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D 000	Initial Comments The Adult Care Licensure Section and the Dare County Department of Social Services conducted an annual survey on March 2, 2022 and March 3, 2022.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 16 residents including several hazardous items unsecured in residents' private bathrooms and an activity closet in the activity room. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 102 residents with a Special Care Unit (SCU) capacity of 28 residents. The facility's census in the SCU was 16 residents. Observation of the resident rooms on the SCU on 03/02/22 revealed: -There were one to two residents in rooms on the SCU with a private bathroom for the residents	D 079		

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that shared a room.
-There were cabinets above each toilet in each resident's bathroom that had a keyhole on the cabinet door but were unlocked.
-The unlocked cabinets had three shelves.
-There was a typed sign on blue paper posted on the inside of the unlocked cabinet with "For the safety of all residents, please return all personal hygiene items to this locked cabinet after using."

Observation of resident room 236 on the SCU on 03/02/22 at 9:14am revealed:
-The cabinet above the toilet was unlocked.
-There was one disposable razor with a shield on the top shelf.
-There was a disposable razor with a shield on the second shelf.
-There was a disposable razor without a shield on the third shelf.
-There was a 24 fluid ounce bottle of mouthwash on the top shelf that was half full with a warning to keep out of reach of children, in case of accidental ingestion seek professional assistance and contact a poison control center.

Observation of resident room 232 on the SCU on 03/02/22 at 9:37am revealed:
-The cabinet above the toilet was unlocked.
-There were two 8 ounce aerosol air freshener containers on the top shelf with a caution to not use near fire, flame or pilot light, keep out of reach of children, intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.
-There were two 4 ounce containers of skin protectant ointment on the third shelf with a warning to avoid contact with eyes; in case of contact flush thoroughly with water, keep out of reach of children, in case of accidental ingestion contact a physician or poison control center.

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-There was a 4.5 ounce container of diabetic foot cream on the third shelf with a warning to avoid contact with eyes, keep out of reach of children; if swallowed get medical help or contact a poison control center.
-There was a 1.5 fluid ounce container of a roll on deodorant on the third shelf with a warning to ask a physician before use if you have kidney disease, keep out of reach of children, if swallowed get medical help or contact a poison control center.

Observation of resident room 238 on the SCU on 03/02/22 at 9:09am revealed:
-The cabinet above the toilet was unlocked.
-There were two 2.8 fluid ounce bottles of denture foam cleanser in a bag on top of the unlocked cabinet.
-There was a warning on the back label with caution for external use only; do not use foam on natural teeth or in mouth, do not use if you are sensitive to any of the ingredients, may cause an allergic skin reaction, or irritation to the eyes and mucous membranes.

Observation of resident room 221 on the SCU on 03/02/22 at 9:40am revealed:
-The cabinet above the toilet was unlocked.
-There was a manicure set in a plastic container with a snapped enclosure on the second shelf that contained a pair of nail clippers, tweezers and manicure scissors.

Observation of resident room 219 on the SCU on 03/02/22 at 10:21am revealed:
-The cabinet above the toilet was unlocked.
-There was an opened box of denture cleaning tablets that contained 102 tablets.
-The box of denture cleaning tablets had a warning on the back of the box to keep out of

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reach of children, do not put tablets or solution directly in mouth, do not swallow or gargle the product, in case of accidental ingestion, contact a poison control center immediately.

Observation of a closet in the activity room on the SCU on 03/02/22 at 8:45am revealed:
-There was an unlocked closet door that contained various activity supplies.
-There were 5 shelves in the closet.
-There was a plastic basket on the 5th shelf that contained 23 nail polish bottles, two 6 fluid ounce bottles of nail polish remover bottles, one 1.75 ounce container of petroleum jelly and one pair of manicure scissors.
-There was a warning label on the two nail polish remover bottles; keep out of reach of children, extremely flammable liquid and vapors, may ignite do not use when smoking, near heat, flame or fire, keep out of reach of eyes, in case of eye contact immediately flush with water, remove contact lenses and continue to flush eyes with water for 15 minutes, in case of accidental ingestion, give fluids and contact poison control center.
-There was a warning label on the petroleum jelly container to keep out of reach of children, if swallowed get medical help and contact a poison control center.
-There was no staff in the activity room.

Observation of a vanity in the activity room on the SCU on 03/02/22 at 8:58am revealed:
-There were three drawers on the left side of the vanity that were not locked.
-The top drawer contained a 11 ounce aerosol can of hairspray with a warning to keep out of reach of children, do not use near heat, flame or while smoking, can cause serious injury or death, avoid inhalation, intentional misuse by

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deliberately concentrating and inhaling the contents can be harmful or fatal.

Interview with a personal care aide (PCA) on 03/02/22 at 11:57am revealed:
-The facility staff kept cabinets above the toilet in resident rooms on the SCU locked.
-She had observed two residents that were ambulatory attempt to eat alcohol based hand sanitizer when she placed the hand sanitizer in their hands prior to a meal; both residents placed their palm with the sanitizer to their mouth as if they were going to eat it ;she redirected them to rub it into their hands.
-She did not have a key to lock the cabinets above the toilet in the SCU bathrooms.
-She thought the medication aide (MA) and the other PCA had keys to lock the cabinets in the resident bathrooms.
-She thought all the cabinets in the resident bathrooms were locked and did not realize that the cabinets were unlocked with hazards accessible to residents.
-There was a chance that residents may drop hazards down the toilet, cut themselves or accidentally ingest personal care items.

Interview with a second PCA on 03/02/22 at 12:02pm revealed:
-Several residents had attempted to eat decorations on the dining room tables and staff had to remove them to ensure their safety approximately one month ago.
-Two residents had brought pebbles in from the SCU locked courtyard and tried to eat them, staff were able to remove the pebbles from the residents.
-Some residents shared a room and bathroom.
-The SCU staff did not keep all cabinet doors locked above the toilet that contained hazards,

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because some residents used their personal care items correctly and were able to use them independently.
-Staff kept disposable razors away from residents by keeping them locked in their bathroom cabinets.
-It was common sense for staff to know which personal care items needed to be locked to ensure residents safety.
-She was not aware of a policy that determined which residents were able to use their own personal care items.
-She was not aware that the cabinets in resident bathrooms were not locked.

