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
	HAL092156	A. BUILDING: _____ B. WING _____	R 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on May 11, 2022 - May 12, 2022.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7, #8) observed during the medication passes including errors with inhaled medications used to treat asthma (#6), a medication used to treat constipation (#7), and a medication used to treat depression (#8); and for 1 of 5 residents sampled (#4) for record review including medications for pain, infection, sleep, anxiety, and agitation not being administered due to the medications being unavailable. The findings are: 1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00am medication pass on 05/11/22.	D 358	1. An audit on residents medications and inventory will be conducted ~~by 7/15/22.~~ on 7/13/22, by Omnicare Pharmacy. 2. Educations with clinical team members was conducted by 5/20/22 related to medication administration and regulations with documentation related to medication administration. 3. DRC/ED and or designee will review residents medications for proper administration weekly for 3 months then monthly. 4. DRC and/or designee will check all new orders to match MAR and available for administration daily effective 5/13/22. Addendum per Alison Starr-Esposito Op. Specialist on 07-05-22: Audit on Resident medications and inventory was conducted by DRC - 05/20/22 correction date MB 07/05/22	

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Kristie Dreu, ED 06/30/22
The Plan of Correction with Addendum was reviewed and acknowledged on 07/05/22. Refer to pages 1, 16 & 22. M Bennett 07/05/22.

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D 358	Continued From page 1 a. Review of Resident #6's current FL-2 dated 10/11/21 revealed: -Diagnoses included muscle weakness and type II diabetes mellitus. -There was an order for Symbicort 160-4.5mcg 2 puffs twice a day for wheezing. (Symbicort is used to treat asthma.) -There was an order for ProAir HFA 90mcg inhale 2 puffs by mouth every 6 hours as needed for wheezing. (ProAir is used to treat wheezing and shortness of breath caused by asthma. ProAir is not the same as Symbicort.) Observation of the 8:00am medication pass on 05/11/22 revealed: -The medication aide (MA) removed an inhaler from the medication cart labeled as ProAir HFA. -The MA handed the ProAir inhaler to Resident #6 who shook the inhaler briefly and administered 2 puffs at 7:44am. -Resident #6 was sitting in a chair and was not wheezing or short of breath. -Resident #6 did not request to receive the ProAir inhaler. -Resident #6 was administered ProAir HFA instead of Symbicort. -Resident #6 was not offered or administered Symbicort. Review of Resident #6's May 2022 medication administration record (MAR) revealed: -There was an entry for Symbicort 160-4.5mcg inhale 2 puffs by mouth twice daily for wheezing scheduled at 8:00am and 8:00pm. -Symbicort was documented as administered from 05/01/22 through 8:00am on 05/11/22. -There was an entry for ProAir HFA 90mcg inhale 2 puffs by mouth every 6 hours as needed for wheezing. -ProAir HFA was not documented as	D 358		

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D 358	Continued From page 2 administered in May 2022. Interview with Resident #6 on 05/11/22 at 4:21pm revealed: -She received her Symbicort inhaler twice a day to her knowledge. -She used her ProAir inhaler if she needed it in an emergency for shortness of breath. -Her asthma had not been as bad this year as in year's past. -She had not had any shortness of breath or wheezing today. Interview with the MA on 05/11/22 at 1:47pm revealed: -When he gave the ProAir inhaler to Resident #6 that morning, he thought at first it was the Symbicort inhaler. -Both inhalers were red and he did not notice the label had ProAir on it. -He had been giving Resident #6 the ProAir inhaler for about a week because he thought she was out of her Symbicort inhaler. -He thought he sent over a fax for a refill on the Symbicort sometime in the past week. -He had not noticed Resident #6 having any wheezing or shortness of breath nor had she complained of any recently. Observation of Resident #6's medications on hand on 05/11/22 at 1:47pm revealed there was a Symbicort inhaler which was labeled as opened on 04/13/22 and had at least 50 doses remaining according to the dose counter. Interview with the Director of Resident Care (DRC) on 05/11/22 at 2:05pm revealed: -The MAs were expected to read the label on the medication they were giving and make sure it matched the MAR.	D 358		

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-If the medication did not match the MAR, the MA was to notify her.

