STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTWELL HOME	401 US 221 S HIGHWAY RUTHERFORDTON, NC 28139

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/11/22 through 08/12/22.	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 floors were maintained in good repair related to the deterioration of floor tiles in a resident's bathroom. The finding are: Observation of a residents's bathroom on 08/11/22 at 10:15am revealed: -The bathroom was accessed through a resident's bedroom. -There were 12" X 12" linoleum tiles on the floor. -Four tiles between the toilet and the sink had pieces of the tile missing and the subflooring was visible. -Two tiles had multiple cracks in them. -One tile was loose and separated from the adjoining tile, revealing the subflooring below. -The subfloor flexed when stepped on. Interview with a Resident on 08/11/22 at 10:00am	D 074		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Harry Vanderwal - HARRY VANDERWAL | TITLE: ADMINISTRATOR | (X6) DATE: 9/7/22

Reviewed and acknowledged LSB 09/09/2022

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D 074	Continued From page 1	D 074		

and 08/12/22 at 10:10am revealed:
-The flooring in her bathroom was "falling apart" and had been that way since about March 2022 but really started getting worse in May or June 2022.
-She told the facility Manager about the floor and they discovered the tiles were breaking apart because the sink was leaking.
-The Manager told her it would be fixed and turned the water off to the sink.
-The Manager taught her how to turn the water on and off about 2 months ago so she could use the sink periodically.
-It was difficult to navigate her wheelchair in the bathroom because the wheels of her wheelchair got stuck on the buildup of loose tiles.
-Housekeeping staff removed the loose tiles a few weeks ago because it was a hazard and it made it easier to navigate her wheelchair.
-Because she was in a wheelchair, she used her foot to turn the water on when she needed to use the sink to brush her teeth.
-She could not turn the water back off with her foot because the knob needed to be turned in the opposite direction.
-She learned that she could lean down to the floor and use her hand to turn the water off, if she held onto the sink to keep from falling out of her wheelchair.
-Turning the sink water off and on was not an easy task so she usually just used hand sanitizer that she kept in her room.
-She used the sink primarily to brush her teeth.
-She was told two weeks ago that it was on the list of things to be fixed.

Interview with a housekeeper on 08/11/22 at 10:16am revealed:
-She started working at the facility about 4 years ago but transferred to housekeeping about a

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D 074	Continued From page 2	D 074		

month ago.
-Pieces of tile were loose and when she swept the bathroom floor they dislodged so she removed them.
-She told the facility's Manager about a month ago.
-The maintenance staff had been contacted a couple of times to fix it.

Interview with the Manager on 08/11/22 at 10:17am revealed:
-The leaking sink caused the floor damage.
-The water was turned off but the resident used the sink occasionally.
-Housekeeping informed her a couple weeks ago that the tiles were breaking apart and that pieces of the floor were removed.
-A family member who did maintenance at the facility was scheduled to replace the floor and fix the leaking sink.
-He had been reminded about the floor and sink this past weekend.

Telephone interview with a maintenance staff on 08/12/22 at 11:22am revealed:
-He did maintenance jobs at the facility part time.
-He was told about the floor a couple weeks ago.
-He had not been able to get to it because he had another full-time job.
-The Manager sent him pictures 08/11/22 so he knew what exactly needed to be fixed.
-The water was supposed to be turned off so it did not continue to cause damage.
-He had not been there yet to inspect the floor to see exactly what needed to be repaired.

Interview with the Administrator on 08/12/22 at 2:30pm revealed:
-He heard about the floor last week from the maintenance staff.

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D 074	Continued From page 3 -The maintenance staff was now scheduled to repair the sink and floor.	D 074	COMPLETED 8/13/22 ALL REPAIRS WERE MADE. THE ADMINISTRATOR WILL BE RESPONSIBLE FOR PHYSICAL FACILITY REPAIR CO-ORDINATION. DURING THE NEXT STAFF MEETING, STAFF WILL BE INSTRUCTED ON THE IMPORTANCE OF REPORTING MAINTENANCE NEEDS. THIS WILL BE A CONSTANT PROCESS.	8/13/22
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure 1 of 1 sampled resident (Resident #5) had orders to self-administer medications that were observed in a resident's room. The findings are: Review of Resident #5's current FL2 dated 07/27/22 revealed: -Diagnoses included history of stoke with right sided paralysis and depression. -There was no order for Biofreeze (topical medication used for pain relief). -There was no order for Vitamin D3 2,000	D 375		

