STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	C 08/17/2020

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CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a complaint investigation survey onsite on 08/03/20 & 08/13/20 with a desk review survey on 08/04/20 to 08/07/20 and 08/10/20 to 08/14/20 with a telephone exit on 08/17/20.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule	D 188		

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D 188	Continued From page 1 .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents residing in the Assisted Living (AL) unit for 22 of 54 shifts sampled for 18 days between 07/10/20 and 08/13/20. The findings are: Review of NCDHHS Emergency Staffing Recommendations during the COVID-19 pandemic revealed: -Staff who test positive for COVID-19 will be unable to work until they meet the criteria for returning to work. This can cause sudden staffing shortages at a time when extra work is required to control the outbreak. -Facilities should prepare for the possibility of staffing shortages and have a concrete plan with	D 188		

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specific steps to take if they do need additional staff.
-The following options should be considered for emergency staffing:
-Allowing caregivers that are positive but asymptomatic to staff areas dedicated to caring for positive residents (while wearing appropriate PPE).
-Contacting temporary staffing agencies.
-Contacting other sister agencies for temporary staffing support.
-Contacting local hospitals for temporary staffing support.
-If all these options have been exhausted and additional staffing is still needed, your local health department can request emergency staff from the state.
-Emergency staffing requests typically take several days to fill.
-Facilities should begin searching for additional staff as soon as staff are tested rather than waiting for test results to come back, so these emergency staffing requests can be filled if necessary.

Staffing and emergency staffing policies were requested on 08/04/20 12:00pm but none were provided.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living (AL) with a capacity of 100 beds and a Special Care Unit (SCU) with a capacity of 25 beds.

Review of the Resident Bed List Report dated 07/10/20 revealed:
-There was a census of 75 residents in the AL unit.
-There should have been a total of 32 aide hours

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on first shift.
-There should have been a total of 24 aide hours on third shift.

Review of the Employee Time Detail dated 07/10/20 revealed:
-There were 24.72 staff hours provided on the first shift, a shortage of 7.28 hours.
-There were 15.75 staff hours provide on the third shift, a shortage of 8.25 hours.

Review of the Resident Bed List Report dated 07/11/20 revealed:
-There was a census of 75 residents in the AL unit.
-There should have been a total of 32 aide hours on first shift.
-There should have been a total of 32 aide hours on second shift.
-There should have been a total of 24 aide hours on third shift.

Review of the Employee Time Detail dated 07/11/20 revealed:
-There were 28.76 staff hours provide on the first shift, a shortage of 3.24 hours.
-There were 22.80 staff hours provided on the second shift, a shortage of 9.17 hours.
-There were 15.59 staff hours provided on the third shift, a shortage of 8.41 hours.

Review of the Resident Bed List Report dated 07/12/20 revealed:
-There was a census of 75 residents in the AL unit.
-There should have been a total of 32 aide hours on first shift.
-There should have been a total of 32 aide hours on second shift.
-There should have been a total of 24 aide hours

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D 188	Continued From page 4 on third shift. Review of the Employee Time Detail dated 07/12/20 revealed: -There were 25.01 staff hours provide on the first shift, a shortage of 6.99 hours. -There were 22.80 staff hours provided on the second shift, a shortage of 9.20 hours. -There were 15.59 staff hours provided on the third shift, a shortage of 8.41 hours. Review of the Resident Bed List Report dated 08/02/20 revealed: -There was a census of 72 residents in the AL unit. -There should have been a total of 32 aide hours on first shift. -There should have been a total of 32 aide hours on second shift. -There should have been a total of 24 aide hours on third shift. Review of the Employee Time Detail dated 08/02/20 revealed: -There were 28.98 staff hours provided for first shift, a shortage of 3.02 hours. -There were 14.63 staff hours provided for second shift, a shortage of 17.37 hours. -There were 15.38 staff hours provided on the third shift, a shortage of 8.62 hours. Review of the Resident Bed List Report dated 08/07/20 revealed: -There was a census of 71 residents in the AL unit. -There should have been a total of 32 aide hours on second shift. -There should have been a total of 24 aide hours on third shift.	D 188		

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D 188	Continued From page 5 Review of the Employee Time Detail dated 08/07/20 revealed: -There were 30.06 staff hours provided on the second shift, a shortage of 1.94 hours. -There were 15.00 staff hours provide on the third shift, a shortage of 9 hours. Review of the Resident Bed List Report dated 08/08/20 revealed: -There was a census of 71 residents in the AL unit. -There should have been a total of 32 aide hours on first shift. -There should have been a total of 32 aide hours on second shift. -There should have been a total of 24 aide hours on third shift. Review of the Employee Time Detail dated 08/08/20 revealed: -There were 29.64 staff hours provided on the first shift, a shortage of 2.36 hours. -There were 16.41 staff hours provided on the second shift, a shortage of 15.59 hours. -There were 15.00 staff hours provide on the third shift, a shortage of 9 hours. Review of the Resident Bed List Report dated 08/12/20 revealed: -There was a census of 70 residents in the AL unit. -There should have been a total of 28 aide hours on first shift. -There should have been a total of 28 aide hours on second shift. -There should have been a total of 24 aide hours on third shift. Review of the Employee Time Detail dated 08/12/20 revealed:	D 188		

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-There were 14.62 staff hours provided on the first shift, a shortage of 13.38 hours.
-There were 23.61 staff hours provided on the second shift, a shortage of 4.39 hours.
-There were 16.95 staff hours provided on the third shift, a shortage of 7.05 hours.

Review of the Resident Bed List Report dated 08/13/20 revealed:
-There was a census of 71 residents in the AL unit.
-There should have been a total of 32 aide hours on first shift.
-There should have been a total of 32 aide hours on second shift.
-There should have been a total of 24 aide hours on third shift.

Review of the Employee Time Detail dated 08/13/20 revealed:
-There were 23.43 staff hours provide on the first shift, a shortage of 7.57 hours.
-There were 23.28 staff hours provided on the second shift, a shortage of 8.72 hours.
-There were 15.00 staff hours provided on the third shift, a shortage of 9.00 hours.

Telephone interview with a third shift MA on 08/06/2020 at 2:42pm revealed:
-She was the only assigned MA on third shift for the facility from 11:00pm until 7:00am between 07/10/20 and 08/13/20.
-She was responsible for administering PRN medication to residents on third shift.
-She was responsible for responding to incidents or accidents involving residents on third shift.
-The assisted living unit was usually staffed with one or two PCA's on third shift.
-In July 2020, there were numerous occasions of only one PCA being schedule on third shift in the

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assisted living unit.
-She worked an eight-hour shift, seven days per week on third shift at the facility.
-She spent the seven shift hours on the assisted living unit, and a cumulative one-hour total on the SCU unit during third shift.
-She administered PRN medications to all the residents on the SCU, but she couldn't recall which residents she gave their PRN medication that had tested positive for COVID-19.
-She was familiar with some assisted living unit residents that required scheduled medication administration during third shift.
-The facility had been utilizing healthcare agency staff up until approximately June 2020 due to insufficient facility staff.
-She was concern that on numerous occasions during third shift, there were only three staff working in the facility, including one MA and two PCA's between the assisted living unit and SCU.

Confidential telephone interview with a MA revealed:
-The facility had been understaffed since May 2020.
-On first shift, the facility staffed two MA's and one or two PCA's for the assisted living unit.
-On third shift, the facility occasionally staffed one MA and one care aide for the assisted living unit in July 2020.
-She did not know who was responsible for scheduling staff.
-The facility had been utilizing a healthcare agency staff to fill vacancies in the schedule up until approximately May or June 2020.
-The facility Administrator had instructed staff to be careful what information staff shared with surveyors about staffing and other activities occurring in the facility.

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Telephone interview with a first & third shift PCA on 08/14/2020 at 3:00pm revealed:
-She worked as a PCA on the assisted living unit on first shift and occasionally on third shift.
-In July 2020 and August 2020, on occasion, she and another PCA worked on first shift with a first shift MA, but usually there were three PCAs working.
-She did not know how may PCAs the facility needed on first shift.
-There were a lot of residents that required personal care assistance on first shift, and it was difficult to perform personal care assistance with only two PCAs.
-The first shift MA would only assist with resident care if they were not busy passing medications and doing other tasks, such as writing notes in resident records.
-In July 2020 and August 2020, she occasionally worked as a PCA on third shift.
-There were a few occasions in July 2020 and August 2020, when she was the only PCA working on third shift with a third shift MA.

Telephone interview with a lead MA on 08/11/2020 at 11:49am revealed:
-She was responsible for scheduling assisted living unit staff in July 2020.
-She scheduled staff according to pre-set staff schedules and tried to fill schedule vacancies with available facility staff.
-The schedule was shared with the Health & Wellness Nurse (HWN) and the Administrator for review.
-She was not responsible for scheduling healthcare agency staff to fill schedule vacancies; this was the responsibility of the HWN or the Administrator.

Telephone interview with the HWN on 08/14/2020

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at 1:07pm revealed:
-She was responsible for assuring MAs and PCA staff met the healthcare and personal care needs of residents.
-She was not responsible for scheduling staff prior to August 2020.
-She expected the third shift MA to work primarily on the assisted living unit during the third shift, which was 11:00pm until 7:00am.
-She expected the third shift MA to occasionally check-in with the SCU PCAs during third shift and respond to incidents or accidents and administer PRN medications to the AL and SCU residents.
-The facility attempted to utilize a healthcare staffing agency in the past to fill schedule vacancies but, around May 2020, the agency was unable to fulfill all the schedule vacancies for the facility.
-The facility attempted to utilized facility staff since May 2020, to fill all schedule vacancies to the best of their ability.

