheduled for 9:00am. -There was documentation of administration of Cardizem ER from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am. -There was no documentation of administration of Cardizem ER on 08/18/21 and 08/26/21 at 9:00am. -There were 2 doses of Cardizem ER not documented as administered. Observation of Resident #3's medications in the facility on 09/09/21 at 9:40am revealed there were 29 of 30 Cardizem ER 180mg tablets dispensed on 08/23/21 available for administration. Telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am revealed: -Thirty tablets of Cardizem ER 180mg dispensed for Resident #3 on 06/17/21, 07/16/21, and 08/23/21. -The amount dispensed for Resident #3 was a 30-day supply. -There was no Cardizem ER dispensed between 08/16/21 and 08/23/21. -The amount dispensed on 07/16/21 would have provided enough medication up to 08/16/21. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed: -She administered medications to Resident #3. -She did not recall any of Resident #3's medications not being available to administer.	D 358		

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D 358	Continued From page 11 -She thought the lack of documentation for Resident #3's Cardizem was a result of MAs missing to click on the medication in the eMAR system. Based on observations, record reviews, and interview it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care provider's (PCP) office on 09/09/21 at 11:22am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. b. Review of Resident #3's physician orders dated 06/17/21 revealed there was a medication order for cyanocobalamin 500mcg (used to treat vitamin B-12 deficiency) one tablet daily. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for cyanocobalamin 500mcg take one tablet daily, scheduled for 9:00am. -There was documentation of administration of cyanocobalamin 500mcg from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21,	D 358		

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D 358	Continued From page 12 and from 07/22/21 to 07/31/21 at 8:00am. -There was no documentation of administration of cyanocobalamin on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. -There were 7 doses of cyanocobalamin not documented as administered. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for cyanocobalamin 500mcg take one tablet daily, scheduled for 9:00am. -There was documentation of administration of cyanocobalamin from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am. -There was no documentation of administration of cyanocobalamin on 08/18/21 and 08/26/21 at 9:00am. -There were 2 doses of cyanocobalamin not documented as administered. Observation of Resident #3's medications in the facility on 09/09/21 at 9:40am revealed there was no cyanocobalamin available for administration. Telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 08/05/21 at 1:08pm revealed: -There was no order on Resident #3's profile for cyanocobalamin. -The pharmacy had not received an order for cyanocobalamin. -No cyanocobalamin was dispensed for Resident #3. -Cyanocobalamin was available over the counter, but the pharmacy provided over the counter medications for the facility. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 13 09/09/21 at 2:02pm revealed: -She had seen cyanocobalamin in the medication cart previously for Resident #3. -She ordered cyanocobalamin for Resident #3 on 09/08/21 and it had not yet arrived via delivery to the facility. -She did not know the pharmacy did not have the order for Resident #3's cyanocobalamin. -She did not know the pharmacy had not dispensed cyanocobalamin for Resident #3. Based on observations, record reviews, and interview it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care provider's (PCP) office on 09/09/21 at 11:22am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. c. Review of Resident #3's physician orders dated 06/17/21 revealed there was a medication order for galantamine 4 mg (used to treat moderate confusion related to Alzheimer's disease) one tablet daily. Review of Resident #3's physician orders dated 06/28/21 revealed there was a medication order	D 358		

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D 358	Continued From page 14 for galantamine 4mg twice daily. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for galantamine 4mg one tablet daily, scheduled for 9:00am. -There was documentation of administration of galantamine 4mg from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 8:00am. -There was no documentation of administration of galantamine on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. -There were 7 doses of galantamine not documented as administered. -There was no entry for galantamine 4mg twice daily. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for galantamine 4mg one tablet daily, scheduled for 9:00am. -There was no entry for galantamine 4mg twice daily. -There was documentation of administration of galantamine from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am. -There was no documentation of administration of galantamine on 08/18/21 and 08/26/21 at 9:00am. -There were 2 doses of galantamine not documented as administered. Observation of Resident #3's medications in the facility on 09/09/21 at 9:40am revealed: -There were two bubble packages of galantamine	D 358		