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D 375	Continued From page 4 international units (iu), (used as a supplement). Observation during the initial tour on 08/11/22 at 9:38am, 2:50pm and 4:24pm revealed a tube of Biofreeze and Vitamin D3 2,000 international units (iu) on Resident #5's dresser beside her bed. Review of Resident #5's June, July and August 2022 Medication Administration Records (MAR) revealed there was no order for Biofreeze or Vitamin D3 2,000 iu. Interview with Resident #5 on 08/11/22 at 2:50pm revealed: -She had asked her family member to bring the Biofreeze and the Vitamin D3 about a month ago. -She had arthritis in her hands and used the Biofreeze daily for pain relief. -She was tired and thought she would feel better with extra Vitamin D3. -She took the Vitamin D3 2,000 iu daily. -She had been using the Biofreeze and taking the Vitamin D3 every day for about a month. Interview with the Medication Aide (MA) on 08/11/22 at 4:36pm revealed: -Resident #5 did not have an order to self-administer any medications. -She did not know Resident #5 had Biofreeze or Vitamin D3 on her dresser. -She did not know Resident #5 self-administered Biofreeze topically to both her hands daily. -She did not know Resident #5 self-administered Vitamin D 3 2,000 iu daily. Interview with the facility Manager on 08/11/22 at 4:56pm revealed: -Resident #5 did not have a physician's order to self-administer medications.	D 375	D 375 WE WERE NOT AWARE THAT A FAMILY MEMBER HAD BROUGHT THESE OTC MEDICATIONS, ON 8/12/22 THEY WERE REMOVED FROM THE ROOM. IT WAS EXPLAINED TO HER + HER DAUGHTER THAT ALL MEDICATIONS REQUIRE A DOCTOR'S ORDER A STAFF MEETING WILL BE HELD BEFORE 9/30/22 to REMIND THE STAFF. THE STAFF HAS ALREADY BEEN REMINDED VERBALLY. THIS WILL BE INCLUDED IN ANNUAL TRAINING.	8/12-8/15/22 9/30/22

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D 375	Continued From page 5 -Resident #5 did not have an assessment determining her ability to safely self-administer medications. -Resident #5 was not able to safely self-administer medications. -She did not know Resident #5 had Biofreeze and Vitamin D3 in her room. -She did not know Resident #5 had been self-administering Biofreeze and Vitamin D3 daily for the past month.	D 375	THE REST HOME MANAGER WILL BE RESPONSIBLE FOR STAFF TRAINING AND MONITORING ON A CONSTANT BASIS.	
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure an accurate and readily retrievable record of controlled substances was available for review for 2 of 3 sampled residents (#1 & #3) related to Norco (a medication used to treat pain) (Resident #1) and Ativan (used to treat anxiety) (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 01/14/22 revealed: -Diagnoses included Alzheimer's disease, cerebrovascular accident, Parkinson disease,	D 392		

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D 392	Continued From page 6 anxiety, Crohn's disease, history of ankle fracture and shoulder sprain. -An order for Norco 10mg/325mg four times daily at 8:00am, noon, 4:00pm and 8:00pm. Review of Resident #1's July 2022 Medication Administration Record (MAR) revealed: -There was an entry for Norco 10mg/325mg 4 times daily at 8:00am, noon, 4:00pm and 8:00pm. -There was documentation Norco was administered 4 times daily from 07/01/22 through 07/31/22. Review of Resident #1's August 2022 MAR revealed: -There was an entry for Norco 10mg/325mg 4 times daily at 8:00am, noon, 4:00pm and 8:00pm. -There was documentation Norco was administered 4 times daily from 08/01/22 through 08/10/22. -There was documentation Norco was administered at 8:00am and noon on 08/11/22. Observation of Resident #1's medication on hand on 08/11/22 at 2:41pm revealed: -There were 49 Norco 10mg/325mg tablets available for administration. -There were 120 Norco 10mg/325mg tablet dispensed on 07/17/22 and 2 of the 4 cards remained. Review of Resident #1's Controlled Substance Count Sheet (CSCS) revealed: -The CSCS documented administration for Norco 10mg/325mg. -The documentation of the 4:00pm dose on 08/07/22 was crossed out by the Medication Aide (MA) who administered the 8:00pm dose leaving a balance of 66 pills available for administration. -The documentation of the 4:00pm dose on	D 392		

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D 392	Continued From page 7 08/08/22 was written across 2 lines which incorrectly left 62 pills available for administration. -There was documentation tablet #51 was administered at noon on 08/11/22 leaving 50 pills available for administration. Review of Resident #1's shift change controlled substance medication count form revealed: -The number of tablets available on 08/07/22, 08/08/22 and 08/09/22 had been changed. -There was documentation 52 Norco were available at the 7:00am change of shift on 08/11/22. Interview with the MA on 08/11/22 at 2:41pm revealed: -She did not count Resident #1's Norco when she came to work because the MA who was leaving told her the count was correct. -She had not noticed the count on the CSCS and the count on the shift change count form did not match. -She documented she completed a count at the end of her shift even if she did complete a count with the on-coming MA. -She did not know why the counts were changed on 08/07/22, 08/08/22 and 08/09/22 or who made the changes, even though her initials were on 08/07/22 and 08/08/22. -She did not know why her documentation of administration at 4:00pm on 08/07/22 would have been crossed out by the MA who worked after her. Interview with another MA on 08/12/22 at 11:10am revealed: -She did not count any controlled substances when she left work at 7:00am on 08/11/22 because she was tired. -She counted and documented all the controlled	D 392		

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substances in the cart at 4:00am when she had some free time and meant to do it again with the MA who came to work at 7:00am.

