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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/20/21-10/22/21.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the walls, ceilings, and floors were kept clean and in good repair as related to residents' shared bathrooms for rooms #42/#44, #43/#45, #40/41, the shower room and the exit doorways on the back hall and caulking in the front hall bathrooms. The findings are: 1. Observation on 10/20/21 at 10:10am of the resident bathroom for rooms #42/#44 revealed: -There were 7 interconnecting yellow tan water stain marks on the ceiling that circled around the smoke detector, ceiling air register and light fixture. -There was missing paint on the outer edge of the door. -There was no interior door knob.	D 074		

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D 074	Continued From page 1 Observation on 10/20/21 at 10:29am of the resident bathroom for rooms #43/#45 on revealed: -There was a 2 foot by 2 foot cut section in the sheetrock panel at the back left corner of the ceiling across from the double air register and light fixture. -There were dark gray and black stains covering 1/2 of the cut sheetrock panel on the ceiling. -There was a coating of tan dust on the air register grill.. -The ceiling light bulb did not work. Observation on 10/20/21 at 10:42 am of the resident bathroom for rooms #40/#41 revealed: -There were circles of yellow brown water stains at the back right corner, next to the air register. -There were splotches of black stains mixed in with the brown water stains. -There was a coating of yellow dust particles on the air register and smoke detector on the ceiling Observation on 10/20/21 at 3:25pm of the back hall shower room revealed: -The fiber mat covering at the entryway was torn, having jagged edges with pieces of loose mat covering scattered on the floor at the base of the doorway. -The door knobs were loose and pulled away from the door. -There was missing paint and brown and black smears on the door front panel, outside edge and inside panel. -There were dark brown and black marks on the crinkled flooring in the room. -There was a soft dip in the floor across from the shower. -The baseboard at the front edge of the shower was cracked, loose from the flooring and mottled with black dust particles	D 074		

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-The linoleum flooring at the base of the shower was cracked and pulled away from the floor.
-The air registers on the floor were rusted and had a coating of brown particles over the grills.
-The lower edge of the wall and baseboard at both ends of the bathtub was coated with brown and black particles and stains.
-There were yellow water marks on the ceiling of the shower room.

Observation on 10/20/21 at 3:37pm of the 2 back hallway exit doors revealed:
-There was no floor covering over the wood panels at the lower doors thresholds.
-The wood floors were coated with brown and black particles, chips of white paint from the door molding and dead insect body parts.
-The lower door and threshold seals were missing creating open spaces to the outdoors at the bottom edges of the doors.

Interview on 10/21/21 at 9:35am with the maintenance worker revealed:
-He worked part-time at the facility and did not have a set schedule.
-He worked at the facility when he was needed..
-He did not go into the back hall often or make repairs.
-He was not aware if anyone made rounds to check for needed repairs or cleaning on the back hall.
-When he came to work, the Manager would give him a list of work to be done.

Interview on 10/22/21 at 10/25am with the Manager revealed:
-She made rounds of the facility weekly, but had not made rounds for the last 2 weeks.
-Staff knew to inform her of any repairs to be made to resident areas.

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-Staff should have let her know there were repairs to be done in resident areas and exit doors on the back hall.
-There needed to be better communication between staff.
-The facility did not have permanent maintenance staff.
-The facility needed a full-time maintenance staff.

Interview on 10/22/21 at 10:45am with the Administrator revealed:
-There was no permanent staff for maintenance.
-There needed to be better comunication between staff for notifying the Manager of needed repairs.
-There needed to be a full-time maintenance and housekeeping staff.
-Current staff needed more training on observation of needs for maintenance and cleaning.

2. Observations of the front hallway bathrooms on 10/20/21 from 1:03pm-1:13pm revealed the caulking above the bathtubs and showers was cracked and pulling away from the wall.

Interview with the maintenance worker on 10/20/21 at 3:27pm revealed:
-He was an independent contractor.
-The owner or the Manager contacted him when repairs were needed at the facility.

Interview on 10/22/21 at 2:10pm with the maintenance worker revealed:
-He did not routinely conduct walk-through inspections to see if there were any areas needing maintenance.
-The Manager had never asked him to walk around the facility to see if there were any areas needing maintenance.

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-He did not perform any "major or complicated" repairs around the facility.
-He had not been directed to replace the caulking in the front hall bathrooms.

Interview on 10/22/21 at 3:08pm with the Manager revealed:
-There had not been a maintenance worker on staff since February or March 2021.
-She usually walked throughout the building weekly but had not done so for the past two weeks.
-There was no particular employee assigned to walk through the facility to see if there were any needed repairs.
-She routinely told staff to let her know if anything was broken or needed repair.
-The personal care aides (PCA) should notice any areas that need to be repaired.
-The PCA was supposed to report any areas of concern to the shift supervisor.
-The shift supervisor was expected to report to the Resident Care Coordinator (RCC), and the RCC was supposed to report to her.

Interview on 10/22/21 at 4:08pm with the Administrator revealed:
-The Manager was responsible for conducting walk-throughs in the facility to check for needed repairs.
-Before the coronavirus (COVID-19) pandemic, there was a maintenance worker who would complete walk-throughs in the facility.
-He did not know the tub and shower caulking needed to be replaced.
-He walked through the building "every once in a while," checking for water leaks or stopped-up toilets.
-He depended on staff to inform him of any needed maintenance or repairs.

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D 074	Continued From page 5 -If the procedure would have been followed, he would have been informed of the needed repairs. -He routinely met with the co-owner, the RCC, and the Manager to discuss any concerns that had been reported. -The Manager was ultimately responsible for compliance in the facility.	D 074		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the plumbing equipment was maintained in a safe and operating condition related to water pressure in the bathroom. The findings are: Observation of the left front hall bathroom on 10/20/21 at 1:10pm revealed the water flowed out of both sinks in a thin stream. Observations of the left front hall bathroom on 10/21/21 at 7:39am and 4:45pm revealed the water flowed out of both sinks in a thin stream. Interview on 10/20/21 at 3:27pm with the maintenance worker revealed he thought the low water pressure was caused by water being used in another area of the facility at the same time. Interview on 10/22/21 at 8:47am with a resident	D 105		

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revealed she did not remember the water flow in the front left hall bathroom ever being stronger.

Interview on 10/22/21 at 8:53am with a second resident revealed there was "hardly any water flowing" from the sink in the front left hall bathroom.

Interview on 10/22/21 at 8:58am with a third resident revealed:
-The water pressure in the front hall bathroom had always been low.
-She needed to "be patient" while she waited for her cup to fill when she used the sink in the bathroom.
-She did not know to whom she would report the low water pressure.

Interview on 10/22/21 at 9:04am with a fourth resident revealed:
-The water pressure was "very low' in the left front hall bathroom sinks.
-She did not let anyone know about the low water pressure.
-She did not know whom she should tell about the water pressure.
-She kept the water running until she "got what I needed."