Telephone interview with the Administrator on 8/17/2020 at 3:19pm revealed:
-She was aware of the facility staffing requirements for the assisted living unit and SCU according to the daily census.
-She had assigned a lead MA to be responsible for scheduling assisted living unit staff in July 2020.
-The lead MA shared the assisted living unit staff schedule with her and the HWN for review and to address shift vacancies.
-She was aware the assisted living unit maintained approximately 75 residents per day in July and August 2020.
-She expected the third shift MA to float between the assisted living unit and SCU.
-She expected the third shift MA to be on the assisted living unit for a total of four hours per

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shift.
-She expected the assisted living unit to be staffed with two PCA's and one MA on third shift.
-She was not aware the assisted living unit had been staffed with one PCA and one MA on numerous occasions in July 2020 and August 2020.
-She expected staff, including herself, to update staff schedules when a scheduled staff member called-out, was placed on leave, or a schedule vacancy was filled with a healthcare agency staff.
-Occasionally scheduled staff names were crossed out on shift schedules due to calling out and a replacement staff name was added to the vacant shift schedule, if a replacement staff was available to cover the vacant shift.
-When staff called out sick the lead MA and/or the HWN was expected to be notified, so they could find a replacement or take the assignment themselves.
-On 08/08/20 the staff on duty failed to notify someone on the management team that they did not have enough staff to administer medications.
-She did not routinely contact the facility when she was not onsite to check for adequate staffing, she expected the staff to contact management when staffing issues occurred.

Attempted telephone interviews with contract staffing agency manager on 08/14/20 at 12:05pm and 08/17/20 at 11:05am were unsuccessful.

Attempted telephone interviews with contract staffing agency human resources 08/17/20 at 11:15am were unsuccessful.

Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights.

Refer to Tag 358, 10A NCAC 13F .1004(a)

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D 188	Continued From page 11 Medication Administration. _____ Based on record reviews and interviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents residing in the Assisted Living (AL) unit for 22 of 54 shifts sampled for 18 days between 07/10/20 and 08/13/20. The facility's failure resulted in a lack of adequate staff on the unit to supervise and administer medications was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 August 13, 2020 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2020.	D 188		
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 review the facility failed to ensure a therapeutic diet was served as ordered for 1 of 5 sampled residents (Resident #3) with physician's orders for	D 310		

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a nutritional supplement.

The findings are:

Review of Resident #'3's current FL2 dated 11/06/19 revealed diagnoses included Alzheimer's dementia, hyperlipidemia and pre-diabetes.

a. Review of Resident #3's signed Physician Order Report dated 04/20/20 revealed there was an order for a nutritional supplement, used to treat protein deficiency, once daily.

Review of Resident #3's June 2020 electronic medication administration record (eMAR) from 06/01/20 through 06/30/20 revealed:
-There was a computer-generated entry for a nutritional supplement to be administered daily at 8:00am.
-Resident #3's nutritional supplement was documented as administered 30 out of 30 possible opportunities.

Review of Resident #3's July 2020 eMAR from 07/01/20 through 07/31/20 revealed:
-There was a computer-generated entry for a nutritional supplement to be administered daily at 8:00am.
-Resident #3's nutritional supplement was documented as administered 30 out of 31 possibilities.

Review of Resident #3's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for a nutritional supplement to be administered daily at 8:00am.
-Resident #3's nutritional supplement was documented as administered 12 out of 13

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D 310	Continued From page 13 opportunities. Observation in the Special Care Unit (SCU) on 08/13/20 at 9:00am revealed: -There was a case of nutritional supplements on the top of Resident #3's closet. -The case contained thirty-two 8-ounce cartons of vanilla nutritional supplement. -There were nine remaining cartons in the case. -There was a case of nutritional supplements in a box labeled with Resident #3's name in the dining room cabinet. -The case contained twenty-four 8-ounce cartons of vanilla nutritional supplement. -There were seventeen remaining cartons in the case. -Thirty of the fifty-six available nutritional supplements were administered from the 2 cases between February 2020 and July 2020. Telephone interview with Resident #3's Power of Attorney (POA) on 08/13/20 at 10:20am revealed: -She provided the nutritional supplement for Resident #3. -She provided 1 case of 32 protein supplements on 02/13/20. -Prior to the "No Visitor" policy, she kept track of the nutritional supplement stock when she visited Resident #3. -Since the facility restricted non-essential visitors, the previous Special Care Coordinator (SCC) contacted her when the nutritional supplements were low. -She ordered a new case at that time. -No one from the facility had contacted her regarding Resident #3's nutritional supplement supply from 02/13/20 to 07/23/20. -She contacted the facility on 07/23/20 and was told by the staff Resident #3 had no nutritional supplements.	D 310		

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-She provided a second case of 24 protein supplements on 07/25/20.
-Fifty-six nutritional supplements were provided from 02/25/20 through 08/13/20.
-She sent the nutritional supplements directly to the facility since there was a "No Visitor" policy.
-Resident #3 did not always eat her meals and the nutritional supplement had been prescribed for "protein deficiency".
-Resident #3 was cognitively impaired and was unable to feed herself or make her needs known.
-Resident #3 was dependent on the staff for all her needs.

Interview with a medication aide (MA) on 08/03/20 at 2:15pm revealed:
-Nutritional supplements were kept in the dining room cabinet.
-She thought Resident #3's family member provided the supplements.
-The MAs were responsible for serving and documenting nutritional supplements on the eMARs.
-She administered Resident #3's nutritional supplement when she worked as the MA in the SCU.

Telephone interview with a second MA on 08/10/20 at 1:04pm revealed:
-She worked primarily in the SCU as a MA.
-The nutritional supplements for Resident #3 were in her bedroom closet.
-She did not know how the supplements were re-supplied.
-She administered Resident #3's nutritional supplements when she worked as the MA in the SCU.

Telephone interview with a third MA on 08/12/20 at 11:17am revealed:

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D 310	Continued From page 15 -Resident #3 required staff assistance with eating. -Resident #3 has an order for a nutritional supplement. -She administered the nutritional supplement as ordered, once daily. -She would inform the Health & Wellness Nurse (HWN) if the supply ran low. -She did not know who provided Resident #3's nutritional supplement. Interview with the HWN on 08/13/20 at 2:30pm revealed: -The MAs administered nutritional supplements as ordered to the residents. -She knew Resident #3 was on a nutritional supplement for protein deficiency. -She knew the POA provided the nutritional supplements and the MAs were to administer 1 carton daily. -The previous SCC would have been responsible for notifying the POA if Resident #3's nutritional supplement supply was running low. -She knew the amount provided by the POA did not cover the past 6 months. -There was another resident who was also on a nutritional supplement and was deceased. -This second resident had nutritional supplements in the dining room cabinets. -The facility had been providing Resident #3 with the nutritional supplements the second resident left behind. -She was not sure how many nutritional supplements were left behind or what type of nutritional supplement it was. -The second resident's nutritional supplement supply had been completed. -She was not sure when the supply of the second resident's nutritional supplements were completed.	D 310		

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D 310	Continued From page 16 Telephone interview with the hospice registered nurse (RN) on 08/17/20 at 2:32pm revealed: -Resident #3 was a hospice client in 2019 and was discharged from services in February 2020. -The order for the nutritional supplements was implemented during Resident #3's first admission for protein calorie deficiency. -Hospice resumed care for Resident #3 on 07/22/2020 and continued the previous orders that were already in place. -The order for Resident #3's nutritional supplement, once daily, had continued after discharge from hospice in February 2020. -Due to her cognitive impairment, Resident #3 had forgotten how to eat. -Resident #3 would grab a spoon or fork but did not know how to use the utensils. -She has expressed to the staff the necessity to feed Resident #3 at meal time. -She assisted Resident #3 at meal time when the food tray was placed in front of her and Resident #3 was not eating. -Based on the facility's monthly weight assessment, Resident #3 had lost 4 pounds (lbs.) since February 2020 when she was discharged from hospice services. -Resident #3 was documented as 100 lbs in February 2020 and was documented as 96 lbs in July 2020. Telephone interview with the Administrator on 08/17/20 at 3:53pm revealed: -The MAs were responsible for administering physician orders on the eMAR for the residents. -Nutritional supplements for the residents were kept in the SCU. -The SCC was responsible for ensuring the nutritional supplements were available for administration.	D 310		

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D 310	Continued From page 17 -The SCC position was currently not filled. -The HWN was responsible for the administration of medications and physician orders. -She was aware the POA provided the nutritional supplements for Resident #3. -She did not know Resident #3 had not been receiving her nutritional supplements daily. -She expected the MAs to administer the orders on the eMARs for every resident. -If the nutritional supplements were not available to be administered, the MAs should have reported that to the SCC or the HWD.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening and testing of staff and residents, use of personal protective equipment (PPE) by staff and residents, practicing social distancing, and practicing infection control procedures to reduce the risk of transmission and infection.	D 338		

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D 338	Continued From page 18 The findings are: Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities revealed: -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -Social distancing should be implemented among the residents. -If COVID-19 is identified in the facility, restrict all residents to their rooms. -Residents with known or suspected COVID-19 should be cared for using recommended PPE including eye protection, gloves, gown, and a N95 respirator face mask. -A surgical mask can be used if a N95 mask is not available. -Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. -Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency (EPA) registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for coronavirus in healthcare settings. Review of the additional CDC guidelines for Special Care Units (SCU) that should be used to supplement current COVID-19 guidance in LTC facilities revealed: -As it may be challenging to restrict residents to their rooms, consider potential risks and benefits of moving residents out of the memory care unit to a designated COVID-19 care unit.	D 338		

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D 338	Continued From page 19 -Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing at least 6 feet apart. -Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside. -Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are near other residents or personnel. -Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time. -Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. -Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. Review of the NCDHHS for prevention and spread of the coronavirus in LTC facilities revealed: -Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19. -All facility staff should wear a face mask while in the facility. -Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom.	D 338		

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-Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff.

Review of the facility's 2020 infection control policy revealed the policy contained no COVID-19 infection prevention plan to address donning (application of putting on) and doffing (removal of) PPE, appropriate cleaning and disinfecting of high touch surfaces, social distancing, and alternative measures for the management of SCU residents.

