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ABSOLUTE CARE ASSISTED LIVING II	431 JUNNY ROAD ANGIER, NC 27501

(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 06/15/22 - 06/16/22.	D 000		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on record reviews, interviews, and observations, the facility failed to ensure 11 of 11 residents were offered activities designed to promote the residents' active involvement. The findings are: Review of the activities calendar posted in the main hallway on 06/15/22 at 10:45am revealed an activities calendar dated June 2022. Interview with the first resident on 06/15/22 at 9:10am revealed: -He lived in the facility for less than a year. -Activities were not offered to the residents. -Most of the residents sat in the day room and watched television (TV) all day. -If a resident did not like to watch TV, he was "out	D 315		

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D 315	Continued From page 1	D 315		

of luck."
-He did not know what activities would interest him because he did not know what was available for him to do.

Interview with a second resident on 06/15/22 at 9:32am revealed:
-The facility sometimes had church services in a sister facility next door on campus.
-He usually exercised on his own.
-He was not aware of any other activities available to residents.
-He got bored sometimes at the facility.

Interview with a third resident on 06/15/22 at 9:35am revealed:
-Activities were not offered all the time.
-He would look at the activities calendar and see things he may want to try but did not know where the activity was held or how to attend the activity.
-He could not remember which activities he would like to attend.
-He would watch TV or go outside to the porch throughout the day because there was nothing for him to do.

Interview with a fourth resident on 06/15/22 at 9:45am revealed:
-They used to play bingo but they had not done that "in a while" (could not give specific time frame).
-He usually exercised on his own during the day.
-He was not aware of any activities available to the residents.

Interview with a fifth resident on 06/15/22 at 10:45am revealed:
-There were no activities offered to the residents.
-He usually watched TV or played solitaire to keep himself busy.

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D 315	Continued From page 2 -He enjoyed playing cards. Review of the June 2022 activities calendar for 06/16/22 revealed: -There was a "Morning News" activity scheduled from 10:00am - 11:00am. -Bingo was scheduled from 2:00pm - 4:00pm. Observations of the facility on 06/16/22 from 09:00am to 6:45pm revealed: -No activities were offered to the residents that day. -There were 3 residents seated in the day room watching TV throughout the day. -Staff on duty had not conducted or offered to facilitate the "Morning News" activity scheduled for 10:00am or the Bingo activity scheduled for 2:00pm. Interview with the first resident on 06/16/22 at 11:57am revealed there was no activity done that morning. Interview with the fifth resident on 06/16/22 at 11:57am revealed: -The "Morning News" activity nor any other activity had been done. -He did not know what the "Morning News" activity entailed. Interview with the fourth resident on 06/16/22 at 12:04pm revealed: -He did not know what the "Morning News" activity was. -There was no activity done that morning. Interview with a sixth resident on 06/16/22 at 12:04pm revealed no "Morning News" activity or any other activity had been initiated by staff.	D 315		

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Interview with a medication aide (MA) on 06/15/22 at 8:54am revealed:
-She did not provide or facilitate activities while working in the facility.
-The Activity Director (AD) was responsible for providing activities.
-The AD was not currently in the facility.

Interview with the AD on 06/15/22 at 10:27am revealed:
-The activities calendar was used for all four facilities on campus.
-She usually worked on Mondays - Fridays from 9:00am - 5:00pm.
-She was responsible for activities for all four facilities on the campus.
-The activities calendar did not specify the facility or location of the activity scheduled.
-Activities were conducted by staff on duty in the facility when she was off during the week and on weekends.
-When she was not available, the staff on duty in the facility were supposed to look at the activities calendar and take control of conducting those activities.
-If there was a major activity on the weekends, such as a cook-out, she would come to the facility herself to lead the activity.

Attempted second interview with the AD on 06/16/22 at 5:07pm was unsuccessful.