Attempted telephone interview with Resident #6's primary care provider (PCP) on 05/12/22 at 10:15am was unsuccessful.

b. Review of Resident #7's current FL-2 dated 03/28/22 revealed:
-Diagnoses included Alzheimer's Disease and gastro-esophageal reflux disease (GERD).
-Her current level of care was special care unit (SCU).
-She had an order for Miralax, mix 17 grams (g) in 4 ounces of suitable liquid and drink daily.

Review of the facility's medication management policy revealed:
-Medication omissions and/or refusals are documented on the medication administration record (MAR).
-The Director of Resident Care (DRC) is notified and the DRC assesses the resident and notifies the resident's primary care provider (PCP).

Observation of the 8:00am medication pass on 05/11/22 revealed:
-The medication aide (MA) could not find Miralax on the medication cart for Resident #7.
-The MA prepared and administered 3 pills to Resident #7 at 8:27am.
-Resident #7 did not receive her ordered dose of Miralax.

Review of Resident #7's May 2022 MAR revealed:
-There was an entry for Miralax mix 17g in 4 ounces of suitable liquid and drink by mouth every day scheduled for 8:00am.
-Miralax was documented as administered from

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05/01/22-05/07/22.
-Miralax was documented as refused on 05/08/22 and 05/09/22.
-The MA's initials were circled on 05/10/22 and 05/11/22 with no reason for the omission documented.

Interview with the MA on 05/11/22 at 1:18pm revealed:
-Resident #7 just ran out of Miralax today.
-Resident #7's Miralax was usually stored in a bottle on the medication cart.
-She noticed that the Miralax was circled on the MAR for 05/08/22 and 05/09/22 and documented as refused on those days.
-She was not sure if Resident #7's Miralax was on the medication cart yesterday, 05/10/22, or not.
-If a resident ran out of medication and it had not been received from the pharmacy after 2 to 3 days the MA would contact the pharmacy for a refill.
-The MAs should reorder a resident's Miralax when there was about a half of a bottle left.
-She had not reordered Resident #7's Miralax and she did not know if anyone else had reordered it.

Interview with a second MA on 05/12/22 at 10:21am revealed:
-Resident #7 had Miralax on the medication cart on 05/08/22 and 05/09/22 but she refused it and did not want to drink the water.
-If Resident #7 did not have Miralax on the cart he would have reordered it.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/12/22 at 9:30am revealed:
-The facility requested a refill for Resident #7's Miralax on 05/11/22 and the Miralax was dispensed and sent out to the facility that night.

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D 358	Continued From page 5 -The last time Resident #7's Miralax was dispensed prior to 05/11/22 was on 10/10/21 and the facility received a 30-day supply. -There were orders signed for Resident #7's Miralax on 02/12/22 so the resident had refills on the medication. -She was not sure where Resident #7 was getting her Miralax after 10/10/21 unless a family member brought it in for her. Telephone interview with Resident #7's family member on 05/12/22 at 11:20am revealed: -He had never brought medication into the facility for the resident. -The resident always received her medications from the facility's pharmacy. Interview with the DRC on 05/11/22 at 2:05pm revealed: -If a resident missed a dose of medication for 3 days the PCP should be notified. -The MAs reordered medications for residents. -A MA should reorder a resident's Miralax when the bottle felt light since there was no way to see how much medication was in the bottle. -She was not sure when Resident #7's Miralax was last ordered but thought it was the end of March 2022. -She was just made aware that Resident #7 was out of Miralax and it had been reordered. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. Attempted telephone interview with Resident #7's PCP on 05/12/22 at 10:15am was unsuccessful. c. Review of Resident #8's current FL-2 dated 07/15/21 revealed:	D 358		

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D 358	Continued From page 6 -Diagnoses included dementia and hypertension. -Her current level of care was special care unit (SCU). -There was an order for Zoloft 100mg take one tablet daily. (Zoloft is used to treat depression.) -There was an order for Zoloft 25mg one tablet nightly. Review of Resident #8's physician's order sheet dated 02/17/22 revealed: -There was an order to stop Zoloft 100mg one tablet and Zoloft 25mg one tablet. -There was an order to start Zoloft 100mg 1.5 tablets (150mg) daily for depression. Observation of the 8:00am medication pass on 05/11/22 revealed the medication aide (MA) prepared and administered one 100mg tablet of Zoloft to Resident #8 at 8:40am instead of one and a half tablets (150mg) as ordered. Review of Resident #8's May 2022 medication administration record (MAR) revealed: -There was an entry for Zoloft 100mg tablet, take 1.5 tablets (150mg) by mouth once a day scheduled at 8:00am. -Zoloft 150mg was documented as administered from 05/01/22-05/11/22. Observation of Resident #8's medications on hand on 05/11/22 at 1:18pm revealed: -There was a medication card dispensed on 04/20/22 and each bubble contained Zoloft 100mg one whole tablet. -There were 21 of 30 whole tablets left in the medication card. -There was a second medication card dispensed on 04/20/22 and each bubble contained Zoloft 100mg one half tablet. -There were 26 of 30 half tablets left in the	D 358		