Review of the LHD guidelines for prevention and spread of the COVID-19 in LTC facilities dated June 2020 revealed:
-All LTCFs should be prepared with adequate testing capacity to quickly detect and respond to any cases of COVID-19 in the facility.
-In addition to on-going symptom screening and monitoring of staff and residents the facility should develop a plan for weekly testing of all staff.
-Facilities with identified cases of COVID-19 was to perform testing on all residents and staff.
-When one or more cases of COVID-19 was identified the facility was to continue repeat viral testing of all asymptomatic previously negative residents and staff approximately every 3-7 days of at least 14 days since the most recent positive result.
-After 14 days passed continue screening symptom and monitoring of all staff and residents.
-Complete LHD COVID-19 Monitoring Log to report staff and residents' date of birth, gender, title, onset date, date symptoms resolved, date tested and results, visits to urgent care, visits to

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emergency room (ER), and date of hospitalizations with location.

Review of the facility LHD COVID-19 Monitoring Log on 08/04/20 provided by the Administrator revealed:
-Eleven Residents had tested positive for COVID-19.
-Three Staff members had tested positive for COVID-19.
-One Resident tested positive on 07/10/20 and was hospitalized 07/14/20 and returned to the facility on 07/22/20.

Review of the COVID-19 screening logs for staff working on the SCU on 08/13/20 at 9:30am revealed:
-There was no screening log for the MA and 2 PCAs currently working on the SCU.
-The COVID-19 screening logs dated 08/06/20 to 08/12/20 had temperatures documented with ranges taken by staff ranging from "87.6 to 97.1".
-There were no second temperatures taken.

Review of the LHD Environmental Health Request for Service Report dated 07/06/20 revealed:
-The County Environmental Health Specialist reached out to facilities experiencing health outbreaks to give guidance on approved cleaning products, usage and frequency.
-The County Environmental Health Specialist detailed a phone conversation on 07/06/20 with the Health & Wellness Nurse (HWN) at the facility.
-The HWN reported the facility was using orange top bleach germicidal disposable wipes, a defogging machine and green top sani-cloth germicidal disposable wipes for cleaning and disinfecting.

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-The Health Specialist stated the green top sani-cloth germicidal disposable wipes were not on the EPA approved list to kill COVID using List N.
-The HWN also reported the staff were taking temperature screenings of the residents 3 times a day.

Review of the efficacy data sheet for the disinfectant used in the SCU on 08/03/20 revealed:
-The disinfectant was a hospital grade one-step cleaner, bactericidal, viricidal, mildewcidal, fungicidal disinfectant.
-The disinfectant killed Human Coronavirus in 10 minutes after 2 ounces of solution is diluted in one gallon of water and applied to a non-porous surface.

Review of the facility's SCU current census and move-out roster dated 08/03/20 revealed:
-There were 15 residents residing in the SCU.
-One of the residents was in the hospital.
-There were five residents identified as testing positive for COVID-19.
-There were five empty rooms one was last occupied on 07/22/20 and the other four empty room was last occupied on 07/24/20.

Review of "Daily Temperature Log Reports" for the SCU residents revealed:
-Resident temperatures were to be completed on each shift.
-The most recent entry was documented on 05/31/20.

Observations upon entry into the SCU on 08/03/20 between 12:30pm-2:00pm revealed:
-A medication aide (MA) allowed entry of essential visitors through a locked door after the

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doorbell alerted her of their arrival.
-Immediately after prompting the MA, took the essential visitors' temperatures and asked them about the appropriate screening questions.
-The MA was wearing nursing scrubs and a surgical mask.
-The MA pointed her finger and named four residents who were identified as tested positive for COVID-19 in the SCU sitting in the common area with five other residents.
-The MA resumed her activity in the dining room at the medication cart.
-The MA left the enclosed dining room and was in the common room where the residents who were identified as COVID-19 positive were co-mingling with the residents who had not been identified as COVID-19 positive.
-The MA did not put on a gown, eye shields or gloves before entering the common area.
-The MA moved freely amongst the residents.
-In the common area in the beginning of the observation a personal care aide (PCA) was standing the center of the room observing 9 residents sitting in the room.
-None of the residents in the SCU wore masks.
-The PCA was wearing nursing scrubs, gloves and a surgical mask but no gown and eye shields.
-The PCA was removing disposable lunch items from the tables set up for dining.
-A second PCA entered the unit came back wearing a mask but no gown, gloves, and eye shields.
-The 2 PCAs proceeded to bring a resident who was identified as COVID-19 positive to her room to provide personal care.
-Neither staff wore gowns and eye shields when entering the resident's room.
-The PCA clearing lunch items did not change her gloves before entering the room to provide care.

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-Neither staff changed their face masks upon exiting the resident's room.
-There were two residents sitting at one table that was approximately 6 feet in length and 3 feet wide (One resident was identified as tested positive for COVID-19).
-There were two residents sitting at two different round tables, that were positioned within 3 feet of each other; one resident which was sitting with the side of her wheelchair directly behind the other resident at the second table (One resident was identified as tested positive for COVID-19).
-When the Administrator arrived in the common area on the SCU, she was wearing a cloth face covering that was not covering her nose.
-During the tour of the residents' room the rooms occupied by residents who were identified as COVID-19 positive had a letter "C" on their door.
-A tour of the residents' rooms revealed one room assigned to two residents (One resident was identified as tested positive for COVID-19).
-The current census was 15 residents with the capacity of 25 residents.
-The Administrator demonstrated there were 5 empty rooms being used to store previous resident's personal items until their families came to remove them.
-An additional PCA, who was not wearing a mask, gown or eye shield arrived on the SCU from an outside entrance.
-She walked into the medication room, put on a mask, began assisting residents without washing her hands or using an alcohol-based hand sanitizer (ABHS).
-The MA walked into the common area where one resident that was identified as tested positive for COVID-19 was seated.
-She pushed a wheelchair forward out of her way, to get between two residents, wearing an unsecured PPE gown with the opening exposing

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the front of her nursing scrubs, a N95 mask, and no gloves.
-The MA walked back into the medication room after speaking to residents seated at a table, removed the PPE gown and placed it on the barber chair located in the middle of the room.
-She reached and removed items from a cabinet without washing her hands or using an ABHS.
-One resident who was identified as tested negative for COVID-19 was walking around the entire building in the hallway using handrails to ambulate.
-One resident who was identified as tested positive for COVID-19 was ambulating with his walker stopping to touch handrails along the walls.
-There was no observation of often-touched surfaces being cleaned.
-One of the PCAs used a disinfectant after putting on gloves to spray down a table and wiped it dry without cleaning the surface first with soap and water and allowing the disinfectant to remain in place to dry.
-When the PCA finished cleaning the tables she removed her gloves but was not observed washing her hands or using an ABHS.

Observation of the PPE supply area on 08/03/20 at 1:54pm revealed:
-There was a plastic bin in the medication room on top of the refrigerator.
-The bin was labeled "PPE Kits Inside".
-A note was attached to the outside of the bin-"direct care staff use face shields with COVID positive residents; eye and face shields are re-usable".
-There were 6 blue gowns, 1 pair of goggles and 10 face masks.

Interview with a PCA 08/03/20 between

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D 338	Continued From page 26 12:30-2:00pm revealed: -There was not a housekeeper assigned to the SCU. -The PCAs were responsible for all housekeeping duties and personal care duties. -She used one product to clean high touch services and dining room tables. -The product was a disinfectant kept in the cleaning closet. -The product was light red in color and was premixed in a spray bottle. -She used the disinfectant to spray surfaces and wiped it away the product after it remain in place for a couple of minutes. -There was not a set schedule or time to clean all high touch surfaces. -She cleaned when things needed cleaning throughout her shift. -She did not receive any specific instruction on how to use the disinfectant. -No one told her that the disinfectant spray needed to remain in place for ten minutes. -She did not clean any surface prior to applying the disinfectant. Interview with the MA on 08/03/20 between 12:55pm-1:45pm revealed: -She worked as the MA on the first shift in the SCU. -Residents were not required to remain in their rooms. -It was "dangerous" to leave the residents in their rooms. -She was concerned they may fall or have an accident. -She verbally explained the proper donning and doffing of personal protective equipment. -The HWN had reviewed the proper usage of PPE with her last month. -The HWN had instructed the staff to wear	D 338		

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gowns, gloves and a face mask when providing personal care for COVID-19 positive residents.
-The staff wore gowns the entire shift since several COVID-19 positive residents.
-She wore the same gown the entire shift.
-When she left a COVID-19 positive resident's room, she changed her gown, double bagged the gown and placed it in the trash receptacle located in the hallway.
-Sometimes she "loses track" and "forgets" to wear her gown.
-The gown was very hot and sometimes she removed it and placed the gown over a chair if she was in the medication room by herself.

Interview with the Administrator during a tour of the SCU on 08/03/20 between 12:30pm-2:00pm revealed:
-The staff were instructed to put on PPE consisting of mask, gown, gloves, and eye shields prior to entering a resident's room to provide personal care.
-The PPE was to be disposed of in a bin outside of the residents' room in the hallway.
-The staff were to wash their hands in the medication room or use an ABHS.
-The staff were not expected to wear PPE when residents were in the common area eating because they were not providing personal care to the residents.
-The HWN was responsible for training and checking off the staff on standard infection control procedures and COVID-19 infection control procedures.
-All staff were trained upon hire and checked off by the HWN on PPE.
-The two residents one that was indicated as tested positive for COVID-19 seated together at the two round tables less than 3 feet apart were not directly facing other residents, and she did not

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think it was necessary to separate them any further apart.
-She did not stop communal dining because the SCU residents did not want to eat in their rooms, and she decided allowing communal dining would be more efficient and safer.
-The SCU residents all required constant supervision and it was unsafe for them to eat alone and be in their rooms alone.
-All the residents on the SCU were cognitively impaired which indicated to her the staff was not going to be capable of restricting them to their own room.
-The resident who was identified as testing positive for COVID-19 remained in the same room with their roommate who was not identified as tested positive COVID-19 because the 5 unoccupied room had not yet been cleaned after the previous residents were discharged.
-She considered placing the five COVID-19 positive SCU residents together, but she was not allowed the time to do it.
-She received the guidance provided from all available resources mentioned, but it was different from all of them.
-She didn't know which guidance to follow.
-She wore a cloth face mask because the N95s were too hot and uncomfortable; it was always difficult to keep a mask over her nose.
-The facility had an abundant PPE supply that was delivered through the county community resources.
-She wanted to be told what to do when it came to manage the SCU with positive COVID-19 residents.