Interview with the Administrator on 06/16/22 at 6:08pm revealed:
-Activities were supposed to be completed based upon the activities calendar.
-All staff on duty in the facility, including the MAs, were responsible for facilitating activities when the AD was not in the facility.
-All staff had been trained by herself, the

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D 315	Continued From page 4 Resident Care Coordinator, and the Administrator-in-Charge that all staff were responsible to provide activities when the AD was not in the facility.	D 315		
D 329	10A NCAC 13F .0907(a)(b) Respite Care 10A NCAC 13F .0907 Respite Care (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to an adult care home on a temporary basis for temporary caregiver relief, not to exceed 30 days. (b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0702, .0704(b), .0801, .0802 and .1201. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure respite care services did not exceed 30 days for 1 of 1 respite residents (#1) residing in the facility. The findings are: Review of the facility's current census report dated 06/15/22 revealed Resident #1 was a respite resident. Review of Resident #1's Face Sheet revealed the resident was admitted to the facility from a hospital on 03/23/22. Review of Resident #1's current FL-2 dated 03/23/22 revealed: -Diagnoses included decompensated liver cirrhosis and severe protein-calorie malnutrition. -The resident's documented level of care was	D 329		

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D 329	Continued From page 5	D 329		

assisted living.
-Documentation on the FL-2 noted to see discharge summary.

Review of Resident #1's hospital discharge summary dated 03/23/22 revealed:
-The resident was admitted to the hospital on 02/12/22 and was discharged on 03/23/22.
-The discharge diagnoses included decompensated liver cirrhosis with refractory ascites, esophageal varices, gastrointestinal bleed, hepatic encephalopathy, hypotension, chronic anemia, hyponatremia, and severe protein-calorie malnutrition.
-The resident was being discharged to a medical respite bed.

Review of Resident #1's Resident Register revealed:
-The resident's date of admission was 03/23/22.
-The resident was admitted to the facility from a hospital.

Review of Resident #1's assessment and care plan dated 04/29/22 revealed:
-The resident was admitted to the facility on 03/23/22 from a hospital through the hospital's respite program.
-The resident was currently receiving hospice services due to a decline in health.
-The resident required limited assistance by staff with ambulation, dressing, and transferring.
-The resident required extensive assistance by staff with eating, toileting, bathing, and grooming.
-The resident was non-ambulatory and used a wheelchair.
-The resident was oriented and his memory was adequate.

Review of Resident #1's Medical Respite Referral

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D 329	Continued From page 6	D 329		

form with a revision date of 03/25/21 revealed:
-The hospital had contracted with the facility to provide medical respite beds.
-The medical respite facility would be staffed 24 hours a day, 7 days per week.
-The facility staff would provide meals, activities of daily living support, administering of medications, and transportation to medical appointments.
-The resident was a patient of the hospital.
-The resident agreed to participate in the medical respite home referral.
-The resident understood this was short term, recuperative care placement (approximately 14 days).
-The resident was able to articulate a plan for post respite home placement.
-The resident agreed to working with the case management team to ensure the resident executed a plan for post respite home placement.
-The resident was aware of the location of the facility.

Review of Resident #1's Consent for Participation form dated 03/23/22 revealed the resident signed and consented to participate with the facility to provide short term respite care services.

Review of Resident #1's hospice note dated 04/15/22 revealed the resident was admitted to hospice services on 04/15/22.

Interview with Resident #1 on 06/15/22 at 10:38am revealed:
-He was not sure how long he had lived at the facility.
-He did not know how long he would be at the facility.
-The plan was for him to feel good and go back to work.

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D 329	Continued From page 7 Interviews with the Administrator-in-Charge (AIC) on 06/16/22 at 11:30am and 5:10pm revealed: -Resident #1 was admitted as a respite resident on 03/23/22. -She was aware respite care was supposed to be no longer than 30 days according to the rules. -Resident #1 was originally supposed to be admitted to the facility as respite care to recover after surgery. -The resident's initial discharge date from the facility was supposed to be 05/03/22. -The resident was unable to have the surgery due to his condition and then the resident started receiving hospice services. -The facility had no plans to discharge the resident and there had been no discussions to admit the resident as a permanent resident to the facility. -The resident was still respite and continued to be funded through the hospital respite program. -She thought the resident was still at the facility because he was currently a hospice resident. Telephone interview with Resident #1's hospital respite case worker on 06/16/22 at 1:57pm revealed: -Resident #1 was currently still receiving respite services and there was no date to discharge the resident from the facility because he was receiving hospice services. -The hospital respite team re-evaluated respite residents each week to continue to provide funding for respite care. -The facility had not discussed any concerns with her about providing respite services to the resident for more than 30 days.	D 329		