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D 358	Continued From page 7 medication card. Interview with the MA on 05/11/22 at 1:18pm revealed: -She had not noticed on the MAR or medication label that Resident #8 was supposed to get a half tablet of Zoloft along with the whole tablet. -She had been administering one whole tablet of Zoloft 100mg to Resident #8. Interview with the Director of Resident Care (DRC) on 05/11/22 at 2:05pm revealed: -The MAs were trained to read MARs and administer medications according to the MARs and they should compare the medication label to the MAR before administering a medication to a resident. -She was concerned that Resident #8 did not receive the correct dosage of Zoloft because the resident had depression and was unable to express how she was feeling due to her dementia. Interview with Resident #8's mental health provider (MHP) on 05/12/22 at 10:18am revealed: -In February 2022, Resident #8 was crying and sleeping a lot so she increased the resident's Zoloft and discontinued another medication to help with these symptoms of depression. -The family had reported the resident seemed better since the medication changes. -The resident had less crying and was participating more in activities. -She was notified today, 05/12/22, of the medication error with Resident #8 not receiving the full amount of Zoloft as ordered. -Not receiving the full dosage of Zoloft could increase the resident's crying spells and contribute to the resident not participating in activities.	D 358		

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Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

2. Review of Resident #4's current FL-2 dated 05/11/22 revealed diagnoses included vascular dementia without behavioral disturbance, hypertension, hypothyroidism, and Vitamin D deficiency.

a. Review of Resident #4's physician's order sheet dated 09/13/21 and FL-2 dated 05/11/22 revealed an order for Trimethoprim 100mg ½ tablet (50mg) once a day. (Trimethoprim in an antibiotic used to treat and prevent urinary tract infections.)

Review of Resident #4's May 2022 medication administration record (MAR) revealed:
-There was an entry for Trimethoprim 100mg ½ tablet (50mg) once a day scheduled for 8:00am.
-Trimethoprim was documented as not administered on 05/11/22 due to awaiting delivery.
-Trimethoprim was documented as administered on 05/12/22 at 8:00am.

Observation of Resident #4's medications on hand on 05/12/22 at 3:42pm revealed there was no Trimethoprim available to be administered.

Interview with the medication aide (MA) on 05/12/22 at 3:57pm revealed:
-He documented the 8:00am dose of Resident #4's Trimethoprim was administered that morning on 05/12/22 in error.
-There was no Trimethoprim on hand to administer to Resident #4.
-He just called the pharmacy and the

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Trimethoprim would be refilled and delivered to the facility today, 05/12/22.

Telephone interview with a pharmacist at Resident #4's preferred pharmacy on 05/12/22 at 4:18pm revealed:
-Resident #4's Trimethoprim was last dispensed on 04/05/22 and it was requested by the facility to be refilled today, 05/12/22.
-There were refills available on the Trimethoprim and the facility should let him know to refill a medication before they run out.
-He would deliver the Trimethoprim to the facility that evening, 05/12/22.

Interview with the Director of Resident Care (DRC) on 05/12/22 at 3:42pm revealed:
-She was unaware Resident #4 was out of Trimethoprim.
-Resident #4 used an outside pharmacy for her medications but the MAs were still responsible for ordering refills for her medications when the supply got down to the colored strip on the medication card (8 tablets remaining).
-If a medication needed refills the MAs should contact the provider to get refills when the medication supply got down to the colored strip on the medication card.
-If the MAs were unable to get the medication from the pharmacy, the MAs should let her know.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/12/22 at 10:15am was unsuccessful.