Interview with a MA on 03/02/22 at 12:06pm revealed:
-All residents on the SCU would wander.
-Five residents wandered every day.
-One resident followed residents into their rooms and wandered every day.
-Another resident would go to other residents' tables during meals and attempt to take food off their plates, but staff would redirect him.
-Three female residents wandered in and out of other residents' rooms throughout the day and were easily redirected.
-PCA's were responsible for keeping personal care items locked in the cabinets in resident rooms.

Interview with the Resident Care Director (RCD) on 03/02/22 at 12:20pm revealed:
-All disposable razors, nail clippers, manicure scissors or tweezers were locked and secure on the SCU.
-Staff that worked on the SCU were aware of which residents could keep their personal care items unlocked and use them independently.
-She was not concerned that other residents

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D 079	Continued From page 6 could wander and access personal care items from other resident's bathroom cabinets that were not locked. -She was not aware that personal care items and hazards needed to be locked to ensure all residents safety on the SCU. -She thought that there were not any hazardous items in the unlocked cabinets in any bathrooms on the SCU. -She was aware of at least 3 residents that wandered into other residents' rooms on the SCU. Interview with the Administrator on 03/03/22 at 4:20pm revealed: -She was not aware that there were any unsecured hazards on the SCU. -Disposable razors, nail clippers, tweezers, manicure scissors and personal care items should always be secured in a locked area. -She expected the PCA's to ensure all personal care items were locked to ensure the safety of residents on the SCU.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 270		

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reviews the facility failed to provide supervision to 1 of 5 sampled residents (#3) in accordance with the facility's policies and the resident's assessed needs resulting in the resident falling 6 times since 10/22/21, with 3 of those falls being within an 11-day time frame, and the last fall resulting in injury.

The findings are:

Review of the facility's Safety Check Guidelines revealed:
-Safety checks could be put into place for residents who required additional observation or supervision due to a fall.
-Safety checks were to be implemented by the Administrator or Resident Care Director (RCD).
-Safety checks could be done on residents every 30 minutes or every hour depending on the circumstance.
-Facility staff were to visually check on the resident during safety checks to make sure they were physically safe and comfortable and that any interventions were in place.
-When residents were placed on safety checks the resident's medical record would be documented on by the medication aide (MA) or Supervisor-In-Charge (SIC) every shift.
-Residents were removed from safety checks at the discretion of the Administrator or RCD.

Review of the facility's Fall Risk Management Protocol Interventions revealed:
-Interventions which could be considered for a resident who experienced falls included physical therapy (PT)/occupational therapy (OT) evaluation, medication review, environmental review and intervention, behavioral techniques, and mobility and transfer equipment and safety.
-Interventions such as a fall mat, transfer pole, or

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bed/chair alarm could be put into place for a resident if it was discussed with senior management prior to putting those interventions into place.

Review of the facility's Rose Program revealed:
-Any resident who scored at a higher risk for falls upon assessment was automatically placed on the Rose Program.
-Any resident who experienced 2 falls within 30 days was immediately placed on the Rose Program.
-Interventions to prevent the resident's risk of falling were developed for residents on the Rose Program.
-Any resident on The Rose Program would have "The Rose Program" written on their personal care service log and highlighted in pink to indicate they were in the program.
-Facility staff were informed of specific interventions to be put into place for any residents on The Rose Program and education was to be provided to ensure compliance with those interventions.

Review of Resident #3's current FL-2 dated 01/06/22 revealed:
-Diagnoses included dementia, hypertension (HTN), chronic embolism and deep vein thrombosis (DVT) of the left upper extremity, and status post right hip fracture.
-The resident was intermittently disoriented.
-He was incontinent of bowel and bladder.
-He ambulated with the assistance of a walker.
-He required assistance with bathing and dressing.

Review of Resident #3's Resident Register dated 01/08/20 revealed:
-He was admitted to the facility on 01/08/2020.

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D 270	Continued From page 9 -He was forgetful and needed reminders. Review of Resident #3's current Care Plan dated 01/06/22 revealed: -He was sometimes disoriented and was forgetful and needed reminders. -He required supervision with ambulation. -He required extensive assistance with toileting and activities of daily living (ADLs). Review of Resident #3's Fall Risk Assessment dated 08/17/21 revealed: -He had a fall risk score of 19. -A score of 16 or greater indicated the resident was at high risk for falls. -There was no documentation on the form that fall interventions were reviewed, implemented, or documented on the resident's care plan. Review of Resident #3's Incident/Accident (I/A) Report dated 10/22/21 revealed: -At 12:05pm the resident was observed on the floor of his room by a medication aide (MA). -He fell while getting up to go to lunch. -He sustained a wound to his left elbow which required first aide. Review of Resident #3's I/A Report dated 11/06/21 revealed: -At 10:20am the resident slipped while getting up out of bed and fell. -He sustained a wound to his right arm which required first aide. Review of Resident #3's I/A Report dated 12/13/21 revealed: -The supervisor in charge (SIC) found the resident lying in the floor. -He sustained a skin tear to his right wrist which required first aide.	D 270		

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D 270	Continued From page 10 Review of Resident #3's Fall Risk Assessment dated 01/18/22 revealed: -He had a fall risk score of 21. -A score of 16 or greater indicated the resident was at high risk for falls. -There was no documentation on the form that fall interventions were reviewed, implemented, or documented on the resident's care plan. Review of Resident #3's I/A Report dated 02/11/22 revealed: -At 5:00pm the resident has a fall which was witnessed by a personal care aide (PCA). -He fell back against the wall in his bathroom and onto the floor. -He did not sustain any injuries from his fall. Review of Resident #3's I/A Report dated 02/12/22 revealed: -At 1:30am Resident #3's roommate used his call bell to call for help and told staff he found the resident on the floor. -When a PCA entered the room the resident was on the floor on his back with his head under his bed. -The resident stated, "I was trying to get up to get away from the noise." -The resident sustained skin tears to the front and back of his left shoulder which required first aide. Review of Resident #3's progress note dated 02/12/22 revealed that at 11:00pm he was observed to be very unsteady while he was walking and was having trouble holding himself upright. Review of Resident #3's I/A Report dated 02/22/22 revealed: -At 5:00am the resident tripped over his walker,	D 270		

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lost his balance, and fell.
-The resident hit his head and was profusely bleeding from a cut over his left eye.
-Previous skin tears that he had reopened and were also bleeding.
-Emergency Medical Services (EMS) was called and the resident was transported to the Emergency Department (ED) via ambulance.