Interview on 10/22/21 at 2:10pm with the maintenance worker revealed:
-He did not routinely conduct walk-through inspections to see if there were any areas needing maintenance.
-The Manager had never asked him to walk around the facility to see if there were any areas needing maintenance.

Interview on 10/22/21 at 3:08pm with the Manager revealed:

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D 105	Continued From page 7 -She routinely told staff to let her know if anything was broken or needed repair. -She told the personal care aides (PCA) to let her know if anything needed repairs. -She and the RCC led the last Resident Council meeting in September 2021. -The residents were asked for comments during the meeting. -None of the residents reported the water pressure was low in the left front hall bathroom. Interview on 10/22/21 at 4:08pm with the Administrator revealed: -The Manager was responsible for conducting walk-throughs in the facility to check for needed repairs. -He walked through the building "every once in a while." -He was not aware of the low water pressure in the front left hall bathroom sinks before today. -He depended on staff to communicate with him about needed maintenance and repairs. -If the procedures would have been followed, he would have been informed of the needed repair. -The Manager was ultimately responsible for compliance in the facility.	D 105		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to provide personal care assistance for 1 of 6 sampled residents (#14) related to emptying of his urinal in a timely manner.

The findings are:

Review of Resident #14's current FL-2 dated 05/25/21 revealed:
-Diagnoses included lumbago with sciatica, spinal stenosis, manic depressive disorder, schizophrenia, delusional disorder, hypertension, dementia, diabetes mellitus, and chronic pain syndrome.
-Resident #14 needed assistance with bathing, feeding and dressing.

Review of Resident #14's care plan dated 10/12/21 revealed:
-Resident #14 had no licensed health professional support task listed.
-Resident #14 needed limited assistance with eating and ambulation/locomotion.
-Resident #14 was totally dependent for toileting, bathing, dressing, grooming/personal hygiene, and transferring.

Observation of Resident #14 on 10/20/21 at 10:05am revealed:
-Resident #14 was in a hospital bed and had a motorized wheelchair next to his bed.
-Resident #14 had a urinal and a soda bottle lying next to each other beside his right thigh on the bed.

Observation of Resident #14 with a personal care aide (PCA) and medication aide (MA) on

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10/22/21 at 10:52am revealed:
-Resident #14's urinal was half full of urine and he had the soda bottle beside his urinal.
-The PCA moved the urinal and soda bottle prior to rolling Resident #14 to his right side.
-Resident #14's back was moist to the touch from the middle portion of his back to his buttocks.
-The sheet below Resident #14 had a large circular light brown stain located from the edge of the bed to the middle portion of the bed.
-Resident #14 had a 4-inch circular grayish area at the lumbar area of his back with some spots of peeling skin.

Interview on 10/22/21 at 8:10am with Resident #14 revealed:
-Staff did not check on him every 2 hours.
-He was not able to walk or get out of bed.
-Prior to June 2021, he gained staff's attention by having his room door left opened about 4 inches and yelling out when staff passed the door.
-After June 2021, his new roommate did not want the door left open, so he depended on staff to check on him.
-He received a bell to use to call staff on 10/21/21 and this was the first bell he had received since his admission.
-He did not think staff could hear the bell when his door was closed or if staff were far away from his door.
-There were times in the past when he needed staff to empty his urinal because it was full.
-He had to pour some of the urine from his urinal into the soda bottle he kept.
-Staff emptied out both the urinal and the bottle when they came in to help him.
-This had occurred "a couple of times".
-He never told anyone because he thought the facility did not have enough staff.
-He thought there was one person working on the

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second shift, from 7:00pm to 7:00am.

Interview on 10/22/21 at 5:05pm with another resident revealed:
-He was Resident #14's roommate and staff did not come in to check on Resident #14 every 2 hours.
-He thought staff needed to check Resident #14 every 30 minutes because Resident #14 could not walk or get out of the bed.
-He had left the room to tell staff that Resident #14 needed assistance in the past.

Telephone interview on 10/22/21 at 2:12pm with Resident #14's primary care provider (PCP) revealed:
-Resident #14 could not walk or get himself out of bed and used a urinal for toileting.
-He required assistance with bathing, dressing, transferring, and toileting.
-She expected staff to check and turn him every 2 hours because he was bed bound.
-Her last visit with Resident #14 was in August 2021 and he had no skin breakdown at that time.
-She had not written an order to turn Resident #14 but assumed that was part of the care for a bed bound resident to prevent skin breakdown.

Interview on 10/20/21 at 4:20pm with a first shift PCA revealed:
-There was supposed to be a staff present in the lobby to supervise the residents while another staff walked the hallways and checked on residents in their rooms.
-Staff were supposed to make rounds every 2 hours for incontinent care.

Interview on 10/21/21 at 7:00am with a second shift PCA revealed:
-Staff made rounds every 1 hour or 2 hours,

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depending on the resident and checked residents to determine if incontinent care was needed.
-There was a resident who received hospice services who was checked every 30 minutes because he was bed bound.
-There were call bells in the spa bathrooms, but not in the residents' rooms.
-Many residents yelled out if they needed assistance from staff.

Interview on 10/21/21 at 7:03am with a second shift PCA revealed:
-She worked from 7:00pm to 7:00am.
-She made rounds every 2 hours to ensure residents had not fallen and to determine if residents needed anything.
-She also washed towels, wash cloths and bed linens.
-She checked on bed bound residents and she was assigned to both the front and back hallway sometimes.
-She made a round prior to going into a resident's room to perform incontinent care to ensure no one needed her immediately.
-There were call bells in the bathrooms only, not in resident rooms.
-She had not seen any call bells in resident rooms.
-Resident #14 was bed bound and all his activities of daily living were performed in his bed.

Interview on 10/20/21 at 4:25pm with a first shift MA revealed:
-Her job duties were to pass medications, obtain residents' blood pressures, ensure residents were dressed appropriately, and ensure the PCAs were doing their duties.
-There was one PCA assigned to the front hallway and one PCA assigned to the back hallway.

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-Staff made rounds every 2 hours to check residents.
-If Resident #14 needed anything, he sent his roommate out to tell staff.
-Resident #14 had a manual call bell but his roommate complained that he did not like the bell.
-The call bell was taken out of Resident #14's room by his roommate.
-Staff were supposed to walk up and down the hallway to check residents every 2 hours.

Interview on 10/21/21 at 10:42am with another MA revealed:
-She was always checking the residents and asking them if they needed something.
-She expected the PCAs to keep the resident rooms, beds and residents clean.
-She expected the PCAs to clean residents when they had odors or needed to be cleaned, not just on shower days.
-She gave Resident #14 a call bell on 10/20/21.
-She thought Resident #14 had another call bell previously that was lost or removed.
-If residents needed assistance, they called out to staff from their rooms or had their roommates come to get staff.