b. Review of Resident #4's physician's order

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D 358	Continued From page 10 sheet dated 09/13/21 and current FL-2 dated 05/11/22 revealed an order for Tramadol 50mg ¼ tablet (12.5mg) twice a day. (Tramadol is a controlled substance used to treat moderate to severe pain.) Review of Resident #4's May 2022 medication administration record (MAR) revealed: -There was an entry for Tramadol 50mg ¼ tablet (12.5mg) twice a day scheduled for 8:00am and 8:00pm. -Tramadol was documented as not administered from 8:00pm on 05/10/22 - 8:00am on 05/12/22 due to awaiting delivery. Review of Resident #4's controlled substance (CS) records for Tramadol 50mg ¼ tablet revealed: -There was a supply of 30 quarter (1/4th) tablets received on 04/05//22 and administration of the first dose was on 04/25/22 and the last dose was administered on 05/10/22 at 8:11am, leaving a balance of 0. -There was no Tramadol available to administer after 8:00am on 05/10/22. Observation of Resident #4's medications on hand on 05/12/22 at 3:42pm revealed there was no Tramadol available to be administered. Telephone interview with a pharmacist at Resident #4's preferred pharmacy on 05/12/22 at 4:18pm revealed: -Resident #4's Tramadol was last dispensed on 04/04/22 and again on 05/10/22, which would be delivered today, 05/12/22. -There were refills available on the Tramadol and the facility should let him know to refill a medication before they ran out.	D 358		

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Interview with the Director of Resident Care (DRC) on 05/12/22 at 3:42pm revealed:
-She was unaware Resident #4 was out of Tramadol.
-Resident #4 used an outside pharmacy for her medications but the MAs were still responsible for ordering refills for her medications when the supply got down to the colored strip on the medication card (8 tablets remaining).
-If a medication needed refills the MAs should contact the provider to get refills when the medication supply got down to the colored strip on the medication card.
-If the MAs were unable to get the medication from the pharmacy, the MAs should let her know.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/12/22 at 10:15am was unsuccessful.

c. Review of Resident #4's physician's order sheet dated 09/13/21 revealed an order for Lorazepam 0.5mg ½ tablet (0.25mg) at bedtime. (Lorazepam is a controlled substance used to treat anxiety and agitation.)

Review of Resident #4's April 2022 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 0.5mg ½ tablet (0.25mg) at bedtime scheduled for 8:00pm.
-Lorazepam 0.5mg ½ tablet was not documented as administered from 04/04/22 - 04/11/22 due to awaiting delivery.

Review of Resident #4's controlled substance (CS) records for Lorazepam 0.5mg ½ tablet

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revealed:
-There was a supply of 30 half tablets received on 02/09/22 and administration of the first dose was on 03/05/22 and the last dose was administered on 04/03/22, leaving a balance of 0.
-The next supply of Lorazepam 0.5mg half tablets was received on 04/12/22 and the first dose was administered on 04/12/22 at 8:00pm.
-No Lorazepam 0.5mg half tablets were administered from 04/04/22 - 04/11/22, a total of 8 days.

Telephone interview with a pharmacist at Resident #4's preferred pharmacy on 05/12/22 at 4:18pm revealed:
-He thought Resident #4 was out of refills for Lorazepam 0.5mg in April 2022 but he could not recall for sure.
-The facility should let him know before a medication ran out if refills were needed.

Interview with the Director of Resident Care (DRC) on 05/12/22 at 3:42pm revealed:
-She was unaware Resident #4 ran out of Lorazepam in April 2022.
-Resident #4 used an outside pharmacy for her medications but the MAs were still responsible for ordering her medications when the supply got down to the colored strip on the medication card (8 tablets remaining).
-The Lorazepam was probably out of refills and needed a new prescription.
-The MAs should contact the provider to get a new prescription when the medication supply got down to the colored strip on the medication card.
-If the MAs were unable to get the medication from the pharmacy, the MAs should let her know.

Based on observations, interviews, and record review, it was determined that Resident #4 was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

(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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not interviewable.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/12/22 at 10:15am was unsuccessful.

d. Review of Resident #4's physician order dated 04/18/22 revealed an order for Melatonin 2mg take 1 tablet at bedtime. (Melatonin is used to help with sleep.)

Review of Resident #4's April 2022 medication administration record (MAR) revealed:
-There was a handwritten entry for Melatonin 2mg take 1 tablet at bedtime scheduled for 8:00pm.
-Documentation for Melatonin 2mg started on 04/19/22 and all initials were circled from 04/19/22 - 04/30/22 with reason not administered documented as family sent wrong dosage and awaiting family to bring the right dose.