Review of Resident #3's ED after visit summary report dated 02/22/22 revealed:
-The resident was seen for an accidental fall.
-He was unable to provide a history.
-He was noted to have old skin tears to his left arm.
-He had a 5-centimeter laceration (cut) to his left eyebrow which required sutures.
-He received a computerized tomography (CT) scan of his head which revealed he had a subdural hematoma related to his fall. (A subdural hematoma is a condition where blood collects between the skull and the surface of the brain.)
-He was held for 12-hours for observation and a repeat CT scan of his head to assess for worsening of the subdural hematoma.
-There was a critical care attestation which stated the resident had a high probability of life-threatening deterioration in conditions at the initial presentation or during his ED course related to his subdural hematoma.
-After observation and a repeat CT scan of his head the resident was discharged back to the facility.

Review of Resident #3's progress note dated 02/24/22 revealed that at 6:00am the resident required 2 staff members to assist him with toileting and that he was unable to reposition himself or turn in his bed on his own.

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Review of Resident #3's progress note dated 02/26/22 revealed that at 2:45pm he was having a hard time balancing himself.

Review of Resident #3's Fall Risk Assessment dated 03/01/22 revealed:
-He had a fall risk score of 22.
-A score of 16 or greater indicated that the resident was at high risk for falls.
-There was no documentation on the form that fall interventions were reviewed, implemented, or documented on the resident's care plan.

Review of Resident #3's personal service logs for 02/01/22-02/28/22 and 03/01/22-03/02/22 revealed. there was no documentation that indicated the resident received any increased supervision.

Review of Resident #3's record revealed:
-There was a Rose Program cover sheet dated as updated on 03/01/22 that listed all residents on The Rose Program.
-Resident #3 was listed as being on The Rose Program.
-There was no documentation of any increased supervision or safety checks for Resident #3.
-There was no documentation that any fall prevention interventions were put into place for Resident #3 after any of his falls.

Observation and interview with Resident #3 on 03/03/22 at 3:32pm revealed:
-He was sitting in his room in his wheelchair out of sight of facility staff.
-He stated he had not had any falls.
-If he needed assistance, he just asked for it but he did not know how he would ask for assistance if he needed it.
-He was not able to identify the call bell as a way

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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 270	Continued From page 13 to call for assistance. Interview with a personal care aide (PCA) on 03/03/22 at 3:24pm revealed: -It was concerning if Resident #3 tried to walk independently because he was unsteady on his feet. -She had never been present for any of Resident #3's falls, but after his most recent fall, he required two people to assist him to move up in bed. -She checked on Resident #3 every 2-hours. -She checked on all residents every 2-hours unless she was instructed to check on them more often. -She was not instructed to check on Resident #3 more often than every 2-hours. -She had never heard the resident ask for assistance or use his call bell. Interview with a second PCA on 03/03/22 at 3:36pm revealed: -Resident #3 had begun to slowly deteriorate in his functional status approximately 1-2 months prior to his fall. -Resident #3 had a big change in his ability to walk after his most recent fall on 02/22/22. -Since his most recent fall, Resident #3 needed 1-2 people to assist him to stand or walk. -Resident #3 had been in a wheelchair since his most recent fall on 02/22/22. -She checked on Resident #3 every hour because she knew he needed to be checked on more often so he would not try to stand up on his own. -She had not been instructed by facility staff to check on Resident #3 more often. -She did not recall Resident #3 ever using his call bell to call for assistance. -The resident's roommate would call for	D 270		

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assistance for Resident #3 if it was needed.
-Resident #3 would not be able to remember instructions to use his call bell for assistance.
-Resident #3 had gotten up on his own before without calling for assistance.

Interview with a medication aide (MA) on 03/03/22 at 12:04pm revealed:
-Resident #3 had a decline in his functional status over the past 2 months.
-Resident #3 needed 2 people to assist him to stand since his fall on 02/22/22.
-Resident #3 tried to get up independently when it was time to attend the dining room for meals.
-She was not sure if Resident #3 knew how to use his call bell because she had never seen him use it.
-The PCAs were responsible to provide all resident's with supervision/safety checks every 2 hours which included visually checking on the residents to make sure they were safe.
-The MAs would assist with supervision/safety checks when they were not administering medications.
-She had never received any instructions to provide increased supervision to Resident #3.
-She had never been told any fall prevention interventions were put into place for Resident #3 but thought maybe non-slip shoes would be a good intervention for him.

Interview with the Resident Care Director (RCD) on 03/03/22 at 4:00pm revealed:
-After his last fall on 02/22/22 Resident #3 was put in a wheelchair by facility staff until he could be evaluated by physical therapy (PT), occupational therapy (OT), and his primary care provider (PCP).
-Resident #3 had been getting weaker since the beginning of the week and she had not seen him

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ambulate since his most recent fall.
-Resident #3 received 2-hour safety checks because he required incontinence care.
-Resident #3 could use his call bell if he needed assistance.
-Resident #3 might need to be checked on more often than every 2-hours because of his frequent falls, but that had not been put into place yet.
-It would have been her or the Administrator's responsibility to ensure increased safety checks were put into place for Resident #3, she was not sure why they had not done it yet.
-Resident #3 was not on any increased safety checks because she just noticed at the beginning of the week that he was getting weaker.
-When a resident fell they were placed in the hot box until the RCD, the Assistant Resident Care Director (ARCD), or the Administrator took them out.
-Care notes were made on residents every shift while in the hot box.
-She thought Resident #3 got checked on more frequently because the staff just knew that he needed to be checked on more frequently.
-A resident with a high fall risk was communicated to staff through The Rose Program with pink paper notification posted throughout the facility with the resident's room numbers on them to notify the staff.