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D 358	Continued From page 15 4 mg. -One bubble package was dispensed on 06/28/21 with 12 of 60 tablets available for administration. -The second bubble package was dispensed on 08/23/21 with 60 tablets available for administration. Telephone interview with a phamacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58pm revealed: -There was an order for galantamine 4 mg twice daily dated 06/28/21. -Sixty tablets of galantamine 4 mg were dispensed on 06/28/21 and 08/23/21. -The amounts of galantamine dispensed were a 30-day supply. -There were no dispense dates for galantamine in July 2021 for Resident #3. -There were no dispense dates for galantamine between 06/28/21 and 08/23/21. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed: -She administered galantamine to Resident #3 daily. -She did not know Resident #3 had an order for galantamine 4 mg twice daily. -She thought the reason the order was not placed into the eMAR system was because of shortages in staffing and doing multiple tasks during a shift. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's primary care provider's (PCP) office on 09/09/21 at 11:22am was unsuccessful. Attempted interview with the DRC on 09/09/21 at	D 358		

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D 358	Continued From page 16 8:00am was unsuccessful. Refer to telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. d. Review of Resident #3's current FL-2 dated 05/19/21 revealed there was a medication order for vitamin D3 (used to treat vitamin D deficiency) 1,000 units take one tablet daily. Review of Resident #3's July 2021 electronic medication administration records (eMAR) revealed: -There was an entry for vitamin D3 1,000 units one tablet daily, scheduled for 9:00am. -There was documentation of administration of vitamin D3 from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 8:00am. -There was no documentation of administration of vitamin D3 on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. -There were 7 doses of vitamin D3 not documented as administered in July 2021. Review of Resident #3's August 2021 eMARs revealed: -There was an entry for vitamin D3 1,000 units one tablet daily, scheduled for 9:00am. -There was documentation of administration of vitamin D3 from 08/01/21 to 08/17/21, from	D 358		

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D 358	Continued From page 17 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am. -There was no documentation of administration of vitamin D3 on 08/18/21 and 08/26/21 at 9:00am. -There were 2 dose of vitamin D3 not documented as administered in August 2021. Observation of Resident #3's medications on hand on 09/09/21 at 10:25am revealed: -There were two bubble packages of vitamin D3 tablets. -One bubble package was dispensed on 07/12/21 with 1 of 30 tablets remaining. -Another bubble package was dispensed on 08/23/21 with 30 of 30 tablets remaining. Telephone interview with a pharmacist at Resident #3's pharmacy on 09/09/21 at 11:58am revealed: -There were no dispense dates for June 2021 for vitamin D3. -Thirty tablets of vitamin D3 were dispensed on 07/12/21 and 08/23/21 which was a thirty day supply. Based on observations, record reviews, and interviews it was determined Resident #3 not interviewable. Attempted telephone interview with Resident #3's primary care provider's (PCP) office on 09/09/21 at 11:22am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am.	D 358		

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D 358	Continued From page 18 Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. e. Review of Resident #3's physician orders dated 06/17/21 revealed there was a medication order for Eliquis 2.5mg (used to treat prevent blood clots) one tablet twice daily. Review of Resident #3's July 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 2.5mg take one tablet twice daily, scheduled for 9:00am and 8:00pm. -There was documentation of administration of Eliquis from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 9:00am. -There was documentation of administration of Eliquis from 07/01/21 to 07/31/21 at 8:00pm. -There was no documentation of administration of Eliquis on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. -There were 7 doses of Eliquis not documented as administered in July 2021. Review of Resident #3's August 2021 eMAR revealed: -There was an entry for Eliquis 2.5mg take one tablet twice daily, scheduled for 9:00am and 8:00pm. -There was documentation of administration of Eliquis from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am.	D 358		

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D 358	Continued From page 19 -There was documentation of administration of Eliquis from 08/01/21 to 08/31/21 at 8:00pm. -There was no documentation of administration of Eliquis on 08/18/21 and 08/26/21 at 9:00am. -There were 2 doses of Eliquis not documented as administered in August 2021. Observation of Resident #3's medications in the facility on 09/09/21 at 9:40am revealed there were 54 of 60 Eliquis tablets dispensed on 09/03/21. Telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am revealed: -There was an order for Resident #3 dated 09/03/21 for Eliquis 2.5mg twice daily. -There was a previous order date of 06/17/21 for Eliquis 2.5mg twice daily. -Sixty tablets of Eliquis 2.5mg were dispensed for Resident #3 on 06/17/21, 07/12/21, and 09/03/21. -The amounts dispensed were 30-day supply. -There was no Eliquis dispensed for Resident #3 in August 2021. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed: -She administered Eliquis to Resident #3 when she worked. -She did not know why there were blank areas on Resident #3's July 2021 and August 2021 eMARs. -She did not recall Resident #3 not having Eliquis available for administration. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's	D 358		