Interview on 10/22/21 at 9:44am with the Resident Care Coordinator (RCC) revealed:
-She expected staff to make rounds by checking residents to ensure they were clean, offered assistance with toileting, nails trimmed, groomed, dressed and all personal care offered.
-She expected staff to do an hourly round to locate residents and every 2 hours for toileting assistance.
-She told staff to specifically check on bed bound residents.
-There were currently 4 bed bound residents who

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resided in the facility.
-She walked the halls and checked on residents.
-She ensured the second shift staff were making rounds by coming into the facility during the night shift.
-She came to the facility at night on 10/12/21 at 2:00am.
-She had spoken with Resident #14 previously, but he had not told her he was having difficulty getting his urinal emptied.
-She did not know Resident #14 was not being checked every 2 hours.
-Staff went into his room to bathe him and clean him when he was soiled.
-She went shopping for him if he wanted anything from the store.
-Resident #14 had a big blue bell but his roommate removed it from the room.
-She knew Resident #14 was given a new call bell on 10/21/21.
-Resident #14 told staff what he needed when they passed by his door.
-Since Resident #14 did not have a call bell, Resident #14 had to tell staff his needs when they walked past his door.
-She was responsible for ensuring personal care was offered and given to residents in the facility.

Interview on 10/22/21 at 11:11am with the Manager revealed:
-She oversaw the staff, scheduling, admissions, staff paperwork upon hire, ordered food, and ensured residents received care.
-She expected staff to check residents every 2 hours to ensure they were safe, cleaned, assisted with toileting, groomed, rooms cleaned, and beds made.
-She expected staff to conduct hourly rounds to locate residents.
-She thought the staff knew her expectations

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because she told them her expectations.
-She expected staff to check bed bound residents and select female residents more frequently because they were not able to ambulate and obtain what they needed.
-She knew staff were checking residents because she walked the hallways and saw them entering resident rooms.
-She also came to the facility twice a month during the night shift entering at 4:00am or 6:00am.
-Resident #14 had only shared his concerns about his roommate.
-She did not know Resident #14 used a soda bottle to empty urine into when his urinal was full.
-She expected staff to assist bed bound residents with bathing, nailcare, toileting, food delivery and setup to eat the food, and hair care.
-She expected staff to change the linen any time it was soiled.
-She knew Resident #14 did not have a call bell prior to 10/21/21 but she did not tell staff to check on him more frequently.
-This lack of communication with staff was her fault and she should have told staff after Resident #14's call bell was removed by his roommate.
-The RCC and MAs were responsible for ensuring personal care was completed for all residents.

Interview on 10/22/21 at 3:38pm with the Administrator revealed:
-The Manager was designated by him to manage the facility and the care of the residents.
-He depended on her to keep him abreast of any issues within the facility.
-He expected staff to make rounds every 2 hours and as needed dependent upon the residents' needs.
-He expected staff to check bed bound residents

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D 269	Continued From page 15 based on their needs. -He thought residents who were bed bound or a falls risk should be focused on because everything had to be done for those residents. -Staff told him about Resident #14's urinal not being emptied enough so that he used a soda bottle to pour some of the urine into to prevent overflowing. -He expected residents to not lie in moisture and he thought Resident #14 should be checked more frequently. -He held the RCC and MAs responsible for ensuring residents received the personal care assistance based on their needs.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (Residents #1 and #3) related to swelling in the right leg and falls (Resident #1) and an order for eyeglasses (Resident #3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/15/21 revealed: -Diagnoses included bi-polar disorder, anxiety, mild cognitive impairment, major depressive disorder, chronic obstructive pulmonary disease (COPD), restlessness and agitation.	D 273		

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-Resident #1 was ambulatory using a wheelchair.
-She needed assistance with bathing and dressing.

Review of Resident #1's Care Plan dated 09/21/21 revealed:
-She needed extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring.
-She could become agitated, wandered and needed redirection from staff.
-Resident #1 resided in the facility's memory care unit.

Review of incident reports for Resident #1 revealed:
-On 08/06/21 the resident had redness and swelling in her right leg and was sent to the local hospital for evaluation.
There was documentation a facsimile (fax) of the report was sent to the county department of social services.
-There was no documentation the Primary Care Provider (PCP) was notified Resident #1 had swelling in her right leg and was sent to the hospital.
-On 10/16/21 the resident tried to stand and get out of her wheelchair but slid onto the floor on her buttocks.
-There was no documentation the PCP was notified Resident #1 had swelling in her right leg and was sent to the hospital on 10/16/21.
-On 10/18/21 the resident slid out of her wheelchair hitting her bottom on the floor.
-There was no documentation the PCP was notified Resident #1 fell out of her wheelchair onto the floor on 10/18/21.
-On 10/19/21 the resident tripped over her feet and fell to the floor, landing on her bottom.
-There was documentation the incident report

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was sent to the county department of social services.
-There was no documentation the PCP was notified Resident #1 fell out of her wheelchair onto the floor.

Review of Resident #1's record revealed there were no documented progress notes for Resident #1.

Attempted telephone interview on 10/22/21 at 4:40pm with Resident #1's Power of Attorney (POA) was unsuccessful.

Interview on 10/22/21 at 3:35pm with the Medication Aide (MA) revealed:
-On 10/16/21, Saturday, she was standing at the medication cart and saw Resident #1 trying to stand up from the dining room table.
-Resident #1 stood, then fell, sitting on the floor.
-She was supposed to notify Resident #1's PCP but did not call because Resident #1 did not hit her head.
-The MA wrote the incident report to give to the facility Manager.
-There was no documentation notifying Resident #1's PCP of the fall.
-The MA did not know if Resident #1's PCP was notified of the fall.

Interview on 10/22/21 at 4:15pm with the Resident Care Coordinator (RCC) revealed:
-On 10/18/21, Resident #1 was seated in her wheelchair watching television.
-The RCC heard Resident #1 "hit the floor" and saw her trying to get up.
-The RCC helped Resident #1 off the floor and seated her in her wheelchair.
-The RCC filled out an incident report to put on the Manager's desk.

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-There was no documentation on the incident report of an attempted call to Resident's PCP.
-The facility did not have a plan in place for contacting and documenting residents' PCP after an incident.
-The incident form had a signature line for the Administrator and Supervisor only.
- The MA writing the incident report documented contact on the Administrator and Supervisor lines.
-There was no space designated for contacting the PCP on the incident report.
-She did not know if the PCP wanted to be contacted when Resident #1 had falls.

Interview on 10/22/21 at 4:00pm with the Manager revealed:
-On 10/16/21 (Thursday) she was notified by the MA Resident #1 slid out of her wheelchair and fell onto the floor hitting her buttocks.
-Resident #1 appeared to have no injuries and the PCP was not contacted; the resident's vital signs were normal.
-The incident report of Resident #1's fall was given to the PCP the following Tuesday (10/21/21) on resident visit day.
-Incident reports were slid under her office door by the MA when she was not in her office.
-If a resident did not appear injured, an incident report would not be sent to the PCP.