Interview with the Administrator on 03/03/22 at 10:24am revealed:
-All residents were checked on every two hours.
-Facility staff did not document 2-hour checks on residents, but shift reports were done on residents after every shift.
-If a resident needed to be checked on more often, the Administrator would write a note which was left at the time clock or she sent out a mass text to facility staff which identified the resident by

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their room number to communicate to them to check on a resident more frequently.
-Resident #3 was getting weaker and had declined over the last several months, so the facility placed the resident in a wheelchair after his most recent fall on 02/22/22 because he had tripped over his walker which caused him to fall.
-Resident #3 was not able to propel himself in the wheelchair and he required staff assistance to go anywhere.
-There was no order for the wheelchair because the facility was waiting for Resident #3's PCP to evaluate him at an appointment on 03/03/22.
-Resident #3 did not receive checks more often than every 2-hours because she did not know he would try to get up on his own and she thought he was able to use his call bell if he needed assistance.
-Facility staff kept his door open to make it easier to check on him.
-She did not put any fall interventions such as a bed/chair alarm, fall matt, or concave mattress into place for Resident #3 because she thought she could not do that for residents in the Assisted Living Unit (AL).
-Resident #3 had not been referred to PT for evaluation after any of his falls because of insurance issues.
-She was concerned about Resident #3's frequent falls because he had hit his head hard during his last fall and she was concerned that another fall could cause more severe injuries or result in his death.

Interview with Resident #3's primary care provider (PCP) on 03/03/22 at 12:20pm revealed:
-She had been notified of Resident #3's falls on 10/22/21, 11/06/21, 12/13/21, 02/11/22 ,02/12/22, and 02/22/22.
-She was not aware the facility had placed the

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D 270	Continued From page 17 resident in a wheelchair after his most recent fall and expected the facility to notify her and request an order to ensure it was an appropriate intervention. -She was unsure how often the resident received safety checks but she expected more frequent supervision than usual by facility staff in the days after his falls until he returned to his baseline. -If the facility had requested interventions for Resident #3 such as a bed/chair alarm, fall mat, or concave mattress, she would have provided them with an order for the interventions to prevent further falls. -Resident #3 had been slowing declining and progressing in his dementia and she expected the facility to watch the resident more closely due to these issues. -If the resident needed a higher level of care than what the facility could provide she expected the facility to notify her of that. Attempted telephone interview with Resident #3's family member on 03/03/22 at 3:15pm was unsuccessful. _____ The facility failed to provide interventions and supervision to 1 of 5 sampled residents (#3) in accordance with the facility policies and his current needs which resulted in the resident falling 6 times since 10/22/22 with 3 of those falls within an 11-day time frame after observation that the resident had an unsteady gait for which no interventions were put into place in which he sustained a large facial laceration and a subdural hematoma resulting in the resident being unable to walk without assistance and being confined to a wheelchair and requiring increased assistance with his activities of daily living. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B	D 270		

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D 270	Continued From page 18 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 17, 2022.	D 270		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.	D 280		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a quarterly Licensed Health Professional Support (LHPS) evaluation was completed for 1 of 5 sampled residents (#3) with needed LHPS tasks of ambulation while using an assistive device in which he required physical assistance and wound care with dressing changes.

The findings are:

Review of Resident #3's current FL-2 dated 01/06/22 revealed:
-Diagnoses included dementia, hypertension (HTN), chronic embolism and deep vein thrombosis (DVT) of the left upper extremity, and status post right hip fracture.
-The resident was intermittently disoriented.

a. Review of Resident #3's current Care Plan dated 01/06/22 revealed:
-He had skin tears to both arms and an open wound to his buttocks for which he was receiving weekly wound clinic visits and twice weekly home health visits for wound care.
-He was to receive clean dressing changes.
-He was to have wound care performed by home health to both arms.

Review of Resident #3's physician consult/visit note and order dated 10/06/21 revealed there was a new order to apply Triamcinolone 1% and a dressing to a peri-wound every other day.

Review of Resident #3's wound clinic physicians orders dated 12/23/21 and 01/27/22 revealed:
-There was an order to provide wound care to his right posterior and superior arm and his left

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anterior arm.
-There was an order to cleanse the wounds with normal saline, apply adaptic dressing, and then cover with gauze and coban (used to secure dressings in place without adhesive) without compression.
-Caution was to be used when removing the old dressing and to moisten the soiled dressing with normal saline before removing it due to the resident's thin skin, tears, and ease of bleeding.
-The dressings were to be changed every other day and as needed when soiled.
-Staff providing wound care were to wash their hands before and after wound care and call the wound clinic, notify the resident's primary care provider (PCP), or send the resident to the emergency department (ED) for any signs and symptoms of infection, increased drainage, increased odor, or redness.

Review of Resident #3's home health visit notes revealed he received wound care with dressing changes from home health staff on 12/07/21, 12/14/21, 12/17/21, 01/11/22, 01/11/22, 01/14/22, 01/30/22, 02/11/22, 02/13/22, and 02/25/22.

Review of Resident #3's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Triamcinolone 0.1% cream to be applied to a peri-wound with a dressing change every other day.
-The Triamcinolone and dressing change was documented as administered by home health staff as ordered every other day from 01/01/22-01/31/22 except on 01/03/22, 01/11/22, 01/15/22, 01/17/22, 01/29/22, and 01/31/22 which were documented as administered by a medication aide (MA) who worked at the facility.
-There was an entry for wound care with adaptic

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touch dressings to be administered every other day.
-The adaptic touch dressings were documented as administered by home health staff as ordered every other day from 01/01/22-/01/31/22 except on 01/15/22, 01/17/22, 01/29/22, and 01/31/22 which were documented as administered by a MA who worked at the facility
-There was an entry for a non-compression dressing change to be administered every other day and as needed if soiled or dislodged.
-The non-compression dressing was documented as administered by home health staff as ordered every other day from 01/01/22-01/31/22 except 01/15/22, 01/17/22, 01/21/22, 01/29/22, and 01/31/22 which were documented as administered by a MA who worked at the facility.