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D 333	Continued From page 8	D 333		
D 333	10A NCAC 13F .0907 (f) Respite Care 10A NCAC 13F .0907 Respite Care (f) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0703 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure 1 of 1 respite residents (#1) residing in the facility had been tested for tuberculosis (TB) disease in accordance with the rule. The findings are: Review of the facility's Admission Policies (no date) revealed: -Prior to admission to the facility, each resident should be tested for a first step tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. -The second step would be completed 2 to 3 weeks after the first step TB skin test was read.	D 333		

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D 333	Continued From page 9	D 333		

Review of the facility's current census report dated 06/15/22 revealed Resident #1 was a respite resident.

Review of Resident #1's current FL-2 dated 03/23/22 revealed diagnoses included decompensated liver cirrhosis and severe protein-calorie malnutrition.

Review of Resident #1's Resident Register revealed:
-The resident's date of admission was 03/23/22.
-The resident was admitted to the facility from a hospital.

Review of Resident #1's hospital discharge summary dated 03/23/22 revealed:
-The resident was admitted to the hospital on 02/12/22 and was discharged on 03/23/22.
-The resident was being discharged to a medical respite bed.
-The resident's chest x-ray was negative for signs of TB on 03/22/22.
-There was no documentation of a history of a positive TB skin test, an allergy to TB skin test, or refusal of a TB skin test.
-There was no documentation of any TB skin tests for the resident.

Review of Resident #1's record revealed:
-The resident had a chest x-ray on 03/22/22 to evaluate for TB and no evidence of TB disease was documented on 03/23/22.
-There was no documentation the resident had a history of a positive TB skin test, an allergy to TB skin test, or refusal of a TB skin test.
-There was no documentation of any TB skin tests for Resident #1.

Interview with Resident #1 on 06/15/22 at

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D 333	Continued From page 10 10:38am revealed he was unable to provide any information regarding TB testing. Interview with the Administrator on 06/16/22 at 3:14pm revealed: -Chest x-rays were usually done if there was a history of a positive TB skin test or if a resident refused a TB skin test. -Resident #1 was a respite resident and the facility had not had any TB skin tests completed for Resident #1. -Resident #1 had a chest x-ray from the hospital when he was admitted to the facility. -She did not know if Resident #1 had a history of a positive TB skin test or if he had any TB skin tests prior to admission to the facility. Telephone interview with Resident #1's hospital respite case worker on 06/16/22 at 1:57pm revealed: -Resident #1 was currently still receiving respite services and there was no date to discharge the resident from the facility because he was receiving hospice services. -The resident had a chest x-ray to rule out TB disease before he was discharged from the hospital on 03/23/22. -When placing a resident in respite care, the hospital usually did a chest x-ray initially instead of TB skin tests because the placement usually needed to be done immediately and there would not be enough time to place a TB skin test and have it read 2 days later. Interview with the Administrator-in-Charge (AIC) on 06/16/22 at 5:10pm revealed: -Any newly admitted resident to the facility was required to have a two-step TB skin test, including residents receiving respite care. -She did not know why TB skin tests had not	D 333		

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D 333	Continued From page 11 been completed for Resident #1.	D 333		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1, #3) including orders for two diuretics used treat excess fluid for a resident with liver disease (#1), two oral inhalers used to treat lung disease and breathing problems (#3). and a medication used to prevent heart disease (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/23/22 revealed diagnoses included decompensated liver cirrhosis (scarred, damaged liver) and diuretic resistant ascites (abnormal build up of fluid in the abdomen that may be cause by liver disease).	D 344		