Interview on 10/22/21 at 3:10pm with the PCP revealed:
- She made visits to the facility on Tuesdays and when called to see residents.
-Resident #1 had shortness of breath, muscle weakness, cognitive changes and was a falls risk.
-She had not received calls or incident/accident reports for Resident #1's falls on 10/16/21, 10/18/21 or 10/19/21.
- She found bruises on Resident #1's buttocks

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when she was assessed on 10/21/21.
-She did not know why she was not notified about Resident #1's falls as they happened instead of waiting to be told by the MA days or a week later.
-She carried a pager so she could be notified of any changes or incidents with her patients
-Resident #1 had repeated falls on 10/16/21, 10/18/21 and 10/19/21.
-Resident #1 would have been sent to the hospital for assessment if she had been notified of the falls as they occurred.
-The MA or RCC staff should have informed her of Resident #1's falls when they happened.

Interview on 10/22/21 at 5:30pm with the Administrator revealed:
-When a resident had a fall, the facility protocol was the MA checked their vital signs immediately and made observations of the resident, asking if they were hurt or having pain.
-After checking the resident, the MA should call the resident's responsible person and notify the PCP.
-There was no documentation of contact with the PCP on the Incident/Accident report for Resident #1's falls on 10/16/21, 10/18/21 or 10/19/21.
-There was no place on the incident reports designated for documenting contact with the PCP after Resident #1's falls.
-There was no documentation of contact with the PCP after Resident #1's falls on 10/16/21, 10/18/21 and 10/19/21.
-There was no evidence of obtaining follow-up instructions from the PCP for Resident #1's falls on 10/16/21, 10/18/21 and 10/19/21.
2. Review of Resident #3's current FL-2 dated 10/07/21 revealed diagnoses included unspecified dementia, diabetes, generalized muscle weakness, and high blood pressure.

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Review of Resident #3's record revealed she had an eye examination on 06/07/21.

Telephone interview on 10/22/21 at 10:18am with Resident #3's family member revealed:
-Resident #3 was examined by the optometrist at the facility three or four months ago and had not yet received her eyeglasses.
-She asked the Manager for Resident #3's eyeglass prescription in September 2021 so she could get eyeglasses made for Resident #3.
-She was not given the prescription; the Resident Care Coordinator (RCC) told her Resident #3's glasses would be delivered the next week.
-Resident #3 did not have eyeglasses when she visited her last week.
-She had not received any further information on the status of Resident #3's eyeglasses.

Interview on 10/22/21 at 10:48am with Resident #3 revealed:
-No one at the facility had talked with her about when she would receive her eyeglasses.
-"I need them [eyeglasses]."

Interview on 10/22/21 at 11:28am with the RCC revealed:
-The optometrist came to the facility to examine Resident #3.
-Resident #3's eyeglasses had not yet been delivered.
-She spoke with the optometrist's secretary in early October 2021 and was told the eyeglasses were delayed "for some reason."

Telephone interviews on 10/22/21 at 11:47am and 1:05pm with the optometrist revealed:
-He visited the facility every 3-4 months.
-He intended to visit the facility during the last week of October 2021.

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-He examined Resident #3 on 06/07/21 and ordered her eyeglasses on 06/09/21.
-It usually took 4-6 weeks for eyeglasses to be delivered.
-The eyeglasses were completed and shipped to him on 06/14/21.
-He normally would stop by the facility and deliver the eyeglasses to the residents.
-He may have mailed the eyeglasses to the facility.
-He had not been contacted by anyone about Resident #3 not receiving her eyeglasses.

Interview on 10/22/21 at 3:08pm with the Manager revealed:
-Resident #3 was examined at the facility by the optometrist.
-The optometrist's secretary said Resident #3's eyeglasses were on backorder.
-She had not spoken with Resident #3 or Resident #3's family member about the status of the eyeglasses.
-The RCC was more informed about this situation.
-The RCC spoke with Resident #3's family member about the eyeglasses.

Second interview on 10/22/21 at 3:50pm with the RCC revealed:
-She called the optometrist's office two weeks ago and was told the eyeglasses would be delivered by the end of October 2021.
-She did not know if Resident #3's family member was told about the delay.

Interview on 10/22/21 at 4:08pm with the Administrator revealed:
-The Manager and the RCC worked together to make sure concerns were followed-up.
-He did not know Resident #3 had not received

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D 273	Continued From page 22 her eyeglasses. -Neither the Manager nor the RCC discussed this matter with him. -The Manager and the RCC were ultimately responsible for following-up in this situation. Telephone interview on 10/27/21 at 12:02pm with the optometrist revealed: -The laboratory shipped Resident #3's eyeglasses to him in June 2021. -Because he was not available to sign for receipt of the eyeglasses, they were returned to the laboratory. -He did not receive notification that the eyeglasses had been returned to the laboratory. -He contacted the laboratory on 10/25/21 and had Resident #3's eyeglasses shipped to him overnight. -He visited the facility on 10/27/21 and delivered the eyeglasses to Resident #3.	D 273		
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: Based on observations, interviews and record reviews, the facility failed to serve therapeutic diets as ordered by the physician for 1 of 5	D 310		

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sampled residents (Resident #4) with a diet order for a nutritional shake supplement.

The findings are:

Review of Resident #4's current FL-2 dated 02/24/21 revealed:
-Diagnoses included Alzheimer's disease with late onset, Vitamin B12 deficiency, anemia, insomnia, major depressive disorder, and anxiety disorder.
-There was an order for nutritional shakes three times a day.

Review of Resident #4's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for a nutritional shake three times a day with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation nutritional shakes had been given 93 of 93 opportunities.

Review of Resident #4's September 2021 eMAR revealed:
-There was an entry for a nutritional shake three times a day with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation nutritional shakes had been given 90 of 90 opportunities.

Review of Resident #4's October 2021 eMAR revealed:
-There was an entry for a nutritional shake three times a day with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was documentation nutritional shakes had been given 59 of 59 opportunities.

Observation of the lunch meal on 10/21/21 from 12:00pm-12:45pm revealed:

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-Resident #4 was served ground meatballs with gravy, green beans, noodles, a slice of bread, applesauce, milk, and water.
-Resident #4 ate less than 10% of her lunch meal.
-Resident #4 was not served a nutritional shake with her meal.
-Resident #4 left the dining room at 12:38pm.
-The Medication Aide (MA) entered the kitchen with a container of nutritional shakes at 12:45pm.

Observation of the facility common area from 12:45pm-1:05pm revealed:
-Resident #4 was in her wheelchair in the common area of the facility.
-Resident #4 did not receive a nutritional shake.

Interview with the MA on 10/21/21 at 1:09pm revealed:
-She usually served Resident #4's lunch shake at 12:30pm.
-She had the nutritional shake in her hand to give to Resident #4 during the lunch meal on 10/21/21, but she was needed in another area of the facility and left the kitchen without providing the shake to Resident #4.