Review of Resident #4's physician's order dated 05/02/22 revealed an order for Melatonin 3mg take 1 tablet at bedtime.

Review of Resident #4's May 2022 MAR revealed:
-There was no entry for Melatonin 2mg and no Melatonin was documented as administered on 05/01/22.
-There was a handwritten entry for Melatonin 3mg 1 tablet at bedtime scheduled for 8:00pm and it was documented as administered from 05/02/22 - 05/11/22.

Telephone interview with Resident #4's family member on 05/12/22 at 11:26am revealed:
-When the Melatonin was first ordered, she told the Director of Resident Care (DRC) that she would get the Melatonin from an online store but

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D 358	Continued From page 14 the online store did not have the correct dosage. -She went to a local retail store and bought some Melatonin and took it to the facility (could not recall date). -At some point, the order was changed but she could not recall the details. Interview with the DRC on 05/12/22 at 3:42pm revealed: -Resident #4 was having trouble sleeping so the provider ordered Melatonin 2mg in April 2022. -Resident #4's family member brought the wrong dosage to the facility. -There was a delay in starting the Melatonin because she was waiting for the family member to bring the correct dosage. -The order was changed to 3mg and she went to a local store and bought a supply of Melatonin 3mg for the resident because the family had not brought the correct dosage. -She could not explain why there was a delay in obtaining the correct dosage for the resident. -She did not usually wait for the family to bring the correct dosage that long; she usually got the medication from the facility's pharmacy if the family did not respond. Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable. Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/12/22 at 10:15am was unsuccessful.	D 358		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION	D 612		

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D 612	Continued From page 15 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: TYPE B VIOLATION 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 protect residents from infection during the global coronavirus (COVID-19) pandemic as related to the screening of staff and visitors and staff not wearing face masks while on duty. The findings are: Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel (HCP) during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify	D 612	10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM Community Leadership immediately reimplemented screening of all visitors and all staff, as well as use of masks for visitors and staff. Corrected during Survey on May 10, 2022. Executive Director or Designee will be responsible to monitoring for compliance with screening and mask wearing. 07/05/22 Correction date: 05/13/22 Addendum per A. Starr-Esposito on 07/05/22.	

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D 612	Continued From page 16	D 612		

anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection.
-The options could include (but were not limited to): individual screening upon arrival to the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
-Source control measures were to be implemented for HCP.
-Source control referred to the use of a well-fitting face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.
-Fully vaccinated HCP should wear source control (face mask) when they were in areas of the facility where they could encounter residents.
-The face mask should cover the nose and mouth.

Review of the Department of Health and Human Services (DHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed:
-Facilities should continue to screen all who enter for visitation. Individuals describing new onset of mild symptoms should be excluded from visitation, as even mild symptoms may be a sign of COVID-19 infection.
-Visitors should wear face coverings or masks when around other residents or healthcare personnel, regardless of vaccination status.

Review of a fax sent to all adult care home (ACH) and family care home (FCH) providers on 02/14/22 at 10:45am revealed ACHs and FCHs are required to adhere to the guidance dated

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D 612	Continued From page 17 02/10/22 in accordance with N.C. G.S. 131D-4.4A and rules 10A NCAC 13F .1801/.1802 (ACH) and 10A NCAC 13G .1701/.1702 (FCH). Review of the facility's current license for 2022 revealed the capacity was 97 which included a 16 bed special care unit (SCU). Review of the facility's Procedure titled Coronavirus (COVID-19) with an effective date of 05/01/22 revealed: -The procedure provided guidelines regarding symptoms of COVID-19, criteria for potential suspicion of a case of COVID-19 and management processes when a suspected or confirmed case was identified. -It was reasonable to suspect a case of COVID-19 if a resident or staff exhibited symptoms and tested negative for other respiratory illnesses, were asymptomatic and had close contact with at-risk individuals or individuals confirmed with COVID-19 or had symptoms and had close contact with at-risk individuals or individuals confirmed with COVID-19. -Close contact was defined as "being within approximately 6 feet (2 meters) of an individual confirmed with COVID-19 for a prolonged period of time (defined as a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated)" and/or "having direct contact with infectious secretions of an individual confirmed with COVID-19". -The community is considered "fully open" if there had been no resident or staff member COVID-19 cases in the last 14 days and a low or moderate community transmission rate according to the CDC's COVID-19 data tracker website.	D 612		