Telephone interview with another MA on 08/11/20 at 11:20am revealed:
-She worked as a MA and a PCA on the SCU.
-When she was assigned to work as a CNA her

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duties include housekeeping tasks since the housekeeper assigned to Memory Care resigned.
-The Administrator gave the staff a list of chores to be completed during their shift, which included cleaning common areas, resident's bedrooms and bathrooms, and laundry.
-She used an orange solution in a spray bottle that was left in the housekeeping closet to clean hard surfaces.
-She sprayed tables, ledges, hand rails and wiped off the solution with a cloth or paper towel.
-She did not wait any length of time before wiping the area down.
-She did not know what the directions were for proper usage of the chemical spray.
-She did not receive any guidance/instructions on what cleaning products to use or how to properly use them.
-She was given an orientation packet by the Business Office Manager (BOM) upon hire that included infection control training.
-She was instructed to read the information, sign and return to the BOM.
-She did not attend an infection control class or presentation or any special COVID 19 instructions upon hire.
-She had instructions on PPE by the Health and Wellness nurse recently.
-She was instructed to wear gowns, face mask or face shield, gloves and shoe coverings if she went into a COVID positive room.
-She was instructed to remove PPE outside of the room, put it in a plastic bag and place the bag in the trash receptacle in the hallway.
-Hand sanitizers were in the medication room and on the medication cart for staff to use.
-There was a common bathroom in the front hall for staff to wash their hands with soap and water.
-The staff had been instructed by the Administrator and the HWN to inform them if any

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resident has symptoms of shortness of breath, cough or a fever.

Telephone interview with the Maintenance staff on 08/10/20 at 8:44am revealed:
-One of his duties was to use the "fogging machine" in the SCU.
-The fogging machine used a fine mist to apply disinfectant cleaning chemicals.
-The area should be cleaned prior to fogging.
-The SCU staff were responsible for cleaning the area before he arrived with the fogging machine.
-He did not use the fogging machine in the COVID-19 positive rooms.
-The staff used the EPA approved disinfectant product diluted in water in a spray bottle kept in the housekeeping closet in the SCU.
-The Maintenance manager prepared the disinfectant mixed with water into the spray bottle.
-The staff should spray the solution onto hard surfaces and wait 10 minutes before wiping the surface down.
-He did not know who trained the PCAs on using the cleaning products.

Telephone interview with the Maintenance Manager on 08/10/20 at 10:32am revealed:
-He recommended the purchase of the fogging machine during the COVID-19 outbreak as the best and quickest way to disinfect the facility.
-He used an EPA approved disinfectant with the operation of the machine.
-He did not clean the area before using the machine.
-He was trained on the proper usage of the machine by the company it was purchased from.
-He did not remember the name of the company.
-He used the fogging machine throughout the common areas while the residents stayed in their rooms.

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-He used the fogging machine in the non COVID-19 resident rooms while the residents were seated in the common area.
-There was no special cleaning before the fogging application.
-It took about 10 minutes to dry.
-The SCU was cleaned with the fogging machine 2-3 times a week.

Follow up email to a telephone interview with the County Environmental Health Specialist on 08/10/20 at 3:44pm revealed:
-Fogging machines were approved to use on hard surfaces for disinfecting.
-The nurses needed to disinfect the areas before and after use and that would be the guidance for proper disinfecting.

Another observation upon entry into the SCU on 08/13/20 between 8:00am-9:15am revealed:
-A PCA allowed entry of two essential visitors through a locked door after the doorbell alerted her of their arrival.
-The PCA was wearing a surgical mask but no gown or gloves.
-The PCA screened the two essential visitors using temporal thermometer providing very low readings of less than 90 degrees for both visitors.
-During a tour of the SCU there were 15 residents present.
-In the living room there were two tables 6 feet in length and 3 feet wide set up along one wall.
-Two residents were sitting at one of the tables eating breakfast, seated less than 3 feet apart.
-After the two residents that were seated together finished their breakfast, they ambulated to a 5 ft long sofa facing a television, and they sat down less than 5 ft apart at different times on the sofa.
-A resident was sitting in a wheelchair that was located directly at the right end of the sofa

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allowing all three residents to be seated less than 6 feet apart.
-The PCA did not attempt to separate the three residents and allowed them to remain seated.
-The PCA rolled the resident to the same table where the two residents were eating and left to sit on the sofa.
-The PCA placed the resident in the wheelchair at the table and went to get her breakfast.
-She did not wash her hands before she removed the resident's food tray from a cart and returned to the living room
-The PCA placed the resident's breakfast tray, on the table in front of her opened her milk, water bottle, and food container lid.
-The resident picked up her toast and began to eat.
-The PCA did not clean the table and did not wash the resident's hands prior to bringing the resident to the table.
-The remainder of the 15 residents were in their rooms.

Interview with the PCA on 08/13/20 between 8:00am-9:15pm revealed:
-The current census on the SCU was 15 residents.
-She was required to self-screen for COVID-19 by taking her temperature and answer questions on a questionnaire.
-She did not complete a COVID-19 screening sheet when she arrived at work because she was the only person available to take care of the residents.
-The thermometer used for screenings was broken and the MA would have to open the medication cart to get another thermometer that worked.
-She was trained on infection control and she knew she was supposed to wash and disinfect

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the tables between residents.
-She knew she was supposed to wash residents' hands and her own hands before serving the residents their breakfast, but she forgot.
-She did not try to separate the residents 6 feet apart because they would get agitated.

Interview with the MA on 08/13/20 at 9:30am revealed:
-The thermometer worked sometimes and other times it did not work.
-She removed another thermometer from the medication cart, and it did not provide an accurate reading.
-The batteries in the second thermometer had been replaced but it still did not provide an accurate reading.
-She was responsible for screening all the residents and staff on her shift.
-She did not screen resident's temperatures daily.
-There was no entry on the electronic Medication Administration Records (eMARs) to document resident's temperatures during first or second shift.
-Residents and staff were screened using the thermometer that provided inaccurate readings.
-She had not reviewed the staff screening logs because it was the HWN responsibility to collect them and review them.
-She informed the HWN "a few days ago" that the thermometer was broken, and she did not get a replacement yet.
-She did not know when the HWN last reviewed the COVID-19 staff screening logs.
-She was told to submit all residents' temperatures weekly to the HWN.

Telephone interview with a Registered Nurse (RN) from the LHD on 08/06/20 at 9:08am revealed:

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D 338	Continued From page 34 -The facility was in their second outbreak of COVID-19. -The first outbreak was in April 2020 with 13 residents who identified with positive test results for COVID-19 on the Assisted Living side. -The last positive reported on 04/28/20 and after 28 days it was resolved with no additional positive results. -The Administrator and the HWN informed her on 07/15/20 the facility had four residents who tested positive for COVID-19. -During the second outbreak beginning 07/10/20 to the present there were 3 staff and 11 residents who were identified with positive test results for COVID-19. -There were 2 of 11 of residents who indicated positive test results that died within the 3 weeks following testing positive for COVID-19 or the onset of their symptoms. -The last positive test was a resident on 07/21/20. -She emailed the Administrator the LHD guidelines with the necessary links for CDC and NCDHHS guidelines for LTC facilities the same day (07/15/20). -She instructed them to monitor staff and residents daily for signs and symptoms of COVID-19 by checking temperatures and noting any symptoms of COVID-19. -She highlighted the instructions with LHD guidelines for "facilities with identified cases of COVID-19 perform testing on all residents and staff if there are one or more cases of COVID-19, identified continue repeat viral testing of all asymptomatic previously negative residents and staff approximately every 3-7 days of at least 14 days since the most recent positive result". -She instructed them to review the Long-Term Care Infection Prevention Assessment Tool for COVID-19 and discussed it with them along with attaching it to them in an email.	D 338		

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-She instructed them to evaluate their current capacity to test all residents and staff in the facility.
-She instructed them to place all residents that tested positive for COVID-19 in isolation.
- If the facility had multiple COVID-19 cases confirmed in residents, it was recommended that they be confined to one wing or location of the facility to prevent the spread of COVID-19.
-She instructed them to assign dedicated staff to the care of COVID-19 positive residents.
-She instructed them to use PPE, including universal use of facemasks for all staff while in the facility.
-She instructed them to follow appropriate infection prevention guidelines and to use EPA approved cleaning supplies.
-She placed a referral for the county environmental health staff to reach out to the facility to ensure adequate amount of PPE and appropriate cleaning supplies were available and being used.

Telephone interview with the LHD RN and Medical Director on 08/08/20 at 1:00pm revealed:
-Their recommendations included isolating and separating all residents who tested positive for COVID-19 be isolated for at least 14 days, and ideally 20 days from the residents who were identified as testing negative for COVID-19.
-Their recommendations included stopping communal dining, and group activities, placing residents who indicated as testing positive for COVID-19 in a room alone, cohort COVID-19 positive residents with dedicated staff in one area and COVID-19 negative residents with dedicated staff in a separate area, and wearing the appropriate PPE when caring for COVID-19 positive residents.
-This was the second outbreak this facility was

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currently experiencing.
-The facility did not reach out to the LHD to express any challenges or clarification of the guidance provided until 08/03/20.
-During the second outbreak beginning 07/10/20 to the present there was 3 staff and 11 residents who indicated positive test results for COVID-19.
-There were 2 of the 11 of residents who were identified with positive test results that died within the 3 weeks following testing positive for COVID-19 or the onset of their symptoms.