Review of Resident #3's February 2022 eMAR revealed:
-There was an entry for Triamcinolone 0.1% cream to be applied to a peri-wound with a dressing change every other day.
-The Triamcinolone and dressing change were documented as administered by home health staff as ordered every other day from 02/01/22-02/28/22 except on 02/02/22, 02/09/22, 02/18/22, 02/24/22, and 02/26/22 which were documented as administered by a MA who worked at the facility.
-There was an entry for wound care with adaptic touch dressings to be administered every other day.
-The adaptic touch dressings were documented as administered by home health staff as ordered every other day from 02/01/22-02/28/22.
-There was an entry for a non-compression dressing change to be administered every other day and as needed if soiled or dislodged.
-The non-compression dressing changes were

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documented as administered by home health staff as ordered every other day from 02/01/22-02/28/22 except on 02/16/22, 02/20/22, and 02/24/22 which were documented as administered by a MA who worked at the facility.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 08/26/21 revealed:
-There was documentation that included a required task for the resident to receive clean dressing changes excluding packing wounds and application of prescribed enzymatic debriding agents.
-There was documentation that home health was to provide Resident #3's wound care.

Review of Resident #3's record revealed:
-There was no documentation of quarterly LHPS reviews and evaluations for 4th quarter 2021 or 1st quarter 2022.
-There was no documentation of quarterly LHPS reviews and evaluations after 08/26/21.

Interview with a MA on 03/03/22 at 12:04pm revealed:
-If Resident #3's dressings on his wounds became soiled she would change them.
-She had not received any specific training on how to perform Resident #3's dressing changes.
-She was a Certified Nurse Assistant II (CNA) so she had received basic training on how to perform dressing changes through the state CNA program.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 4:00pm revealed:
-Home Health normally performed Resident #3's wound care.
- She was not aware that facility staff were

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performing wound care without a current LHPS.
-It was concerning that staff were performing wound care without training because the wounds needed to be cleansed properly and with proper technique and correct supplies needed to be used to avoid complications and infection.
-Facility staff were probably performing dressing changes differently than a nurse would do them, which was why it was important to have a LHPS assessment in place and performed every quarter as expected.

Interview with the Administrator on 03/03/22 at 10:24am revealed:
-She was not aware that a LHPS evaluation and assessment was needed on a resident if they were receiving home health services from a 3rd party provider.
-She thought home health staff were performing Resident #3's dressing changes and did not know that facility staff were also performing dressing changes on the resident.
-Upon being made aware that a facility MA was changing Resident #3's dressings, she stated the MA likely had basic knowledge of how to change a dressing but had no specific training on Resident #3's dressing change needs.

Interview with Resident #3's PCP on 03/03/22 at 12:20pm revealed:
-She was concerned that Resident #3's wounds were not healing and did not know facility staff did not have specific training to address and provide Resident #3's wound care as needed when home health staff was unavailable.
-She expected the facility staff and residents with LHPS tasks to have a current LHPS evaluation and training on tasks such as wound care to show they were properly trained on how to perform those tasks competently.

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D 280	Continued From page 24 Refer to interview with the RCD on 03/03/22 at 4:00pm. Refer to interview with the Administrator on 03/03/22 at 10:24am. b. Review of Resident #3's current FL-2 dated 01/06/22 revealed he ambulated with the assistance of a walker. Review of Resident #3's current care plan dated 01/06/22 revealed he ambulated with the assistance of a walker. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 08/26/21 revealed: -His previous LHPS evaluation was done on 04/09/20. -There was documentation that included the task of ambulation using assistive devices that required physical assistance in the use of a walker. Observation of Resident #3 on 03/03/22 at 3:32pm revealed: -He was in his room in a wheelchair. -There was a walker in his room. Review of Resident #3's I/A Report dated 02/22/22 revealed at 5:00am the resident tripped over his walker, lost his balance, and fell. Review of Resident #3's record revealed: -There was no documentation of quarterly LHPS reviews and evaluations for 4th quarter 2021 or 1st quarter 2022. -There was no documentation of quarterly LHPS reviews and evaluations after 08/26/21.	D 280		

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D 280	Continued From page 25 -There was no documentation of an order for a wheelchair. Interview with a personal care aide on 03/03/22 at 3:36pm revealed Resident #3 had been in a wheelchair since his most recent fall on 02/22/22. Interview with the Resident Care Director (RCD) on 03/03/22 at 4:00pm revealed: -After Resident #3's last fall on 02/22/22, the resident was placed in a wheelchair as a facility intervention because he was getting weaker. -There was no order for the wheelchair because they were waiting for him to be seen by his primary care provider (PCP) that day (03/03/22). Interview with the Administrator on 03/03/22 at 10:24am revealed: -Resident #3 was placed in a wheelchair by the facility after his most recent fall on 02/22/22 because he had tripped over his walker which caused him to fall. -She felt Resident #3's walker contributed to many of his falls and he had been declining and requiring increased assistance since his most recent fall. -Resident #3 was not able to propel himself in the wheelchair and he required staff assistance to go anywhere. -There was no order for the wheelchair because the facility was waiting for Resident #3's PCP to evaluate him at an appointment on 03/03/22. Interview with Resident #3's PCP on 03/03/22 at 12:20pm revealed: -She was not aware the facility had placed Resident #3 in a wheelchair after his most recent fall. -She expected the facility to notify her and request an order for the wheelchair prior to use to	D 280		