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D 612	Continued From page 18 -When the community status was "fully open", mask use was optional for fully vaccinated staff and required for staff that were unvaccinated. -The procedure did not outline procedure for screening of staff, residents or visitors for symptoms and/or exposure to COVID-19. Observation of entrance into the facility on 05/10/22 at 11:15am revealed: -There were no signs posted to instruct visitors to screen or wear a mask inside the facility. -There was no table set up for screening of visitors prior to entering the community. -The receptionist was sitting at the front desk inside the lobby without a mask. Interview with the Director of Resident Care (DRC) on 05/10/22 at 11:15 revealed there was no screening for visitors because the facility had reached the required percentage of residents that were vaccinated, but she was not sure what the percentage was. Observation of the SCU dining room on 05/10/22 from 12:08pm - 12:28pm revealed: -There were 3 staff assisting residents in the dining room, including 2 personal care aides (PCAs) and the SCU Director. -One of the PCAs and the SCU Director were not wearing masks. -The PCA, who was not wearing a mask, prepared and served liquids and plates to the residents; assisted residents with cutting up food; and provided feeding assistance to a resident while sitting next to the resident at eye level. -The SCU Director, who was not wearing a mask, prepared and served liquids and plates to the residents, physically assisted residents to their seats, and assisted residents with cutting up food.	D 612		

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D 612	Continued From page 19 Interview with the SCU Director on 05/10/22 at 1:05pm revealed: -She was not wearing a mask because it was staff's choice if they wore a mask if they were fully vaccinated including the booster. -This started about 2 weeks ago and prior to that all staff wore masks. Observation of the first floor dining room on 05/10/22 at 12:16pm revealed: -There was a personal care aide (PCA) walking around with a medical mask that was pulled down under her chin. -A second PCA was not wearing a face mask while seated next to a resident to assist with feeding. Interview with the PCAs on 05/10/22 at 12:16pm revealed they were not wearing facemasks because they were optional and not required. Observation of a family member visiting with a resident on the 200 hall on 05/10/22 at 12:20pm revealed the family member was not wearing a face mask. Observation of the 300 hall on 05/10/22 at 1:35pm revealed a visiting family member exited the elevator and was not wearing a facemask. Interview with the Interim Administrator on 05/10/22 at 2:17pm revealed: -As of 04/29/22 per guidance they received from their corporate office, face masks were optional for staff and visitors. -DHHS guidelines had been reviewed and the guidelines stated face masks "should be" worn so it was understood to be a recommendation but not a requirement. -The facility also stopped screening staff and	D 612		

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D 612	Continued From page 20 visitors last week because the guidance stated "should" and did not state "must". -All staff and residents were fully vaccinated. -January 2022 was the last time there was COVID-19 positive persons in the facility but she did not state if it was staff or resident(s). Interview with the communicable disease nurse at the local health department on 05/11/22 at 9:33am revealed: -The county in which the facility operated had rising transmission rates of COVID-19. -He expected the facility to be screening staff and visitors prior to entering the facility. -Staff and visitors should be wearing facemasks while in the facility. -Staff and visitors had increased exposure to COVID-19 because they were out in the public community and could introduce the virus into the facility and infect the residents. The facility failed to maintain the recommendations established by the CDC and the NC DHHS for the screening of staff and visitors and staff wearing personal protective equipment appropriately. The facility's failure to follow the guidance related to infection prevention for COVID-19 placed the residents at risk for increased transmission for the virus to spread. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED June 26, 2022.	D 612		

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D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection prevention and control program. The findings are: 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 protect residents from infection during the global coronavirus (COVID-19) pandemic as related to the screening of staff and visitors and staff not wearing face masks while on duty. [Refer to Tag D612 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)].	D912	G.S. 131D-21(2) Declaration of Residents' Rights Community Leadership immediately reimplemented screening of all visitors and all staff, as well as use of masks for visitors and staff. Corrected during Survey on May 10, 2022. Executive Director or Designee will be responsible to monitoring for compliance with screening and mask wearing. Correction date: 05/13/22 MBorlase 07/05/22 Addendum per A. Starr-Esposito, QS on 07/05/22.	