Interview on 10/22/21 at 8:18am with the Resident Care Coordinator (RCC) revealed:
-Nutritional shakes were ordered to provide extra nutrition.
-Resident #4 routinely did not eat a whole meal.
-The MA was ultimately responsible for providing the nutritional shakes to Resident #4.
-Resident #4 should have been served the nutritional shake while she was eating her lunch meal in the dining room on 10/21/21.

Telephone interview on 10/22/21 at 9:10am with Resident #4's primary care provider (PCP)

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D 310	Continued From page 25 revealed: -She ordered the nutritional shakes for Resident #4 to prevent weight loss and to ensure protein intake. -She expected Resident #4 to receive her nutritional shakes as ordered. Interview on 10/22/21 at 9:53am with the MA revealed: -She was responsible for serving Resident #4's nutritional shake during meals. -She was the only MA working in the facility during the lunch meal on 10/21/21. -"It would have hit me when I looked at her, to give it to her." Interview on 10/22/21 at 3:08pm with the Manager revealed: -The RCC was responsible for managing nutritional shake administration. -Resident #4 should have been served the nutritional shake with her lunch meal on 10/21/21. Interview on 10/22/21 at 4:08pm with the Administrator revealed: -He expected orders for nutritional shakes to be followed. -Resident #4 should have received the nutritional shake with her lunch meal on 10/21/21. -The well being of Resident #4 was his concern. Based on interviews and observations, it was determined Resident #4 was not interviewable.	D 310		
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	D 315		

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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 observations and interviews, the facility failed to ensure activities were provided for the residents.

The findings are:

Review of the October 2021 activities calendar in the hallway revealed:
-Activities included arts and crafts, movies, exercise, bingo, and relaxing.
-On 10/18/21 from 2:00pm-4:00pm, bingo was listed.
-On 10/20/21 from 1:00pm-3:00pm, bingo was listed.
-On 10/21/21 from 2:00pm-4:00pm, an exercise session was listed.

Observation of the common room and dining room revealed:
-There were no activities held on 10/20/21 from 1:00pm-3:00pm.
-There were no activities held on 10/21/21 from 2:00pm-4:00pm.
-There were no activities announced over the intercom system.

Interview on 10/20/21 at 10:40am with a resident revealed:

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-The Activity Director (AD) was not at the facility every day.
-Activities were offered twice a month.

Interview on 10/20/21 at 10:48am with a second resident revealed activities were not offered at the facility.

Interview on 10/22/21 at 8:18am with the Resident Care Coordinator (RCC) revealed:
-There had not been an AD employed by the facility for the last month.
-She took over the responsibility for providing activities after the AD left.
-She scheduled the activities around her other responsibilities at the facility.
-She was responsible for providing transportation for the residents.
-She met with the facility's primary care provider (PCP) every Tuesday and the facility's psychiatric care provider every other Wednesday.
-She did not have certification as an AD.
-She intended to complete AD certification within the next nine months.
-Activities were announced over the main intercom system.
-Bingo was offered frequently.
-There was a craft activity last week.
-No activities were offered while the survey was being conducted.
-She had not been able to go to the store to purchase prizes for bingo that was scheduled for 10/20/21.
-The exercise session scheduled for 10/21/21 was not offered because she was assisting with the survey.
-The last activity offered at the facility was providing coloring sheets for the residents on 10/18/21.

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Interview on 10/22/21 at 8:47am with a third resident revealed the last activity at the facility was arts and crafts on 10/14/21.

Interview on 10/22/21 at 3:08pm with the Manager revealed:
-Activities were offered to keep the residents entertained and socialized.
-She walked with the residents and spent one-to-one time with them.
-Fourteen hours of activities were provided each week.
-The RCC intended to get AD certification and had nine months to complete it.
-The RCC provided activities on Mondays, Thursdays, and Fridays.
-On Tuesdays and Wednesdays, the RCC met with the facility's healthcare providers.
-A volunteer visited the facility three times each week and provided crafts and Bible study.
-The RCC was assisting with the survey and did not offer activities to the residents on 10/20/21 and 10/21/21.

Interview on 10/22/21 at 4:08pm with the Administrator revealed:
-There had not been an AD employed by the facility for one and one-half months.
-The RCC was making sure activities were being offered.
-The RCC led activities or delegated the responsibility to others.
-The RCC intended to pursue AD certification.
-Fourteen hours of activities were supposed to be provided each week.
-He did not know there had not been any activities offered on 10/20/21 and 10/21/21.
-The Manager and RCC knew how important activities were for the residents.
-The RCC was ultimately responsible for

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D 315	Continued From page 29 providing activities for the residents.	D 315		
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 for 1 of 5 sampled residents (Resident #4) related to the administration of a topical gel used to treat pain. The findings are: Review of Resident #4's current FL-2 dated 02/24/21 revealed: -Diagnoses included Alzheimer's disease with late onset, major depressive disorder, and anxiety disorder. -There was an order for Voltaren 1% gel (used to treat pain) apply 2 grams (G) topically to both knees twice a day. Review of Resident #4's August 2021-October electronic medication administration records (eMAR) revealed: -There was an entry for Voltaren 1% gel apply 2G topically to both knees twice a day scheduled for administration at 9:00am and 9:00pm.	D 358		

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-There was documentation Voltaren had been administered as ordered.
-There were no exception notes related to the administration of Resident #4's Voltaren gel.

Observation of Resident #4's medication available for administration on 10/21/21 at 4:27pm revealed:
-There were two unused 100G tubes of Voltaren 1% gel.
-The labels indicated the pharmacy dispensed both tubes on 05/24/21.
-The instructions on the labels read apply 2G topically to both knees twice a day.

Telephone interview on 10/22/21 at 9:35am with a pharmacist from the facility's contracted pharmacy revealed:
-The pharmacy dispensed two 100G tubes of Voltaren 1% gel for Resident #4 on 05/24/21.
-The facility had not requested any further Voltaren 1% gel refills for Resident #4.

Interview on 10/21/21 at 4:27pm with a medication aide (MA) revealed:
-Resident #4 routinely refused the Voltaren gel.
-Resident #4 did not indicate that she was experiencing pain.
-She did not tell the Resident Care Coordinator (RCC) or the primary care provider (PCP) that Resident #4 continually refused the Voltaren gel.
-She removed the Voltaren gel from the cart and intended to talk with the PCP about it when the PCP visited the facility the next week.

Interview on 10/22/21 at 8:18am with the RCC revealed:
-She did not know why the MA documented she had administered Resident #4's Voltaren gel if it had not been administered.

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-She reviewed the MARS at least once each week.
-She did not review the medications that were available for administration on the medication cart.