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D 358	Continued From page 20 PCP office on 09/09/21 at 11:22am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to telephone interview with a pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. Telephone interview with the pharmacist at Resident #3's facility contracted pharmacy on 09/09/21 at 11:58am revealed: -Staff at the facility had to request refills for residents. -Staff could fax or call concerning refills for residents. -If a new order was needed for a resident's medication, the pharmacy staff notified staff at the facility. -Staff at the facility notified the resident's PCP concerning the need for a new order. Interview with the MA on 09/09/21 at 2:02pm revealed: -She and the previous Administrator entered medication orders into the eMAR system. -The previous Administrator verified the orders once the orders were entered. -She requested refills from the pharmacy when a resident's remaining tablet amount was within the red area on the bubble package. -Usually, the pharmacy delivered medications the next day.	D 358		

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D 358	Continued From page 21 -If the medication was not delivered, the pharmacy contacted them concerning the reason why the medication was not refilled. -If a new order was needed, she faxed or called the resident's primary care provider (PCP). Interview with the Administrator on 09/09/21 at 4:26pm revealed: -At the facility, there was a designated MA who entered orders into the eMAR system, and the DRC verified the orders. -The pharmacy did not enter orders into the eMAR system for the facility. -She saw that Resident #3 was not administered some medications on the July 2021 and August 2021 eMARs. -She thought maybe Resident #3 was on a leave of absence with family or that Resident #3 had medications remaining from another dispense date. -She read through Resident #3's progress notes and saw that Resident #3 was not out of the facility on the dates where documentation of administration was missing on the eMARs. -She did not know before, 09/09/21, that Resident #3 had not received medications as ordered by her PCP. -She expected MAs to request refills when there were 7 to 8 tablets remaining in the bubble package. -She held MAs responsible for accurate documentation of administration of residents' medications. -She held the DRC responsible for ensuring medication orders were entered into the eMAR system.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 22 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 the accuracy of medication administration records for 2 of 5 sampled residents (#3 and #5), including a medication used to treat depression, thyroid hormone replacement, and a medication used to treat Alzheimer's disease (#3) and a medication used to treat pain, a medication used to treat potassium deficiency, and medication used to treat depression (#5). The findings are: 1. Review of Resident #3's current FL-2 dated 05/19/21 revealed diagnoses included vascular	D 367	* Med cart audits will be completed by October 8, 2021 by DRC and pharmacy * All carts will have sufficient meds on them based on MAR to cart audit * Plan put in place for 3rd shift med tech to perform cart autids on a weekly basis to ensure that all meds are in-house and available * DRC to spot check med carts for medication availability and accuracy * The weekly audits will be on-going * report for missed meds to be run each morning for accuracy * med techs receive re-education on the importance of having medications Correction date- 11/15/21-SS amended on 10/18/21	

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D 367	Continued From page 23 dementia, major depressive disorder, atrial fibrillation, idiopathic peripheral autonomic neuropathy, hypothyroidism and hypertension. a. Review of Resident #3's current FL-2 dated 05/19/21 revealed there was a medication order for Effexor XR capsule 37.5 mg (used to treat depression) take two capsules daily. Review of Resident #3's July 2021 electronic medication administration records (eMAR) revealed: -There was an entry for Effexor XR 37.5 mg two capsules daily, scheduled at 9:00am. -There was documentation of administration of Effexor XR from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, from 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and 07/22/21 to 07/31/21 at 9:00am. -There was no documentation of administration of Effexor XR on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 9:00am. Review of Resident #3's August 2021 eMARs revealed: -There was an entry for Effexor XR 37.5 mg two capsules daily, scheduled at 9:00am. -There was documentation of administration of Effexor XR from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 9:00am. -There was no documentation of administration of Effexor XR on 08/18/21 and 08/26/21 at 9:00am. Observation of Resident #3's medications on hand on 09/09/21 at 10:25am revealed: -There were two bubble packages of Effexor XR 37.5 mg. -One bubble package of Effexor XR was	D 367		