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D 280	Continued From page 26 ensure it was an appropriate intervention. -She expected the facility to notify her if they were concerned that Resident #3 needed an increased level of care. -She expected the facility to ensure staff and residents received quarterly LHPS evaluations, assessments and trainings as required so that residents could be competently cared for by staff. Refer to interview with the RCD on 03/03/22 at 4:00pm. Refer to interview with the Administrator on 03/03/22 at 10:24am. _____ Interview with the Resident Care Director (RCD) on 03/03/22 at 4:00pm revealed: -The facility had a Registered Nurse (RN) who was contracted to do LHPS evaluations on the residents at the facility each quarter. -She was not sure who was responsible for making sure the RN did the LHPS evaluations on residents. -It was concerning that Resident #3 did not have an LHPS assessment because it was important to ensure staff were trained properly to care for his need accordingly. Interview with the Administrator on 03/03/22 at 10:24am revealed: -The facility had a RN who was contracted to do LHPS evaluations on the residents at the facility each quarter. -It was her responsibility to ensure residents received LHPS evaluation reviews every quarter as required. -She was not aware Resident #3 required a LHPS evaluation because she thought because he received services from a third-party provider, he did not need one.	D 280		

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D 280	Continued From page 27 -She missed notifying the RN to complete the LHPS evaluation for Resident #3.	D 280		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 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: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 1 sampled residents (#3) who had an order for a mechanical soft therapeutic diet. The findings are: Review of Resident #3's current FL-2 dated 01/06/22 revealed: -Diagnoses included dementia, gastroesophageal reflux disease (GERD), and dysphagia. (Dysphagia is difficulty swallowing.) -The resident was intermittently disoriented. -His diet was regular soft. Review of Resident #3's previous FL-2s dated 01/03/20, 07/09/20, and 12/10/20 revealed his diet was regular soft.	D 310		

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D 310	Continued From page 28 Review of Resident #3's current care plan dated 01/06/22 revealed he had a diet order of a regular mechanically soft diet. Review of Resident #3's primary care physician (PCP) doctor visit form dated 02/17/22 revealed a swallow study was ordered for the resident due to concerns about his weight loss and the resident choking on food. Review of the facility's March 2022 diet menu revealed: -The lunch menu for 03/02/22 listed soup du jour, beef stir fry with vegetables, fried rice, wheat dinner roll, and black forest pudding. -The beef stir fry was substituted with pot roast and the black forest pudding was substituted with peach pie. -The breakfast menu for 03/03/22 listed cream of wheat, orange wedges, sausage, and multigrain pancakes. -The multigrain pancakes were substituted with French toast. Observation of the facility's kitchen on 03/02/22 revealed there was not a therapeutic diet list. Observation of Resident #3 during lunch on 03/02/22 from 12:01pm to 12:49pm revealed: -He was seated in a wheelchair at a table in the common dining room. -He was served a lunch which consisted of shredded roast beef with carrots, rice, green beans, a dinner roll, and ice cream. -He ate 50 percent of the roast beef with carrots, 30 percent of the rice, 50 percent of the green beans, 100 percent of the dinner roll, and 75 percent of the ice cream. -The resident was observed on two occasions	D 310		

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chewing on his green beans for an extended period and then spitting them into a napkin.
-The resident was observed to have difficulty chewing and swallowing and was holding food in his mouth, sipping water, and swishing the water in his mouth to swallow.

Observation of Resident #3 during breakfast on 03/03/22 from 8:09am to 8:40 am revealed:
-He was seated in a wheelchair at a table in the common dining room.
-He was served a breakfast which consisted of a sausage patty cut into approximately 1 to 1 ½ inch pieces, scrambled eggs, and French toast with syrup cut into approximately 1 to 1 ½ inch pieces.
-He would occasionally hold and move food around in his mouth and take a sip of orange juice or water and swish a couple of times to complete swallowing the food.
-He ate 100 percent of the sausage patty, 100 percent of the scrambled eggs, and 100 percent of the French toast.

Interview with a dietary cook on 03/03/22 at 8:37am revealed:
-She was unaware if Resident #3 had a therapeutic diet ordered or not.
-Resident #3 had recently been choking on his food.
-Resident #3 had a recent choking episode while eating ham because he was having a hard time chewing it.
-She did not recall when the choking episode occurred.
-About a month ago the Food Service Director (FSD) had told her to start cutting up Resident #3's food.

Interview with a dietary server on 03/03/22 at

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8:52am revealed:
-Resident #3 would sometimes receive his food cut up because the FSD had instructed the dietary staff to cut his food.
-She did not know why the dietary staff were instructed to cut Resident #3's food, but she thought it was because he had experienced a choking incident about 2 weeks prior in which facility staff had to respond to assist him in clearing his airway.
-She heard Resident #3 had recent issues with swallowing but had not actually observed the issues herself and was unsure exactly what was contributed to the resident's swallowing issues.
-She was not aware of a therapeutic diet order or list for any residents in the facility.

Interview with a dietary cook on 03/03/22 at 7:52am revealed:
-There were not any residents on a mechanical soft or any other type of therapeutic diet at the facility.
-If there were residents on a therapeutic diet, she would prepare the resident's food according to the therapeutic diet menu list and recipe created by the dietician and food service provider.

Interview with the FSD on 03/02/22 at 11:34pm revealed:
-There were no residents on a therapeutic diet order therefor there was no therapeutic diet list in the kitchen.
-Resident #3 was slow to eat since his fall on 02/22/22 and recently required prompting to eat.

Interview with a personal care aide (PCA) on 03/03/22 at 3:24pm revealed:
-She was unaware that Resident #3 was on a therapeutic diet.
-The kitchen staff did not cut up Resident #3's

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food but she sometimes cut it up for him because he was weak.
-Resident #3 sometimes coughed while he was eating and it was reported to the Resident Care Director (RCD).
-She was unaware that Resident #3 recently had a choking episode while eating.

Interview with a second PCA on 03/03/22 at 3:36pm revealed:
-Resident #3 was having trouble eating after his most recent fall on 02/22/22.
-Resident #3 had trouble chewing due to ill-fitting dentures.
-She would cut up Resident #3's food for him to help him with his chewing difficulties.
-She was not sure if Resident #3 was having trouble swallowing but he would hold food in his mouth for long periods of time.
-Resident #3 sometimes coughed when he was eating.