Telephone interview on 10/22/21 at 9:10am with the PCP revealed:
-She ordered the Voltaren gel and expected it to be administered as ordered.
-She ordered it to treat the pain and inflammation in Resident #4's knees.
-A topical gel was preferable for treating Resident #4's pain because there would be fewer side effects than if an oral medication was ordered.
-She expected to be told the first time Resident #4 refused a medication.
-No one told her Resident #4 was refusing the Voltaren gel.
-She did not know if it was a "true refusal" of the medication.
-Resident #4 may have displayed nonverbal cues of pain.
-She wanted to be told if Resident #4 no longer needed the Voltaren to help with her pain.
-She would discontinue a medication if Resident #4 no longer needed it.
-"If I'm not told, I can't make changes. I want the best care" provided to Resident #4.

Interview on 10/22/21 at 9:53am with the same MA revealed:
-She documented the administration of medications after she administered them.
-Medication refusals were supposed to be documented on the eMAR.
-She did not document Resident #4's refusal of the Voltaren gel.
-If a resident refused a medication, she usually offered the medication again ten minutes later.

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-Resident #4 would shake her head to refuse a medication.
-She applied the Voltaren gel to Resident #4's arms and knees in the past.
-She did not remember the last time she administered Resident #4's Voltaren gel.
-Sometimes Resident #4 was given Tylenol for her pain.
-She did not tell anyone Resident #4 was refusing the Voltaren gel.
-"Once I get busy, it drops out of my mind."
-The PCP was supposed to be notified if a resident refused a medication more than once.
-If a medication was repeatedly refused, it may need to be discontinued.
-She did not inform the PCP of Resident #4's refusals of the Voltaren gel.
-She did not apply the Voltaren gel to Resident #4, but she documented that she had applied it.
-She documented she had applied the Voltaren gel on the morning of 10/22/21 even though she had removed the medication from the medication cart on 10/21/21.
-She documented the administration of the Voltaren gel out of "habit."

Interview on 10/22/21 at 3:08pm with the Manager revealed:
-"If it's listed on the eMAR, it should be administered."
-The MA was supposed to document on the eMAR after the medication had been administered.
-The MA was supposed to document non-administrations or refusals of medications on the eMAR.
-The MA was expected to tell the RCC if a resident had refused a medication three times.
-The RCC would notify the PCP about the medication refusal.

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D 358	Continued From page 33 -Staff needed training on medication administration, documentation, and notifying the PCP. Interview on 10/22/21 at 4:08pm with the Administrator revealed: -He expected medications to be administered as ordered. -Residents had a right to refuse medications. -The PCP was supposed to be informed after three refusals of a medication. -He did not know how often the RCC conducted medication cart audits or eMAR audits. -The MA did not administer Resident #4's Voltaren gel according to the PCP's order. -The MA should not have documented that she had applied Resident #4's Voltaren gel if it had not been applied. -The RCC was ultimately responsible for medication administration. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.	D 358		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or	D 482		

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convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to obtain physician's orders for the use of physical restraints for 1 of 1

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sampled resident (#2) related to the use of full bed rails.

The findings are:

Review of Resident #2's current FL-2 dated 12/15/20 revealed:
-Diagnoses included dementia with behavioral problems, arterial hypertension, psychosis, and coronary artery disease.
-Resident #2 was ambulatory and a wanderer.
-There was no order for physical restraints or bed rails.

Review of Resident #2's care plan dated 03/15/21 revealed:
-Resident #2 currently received medication to treat behaviors.
-Resident #2 was independent for toileting, eating, ambulation, and transferring.
-Resident #2 needed limited assistance with bathing, grooming/personal hygiene and dressing.

Observation on 10/20/21 from 10:40am to 10:49am of Resident #2's room revealed:
-Resident #2 was lying in a hospital bed.
-Resident #2's bed was pushed against the wall.
-There were two raised full bed rails on both sides of the bed.
-When Resident #2 got out of the bed, he held on to the full bedrail with his hands, lifted his left leg, swung it over the full bedrail, placed his left foot on the floor, then lifted his right leg, and swung it over the full bedrail.

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 07/30/21 revealed the LHPS task restraints/alternatives was not checked or

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D 482	Continued From page 36 indicated for Resident #2. Review of Resident #2's physician orders revealed: -There was no order for a hospital bed. -There were no orders for physical restraints or bedrails. Interview on 10/20/21 at 10:45am with Resident #2 revealed: -He had the same bed since he came to the facility and bed rails were already on the bed. -He crawled over the bed rails to enter and exit the bed or used the gap between the end of the bedrail and the foot of the bed. -He had not asked any staff to remove the bed rails. -He could understand why some residents may have bedrails to prevent them from rolling out of bed. -He did not need them because he did not roll out of bed. Interview on 10/20/21 at 4:25pm with a medication aide (MA) revealed: -Resident #2 walked, turned and repositioned himself in the bed. -Staff assisted Resident #2 with medications and bathing. -Resident #2 had not fallen. -Resident #2's bed had rails. -She did not know why Resident #2 had bed rails on his bed. -She thought the bed rails came with the hospital bed. -Staff checked all residents every 2 hours to determine if they needed anything, such as incontinent care. -She thought Resident #2 had the same hospital bed since 2020.	D 482		

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-She was not aware if Resident #2 had an order for the hospital bed, bed rails or for restraints.
-She thought Resident #2's bed rails were a restraint because it was against the wall and there were two full bed rails in the up position.
-She did not know why she did not remove the bed rails from Resident #2's bed.
-She did not know how Resident #2 exited the bed with the bed rails in the up position.

Observation of Resident #2's room with a MA on 10/20/21 at 4:34pm revealed:
-There were no residents in the room.
-The full bed rails were lifted into the up position on both sides of Resident #2's bed.

Interview on 10/21/21 at 7:03am with a personal care aide (PCA) revealed:
-She worked second shift from 7:00pm to 7:00am on 10/20/21.
-She knew Resident #2 and had never noticed bed rails were up on his bed during her shift.
-She did not remove the bed rails or lift the bed rails on his bed.
-She did not know why she had never noticed Resident #2's bed rails.
-She knew bed rails could be considered a restraint.
-She did laundry at night and his room was directly across from the laundry room.
-She had not noticed the bed rails in the up position on Resident #2's bed while doing laundry at night.
-She did not know if he had an order for restraints or not.
-She did not know how Resident #2 entered or exited the bed with the bed rails in the up position.
-Resident #2 went to bed independently, so she had not observed him getting in and out of the

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D 482	Continued From page 38 bed. Observation of Resident #2 in his room with a PCA on 10/21/21 at 7:05am revealed: -Resident #2 was lying on his right side covered with a blanket in his bed. -There was one full bedrail in the up position and the full bedrail near the wall was down. -Resident #2's bed was pushed against the wall and the full bedrail was up on the opposite side of his bed. Interview on 10/21/21 at 7:30am with the Resident Care Coordinator (RCC) revealed she was told by the Manager that the facility did not have a restraint policy because it was a restraint free facility. Telephone interview on 10/21/21 at 4:50pm with Resident #2's primary care provider (PCP) revealed: -She did not write an order for a hospital bed for Resident #2 in 2020, but the previous provider may have written the order. -Resident #2 could walk and reposition himself. -She had not completed an assessment for the use of restraints, and she did not know Resident #2 had full bed rails used in the upward position. -She did not know Resident #2's bed was pushed against the wall. -If Resident #2's bed rails were positioned in an up position and the bed was against the wall, then that qualified as a restraint. -Resident #2 did not require restraints and she had not written an order for restraints for Resident #2. -If Resident #2 was entering and exiting the bed by climbing over the full rails, it caused him to be at risk for falling.	D 482		