Refer to interview with the Manager on 08/11/22 at 4:00pm.

Refer to telephone interview with the facility's contracted pharmacist on 08/12/12 at 9:22am.

Refer to interview with the Administrator on 08/12/22 at 2:30pm.

2. Review of Resident #3's current FL2 dated 05/31/22 revealed diagnoses included chronic lung disease and anxiety disorder.

Review of Resident #3's July 2022 medication administration record (MAR) revealed:
-There was an entry for Ativan 1mg tablet every 4 hours as needed.
-There was documentation Ativan was administered 7 times between 07/01/22 and 07/31/22.

Review of Resident #3's August 2022 MAR revealed:
-There was an entry for Ativan 1mg tablet every 4 hours as needed.
-Ativan 1mg was documented as administered 2 times between 08/01/22 and 08/11/22.

Observation of Resident #3's medication on hand on 08/11/22 at 3:09pm revealed there were 17 Ativan 1mg tablets available for administration.

Review of Resident #3's Controlled Substance Count Sheet (CSCS) revealed:
-The CSCS documented administration for Ativan 1mg every 4 hours as needed.

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D 392	Continued From page 9 -The CSCS count sheet revealed there were 18 Ativan 1mg tables available for administration. Interview with the Medication Aide (MA) on 08/11/22 at 3:09pm revealed: -She did not complete the controlled substance medication count with the offgoing MA on 08/11/22. -The offgoing MA told her the count was correct and gave her the keys to the medication cart. -She was not aware the CSCS log and the medication count did not match. -It was at least a week ago since she last counted off with any MAs when she was coming on shift. -She told the Manager about this because it was an ongoing issue. Refer to interview with the Manager on 08/11/22 at 4:00pm. Refer to telephone interview with the facility's contracted pharmacist on 08/12/12 at 9:22am. Refer to interview with the Administrator on 08/12/22 at 2:30pm. Interview with the Manager on 08/11/22 at 4:00pm revealed: -MAs were instructed to count all controlled substances at shift change. -A MA came to her about a month ago and complained that some MAs were not counting controlled substances at shift change. -She instructed all MAs to count controlled substances at the end of their shift and if they did not do it they would be "written up" for not following proper procedure. -The controlled substances counts should always be accurate, and if they were not, the MAs working should inform her of the problem.	D 392		

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D 392	Continued From page 10 Telephone interview with the facility's contracted pharmacist on 08/12/22 at 9:22am revealed: -She conducted controlled substance audits quarterly. -Documentation of controlled substances was not always complete when she conducted her audits and she informed the Manager in April 2022 and June 2022 . Interview with the Administrator on 08/12/22 at 2:30pm revealed: -He was told there was a CSCS documentation problem on 08/11/22. -It was important the CSCS be accurate. -MAs were trained to count controlled substances at shift change so any errors could be found quickly. -He did not know why MAs were not documenting as they had been trained.	D 392	THE QI COMMITTEE HAS THE FOLLOWING SCHEDULE OF TRAINING WITH THE GOAL OF STREAMLINING & INCORPORATING THE NEW ONE PAGE NARCOTICS SHEET AS RECOMMENDED BY THE SURVEY TEAM. STAFF MEETINGS EMPHASIS WILL BE ON THE NEW NARCOTIC SHEET AND THE IMPORTANCE OF RECONCILING THE COUNT. THE NEW PROCEDURES WILL BE IN PLACE BY 10/1/22 WE HAVE ALREADY REMINDED THE STAFF OF THE IMPORTANCE OF ACCURATE COUNTS. THE REST HOME MANAGER WILL CONFIRM THAT THE DOCUMENTATION IS BEING COMPLETED PROPERLY. ANY DISCREPANCY IN THE NARCOTICS COUNT WILL BE REPORTED IMMEDIATELY TO THE REST HOME MANAGER FOR INVESTIGATION.	9/7 – 9/21/22
D 610	10A NCAC 13F .1801 (a) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control	D 610		

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(CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic related to the use of personal protective equipment (PPE) by staff.

The findings are:

Review of the 1/21/22 CDC guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility revealed:
-Personnel should always wear a face mask in the facility.
-Face masks should not be worn under the nose or mouth.
-A surgical mask can be used if a N95 mask is not available.
-Appropriate PPE should be used by personnel when coming in contact with the resident.