Interview with a medication aide (MA) on 03/03/22 at 12:04pm revealed:
-She was unsure if Resident #3 was on a therapeutic diet.
-She thought he was on a regular diet.
-Over the past two months, the resident had not been eating as well as he once did.

Interview with the RCD on 03/03/22 at 4:00pm revealed:
-She was not aware there was no therapeutic diet list in the kitchen for residents.
-She was not aware that Resident #3 was on a mechanical soft diet; she was unaware any residents at the facility were on therapeutic diets.
-She cut up Resident #3's food as a precaution to prevent him from choking, but she was not told to do so by anyone.

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-She had noticed Resident #3 cough when he ate.
-She was not sure how resident records got audited to make sure dietary orders were being followed.

Interview with the Administrator on 03/03/22 at 10:24am revealed:
-She was unaware that there was not a therapeutic diet list in the kitchen for residents
-She was unaware any residents at the facility were on a therapeutic diet.
-The FSD was responsible for maintaining the therapeutic diet list for residents
-The FSD received a copy of all diet orders from her or the RCD each time one was received.
-She expected the FSD to serve meals to residents as ordered per the regular and therapeutic diet menu.
-She did not know Resident #3 was on a mechanical soft diet until she saw it in his record on 03/02/22.
-Resident #3 had his food cut up since June 2021 when she started working at the facility, but she was unsure why.
-She thought the FSD was who told the kitchen staff to cut up Resident #3's food.
-Resident #3 recently had a choking incident with ham on 02/17/22; he was able to recover with minimal assistance from staff.
-She had not witnessed any other choking, gagging, or swallowing issues with Resident #3 but did notice that he sometimes coughed when he ate.
-After Resident #3's choking incident, the kitchen staff was instructed by her not to give Resident #3 ham.
-She notified Resident #3's primary care provider's (PCP) nurse of Resident #3's choking incident on 02/17/22 and was notified in return

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there was an order for the resident to receive a swallow study.

Interview with Resident #3's primary care provider (PCP) on 03/03/22 at 12:20pm revealed:
-She expected the facility to provide a mechanical soft diet as ordered for Resident #3.
-It was concerning that Resident #3 was not served his therapeutic diet as ordered because it put him at increased risk for choking because he was not getting a mechanical soft diet.
-She had been made aware of the resident's choking incident on 02/17/22.
-She ordered a swallow study due to the choking incident.
-The swallow study had not been scheduled yet, due to a delay by the PCP's office.

Attempted telephone interview with Resident #3's family member on 03/03/22 at 3:15pm was unsuccessful.

Attempted interview with the FSD on 03/03/22 at 10:24am was unsuccessful.

_____

The facility failed to ensure that a therapeutic diet was available and served as ordered to 1 of 1 sampled residents (#3) who had a diagnosis of dysphagia and an order for a mechanical soft diet who sometimes coughed while eating and had a choking episode on 02/17/22. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/03/22 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 17,

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D 310	Continued From page 34 2021.	D 310		
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 (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protections and reduce the risk of transmission and infection to residents regarding proper use of face masks and staff screening. The findings are: Review of the Centers for Disease Control (CDC) Infection Prevention and Control	D 612		

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Recommendations for Healthcare Personnel During the COVID-19 Pandemic dated 02/02/22 revealed facilities shall implement source control which includes use of respirators or well-fitting facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22:
-NCDHHS recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.
-Facilities shall continue to screen all who enter for signs and symptoms of COVID-19.

Review of the facility's policy for the Utilization of Face Masks dated 03/31/20 revealed:
-Staff were to mold or pinch the stiff edge of the mask to the shape of their nose and pull the bottom of the mask over your mouth and chin.
-Staff were to wear a face mask when providing assistance or care to a resident.
-Staff were to wear face masks when in common areas, such as hallways, laundry rooms, supply closets and office space.
-Masks are not to be worn pulled under the chin.
-Staff were allowed to not wear face masks if they were on a break or lunch.

The facility's policy on staff screening related to COVID-19 was requested on 03/03/22 at 9:52am and none was provided prior to exit.

1. Observation of the breakfast dining service on 03/03/22 from 7:40am to 8:40am revealed:
-When the surveyor entered the kitchen at

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D 612	Continued From page 36 7:40am there was a server that was not wearing a mask, she placed a mask over her mouth and nose after the surveyor entered the kitchen. -A cook entered the kitchen at 7:52am without a mask on but placed a mask on after washing her hands. -The cook's mask remained below her nose only covering her mouth, or below her chin covering neither her mouth nor nose from 7:52am to 8:40am while she intermittently prepared food for the residents. -The cook was prompted by the Administrator at 8:25am to pull her mask up to cover her mouth and nose. -The Administrator left the kitchen at 8:28am and the cook pulled her mask down below her nose again. -There were 20 residents eating in the dining room. -The cook walked around the dining room from 8:28am to 8:33am and asked if everything tasted okay or if the residents needed anything. -The cook's face mask was below her nose from 8:28am to 8:33am when she spoke to each of the 20 residents. -The cook's mask was below her nose the entire time she rounded on the 20 residents remaining in the dining room at that time. -The cook returned to the kitchen at 8:35am and began to prepare food again. -The cook pulled her mask down below her chin when she returned to the kitchen at 8:35am. and preparing food at 8:35am, the cook again pulled her mask down below her chin. Interview with the cook on 03/03/22 at 9:30am revealed: -She was always expected to wear her mask over her mouth and nose when preparing food, around other staff, or around residents.	D 612		

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-There was a risk of contamination or making others sick if she did not wear her mask as instructed.
-She did not wear her mask as instructed that day because she was hot, and it was hard for her to breath when she wore it over both her mouth and nose.

Observation of a personal care aide (PCA) on assisted living (AL) side of the facility 03/03/22 from 3:24pm to 3:30pm revealed:
-She was wearing a cloth mask below her nose but covering her mouth.
-She was going room to room offering residents ice water and filling up their reusable cups with ice and water as needed.
-She pulled her mask over her nose upon interview and prompting.