Telephone interview with the previous Special Care Coordinator (SCC) on 08/05/20 at 2:07pm revealed
-She last tested negative for indications of COVID-19 on 07/06/20.
-She was not instructed to retest after her negative test.
-The HWN was responsible for managing all staff trainings of Infection Control (IC) policies and procedures.
-She witnessed the HWN not checking off staff on IC tasks for annual IC trainings.
-New staff was not checked off on proper putting on and taking off PPE consisting of masks, gowns, and gloves, and eye shields.
-She was instructed to wear PPE gowns, and gloves when providing personal care for COVID-19 or other respiratory diseases like tuberculosis but she never provided a formal return demonstration to the Wellness Nurse because she was a Certified Nursing Assistant.
-She observed improper use of PPE by staff on the SCU and on the spot corrections, but staff continued to be non-compliant.
-The residents on the SCU were not isolated to their room, appropriately social distancing because they required more staff to ensure these guidelines were followed.

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-The capacity of the SCU was 25 residents and the census on her last day of work (07/14/20) was 24 residents with two residents in the hospital.
-There was not a plan put in place to isolate the residents who tested positive for COVID-19.
-There was not a plan to acquire additional staff because the she was told the facility was utilizing too many contract PCAs and MAs.
-She reported her findings and all her concerns to the Administrator and the HWN.
-The Administrator and HWN told her it was requiring too many contract staff to accommodate isolating the residents, ensuring social distancing and stopping communal dining.
-She was told she would have to assign herself to assist with personal care almost every day.
-When she discussed moving residents to other rooms to isolate them, the HWN told her it wasn't necessary to move one COVID-19 positive resident with dedicated staff to one area and leave COVID-19 negative residents with dedicated staff in a separate area.
-One resident who tested positive for COVID-19 remained in the same room as a resident who tested negative for COVID-19 when the resident who was tested negative could have been placed in another vacant room.

Telephone interview with the HWN on 08/12/20 at 2:00pm revealed:
-She was responsible for the Infection Control Plan and training the MAs/PCAs on infection control measures.
-She was aware of the CDC, NCDHHS, and LHD guidelines in management of COVID-19 outbreak.
-Upon hire she trained all the staff on appropriate use of PPE.
-She had observed staff assigned in the SCU utilizing PPE inappropriately and she re-educated

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them.
-She was very "hands-on" when educating the staff about infection control to include handwashing, PPE use, and proper cleaning of high touch surfaces.
-The residents who were identified as COVID-19 positive were not isolated to their rooms from other residents identified as COVID-19 negative because it was not safe for them to remain in their rooms alone.
-She suggested moving residents who were identified as COVID-19 positive away from residents identified as COVID-19 negative to the Administrator.
-She was not responsible for the decision for residents identified as COVID-19 negative to remain in the same room with residents indicated as COVID-19 positive.
-As of today (08/12/20), all the residents were on day #26 since the last resident tested positive on 07/21/20 and all the residents no longer required isolation from her understanding.
-She was responsible for the surveillance and testing of all the staff and residents during the outbreak.
-The staff were responsible for their own self screening upon arrival to work and were instructed to remain home if they became sick.
-During all staff meetings she provided education on signs/symptoms to report to her, but she did not have a sign-in roster or minutes from those meetings.
-She instructed the staff to report the SCU residents' temperatures to her every Monday.
-She "continuously" had to tell the SCU staff to get the SCU residents' vital signs and report any COVID-19 symptoms.
-The SCU MAs did not provide her with all the residents' vital signs like they were supposed to do.

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-She did not go behind the staff to assess the residents' vital signs and symptoms every day.
-After the previous SCC left, she visited the SCU daily to check on the residents and staff.
-All the staff and residents who identified as COVID-19 negative were not retested every 3-7 days for 14 days because it was a challenge to get the laboratory service to come that frequently.
-The laboratory service did not show up on 08/07/20 to retest the negative residents and staff.
-When she reached out to them via email on 08/10/20 they informed her they were "booked up" until 08/21/20.
-She was going to test all the staff and residents identified as COVID-19 negative today (08/12/20).
-She received an email and telephone call from the LHD-RN on 07/15/20 with all the resources for laboratory services.
-She did not reach out to the LHD for assistance because she felt "it would take too long".
-All the staff were offered COVID-19 testing and they refused to test.
-She did not create a COVID-19 infection prevention plan and policies prior to the outbreak to address proper use of disinfecting high touch surfaces, social distancing, isolation, and surveillance measures to have in place for the outbreak of COVID-19.

Interview with the Administrator on 08/13/20 at 12:05pm revealed:
-She expected all the staff to follow their training and the 2020 infection control policy in place for infection prevention which included PPE and disinfecting high touch surfaces.
-Weekly testing and information from the LHD RN were received during the previous outbreak in April 2020 via email to her inbox.
-When she observed staff not following their

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training and facility policies, she corrected them immediately.
-She did not receive the recent email dated 07/15/20 addressed to her email address because it might have gone into her spam folder.
-She spoke to the LHD RN during the current outbreak that began 07/10/20.
-The HWN was responsible for ensuring the screening and weekly testing of COVID-19 negative staff and residents.
-The HWN was expected to report all COVID-19 positive staff and residents to the LHD.
-She was not aware of any COVID-19 positive related deaths of residents.
-The residents' death since the outbreak were all hospice residents.
-She knew the HWN had problems getting weekly testing completed for the staff and residents because the facility's laboratory service provider was not available to perform testing weekly.
-Not all the staff was compliant with testing.
-She did not reach out to the LHD for further assistance or guidance.
-If she reached out via the links provided in the email from the LHD it would not been a solution to get all the staff to consent to testing.
-The LHD was not going perform COVID-19 weekly testing, and they struggled to get a laboratory service provider to come and perform the testing.
-She did not consider obtaining a decline to consent to test from the staff.
-She knew staff were not documenting their daily screenings and performing the residents' screening.
-The HWN was performing the test without consent to obtain them.
-She needed more help than emails with links to attached documents and websites.
-She needed someone to show up and tell her

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D 338	Continued From page 41 exactly what she needed to be doing to prevent COVID-19. -She did not get the assistance she needed from the state and local health department. -She did not create a specific policy and procedure manual specific to the management of COVID-19. Refer to Tag 0188, 10A NCAC 13F .0604(e) Personal Care & Other Staffing. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration. Refer to Tag 0465, 10A NCAC 13F 1308(a) Special Care Staff. _____ The facility failed to maintain the guidelines and recommendations established by the CDC, LHD, and NC DHHS for infection prevention and transmission during the COVID-19 pandemic related to the improper usage of disinfectants in order to effectively eliminate the coronavirus; not screening staff or resident temperatures and not providing reliable thermometers to do so; allowing COVID positive residents and COVID negative residents to dine and gather in common areas without any regard for social distancing; not cohorting COVID positive residents and COVID negative residents into separate rooms when there was potential to do so; staff not donning the appropriate PPE when necessary and also not donning PPE correctly when indicated; and not testing staff or retesting COVID negative residents as instructed all of which resulted in 11 residents residing in the facility diagnosed with COVID-19, 1 hospitalization, 2 deaths, and 3 staff diagnosed with COVID-19. These failures resulted in serious harm and neglect which constitutes a Type A1 Violation.	D 338		

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D 338	Continued From page 42 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/03/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 16, 2020.	D 338		
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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents (Residents #2, #3, #4, #5, #6 and #7), including several medications to control blood sugar, a medication to control blood pressure, a medication for nerve pain, an anticoagulant, mood stabilizers, a medication for cholesterol and an overactive bladder (Resident #5); medications for bipolar disorder and a mood stabilizers (Resident #3); medications to treat depression, dementia, chronic pain, cholesterol, to control	D 358		

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blood sugar, to control blood pressure, and a mood stabilizer (Resident #4), medications for pain, anxiety, acid reflux, and high blood pressure (Resident #2), medications for pain, anxiety and high blood pressure (Resident #6), and medications for pain control, high blood pressure, depression, and respiratory issues (Resident #7). In addition, the facility failed to ensure 15 out of 15 residents, residing in the Special Care Unit, received their medication on 08/08/20, and two residents on the Assisted Living community received their medications on 08/08/20 and 08/09/20.

Review of the facility's Medication Errors Policy and Procedures revealed:
-If a medication error occurs, notify the Wellness Director immediately and follow his/her directions.
-Some situations also require the completion of an Incident Report form. This should be done in situations such as the following: a resident missed a medication because it was not offered to him/her.
-The completed Medication Incident Report form must be reviewed and signed by the Wellness Director and Executive Director (ED), with a plan formulated to prevent recurrence the error.

1. Review of Resident #'5's current FL2 dated 05/22/20 revealed diagnoses included dementia, anxiety disorder and diabetes mellitus type 2 (DMII).

Review of the facility's Variance Report printed 08/13/20 revealed Resident #5's medications were not administered on 08/08/20 and 08/09/20.

a. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Levemir Flex Pen 30 units twice daily, a long acting insulin used to

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treat elevated blood sugar.