Review of the 11/19/21 NCDHHS guidelines for the prevention and spread of the coronavirus in LTC facilities revealed all facility staff should wear a face mask while in the facility.

Observation upon entry to the facility on 08/11/22 at 9:00am revealed:
-The Administrator was not wearing a face mask.
-There was not a sign at the front entrance instructing visitors to wear face masks in the facility.

Interview with the Manager on 08/11/22 at 9:00am revealed:
-Staff were not required to wear face masks.
-She was not sure what the state expectation was regarding the wearing of face masks.
-Guidance from the CDC and the state was

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D 610	Continued From page 12 confusing. -Since the local health department staff did not wear a face mask when they entered the facility she assumed they did not need to wear one either. -Staff at the facility stopped wearing face masks about 6 months ago. -Since there were no COVID-19 cases in the county they eased up on wearing face masks. Observation of the assistant manager on 08/11/22 at 9:16am revealed she was not wearing a face mask. Observation of a Medication Aide (MA) in the hall on 08/11/22 at 9:17am revealed she was not wearing a face mask. Observation of a dietary staff in the dining room on 08/11/22 at 9:17 revealed she was not wearing a face mask. Interview with a dietary staff on 08/11/22 at 9:17am revealed staff stopped wearing face masks about 6 months ago. Interview with a resident on 08/11/22 at 11:38am revealed staff had not worn a face mask since November 2021. Interview with the Administrator on 08/12/22 at 2:30pm revealed: -He received e-mail communications from NCDHHS about infection control and forwarded it to the facility's Manager. -When he had questions he asked his representative from the local department of social services. -When the local health department inspectors were in the facility they did not tell them they	D 610	D610 ON 8/17/22, OUR STAFF MET WITH THE REGIONAL INFECTION PREVENTION, SUPPORT TEAM. FOLLOWING THE MEETING WE ARE USING NCDHHS GUIDELINES + FORMS. THIS CLARIFIED ~~WHAT~~ THE UPDATED POLICIES + PROCEDURES WERE. THERE HAS BEEN MUCH CONFUSION CAUSED BY MORE LAX CDC RECOMMENDATIONS AND LOCAL DSS REQUIREMENTS.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL081007	A. BUILDING: _____ B. WING _____	08/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 610	Continued From page 13 needed to wear a face mask. -The facility did not have any policies about staff wearing face masks.	D 610	PLEASE SEE THE NOTES ON D 611 AS THESE 2 AREAS ARE VERY CLOSELY RELATED.	
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed	D 611		

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D 611	Continued From page 14 reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to	D 611		

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D 611	Continued From page 15 North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure policies and procedures were established and implemented consistent with the federal CDC guidelines related to standard and transmission based precautions related to Coronavirus COVID-19. The findings are: Review of the facility's 2011 Infection Control Training Manual revealed general information about infection control but did not contain any information about COVID-19. Review of the facility's Infection Control Policy and Procedures Manual revealed there were no established infection control policy or procedures, including policies for COVID-19, available for review. Interview with the Assistant Manager on 08/12/22 at 2:3pm revealed: -She did not know where any infection control policies or procedures were located. -No policies or procedures were written or updated at the beginning of the COVID-19 pandemic in 2020. -The Manager used the Infection Control Manual to train new employees but it did not include anything about COVID-19. Interview with the Administrator on 08/12/22 at 2:30pm revealed: -The facility had to provide infection control policies and procedures when the facility was initially licensed so he knew the facility had them	D 611	BASED ON NEW INFORMATION, WE CREATED A POLICY MANUAL — "INFECTION PREVENTION + CONTROL PROGRAM, COVID 19 PROGRAM, EXPOSURE CONTROL PLAN" CURRENTLY, ALL STAFF ARE WEARING MASKS. VISITORS ARE TO WEAR MASKS. ALL RESIDENTS, STAFF + VISITORS HAVE TEMPERATURE CHECKS. ALL STAFF MEETING IN SEPT. WILL INCLUDE A REVIEW OF THE NEW MANUAL. ALSO, THEY MUST DEMONSTRATE COMPETENCY IN HAND-WASHING, PPE USE, OTHER CONTROL PROCEDURES. (WE HAVE APPLIED FOR THE CLIA CERTIFICATION TO PERFORM IN-HOUSE RAPID COVID19 TESTING) ALL PROCEDURES AND UPDATES AS TO REQUIREMENTS WILL BE REVIEWED AT EACH STAFF MEETING. ADHERENCE TO THESE REQUIREMENTS WILL BE MONITORED BY THE QI COMMITTEE.	8/30/22 10/30/22 FOR EDUC. + TRAINING

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D 611	Continued From page 16 but he did not know where they were kept. -There was not a policy for Infection Control.	D 611		