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D 367	Continued From page 24 dispensed on 07/31/21 with 2 remaining bubble packets containing 2 tablets per packet. -Another bubble package of Effexor XR was dispensed on 09/03/21 with 12 remaining bubble packets containing 2 tablets per packet. Telephone interview with a pharmacist at Resident #3's pharmacy on 09/09/21 at 11:58am revealed: -Thirty tablets of Effexor XR 37.5 mg tablets were dispensed on 07/06/21, 07/16/21, 07/31/21, and 09/03/21. -Thirty tablets provided a 15 days supply for Resident #3 because the frequency of her order was twice daily. -Resident #3 had an adequate supply of Effexor XR to administer as ordered for July and August 2021. -The pharmacy did not supply MARs to the facility. Based on observations, record reviews, and interview with Resident #3 was determined not interviewable. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. b. Review of Resident #3's current FL-2 dated 05/19/21 revealed there was a medication order for Namenda 5mg (used to treat Alzheimer's disease) take one tablet twice daily. Review of Resident #3's July 2021 electronic	D 367		

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(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 367	Continued From page 25 medication administration records (eMAR) revealed: -There was an entry for Namenda 5mg one tablet twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Namenda from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 8:00am. -There was documentation of administration of Namenda from 07/01/21 to 07/31/21 at 8:00pm. -There was no documentation of administration of Namenda on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 8:00am. Review of Resident #3's August 2021 eMARs revealed: -There was an entry for Namenda 5mg one tablet twice daily, scheduled for 8:00am and 8:00pm. -There was documentation of administration of Namenda from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 8:00am. -There was documentation of administration of Namenda from 08/01/21 to 08/31/21 at 8:00pm. -There was no documentation of administration of Namenda on 08/18/21 and 08/26/21 at 8:00am. Observation of Resident #3's medications on hand on 09/09/21 at 10:25am revealed there was a bubble package of Namenda dispensed on 08/13/21 with 9 tablets remaining. Telephone interview with a pharmacist at Resident #3's pharmacy on 09/09/21 at 11:58am revealed: -Sixty tablets of Namenda 5 mg were dispensed on 06/08/21, 07/06/21, and 08/13/21. -The pharmacy provided refills in 30-day supply	D 367		

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D 367	Continued From page 26 unless there was an issue with insurance or a limited order. Based on observations, record reviews, and interview with Resident #3 was determined not interviewable. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. c. Review of Resident #3's current FL-2 dated 05/19/21 revealed there was a medication order for levothyroxine (used to treat an underactive thyroid) 88mcg take one tablet daily. Review of Resident #3's July 2021 electronic medication administration records (eMAR) revealed: -There was an entry for levothyroxine 88mcg one tablet daily, scheduled for 8:00am. -There was documentation of administration of levothyroxine from 07/02/21 to 07/08/21, from 07/10/21 to 07/11/21, 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 8:00am. -There was no documentation of administration of levothyroxine on 07/01/21, 07/09/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 8:00am. Review of Resident #3's August 2021 eMARs revealed: -There was an entry for levothyroxine 88mcg one tablet daily, scheduled for 8:00am.	D 367		

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D 367	Continued From page 27 -There was documentation of administration of levothyroxine from 08/01/21 to 08/17/21, from 08/19/21 to 08/25/21, and from 08/27/21 to 08/31/21 at 8:00am. -There was no documentation of administration of levothyroxine on 08/18/21 and 08/26/21 at 8:00am. Observation of Resident #3's medications on hand on 09/09/21 at 10:25am revealed there was a bubble package dispensed on 07/24/21 with 13 of 30 tablets remaining. Telephone interview with a pharmacist at Resident #3's pharmacy on 09/09/21 at 11:58am revealed thirty tablets of levothyroxine 88mcg were dispensed on 06/23/21 and 07/24/21. Based on observations, record reviews, and interview with Resident #3 was determined not interviewable. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. 2. Review of Resident #5's current FL-2 dated 05/10/21 revealed diagnoses included aphasia, dysphagia, muscle weakness, essential hypertension, atrial fibrillation, leukemia, and constipation. a. Review of Resident #5's current FL-2 dated 05/10/21 revealed there was a medication order for tramadol (used to treat moderate pain) 50mg	D 367		