Review of Resident #5's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for Levemir Flex Pen 30 units to be administered twice daily at 8:00am and 8:00pm. Call the physician if the blood sugar is less than 60 or greater than 500.
-Levemir was not documented as administered at 8:00am or 8:00pm on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.
-Resident #5's blood sugar from 08/01/20 through 08/07/20 and 08/10/20 through 08/13/20 at 8:00am was documented in the range of 103 to 275.
-Resident #5's blood sugar was not documented on 08/08/20 or 08/09/20.
-On 08/10/20 at 8:00am Resident #3's blood sugar was 458.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed Resident #3's Levemir Flex Pen, 30 units twice daily, was last dispensed on 07/22/20 for a 30-day supply.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a Levemir Flex Pen with a computer-generated pharmacy label attached to the pen and directions to administer 30 units twice a day.
-The label had a dispense date of 07/22/20.

b. Review of Resident #5's FL2 dated 05/22/20

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revealed there was an order for a Novolog Flex Pen, a fast-acting insulin used to treat elevated blood sugar, inject 10 units twice a day.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Novolog Flex Pen, inject 10 units twice daily, to be administered at 12:00pm and 5:00pm.
-Novolog 10 units was not documented as administered at 12:00pm or 5:00pm on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed Resident #5's Novolog Flex Pen, 10 units twice a day, was filled on 06/15/20 and on 7/23/20 for a 28-day supply.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a Novolog Flex Pen with a computer-generated pharmacy label attached to the pen, and directions to administer 10 units twice a day.
-The label had a dispense date of 07/23/20.

c. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for a Victoza Pen, used to lower blood sugar, inject 1.8mg once daily.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for a Victoza injection 1.8mg to be administered daily

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at 8:00am.
-Victoza was not documented as administered on 08/08/20 or 08/09/20 at 8:00am.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed Resident #5's Victoza pen 1.8mg daily was filled on 06/08/20, 07/23/20 and on 08/14/20 for a 30-day supply.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a Victoza pen with a computer-generated pharmacy label attached to the pen and directions to administer 1.8mg daily.
-The label had a dispense date of 07/23/20.

d. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order to check and record fingerstick blood sugar (FSBS) before meals and at bedtime.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry to check and record FSBS 4 times a day, at 7:30am, 11:30am, 4:30pm, and 8:00pm. Notify the physician if the FSBS was less than 60 or greater than 500.
-The FSBS was not documented as checked on 08/08/20 and 08/09/20 at 7:30am, 11:30am, 4:30pm, or 8:00pm.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.
-Resident #5's blood sugar from 08/01/20 through

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08/07/20 and 08/10/20 through 08/13/20 at 8:00am was documented in the range of 103 to 275.
-Resident #5's blood sugar from 08/01/20 through 08/07/20 and 08/10/20 through 08/13/20 at 11:30am was documented in the range of 151 to 268.
-Resident #5's blood sugar on 08/10/20 was documented as 458 at 7:30am and 386 at 11:30am.

e. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Losartan Potassium 100mg once daily, a medication used to treat elevated blood pressure.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Losartan Potassium 100mg to be administered daily at 8:00am.
-Losartan Potassium was not documented as administered daily on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Losartan Potassium were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Losartan Potassium 100mg were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Losartan

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Potassium 100mg tablets with a computer-generated pharmacy label attached and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The start date on the blister pack for the administration of Losartan was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

f. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order to check and record blood pressure daily, notify the physician if the systolic pressure was above 180 or below 100, or the diastolic pressure was above 100 or below 50.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry to check and record blood pressure daily, notify the physician if the systolic pressure was above 180 or below 100, or the diastolic pressure was above 100 or below 50.
-Resident #5's blood pressure was not documented as administered daily on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.
-Resident #5's blood pressure from 08/01/20 through 08/07/20 and 08/11/20 through 08/13/20 at 8:00am was documented in the range of 117/58 to 153/80.
-Resident #5's blood pressure was documented on 08/10/20 at 8:00am as 178/110.

g. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Duloxetine, a medication used to treat depression and anxiety disorder, 30mg twice daily.

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Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Duloxetine 30mg to be administered twice daily at 8:00am and 8:00pm.
-Duloxetine was not documented as administered twice daily on 08/08/20 or 08/09/20.
-There was no reason documented on the eMAR "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Sixty tablets of Duloxetine 30mg were dispensed for Resident #5 to the facility on 06/01/20.
-Sixty-two tablets of Duloxetine 30mg were dispensed for Resident #5 to the facility on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There were 2 blister packs of thirty-one Duloxetine 30mg tablets each with a computer-generated pharmacy label attached and directions to administer one tablet twice daily.
-One blister pack was labeled "morning" and the second blister pack was labeled "evening".
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-seven tablets remaining in the morning blister pack.
-There were twenty-eight tablets in the evening blister pack.

h. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Risperidone 0.25mg, an antipsychotic medication used to treat

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D 358	Continued From page 50 bipolar disorder, twice daily. Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed: -There was a computer-generated entry for Risperidone 0.25mg twice daily at 8:00am and 8:00pm. -Risperidone was not documented as administered twice daily on 08/08/20 or 08/09/20. -There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed: -Sixty tablets of Risperidone 0.25mg were dispensed for Resident #5 on 06/01/20. -Sixty-two tablets of Risperidone were dispensed for Resident #5 on 07/01/20 and on 07/31/20. Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed: -There were 2 blister packs of thirty-one Risperidone 0.25mg tablets each, with a computer-generated pharmacy label attached and directions to administer one tablet daily. -One blister pack was labeled "morning" and the second blister pack was labeled "evening". -Both pharmacy labels had Resident #5's name and a dispense date of 07/31/20. -The date the medication from the blister pack was started was 08/10/20. -There were twenty-seven tablets remaining in the morning blister pack. -There were twenty-eight tablets in the evening blister pack. i. Review of Resident #5's FL2 dated 05/22/20	D 358		

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revealed there was an order for Gabapentin 400mg once daily, a medication used to treat nerve pain.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Gabapentin 400mg to be administered once daily at 8:00pm.
-Gabapentin was not documented as administered on 08/08/20 and 08/09/20 at 8:00pm.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Gabapentin 400mg were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Gabapentin were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Gabapentin 400mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

j. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Donepezil 5mg

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once daily, a medication used to slow the progression of dementia.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Donepezil 5mg daily to be administered at 8:00pm.
-Donepezil was not documented as administered daily on 08/08/20 or 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Donepezil 5mg were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Donepezil were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Donepezil 5mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

k. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Aspirin 81mg once daily, an over the counter medication used for thinning the blood.

Review of Resident #5's August 2020 eMAR from

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08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Aspirin 81mg, to be administered daily at 8:00am.
-Aspirin was not documented as administered daily on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Aspirin 81mg were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Aspirin 81mg were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Aspirin 81mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

I. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Atorvastatin 10mg, a medication used to treat elevated blood cholesterol, once daily.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Atorvastatin 10mg to be administered daily at

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8:00am.
-Atorvastatin was not documented as administered daily on 08/08/20 or 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Atorvastatin 10mg were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Atorvastatin 10mg were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Atorvastatin 10mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

m. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Myrbetriq 50mg, a medication used to treat an overactive bladder, once daily.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Myrbetriq 50mg to be administered daily at 8:00am.

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-Myrbetriq 50mg was not documented as administered daily on 08/08/20 or 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Myrbetriq 50mg were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Myrbetriq 50mg were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Myrbetriq 50mg tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

n. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Cranberry with vitamin C 450mg daily, a vitamin supplement used for urinary track health.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Cranberry with vitamin C to be administered daily at 8:00am.
-Cranberry with vitamin C was not documented as administered daily on 08/08/20 or 08/09/20.

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-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Cranberry with vitamin C were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Cranberry with vitamin C were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Cranberry with vitamin C tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

o. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Ocuvite lutein capsule once daily, a vitamin supplement used for eye health.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Ocuvite lutein capsule to be administered once daily at 8:00am.
- Ocuvite lutein was not documented as administered daily on 08/08/20 and 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress

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notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-Thirty tablets of Ocuvite lutein were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Ocuvite lutein were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Ocuvite lutein tablets with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

p. Review of Resident #5's FL2 dated 05/22/20 revealed there was an order for Vita-Tab once daily, used as a multivitamin supplement.

Review of Resident #5's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for a Vita-Tab to be administered daily at 8:00am.
-Vita-tab was not documented as administered daily on 08/08/20 or 08/09/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at

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2:45pm revealed:
-Thirty tablets of Vita-Tab one tablet daily were dispensed for Resident #5 on 06/01/20.
-Thirty-one tablets of Vita-Tab were dispensed for Resident #5 on 07/01/20 and on 07/31/20.

Observation of Resident #5's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one Vita Tab tablets with a computer-generated pharmacy label attached and directions to administer one tablet daily.
-The label had a dispense date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the blister pack.

Review of the facility records and Resident #5's chart on 08/13/20 did not produce a completed Medication Incident Report form for the medications that were not offered to Resident #5 on 08/08/20 and 08/09/20.

Attempted telephone interview with a MA on 08/12/20 at 9:54am was unsuccessful.

Attempted telephone interview with a second MA on 08/12/20 at 9:56am was unsuccessful.

Attempted telephone interview with a third MA on 08/12/20 at 9:57am was unsuccessful.

Attempted telephone interview with the nurse practitioner (NP) on 08/17/20 at 8:40am was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #5 was not

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D 358	Continued From page 59 interviewable. Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm. Refer to telephone interview with the personal care aide (PCA) on 08/11/20 at 3:55pm. Refer to telephone interview with another MA on 08/11/20 at 11:20am. Refer to telephone interview with a second MA on 08/12/20 at 10:07am. Refer to telephone interview with the lead MA on 08/17/20 at 10:23am. Refer to interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm. Refer to interview with the Health and Wellness Nurse (HWN) on 08/13/20 at 2:30pm. Refer to interview with the Administrator on 08/17/20 at 3:53am. 2. Review of Resident #'3's current FL2 dated 11/06/19 revealed diagnoses included Alzheimer dementia, hyperlipidemia and pre-diabetes. Review of the facility's Variance Report printed 08/13/20 revealed all Resident #3's medications were not administered on 08/08/20. a. Review of Resident #3's signed Physician Order Report dated 04/20/20 revealed there was an order for Oxcarbazepine, a medication used to treat bipolar disorder, 150mg one tablet twice daily.	D 358		

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D 358	Continued From page 60 Review of Resident #3's August 2020 eMAR from 08/01/20 through 08/13/20 revealed: -There was a computer-generated entry for Oxcarbazepine 150mg twice daily, scheduled to be administered at 8:00am and 8:00pm. -Oxcarbazepine was not documented as administered on 08/08/20 at 8:00am or 8:00pm. -There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes. Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed: -Two blister packs of thirty tablets of Oxcarbazepine 150mg one tablet twice daily were dispensed for Resident #3 on 06/01/20. -Two blister packs of thirty-one tablets of Oxcarbazepine 150mg one tablet twice daily were dispensed for Resident #3 on 07/01/20 and on 07/31/20. Observation of Resident #3's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of thirty-one tablets of Oxcarbazepine with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily in the morning. -There was a blister pack of thirty-one tablets of Oxcarbazepine with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily in the evening. -The labels for both blister packs had a dispense date of 07/31/20. -The date the medication from the blister pack was started was 08/10/20.	D 358		

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-There were twenty-seven tablets remaining in the Oxcarbazepine morning blister pack.
-There were twenty-eight tablets remaining in the Oxcarbazepine evening blister pack.

b. Review of Resident #3's signed Physician Order Report dated 04/20/20 revealed there was an order for Quetiapine 25mg, an anti-psychotic medication used to treat bipolar disorder and depression, once daily at bedtime.