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D 344	Continued From page 12 Review of Resident #1's hospital discharge summary dated 06/02/22 revealed: -The resident was admitted to the hospital on 05/31/22 with distended abdomen and in need of paracentesis (a procedure used to remove excess fluid from the abdomen). -Paracentesis was performed with removal of 4.1 liters of fluid. -There was a new medication order for Spironolactone 50mg 1 tablet daily. (Spironolactone is a diuretic used to treat fluid retention/excess fluid in the body.) -There was a new medication order for Furosemide 20mg 1 tablet daily. (Furosemide is a diuretic used to treat fluid retention/excess fluid in the body.) -The resident was to take these two medications for management of liver disease. Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -There was no entry for Spironolactone. -There was no entry for Furosemide. Observation of Resident #1's medications on hand on 06/16/22 at 3:35pm revealed there was no Spironolactone or Furosemide available for administration. Interview with the Administrator-in-Charge (AIC) on 06/16/22 at 5:10pm revealed: -If a resident's orders on a hospital discharge summary did not match the orders they were previously taking, she or the Resident Care Coordinator (RCC) were responsible for clarifying the orders. -She overlooked the orders for Spironolactone and Furosemide on Resident #1's hospital	D 344		

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discharge summary dated 06/02/22.
-The orders should have been clarified with the resident's hospice provider since the resident did not have orders for those medications prior to the hospitalization on 05/31/22.

Telephone interview with Resident #1's hospice nurse on 06/16/22 at 4:31pm revealed:
-Resident #1 had liver cirrhosis and required weekly paracentesis procedures to remove the excess fluid build up from his abdomen.
-She was not aware of the orders for Spironolactone and Furosemide from Resident #1's hospital discharge on 06/02/22.
-The facility should have contacted hospice when they received the orders to clarify so the hospice provider could determine if the resident needed those medications.
-The hospice team had discussed starting Resident #1 on Spironolactone and Furosemide in the past due to the build up of fluid in his abdomen but decided not to order those medications because of concerns about the resident's blood pressure dropping too low.
-The resident probably did not need to be receiving Spironolactone and Furosemide because the resident currently still had issues with low blood pressure.

2. Review of Resident #3's current FL-2 dated 03/08/22 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, and congestive heart failure.

a. Review of Resident #3's current FL-2 dated 03/08/22 revealed an order for Aspirin 81mg once a day. (Aspirin is used to prevent heart disease.)

Review of Resident #3's hospital discharge summary dated 03/09/22 revealed:

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-It was electronically signed by the provider on 03/09/22.
-The discharge summary did not include orders for Aspirin 81mg.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed there was no entry for Aspirin 81 mg.

Review of Resident #3's May 2022 eMAR revealed there was no entry for Aspirin 81 mg.

Review of Resident #3's June 2022 eMAR revealed there was no entry for Aspirin 81 mg.

Interview with a medication aide (MA) on 06/16/22 at 12:16pm revealed Resident #3 was not receiving Aspirin.

Interview with the Administrator-in-Charge (AIC) on 06/16/22 at 5:14pm revealed:
-The hospital discharge summary was used as physician orders when Resident #3 was readmitted.
-She was not aware the FL-2 dated 03/08/22 included an order for Aspirin and she was not sure if the primary care provider (PCP) wanted Resident #3 to receive Aspirin daily.
-The medication orders should be clarified with the PCP by the MA or herself when there was a question about what medication to administer.

Attempted telephone interview with Resident #3's PCP on 06/16/22 at 2:19pm was unsuccessful.

b. Review of a letter dated 08/15/21 from Resident #3's primary care provider (PCP) and outside pharmacy provider revealed:
-The resident was currently receiving Symbicort. (Symbicort is an inhaler used to treat chronic

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obstructive pulmonary disease (COPD) and asthma.)
-Resident #3's Symbicort was being switched to Wixela. (Wixela is an inhaler used to treat COPD and asthma. Symbicort and Wixela were not the same.)
-The resident's PCP had been notified by the pharmacy of the change and when it was time for the next prescription for Symbicort, the resident would receive Wixela instead.
-Directions on how to use the new inhaler would be included.