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D 367	Continued From page 28 (1.5 tablets) twice daily. Review of Resident #5's July 2021 electronic medication administration records (eMAR) revealed: -There was an entry for tramadol 50 mg (1.5 tablets) twice daily, scheduled for 6:00am and 2:00pm. -There was documentation of administration of tramadol on 07/01/21, from 07/03/21 to 07/04/21, 07/06/21, from 07/08/21 to 07/11/21, from 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, from 07/22/21 to 07/29/21, and 07/31/21 at 6:00am and 2:00pm. -There was documentation of administration of tramadol on 07/02/21 and 07/30/21 at 2:00pm. -There was documentation of administration of tramadol on 07/05/21, 07/07/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 6:00am. -There was no documentation of administration of tramadol on 07/02/21 and 07/30/21 at 6:00am. -There was no documentation of administration of tramadol on 07/05/21, 07/07/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 2:00pm. Review of Resident #5's August 2021 eMARs revealed: -There was an entry for tramadol 50 mg (1.5 tablets) twice daily, scheduled for 6:00am and 2:00pm. -There was documentation of administration of tramadol from 08/01/21 to 08/31/21 at 6:00am. -There was documentation of administration of tramadol from 08/01/21 to 08/04/21, 08/09/21, 08/11/21, from 08/13/21 to 08/15/21, 08/17/21, from 08/19/21 to 08/25/21 and from 08/28/21 to 08/31/21 at 2:00pm. -There was no documentation of administration of	D 367		

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D 367	Continued From page 29 tramadol from 08/05/21 to 08/08/21, 08/10/21, 08/12/21, 08/16/21, 08/18/21, and from 08/26/21 to 08/27/21 at 2:00pm. Observation of Resident #5's medications on hand on 09/09/21 at 10:25am revealed: -There was a bubble package of tramadol packed with 1 1/2 tablets per bubble. -There were 5 remaining bubble packets for the remaining package dispensed on 08/05/21. Review of Resident #5's controlled-substance log for tramadol revealed there was documentation from 07/01/21 to 08/31/21 at 6:00am and 2:00pm with a remaining balance of 5 (1 ½ tablets). Telephone interview with a pharmacist at Resident #5's pharmacy on 09/09/21 at 11:58am revealed: -One-hundred and twenty tablets of tramadol were dispensed on 06/21/21 and one-hundred and five tablets of tramadol were dispensed on 08/05/21. -Ninety tablets of tramadol were dispensed on 09/07/21. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed Resident #5 received tramadol twice daily, until September 2021, when her order for tramadol was changed to as needed. Attempted interview with Resident #5 on 09/09/21 at 10:36am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm.	D 367		

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D 367	Continued From page 30 Refer to interview with the Administrator on 09/09/21 at 4:26pm. b. Review of Resident #5's current FL-2 dated 05/10/21 revealed there was a medication order for citalopram 20mg (used to treat depression) (1.5 tablets) daily. Review of Resident #5's July 2021 electronic medication administration records (eMAR) revealed: -There was an entry for citalopram 20mg one and one-half tablets daily, scheduled for 2:00pm. -There was documentation of administration of citalopram from 07/01//21 to 07/04/21, 07/06/21, from 07/08/21 to 07/11/21, from 07/13/21 to 07/14/21, from 07/17/21 to 07/18/21, 07/20/21, and from 07/22/21 to 07/31/21 at 2:00pm. -There was no documentation of administration of citalopram on 07/05/21, 07/07/21, 07/12/21, from 07/15/21 to 07/16/21, 07/19/21, and 07/21/21 at 2:00pm. Review of Resident #5's August 2021 eMARs revealed: -There was an entry for citalopram 20mg one and one-half tablets daily, scheduled for 2:00pm. -There was documentation of administration of citalopram from 08/01/21 to 08/04/21, 08/09/21, 08/11/21, from 08/13/21 to 08/15/21, 08/17/21, from 08/19/21 to 08/25/21, and from 08/28/21 to 08/31/21 at 2:00pm. -There was no documentation of administration of citalopram from 08/05/21 to 08/08/21, 08/10/21, 08/12/21, 08/16/21, 08/18/21, and from 08/26/21 to 08/27/21 at 2:00pm. Observation of Resident #5's medications on hand on 09/09/21 at 10:25am revealed:	D 367		