Review of Resident #3's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Quetiapine 25mg at bedtime, scheduled to be administered daily at 8:00pm.
-Quetiapine was not documented as administered on 08/08/20.
-There was no reason documented on the eMAR under "Exceptions" or in the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-A blister pack of thirty tablets of Quetiapine 25mg daily at bedtime were dispensed for Resident #3 on 06/01/20.
-A blister pack of thirty-one tablets of Quetiapine 25mg daily at bedtime were dispensed for Resident #3 on 07/01/20 and on 07/31/20.

Observation of Resident #3's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of thirty-one tablets of Quetiapine with a computer-generated pharmacy label attached to the blister pack and directions to administer one tablet daily in the evening.
-The label for the blister pack had a dispense

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date of 07/31/20.
-The date the medication from the blister pack was started was 08/10/20.
-There were twenty-eight tablets remaining in the Quetiapine blister pack.

c. Review of Resident #3's signed Physician Order Report dated revealed there was an order for Sertraline 50mg, a medication used to treat depression, once daily.

Review of Resident #3's August 2020 eMAR from 08/01/20 through 08/13/20 revealed:
-There was a computer-generated entry for Sertraline 50mg once daily to be administered at 8:00am.
-Sertraline was not documented as administered on 08/08/20.
-There was no reason documented on the eMAR under "Exceptions" or the electronic progress notes.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-A blister pack of thirty tablets of Sertraline 50mg daily at bedtime were dispensed for Resident #3 on 06/01/20.
-A blister pack of thirty-one tablets of Sertraline 50mg daily at bedtime were dispensed for Resident #3 on 07/01/20 and on 07/31/20.

Attempted telephone interview with the nurse practitioner (NP) on 08/17/20 at 8:40am was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.

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D 358	Continued From page 63 Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm. Refer to telephone interview with the personal care aide (PCA) on 08/11/20 at 3:55pm. Refer to telephone interview with another MA on 08/11/20 at 11:20am. Refer to telephone interview with a second MA on 08/12/20 at 10:07am. Refer to telephone interview with the lead MA on 08/17/20 at 10:23am. Refer to interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm. Refer to interview with the Health and Wellness Nurse (HWN) on 08/13/20 at 2:30pm. Refer to interview with the Administrator on 08/17/20 at 3:53am. 3. Review of Resident #4's current FL2 dated 04/28/20 revealed diagnoses included dementia, hypertension, diabetes, and depression. Review of the facility's variance report printed 08/13/20 revealed all Resident #4's medications were not administered on 08/08/20. a. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Citalopram (to treat depression) 40mg one tablet daily.	D 358		

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D 358	Continued From page 64 Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Citalopram 40mg one tablet daily to be administered daily at 8:00am. -Citalopram was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of Citalopram 40mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily with a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. b. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Donepezil (to treat dementia) 10mg one tablet daily. Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Donepezil 10mg one tablet daily to be administered daily at 8:00am. -Donepezil was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of Donepezil 10mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily with a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

c. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Gabapentin (to treat nerve pain) 300mg one capsule at bedtime.

Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for Gabapentin 300mg one capsule at 8:00pm.
-Gabapentin was not documented as administered at 8:00pm on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of gabapentin capsules with a computer-generated pharmacy label attached and the directions to administer 1 tablet at bedtime and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

d. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Ibuprofen (to treat pain) 200mg two tablets twice

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D 358	Continued From page 66 daily. Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Ibuprofen 200mg two tablets twice daily to be administered at 8:00am and 8:00pm. -Ibuprofen was not documented as administered at 8:00am and 8:00pm on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of Ibuprofen 200mg tablets with a computer-generated pharmacy label attached and the directions to administer 2 tablets at 8:00am and a dispense date of 08/10/20. -There were 56 tablets remaining in the blister pack. -There was a blister pack of Ibuprofen 200mg tablets with a computer-generated pharmacy label attached and the directions to administer 2 tablets at 8:00pm and a dispense date of 08/10/20. -There were 56 tablets remaining in the blister pack. e. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Levemir (a long acting insulin) 40units every morning and Levemir 30units every evening at bedtime. Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:	D 358		

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-There was a computer-generated entry for Levemir 40 units every morning at 8:00am.
-Levemir 40 units was not documented as administered at 8:00am on 08/08/20.
-There was a computer-generated entry for Levemir 30 units every evening at 8:00pm.
-Levemir 30 units was not documented as administered at 8:00pm on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was Levemir insulin vial with a computer-generated pharmacy label attached and the directions to administer 40units every morning and 30units at bedtime and a dispense date of 07/17/20 with an open date of 07/31/20.

f. On Resident #4's current FL2 dated 04/28/20 there was an order for Novolog (a short acting insulin) 100u/ml 12units three times daily before meals, hold if finger stick fasting blood sugar (FSBS) is 60.

Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for Novolog 12units three times daily before meals, hold if FSBS 60.
-Novolog 12 units was not documented as administered at 8:00am, 12:00pm, and 5:00pm on 08/08/20.
-Resident #4's FSBS was not documented at 8:00am, 12:00pm, and 5:00pm on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress

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D 358	Continued From page 68 notes. -On 08/10/20 at 8:00am Resident #4's FSBS was 187, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/10/20 at 9:16am as waiting on refills. -On 08/10/20 at 12:00pm Resident #4's FSBS was 214, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/10/20 at 11:56am as waiting on refills. -On 08/10/20 at 5:00pm Resident #4's FSBS was 177, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/10/20 at 4:44pm as waiting on refills. -On 08/11/20 at 8:00am Resident #4's FSBS was 131, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/11/20 at 7:56am as waiting on refills. -On 08/11/20 at 12:00pm Resident #4's FSBS was 144, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/11/20 at 11:56am as waiting on refills. -On 08/11/20 at 5:00pm Resident #4's FSBS was not documented, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/11/20 at 4:35pm as waiting on refills. -On 08/12/20 at 8:00am Resident #4's FSBS was 134, and no Novolog was administered. -The reason documented on the eMAR under "exceptions" on 08/12/20 at 8:21am as waiting on refills. -On 08/12/20 at 11:00am Resident #4's FSBS was 231, and no Novolog was administered. -The reason documented on the eMAR under	D 358		

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"exceptions" on 08/12/20 at 11:43am as waiting on refills.
-On 08/12/20 at 5:00pm Resident #4's FSBS was 203, and Novolog 12units was administered.
-Resident #4 missed 3 doses of Novolog and 3 FSBS on 08/08/20.
-Resident #4 missed 8 doses of Novolog from 08/10/20 to 08/12/20 and one FSBS check on 08/11/20 at 5:00pm.
-Resident #4 FSBS ranges from 08/01/20-08/13/20 was 92 on 08/07/20 at 5:00pm to 256 on 08/09/20 at 5:00pm.

Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was Novolog 100u/ml insulin vial with a computer-generated pharmacy label attached and the directions to administer 12uits three times daily with meals hold if FSBS 60 and a dispense date of 08/08/20 with an open date of 08/12/20.

Telephone Interview with the Administrator on 08/17/20 at 3:53pm revealed:
-On 08/13/20 when she was notified Resident #4 missed doses of her Novolog she went to the medication aide (MA) responsible for not administering it.
-The MA informed her that the Novolog was not available to administer it.
-The MA failed to notify the pharmacy to obtain another vial for delivery.
-The MA was responsible for reordering all insulin refills from the pharmacy, and there was no excuse it wasn't reordered.
-Resident #4's insulin should have been order by the MA using the eMAR system from the pharmacy.
-Variance reports were being printing weekly by

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the Health & Wellness Nurse (HWN) until she recently became busy with other assigned responsibilities related to SCU residents after the previous Special Care Coordinator (SCC) resigned.
-Medication cart audits were to be completed monthly and the last time one was completed for Resident #4 was in the beginning of July.

g. Review of Resident #4's current FL2 dated 04/28/20 revealed there was an order for Quetiapine (to treat depression) 25mg one tablet twice daily.

Review of Resident #4's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for Quetiapine 25mg one tablet twice daily to be administered at 8:00am and 8:00pm.
-Quetiapine was not documented as administered at 8:00am and 8:00pm on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #4's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of Quetiapine 25mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet at 8:00am and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.
-There was a blister pack of Quetiapine 25mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet at 8:00pm and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister

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pack.

Attempted telephone interview with the nurse practitioner (NP) on 08/17/20 at 8:40am was unsuccessful.

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

Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm.

Refer to telephone interview with the personal care aide (PCA) on 08/11/20 at 3:55pm.

Refer to telephone interview with another MA on 08/11/20 at 11:20am.

Refer to telephone interview with a second MA on 08/12/20 at 10:07am.

Refer to telephone interview with the lead MA on 08/17/20 at 10:23am.