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D 482	Continued From page 39 Interview on 10/22/21 at 10:15am with the RCC revealed: -Resident #2 was in another room with another resident. -Resident #2 was moved to another room and kept the same bed. -Resident #2's hospital bed was a bed already owned by the facility and previously in storage. -She knew Resident #2's bed had bed rails, but no one removed them. -She thought no one removed them because no one had seen them in the up position. -She thought if staff were making rounds every 2 hours and removing the linen from his bed someone should have seen the bed rails. -She had not seen the bed rails on his bed until 10/20/21. -If she had seen the bed rails, she would have removed them. -She did not know how Resident #2 got in and out of bed with the bed rails. -If he was crawling over the bed rails, she was concerned that he may have slipped and fallen. -Resident #2 did not have an order for restraints or an assessed need for restraints. -She expected staff to report to her or the Manager if there were bed rails being used in the facility. Interview on 10/22/21 at 11:11am with the Manager revealed: -She made rounds throughout the facility daily, but she did not notice the bed rails on Resident #2's bed. -His bed belonged to the facility and did not come with him when he was admitted in December 2020. -The contracted maintenance person removed the bed rails from Resident #2's bed on 10/21/21. -The facility was a restraint-free facility.	D 482		

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PINECREST GARDENS	1984 OLD US 421 LILLINGTON, NC 27546

(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 482	Continued From page 40 -Resident #2 did not have a diagnosis that warranted physical restraints. -She thought staff never reported the bed rails on Resident #2's bed because they never saw them raised or they did not think to tell anyone. -She expected staff to notify her if they observed the use of physical restraints; however, staff did not know all the pieces of equipment that may be used as a physical restraint. -She held the RCC and the MAs responsible for ensuring no restraints were used within the facility. Interview on 10/22/21 at 3:38pm with the Administrator revealed: -The Manager was designated by him to manage the facility and the care of the residents. -He depended on her to keep him abreast of any issues within the facility. -The facility was a no restraint facility. -He was not aware that Resident #2 had two bed rails up or that the bed was pushed against the wall on the opposite side. -He defined a restraint as anything that hindered motion of a resident. -He thought staff noticing the bed rails on Resident #2's bed was missed and fell through the cracks. -He expected staff to report when they saw bed rails in the up position. -He held the RCC and the Manager responsible for ensuring residents were not restrained.	D 482		
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	D 612		

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been identified at the facility or there is an emerging infectious
disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and
published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease
outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health
department, the specific guidance or directives shall be implemented by the facility.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to 58 residents during the global coronavirus (COVID-19) pandemic as related to appropriate use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection and screening of residents.

The findings are:

Review of the North Carolina Department of Health and Human Services (NC DHHS) COVID-19 Ongoing Outbreaks in Congregate Living Settings dated 10/19/21 revealed the facility was in outbreak status with three positive resident having COVID-19 diagnosis.

Review of the facility's infection control notebook revealed:

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-There was a document titled "How "facility name" is Responding to the COVID-19 Pandemic".
-The document was dated 03/09/20.
-There was guidance for staff/associates that daily health screenings were implemented when staff reported to work.
-Staff who were sick were directed to stay home.
-To decrease the chance of COVID-19, the facility would conduct health screenings of anyone entering the facility, and require the person entering to wear a face mask.
-There were daily procedures for reporting to work which included washing hands, putting on a face mask, and temperature checks.

1. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Long-Term Care Facilities dated 09/10/21 revealed:
-The guidance referred to Interim Infection Control Recommendations for Healthcare Personnel during the COVID-19 Pandemic.
-The guidance indicated that source control should be implemented for healthcare personnel.
-Source control included a well-fitting face mask, N95 face mask or respirator.

Review of the NC DHHS Guidance for Best Practices for Infection Prevention in Long Term Care Facilities (LTC) dated 02/10/21 revealed LTC facillities should follow the CDC guidance for appropriate selection and use of PPE.

Observation of the facility upon entrance into facility on 10/20/21 from 9:06am revealed along the hallway near the dining room, the maintenance person wore a scarf or bandana over his nose and mouth.

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D 612	Continued From page 43 Observation of another staff in the facility on 10/20/21 at 9:43am revealed she wore a face mask below her nose. Observations throughout the facility on 10/20/21 at various times revealed: -At 9:44am staff was mopping the dining room floor and was not wearing a facemask. -At 12:58pm a medication aide (MA) was walking in the main corridor without wearing a facemask. -At 12:59pm a personal care aide (PCA) was wearing a facemask below her chin. -At 1:01pm another PCA was wearing a facemask below her nose. -At 11:20am a housekeeper was going from room to room of the residents emptying the trash and cleaning the floors with her face mask below her nose. -At 11:23am another housekeeper was in the hallway where residents passed back and forth with her face mask below her nose. -At 3:00pm another MA had her face mask below her chin while taking a resident's blood pressure. Interview on 10/20/21 at 9:20am with a resident revealed staff did not always wear a face mask inside the facility. Interview on 10/20/21 at 11:07am with a second resident revealed staff wore face masks when he saw them. Interview on 10/20/21 at 4:05pm with a PCA revealed: -She worked 7:00am to 7:00pm. -She had received training concerning COVID-19 and the training occurred two weeks after she was hired during the summer of 2021. -She did not know if the facility had a COVID-19 policy.	D 612		

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D 612	Continued From page 44 -The facility had a COVID-19 outbreak two months ago, but no residents were quarantined at that time. -She wore a face mask at work. -She did not have a face mask over her nose during the entire shift because she could not breath with it in place. -She wore a face mask appropriately when she entered a resident's room, but she also encountered residents in the hallway and lobby. Interview on 10/20/21 at 4:07pm with the Resident Care Coordinator (RCC) revealed: -Staff knew the proper way to wear facemasks. -The Manager was responsible for training staff on the proper way to wear facemasks. -She did not know the date of the last training session. Interview on 10/20/21 at 4:25pm with a MA revealed: -She knew she was supposed to wear a face mask while in the facility. -Staff were supposed to decrease their exposure by not attending parties and decrease interaction in public areas. -She received training in April or May 2020 concerning COVID-19 provided by the Manager and Resident Care Coordinator (RCC). -She got tired of wearing the face mask during the workday and she pulled her face mask below her mouth and nose. Interview on 10/21/21 at 11:10am with another MA revealed: -She was taught by the local health department (LHD) nurse to wear a face mask within the facility. -She tried to wear the face mask during her shift, but she just could not due to a medical condition.	D 612		

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-She removed the face mask because she felt like she could not breath.
-She had discussed wearing a face mask with her physician and was told to take breaks at work by stepping away to remove her mask.