Interview with the PCA on 03/03/22 at 3:24pm revealed:
-She did not know she we supposed to wear a medical grade procedure mask versus a cloth mask in the facility.
-She was always expected to wear her mask over both her mouth and nose and was unsure why she was wearing her mask below her nose.
-It was important to wear her mask as instructed to keep other staff and the residents safe from contamination and pathogens that could make them sick.
-There was PPE available at the facility that she could switch her cloth mask out for a medical grade mask.

Observation of the medication room on the Special Care Unit (SCU) on 03/03/22 at 10:10am revealed there was a flyer hanging from the Center for Disease Control (CDC) that demonstrated photographs and descriptions of

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proper wearing of facemasks titled "Facemask Do's and Don'ts".

Interview with the lead medication aide (MA) on the SCU on 03/03/22 at 10:12am:
-All staff were always expected to wear face masks over their nose and mouths unless they were on break.
-Staff received training on properly wearing face masks at the start of the COVID-19 pandemic in early 2020.

Interview with the Resident Care Director (RCD) on 03/03/22 at 4:01pm revealed:
-She expected all staff to always wear their mask over their mouth and nose to ensure they kept other staff and the residents safe from contamination and pathogens that could make them sick.
-There were a couple staff members who had continued issues with compliance of mask use which was concerning because they had a resident with COVID-19 in the facility approximately 2 weeks ago.

Interview with the Administrator on 03/03/22 at 8:40am revealed:
-She always expected all staff to wear a procedure mask covering both the mouth and nose per the CDC guidance.
-It was concerning that staff were not screening or wearing a mask as directed because the facility recently had a stomach virus that went through the facility and affected many residents approximately 2-weeks ago.
-She was concerned that dietary staff were not wearing masks appropriately because they were preparing food for residents who were ingesting the food that may have been contaminated.
-It was important for all staff to wear a mask

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	HAL028001	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF THE OUTER BANKS	803 BERMUDA BAY BLVD KILL DEVIL HILLS, NC 27948

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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appropriately to protect the residents' health and safety.
-She previously told at least two staff members multiple times in the past to correct their mask use to include the cook.
-She was concerned that the cook continued to pull her mask down and wear it inappropriately even after being prompted to pull it up over her mouth and nose earlier that morning on 03/03/22.
-Staff were always expected to wear their masks unless they were in the "breathing room"/staff breakroom or in a room by themselves.

2. Review of the facility's staff COVID-19 screening log on 03/03/22 at 8:40am revealed none of the staff currently working that day (03/03/22) who had arrived at 7:00am had completed a COVID-19 screening questionnaire and temperature screening.

Interview with a housekeeper on 03/02/22 at 8:30am revealed:
-Staff were expected to screen for COVID-19 symptoms upon arrival to work by completing a questionnaire and documenting their temperature.
-If a staff member's questionnaire or temperature was outside the specified range, they would be sent home and not allowed to work.

Interview with the cook on 03/03/22 at 9:30am revealed:
-When she previously worked at the facility, she was required to complete a COVID-19 screening questionnaire and check her temperature prior to beginning her shift.
-She returned to the facility to work in September 2021 and had not been instructed to complete a COVID-19 screening log or check her temperature.

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-She had checked her temperature prior to the beginning of each shift since September 2021 to ensure she did not have a fever before working with residents but did not document the information anywhere.
-It was important to screen and ensure she did not have a fever before her shift, so she did not risk contamination, or making other staff members and the residents sick.

Interview with a personal care aide (PCA) on 03/03/22 at 3:24pm revealed:
-She was expected to complete a COVID-19 questionnaire and temperature screening at the beginning of her shift.
-She was instructed to complete the screening upon hire on 02/15/22 from the Administrator.
-It was important to complete the screening to ensure she kept other staff and the residents safe from contamination and pathogens that could make them sick.

Interview with the lead medication aide (MA) on the SCU on 03/03/22 at 3:45pm revealed:
-All staff were required to complete a self-screening at the beginning of each shift including symptoms of COVID-19 and a temperature check.
-The self-screening was logged into the book by the staff at the front desk.
-Staff received training on screening prior to the start of the COVID-19 pandemic in early 2020.
-Staff were aware when they had symptoms not to come into work, so the self-screening slowed down as of lately.
-She had not documented self-screening on 03/03/22 at the start of her shift but she was not experiencing any symptoms of COVID-19.

Interview with the Resident Care Director (RCD)

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D 612	Continued From page 41 on 03/03/22 at 4:01pm revealed: -She expected all staff to complete a COVID-19 questionnaire and temperature screening and use hand sanitizer at the beginning of every shift. -It was important for the staff to complete the screening and use hand sanitizer to ensure they protected other staff and the residents from the transmission of pathogens that could make them sick and keep them safe. -Staff often notified management prior to coming to the facility if they were not feeling well. Interview with the Administrator on 03/03/22 at 8:40am revealed: -She expected all staff to complete a COVID-19 screening questionnaire and temperature screening prior to clocking in for their assigned shift and caring for residents every day. -She was not aware staff had not been screening for COVID-19 per policy on a regular basis until reviewing the book on 03/03/22. -Staff would usually call or text her prior to arriving at the facility for their scheduled shift if they were not feeling well. -It was concerning that staff were not screening as directed because the facility recently had a stomach virus that went through the facility and affected many residents approximately 2-weeks ago. -It was important for all staff to screen to protect the residents' health and safety. A second interview with the Administrator on 03/03/22 at 4:20pm revealed: -She was responsible for ensuring that staff completed the self-screening prior to their shift. -She did not have an audit process in place prior to 03/03/22 to ensure that staff completed the screening.	D 612		

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D912	Continued From page 42	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and nutrition and food service. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to provide supervision to 1 of 5 sampled residents (#3) in accordance with the facility's policies and the resident's assessed needs resulting in the resident falling 6 times since 10/22/21, with 3 of those falls being within an 11-day time frame, and the last fall resulting in injury. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, record reviews, and interviews the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 1 sampled residents (#3) who had an order for a mechanical soft diet. [Refer to Tag D0310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)].	D912		

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