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D 367	Continued From page 31 -There was one bubble package of citalopram packaged with 1 ½ tablets per bubble packet. -There were 9 packets remaining in the bubble package which was dispensed on 07/31/21. Telephone interview with a pharmacist at Resident #5's pharmacy on 09/09/21 at 11:58am revealed forty-five tablets of citalopram were dispensed on 07/02/21 and 07/31/21. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed she did not know why Resident #5's citalopram was not consistently documented as administered but she gave Resident #5's citalopram when she worked. Attempted interview with Resident #5 on 09/09/21 at 10:36am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm. Refer to interview with the Administrator on 09/09/21 at 4:26pm. c. Review of Resident #5's physician orders dated 08/20/21 revealed there was an order to start potassium (used to treat or prevent low potassium levels) 10meq take 3 tablets (30 meq) daily. Review of Resident #5's August 2021 electronic medication administration record (eMAR) revealed there was no entry for potassium. Observation of Resident #5's medications on hand on 09/09/21 at 10:25am revealed there	D 367		

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D 367	Continued From page 32 were no potassium tablets available for administration. Telephone interview with a pharmacist at Resident #5's pharmacy on 09/09/21 at 11:58am revealed ninety tablets of potassium were dispensed on 08/20/21 which was a thirty-day supply. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed: -Resident #5 had an order for potassium dated August 2021. -She administered potassium to Resident #5 until she returned to the hospital in September 2021. -After Resident #5's hospitalization, her potassium was discontinued. -She did not know why Resident #5's potassium was never entered onto her August eMAR. Interview with the Administrator on 09/09/21 at 4:26pm revealed: -She did not know Resident #2's docusate was not documented as administered on Resident #2's June 2021 eMAR. -Resident #2 no longer wanted liquid docusate, but she kept the bottle of liquid docusate because she was waiting on a discontinue order for the liquid form. -Resident #2 was admitted with a bottle of liquid docusate. Attempted interview with Resident #5 on 09/09/21 at 10:36am was unsuccessful. Attempted interview with the DRC on 09/09/21 at 8:00am was unsuccessful. Refer to interview with a MA on 09/09/21 at 2:02pm.	D 367		

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D 367	Continued From page 33 Refer to interview with the Administrator on 09/09/21 at 4:26pm. Interview with a MA on 09/09/21 at 2:02pm revealed: -The medication orders were entered into the eMAR system by the Director of Resident Care (DRC) who was a nurse. -The facility did not have a nurse for six months. -During that time, she and the former Administrator entered medication orders into the eMAR system. -She did not know why there were blank spaces on the eMAR system. -She thought that documentation was not completed, but she did not know of another reason for why the documentation was not completed. -She thought the residents received the medications indicated on their eMAR. -When a medication was not clicked upon on the eMAR system, it turned red on the computer screen. -However, if the medication was not clicked on the eMAR, it did not prevent the continuation with administering medications. -The MAs were responsible for ensuring documentation of administration of medications. Interview with the Administrator on 09/09/21 at 4:26pm revealed: -The DRC and a few MAs entered medication orders into the eMAR system not the pharmacy. -The DRC was on vacation. -The medication orders were verified by the DRC or a designated MA before the order could be viewed on the eMAR system. -She did not know there were blank areas on the eMAR and she thought the eMAR system	D 367		