A second interview on 10/22/21 at 9:28am with the RCC revealed:
-The facility had several face masks that were purchased and provided to the staff.
-She expected staff to properly wear face mask over their noses and mouths while in the facility.
-She read the CDC guidelines from March 2020 but had not read the most recent updates.
-The facility had four COVID-19 outbreaks.
-The COVID-19 outbreaks occurred in June 2020, September 2020, December 2020 to January 2021 and at the end of the month of August 2021.
-She had noticed in the past MAs and PCAs were not appropriately wearing their face masks over their noses and mouths.
-She had not noticed staff not wearing their face masks appropriately on 10/20/21.
-She told the MAs and PCAs to wear their face masks properly in the past.
-She and the Manager were responsible for ensuring staff wore their face masks properly in the facility.

Interview on 10/22/21 at 12:00pm with the Manager revealed:
-The facility had an ample supply of face masks and other PPE.
-She expected staff to wear face masks over their nose and mouth.
-When she saw staff wearing their face masks incorrectly, she corrected them.
-The CDC guidelines for COVID-19 were that face masks should be worn in the facility.

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D 612	Continued From page 46 -She was responsible for following the CDC guidelines related to the use of face masks. Interview on 10/22/21 at 3:57pm with the Administrator revealed: -Staff were expected to wear face masks in the facility. -He thought staff were wearing face masks properly in the facility. -He did not know the current CDC guidelines for long term care facilities concerning wearing a face mask in the facility, but he had read previous versions. Attempted telephone interview with the LHD Registered Nurse (RN) on 10/22/21 at 2:08pm was unsuccessful. 2. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed residents should be actively monitored daily for fever, and symptoms consistent with COVID-19. Review of the North Carolina Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19. Interview on 10/20/21 at 10:16am with a resident revealed: -Staff had not obtained his temperature daily and no one had asked him questions concerning COVID-19 symptoms.	D 612		

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D 612	Continued From page 47 -Staff did not obtain a temperature unless a resident complained of not feeling well. Interview on 10/20/21 at 10:50am with another resident revealed he did not have his temperature checked daily and no one asked him any questions about COVID-19 symptoms. Interview on 10/20/21 at 4:07pm with the Resident Care Coordinator (RCC) revealed: -The residents' temperatures were not being taken daily because there were currently no residents who had tested positive for COVID-19. -A resident's temperature would be taken if the resident displayed symptoms of COVID-19. -The residents' temperatures were taken daily only during the COVID-19 outbreaks at the facility. -There had been four COVID-19 outbreaks at the facility: June 2020, September 2020, January 2021, and August/September 2021. -She did not know the source of the guidance on temperature monitoring. Interview on 10/20/21 at 4:25pm with a medication aide (MA) revealed: -The facility had an outbreak in September 2021. -Residents who tested positive had their temperatures monitored every 2 hours and the other residents had their temperatures checked three times a day. -There was a notebook used to document the residents' temperatures. -She did not know where the documented temperatures were now and she could not locate them. -Resident's temperatures were no longer checked but she could not remember when the MAs stopped checking residents' temperatures.	D 612		

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D 612	Continued From page 48 Interview on 10/21/21 at 10:42am with another MA revealed: -She did not take the residents' temperatures daily, but she started on 10/21/21. -She took residents' temperatures if they complained of not feeling well. -There was a thermometer for use at the facility. -Previously, she obtained resident temperatures daily and documented the resident's temperatures in the eMAR system. -Once the facility was COVID-19 free, the daily temperature checks were removed from the eMAR system. -She was sure the facility had a policy for COVID-19, but she had not read it. -The facility had a COVID-19 outbreak in March 2020, December 2020 to January 2021, June 2021, and September 2021. -Each time there was a COVID-19 outbreak the temperatures of residents who tested positive were taken frequently. -She thought the pharmacy placed the temperatures on the eMARs and removed them. -She received training concerning COVID-19 in March 2020 from the local health department (LHD) nurse. -The LHD nurse taught them to heck temperatures daily. A second interview on 10/22/21 at 9:05am with the RCC revealed: -Staff reported when a resident did not feel well or had a fever. -Residents' temperatures were obtained frequently during COVID-19 outbreaks within the facility. -The facility had four COVID-19 outbreaks which occurred at the end of June 2020, September 2020, December 2020 to January 2021, and August 2021 to September 2021.	D 612		

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-Resident temperatures were obtained for residents who tested positive.
-Resident temperatures were discontinued by the primary care provider (PCP) after the outbreak ended.
-The pharmacy removed the temperature entry from the eMARs.
-She did not question the PCP because she thought the PCP knew best concerning COVID-19.

Review of five residents' August 2021, September 2021, and October 2021 electronic medication administration records (eMARs) revealed there was no documentation of any temperatures.

Interview on 10/20/21 at 4:11pm with the Manager revealed:
-The doors to the facility were always locked so no one could enter without being screened.
-Staff was stationed at the front desk to monitor the temperature of anyone entering the facility.
-There used to be a log with COVID-19 screening questionnaires kept at the front desk.
-The questionnaires were used during the COVID-19 outbreaks at the facility.
-She did not know the screening questionnaires still needed to be completed when anyone entered the facility.
-She used the North Carolina Department of Health and Human Services (NC DHHS) website as her source of COVID-19 guidance.

A second interview on 10/22/21 at 12:00pm with the Manager revealed:
-The facility had an infection control and COVID-19 policy.
-Residents were screened for COVID-19 until the PCP discontinued the temperature checks.

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-The PCP told her the residents were fine as long as visitors and staff were screened for COVID-19.
-She thought the current CDC COVID-19 guidelines for long term care facilities was that staff and residents should be screened daily.
-She was responsible for ensuring the guidelines of the CDC concerning COVID-19 screenings with daily temperatures and monitoring of COVID-19 signs and symptoms for residents.

Telephone interview on 10/22/21 at 2:22pm with the PCP revealed:
-She began caring for residents at the facility in June 2021.
-She did not recall writing any orders to discontinue temperature checks for residents.
-During the most recent COVID-19 outbreak in September 2021, she was more concerned with screening the residents for signs and symptoms of COVID-19.
-Many of the residents did not present with fevers and were asymptomatic.

Interview on 10/22/21 at 3:38pm with the Administrator revealed:
-Visitors were still screened and their temperatures were checked.
-He was informed on 10/21/21 that staff stopped obtaining residents' temperatures.
-He was told that the PCP wrote an order to discontinue obtaining resident temperatures daily.
-He expected staff to follow the CDC guidelines related to resident screening for COVID-19.

Attempted telephone interview with the local county health department (LHD) Registered Nurse (RN) on 10/22/21 at 2:08pm was unsuccessful.