Review of Resident #3's current FL-2 dated 03/08/22 revealed:
-Resident #3 was constantly disoriented.
-There was an order for Symbicort 160-4.5mcg inhale 2 puffs twice a day.

Review of Resident #3's hospital discharge summary dated 03/09/22 revealed:
-Resident #3 was admitted to the hospital on 03/03/22 for altered mental status due to low oxygen levels and respiratory failure.
-The discharge medication orders included an order for Symbicort 160-4.5mcg two puffs twice a day.
-The discharge summary was electronically signed by the provider on 03/09/22.

Review of Resident #3's progress notes and physician's orders revealed no documentation the resident's PCP had been contacted to clarify if the resident was to receive Wixela or Symbicort.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs 2 times a day for COPD scheduled

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for 8:00am and 8:00pm.
-Symbicort was documented as administered daily in April 2022.
-There was no entry for Wixela.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs 2 times a day for COPD scheduled for 8:00am and 8:00pm.
-Symbicort was documented as administered daily in May 2022.
-There was no entry for Wixela.

Review of Resident #3's June 2022 eMAR revealed:
-There was an entry for Symbicort 160-4.5mcg inhale 2 puffs 2 times a day for COPD scheduled for 8:00am and 8:00pm.
-The entry for Symbicort 160-4.5 was documented as "medication not at the facility" from 06/01/22 - 06/05/22.
-Documentation for Symbicort was blank after 06/05/22 with no reasons documented.
-There was no entry for Wixela.

Review of Resident #3's progress notes revealed:
-On 06/01/22, the Administrator-in-Charge (AIC) documented Resident #3's Symbicort had not arrived in the mail from the pharmacy.
-She called the pharmacy to see when it would be delivered and was told it needed to be re-ordered from the physician.
-An undated note by the AIC documented she emailed Resident #3's PCP to request a refill on the medication or to discontinue the medication if he would not order a refill.
-On 06/07/22, the AIC called the pharmacy and was told Symbicort was not on Resident #3's medication profile and therefore could not be

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refilled.
-There were no progress notes related to clarifying whether Resident #3 was to receive Symbicort or Wixela after 06/07/22.

Interview with a medication aide (MA) on 06/16/22 at 12:16pm revealed:
-Resident #3 did not use the facility's contracted pharmacy or the PCP who visited the facility.
-She thought Resident #3's Symbicort was discontinued on 06/15/22 but she had not spoken with the PCP or the pharmacy.
-She believed the AIC had contacted the PCP and had gone to get the order from the PCP.

Interview with Resident #3's family member on 06/16/22 at 4:08pm revealed:
-He assisted the facility to obtain Resident #3's medications when needed.
-He had gone to the PCP's medical center / pharmacy provider office the day before due to one of Resident #3's inhalers needing to be refilled (he could not remember the name of the medication).
-He was told the inhaler he asked about had been discontinued and changed to another prescription.
-The prescription for the other ordered inhaler to replace the Symbicort had expired, so the PCP would have to write a new prescription for the replacement inhaler.

Interview with the AIC on 06/16/22 at 5:14pm revealed:
-Resident #3 did not use the facility's contracted pharmacy or the facility's contracted PCP but used an outside pharmacy and PCP clinic which could make it difficult to clarify and order medications.
-The hospital discharge summary was used as

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physician orders when Resident #3 returned from the hospital.
-The pharmacy had sent enough Symbicort to continue to give Resident #3 the medication until the end of May 2022.
-She was not aware the Symbicort had been changed to Wixela until Resident #3 needed a refill.
-When a resident returned from the hospital, a copy of the FL-2 and/or discharge summary would be sent with the resident to the next PCP appointment so the medications could be clarified and verified.
-Resident #3 had an appointment with his PCP on 04/01/22 but she was not sure if the FL-2 or discharge summary paperwork was sent with the resident.
-She had been notified by the MA in May 2022 that the resident would be out of Symbicort on 06/01/22.
-She attempted to call Resident #3's outside pharmacy and was notified that Symbicort was no longer on Resident #3's profile and a new order was needed.
-She attempted to contact Resident#3's PCP for a new order or for an order to discontinue Symbicort.
-No order had been provided by the pharmacy or the PCP about the change from Symbicort to Wixela.
-Medication orders should be clarified with the provider by the MA or herself when there was a question about what medication to administer.