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D 367	Continued From page 34 prompted the MAs to document the administration of the medications. -She expected the DRC to review the eMAR report to ensure there were no blank areas on the eMARs. -If there were blank areas on the eMAR she expected the DRC to determine who was working and the reason why documentation was missed. -The MAs and the DRC were responsible for ensuring residents' MARs were accurate.	D 367		
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, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents	D 612	* Daily temps done along with the COVID screening questions for signs and symptoms of our residents. * Start immediately to ensure compliance is met. *Maintain screening questions in a binder The medication aides and certified nurse assistants will obtain the daily temperatures of residents. Correction date- 10/31/21 for this rule area-SS- amended on 10/18/21	

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D 612	Continued From page 35 during the global coronavirus (COVID-19) pandemic as related to the screening of residents for COVID-19 signs and symptoms. The findings are: Observation upon entrance to the facility on 09/08/21 at 8:00am revealed: -Staff offered screening after entrance was allowed and completed a screening log. -Staff completed the screening at the front desk, which included a temperature check. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed all residents and staff should screen daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue, headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea. 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: -There were guidelines for screening, visitation, face masks, dining room, activities, transportation, admissions, leave of absence, suspected COVID-19 exposure and confirmed COVID-19 for residents. -The guidelines for screening were that all staff should obtain their temperatures at the beginning	D 612		

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D 612	Continued From page 36 of their shifts. -Residents should be screened when returning from a temporary leave of absence such as a medical appointment. -Visitors, vendors and contractors should be screened. -The facility should have one entrance and a method to determine to screen all Assisted Living (AL) residents or identify the AL residents who should be screened. Review of three residents' July 2021, August 2021, and September 2021 medication administration records (MARs) revealed there was no documentation of daily temperatures or COVID-19 signs and symptoms. Review of the Assisted Living (AL) residents temperature logs revealed: -The temperature logs were in a binder. -There were temperature logs dated 4/25/21, 05/01/21, 05/10/21, 05/16/21, and there were two pages without dates. -There were blank temperature logs inside a sleeve of the binder. Interview with a resident on 09/09/2021 at 4:10pm revealed: -Staff checked her temperature occasionally, but she can't remember how often or the last time her temperature was checked. -She doesn't remember any staff ever asking if she had symptoms like shortness of breath or cough. Interview with a second resident on 09/09/2021 at 4:14pm revealed: -She had only been in the facility a few weeks. -She could not remember the last time staff took her temperature and has never been asked if she	D 612		

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D 612	Continued From page 37 had any symptoms. Interview with a third resident on 09/09/2021 at 4:19pm revealed: -Staff took his blood pressure and temperature in physical therapy over a week ago, but not since. -Staff have never asked if he had symptoms like coughing and did not check his temperature often. Interview with a medication aide (MA) on 09/09/21 at 2:02pm revealed: -She did not monitor the residents' temperatures daily when she worked. -When residents were quarantined, their temperatures were taken daily until the quarantine ended. -There was a thermometer for use at the facility. -She documented the resident's temperatures on a temperature log, but only for residents who were on quarantine. -She was not able to locate the documentation of the residents' temperatures for August and September 2021. -She screened herself while at work by taking her temperature daily and documented her temperature on the screening log at the front desk. -Staff monitored residents' temperatures daily in the past, but she did not know the date when staff stopped monitoring residents' temperatures daily. -She did not know the residents' temperatures needed to continue to be taken daily. -There were no residents on quarantine on 09/09/21 so no temperatures were obtained. Interview with the Administrator on 09/09/21 at 4:26pm revealed: -The facility had a COVID-19 policy. -Due to the increase in COVID-19 cases within	D 612		

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	HAL001141	A. BUILDING: _____ B. WING _____	R 09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

(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 612	Continued From page 38 the community, the facility required staff to wear a KN-95 face mask, visitors and staff were screened daily, staff were tested for COVID-19, residents who were new admissions were quarantined for 4-5 days and had to have a negative COVID-19 test. -A staff tested positive for COVID-19 recently, and all the residents were tested but none were positive. -The local health department (LHD) nurse provided guidance on how long to quarantine staff and residents. -The residents who were quarantined were screened for COVID-19 symptoms and had their temperatures taken daily until their quarantine ended. -She did not know the current CDC COVID-19 guidelines for long term care facilities related to screening for residents. -She was responsible for ensuring all staff were following the guidelines of the CDC concerning COVID-19 screenings with daily temperatures and monitoring of COVID-19 signs and symptoms for residents.	D 612		