Attempted telephone interview with Resident #3's PCP on 06/16/22 at 2:19pm was unsuccessful.

Attempted telephone interview with Resident #3's pharmacy provider on 06/16/22 at 2:23pm was unsuccessful.

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D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to 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	D 612		

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D 612	Continued From page 20 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify 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 were 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)	D 612		

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D 612	Continued From page 21 and family care home (FCH) providers on 02/14/22 at 10:45am revealed ACHs and FCHs were required to adhere to the guidance dated 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 12 residents. Review of the facility's census report dated 06/15/22 revealed the current census was 11 residents. Review of the facility's undated COVID-19 Policy revealed: -All medical providers and facility employees must do a COVID-19 screening and have their temperature checked every time they entered the facility. -Facility staff and medical professionals were prohibited from entering the facility if they were sick. -Temperature and COVID-19 questionnaire should be completed daily on all staff and medical providers before each shift upon entering the facility. -All medical providers and facility staff should wear a face covering anytime in the facility, unless he/she were eating. -Staff would practice social distancing at all times. -The facility would continue to follow the guidance of the CDC and the local health department. Observation on 06/15/22 at 8:43am while walking from the parking lot to the facility entrance revealed the dietary cook exited the side door of the facility pushing a heated food cart and she was not wearing a mask.	D 612		

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D 612	Continued From page 22 Observation of entrance into the facility on 06/15/22 at 8:45am revealed: -There was a sign posted outside on the window beside the door with the following instructions: for the health and safety of everyone, please wear a mask. -There were no signs posted outside or inside to instruct visitors to screen for COVID-19. -There was no table set up for screening of visitors prior to entering the facility. -There were 8 residents in the dining room eating breakfast. Observation in the facility on 06/15/22 from 8:48am - 8:54am revealed: -The medication aide (MA) entered the facility via the exit door near the kitchen and walked down the hallway with no face mask. -The MA stated she had to go to a sister facility on campus to get a face mask. -The MA exited the front door of the facility and walked across the yard to another building. -At 8:54am, the MA returned through the front entrance wearing a face mask. -The MA did not offer or instruct the surveyors to screen with a questionnaire or take their temperatures. Observation of the dietary cook on 06/15/22 at 8:59am revealed: -The dietary cook entered the front door of the facility walked through the living room with residents and into the activity room. -The dietary cook retrieved two packages of frozen meat from a freezer in the activity room and walked back through the living room with residents and out the front door. -The dietary cook was not wearing a face mask. Interview with the Resident Care Coordinator	D 612		

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(RCC) on 06/15/22 at 9:51am revealed:
-All staff should wear a face mask at all times.
-Face masks were either stored in the medication room in the facility or in the main office building on campus.
-All staff had face masks and face shields for when they provided personal care.

Interview with the Administrator on 06/15/22 at 10:09am revealed:
-Staff were required to wear face masks in the presence of the residents.
-Staff did not have to wear face masks if they were outside or on break.

Observation of entrance into the facility on 06/16/22 at 8:35am revealed:
-There was a sign posted outside on the window beside the door with the following instructions: for the health and safety of everyone, please wear a mask.
-There were no signs posted outside or inside to instruct visitors to screen for COVID-19.
-There was no table set up for screening of visitors prior to entering the facility.

Interview with a personal care aide (PCA) on 06/16/22 at 8:42am revealed:
-She had never screened for COVID-19 prior to starting her work shift.
-Staff had only worn face masks yesterday (06/15/22) and today (06/16/22) while the state survey team was there.

Interview with the dietary cook on 06/16/22 at 8:44am revealed:
-Staff used to screen for COVID-19 with a questionnaire and temperature check but that stopped about 6 months ago.
-Staff would screen and check their temperature

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in one facility (building #1) before going to other facilities on campus to work.
-She stopped wearing face masks about 6 months ago because she thought it was optional.

Interview with the Administrator on 06/16/22 at 8:49am revealed:
-Every visitor was supposed to be screened for COVID-19 in building #1 (the main office building) on campus.
-The signs to wear masks had been posted near the entrance of each facility since the COVID-19 pandemic started.
-There were no signs at the entrance of this facility to instruct visitors to go to building #1 to screen.
-The staff on duty in the facility should direct all visitors to building #1 to sign in and screen.
-The MAs were responsible for making sure visitors screened.
-Staff in the facility should have redirected the surveyors to building #1 to screen yesterday and today before entering the facility.
-All staff should screen before starting their shifts.
-She could not locate the staff screening forms but she would find them.

Observation of a sister facility (building #1) on campus on 06/16/22 at 8:50am revealed:
-There was a 8 ½ X 11 inch sign posted outside beside the front door with the following: all visiting personnel must report to building #1 before entering any other buildings in our community.
-The writing on the sign was not visible from the driveway or the parking lot.
-There was a visitor sign-in log with questionnaire on a table inside building #1.
-There was a digital no-touch thermometer for checking temperatures.
-Both surveyors were instructed to screen and

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D 612	Continued From page 25 check their temperatures by the Administrator. Interview with a MA on 06/16/22 at 8:56am revealed she thought she told the surveyors to go to building #1 on 06/15/22 to sign in. Interviews with the Administrator-in-Charge (AIC) on 06/16/22 at 11:20am and 5:10pm revealed: -All staff and residents were vaccinated and some had received the booster vaccination. -All visitors were screened with questionnaire and temperature checks. -All staff should wear face masks at all times and there should be a box of masks in each facility on campus. -Staff worked in various facilities on the campus and went in and out of different facilities, including this facility depending on where they were needed. -The dietary staff cooked for all facilities and served the meals to the residents in each facility, including this facility. -There was usually a MA who floated to each facility, including this facility to administer medications to the residents. -Staff were supposed to check their temperatures before starting their work shift. -Staff did not screen with the questionnaire because she was not aware they needed to and she was not aware it was in the facility's COVID-19 policy for staff to complete the questionnaire. -She did not know if anyone monitored or checked the staff temperature logs. -The resident's temperatures were checked twice a day. -There was a COVID-19 outbreak in a sister facility on campus in January or February 2022 but not in this facility.	D 612		

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D 612	Continued From page 26 Interview with the Administrator on 06/16/22 at 4:38pm revealed: -She reviewed the staff temperatures logs today and realized that some staff were not checking their temperatures before starting their shifts. -All staff were supposed to be checking their temperatures when they came into work each day. -Staff were not screening by completing the questionnaire because she did not realize they needed to and did not remember that being in the facility's COVID-19 policies. -She had been conducting monthly COVID tests on all staff and residents. -The last COVID tests were completed last month and everyone was negative. Review of the staff temperature check log for 06/15/22 and 06/16/22 revealed: -Two medication aides, the dietary cook, the AIC, and the Administrator had not documented temperatures on 06/15/22. -One MA, one PCA, the dietary cook, the AIC, and the Administrator had not documented temperatures on 06/16/22. Telephone interview with a nurse at the local health department on 06/16/22 at 9:20am revealed: -She had not given any specific instructions to the facility regarding COVID-19. -The facility was responsible for following the CDC and NC DHHS guidelines. -All staff should be wearing face masks at all times in the facility. -It was especially important for staff to wear face masks in the facility at all times because the staff went back and forth between the sister facilities on the campus which could increase the risk of spreading COVID-19.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043031	A. BUILDING: _____ B. WING _____	R 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 27 -The last COVID-19 outbreak was at a sister facility on the campus with this facility on 01/21/22 with 4 positive staff and 8 positive residents. -The outbreak status was lifted on 03/11/22. -Visitors, staff, and residents should be screened according to the guidelines. -If the facility staff was not screening or wearing masks, they were at risk for spreading COVID-19. -The county was currently in the yellow, at low risk, for COVID-19.	D 612		