Refer to interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm.

Refer to interview with the Health and Wellness Nurse (HWN) on 08/13/20 at 2:30pm.

Refer to interview with the Administrator on 08/17/20 at 3:53am.

4. Review of Resident #2's current FL2 dated 06/15/20 revealed diagnoses included dementia, difficulty walking, muscle weakness, and hypertension.

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D 358	Continued From page 72 Review of the facility's variance report printed 08/13/20 revealed all Resident #2's medications were not administered on 08/08/20. a. Review of Resident #2's current FL2 dated 06/15/20 revealed there was an order for Vitamin D3 (to treat vitamin D deficiency) 1000iu one tablet daily. Review of Resident #2's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Vitamin D3 1000iu one tablet daily be administered daily at 8:00am. -Vitamin D3 was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #2's medications available for administration on 08/13/20 at 12:05pm revealed there was a bottle of Vitamin D3 1000iu soft gel capsules and the directions to administer 1 tablet once daily. b. Review of Resident #2's current FL2 dated 06/15/20 revealed there was an order for hydrochlorothiazide (to treat hypertension) 25mg one tablet daily. Review of Resident #2's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for hydrochlorothiazide 25mg one tablet daily at 8:00am. -Hydrochlorothiazide was not documented as administered at 8:00am on 08/08/20.	D 358		

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D 358	Continued From page 73 -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #2's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of hydrochlorothiazide 25mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. c. Review of Resident #2's current FL2 dated 06/15/20 revealed there was an order for levothyroxine (to treat hypothyroidism) 50mcg one tablet daily. Review of Resident #2's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for levothyroxine 50mcg one tablet daily at 8:00am. -Levothyroxine was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #2's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of levothyroxine 50mcg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack.	D 358		

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D 358	Continued From page 74 d. Review of Resident #2's current FL2 dated 06/15/20 revealed there was an order for mirtazapine (to treat depression) 15mg one tablet daily. Review of Resident #2's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for mirtazapine 15mg one tablet daily at 8:00am. -Levothyroxine was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #2's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of mirtazapine 15mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. e. Review of Resident #2's current FL2 dated 06/15/20 revealed there was an order for omeprazole (to treat heartburn) 20mg one tablet daily. Review of Resident #2's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for omeprazole 20mg one tablet daily at 8:00am. -Levothyroxine was not documented as administered at 8:00am on 08/08/20. -There was no reason documented on the eMAR	D 358		

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under "exceptions" or in the electronic progress notes.

Observation of Resident #2's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of omeprazole 20mg tablets with a computer-generated pharmacy label attached and the directions to administer 1 tablet once daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

Attempted telephone interview with the nurse practitioner (NP) on 08/17/20 at 8:40am was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Refer to telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm.

Refer to telephone interview with the personal care aide (PCA) on 08/11/20 at 3:55pm.

Refer to telephone interview with another MA on 08/11/20 at 11:20am.

Refer to telephone interview with a second MA on 08/12/20 at 10:07am.

Refer to telephone interview with the lead MA on 08/17/20 at 10:23am.

Refer to interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm.

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D 358	Continued From page 76 Refer to interview with the Health and Wellness Nurse (HWN) on 08/13/20 at 2:30pm. Refer to interview with the Administrator on 08/17/20 at 3:53am. 5. Review of Resident #'6's current FL2 dated 11/12/19 revealed diagnoses included dementia, Alzheimer's, protein calorie malnutrition, and anorexia. Review of the facility's variance report printed on 08/13/20 revealed all of Resident #6's morning medications were not administered on 08/09/20. a. Review of Resident #6's physician's order dated 03/05/20 revealed an order for a Lidoderm patch 5% (to treat muscle pain), apply one patch daily in the morning to low back and remove after 12 hours. Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Lidocaine Pad 5%, apply one patch daily and remove after 12 hours. -Lidocaine Pad was not documented as administered at 8:00am on 08/09/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #6's medications available for administration on 08/13/20 at 12:00pm revealed there was a pack of lidocaine pads 5% with a computer-generated pharmacy label attached and the directions to apply 1 patch to low back daily and remove after 12 hours.	D 358		

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D 358	Continued From page 77 b. Review of Resident #6's physician's order dated 02/07/20 revealed an order for lorazepam 0.5mg (to treat anxiety), take one tablet by mouth four times daily. Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for lorazepam 0.5mg, take one tablet by mouth four times daily. -Lorazepam was not documented as administered at 8:00am on 08/09/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #6's medications available for administration on 08/13/20 at 12:00pm revealed: -There was a blister pack of lorazepam 0.5mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth four times daily and a dispense date of 07/01/20. -There were 35 of 62 tablets remaining in the blister pack. c. Review of Resident #6's physician's order dated 02/07/20 revealed an order for losartan 25mg (to treat high blood pressure), take one tablet by mouth daily. Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for losartan 25mg, take one tablet by mouth daily. -Losartan was not documented as administered	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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at 8:00am on 08/09/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #6's medications available for administration on 08/13/20 at 12:00pm revealed:
-There was a blister pack of losartan 25mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth daily and a dispense date of 08/10/20.
-There were 27 tablets remaining in the blister pack.
-There was a second blister pack of losartan 25mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

d. Review of Resident #6's physician's order dated 02/07/20 revealed an order for metoprolol 25mg (to treat high blood pressure), take one tablet by mouth twice daily.

Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for metoprolol 25mg, take one tablet by mouth twice daily.
-Metoprolol 25mg was not documented as administered at 8:00am on 08/09/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #6's medications available for administration on 08/13/20 at

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D 358	Continued From page 79 12:00pm revealed: -There was a blister pack of metoprolol 25mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 27 tablets remaining in the blister pack. -There was a second blister pack of metoprolol 25mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. Interview with the Health & Wellness Nurse (HWN) on 08/13/20 at 2:30pm revealed she was not aware that Resident #6's morning medications were not administered on 08/09/20. Attempted telephone interview with Resident #6's Physician Assistant (PA) on 08/17/20 at 9:00am was unsuccessful. Attempted interview with Resident #6 on 08/13/20 at 2:10pm was unsuccessful. Refer to telephone interview with medication aide (MA) on 08/11/20 at 11:20am. Refer to interview with the HWD on 08/13/20 at 2:30pm. Refer to telephone interview with the lead MA on 08/17/20 at 10:23am. Refer to interview with the Administrator on 08/17/20 at 3:53pm.	D 358		

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D 358	Continued From page 80 6. Review of Resident #'7's current FL2 dated 05/29/20 revealed diagnoses included end stage renal disease, diabetes mellitus type 2, depression, hypertension, and anemia. Review of the facility's variance report printed on 08/13/20 revealed all of Resident #7's morning medications were not administered on 08/08/20. a. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was a physician's order for morphine sulfate 30mg (to treat severe pain), take one tablet by mouth three times daily. Review of Resident #7's July 2020 electronic medication administration record (eMAR) revealed: -There was a computer-generated entry for morphine sulfate 30mg, take one tablet by mouth three times daily at 10:00am, 2:00pm, and 10:00pm. -Morphine sulfate was documented as not administered on 7/25/20 at 9:22pm, 07/26/20 at 9:41pm, 07/27/20 at 8:56am, 07/27/20 at 12:41pm, 07/27/20 at 9:56pm, 07/28/20 at 10:32am, and 07/28/20 at 12:54pm. -The reason documented on the eMAR under "exceptions" was "waiting on refills from MD". -There was no documentation that the pharmacy or physician had been contacted regarding the medication being unavailable. Review of Resident #7's Resident Service Notes from July 2020 revealed: -A written entry dated 07/27/20 "Resident has been demanding narcotic medications all day, resident continuously is calling hospice demanding that he gets the meds, the resident status at the moment was very dizzy and off balanced."	D 358		

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-A written entry dated 07/28/20 "Resident was told about his medication."
-A written entry dated 07/29/20 "Resident ask for his medication to be doubled."
-There was no documentation that the pharmacy or the physician had been called.

Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for morphine sulfate 30mg, take one tablet by mouth three times daily at 10:00am, 2:00pm, and 10:00pm.
-Morphine sulfate was not documented as administered at 10:00am on 08/08/20 and 2:00pm on 08/09/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of morphine sulfate 30mg tablets with a computer-generated pharmacy label attached and the directions to take one tablet by mouth three times daily and a dispense date of 07/28/20.
-There were 8 of 45 tablets remaining in the blister pack.
-There was a second blister pack of morphine sulfate 30mg tablets with a computer-generated pharmacy label attached and the directions to take one tablet by mouth three times daily and a dispense date of 08/07/20.
-There were 41 of 45 tablets remaining in the blister pack.

Telephone interview with the Pharmacist from the

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facility's contracted pharmacy on 08/14/20 at 2:23pm revealed:
-The pharmacy was responsible for dispensing Resident #7's morphine sulfate.
-The pharmacy had dispensed a 15-day supply of morphine sulfate 30mg, take one tablet three times daily to Resident #7 on 07/28/20 and 08/07/20.

Telephone interview with Resident #7's Hospice nurse on 8/14/20 at 1:20pm and 8/17/20 at 1:07pm revealed:
-She had just started working with the resident on 07/27/20.
-He was not out of his controlled medications on 07/27/20.
-She was not aware that he ran out of morphine sulfate in July 2020.
-It was her responsibility to review the need for refills on controlled substances for hospice patients.
-If refills or prescriptions were needed for controlled substances, she would contact the hospice physician.

Telephone interview with the Health and Wellness Nurse (HWN) on 08/17/20 at 10:04am revealed:
-The facility had requested Resident #7's morphine be filled before the resident ran out in July 2020.
-Hospice was supposed to get the prescription for morphine sulfate from the physician but did not due to Hospice nurse being out sick.
-The HWN ended up getting the prescription directly from the physician.
-A new nurse started in mid-July and was not aware the medication had run out.

Telephone interview with a first shift medication aide (MA) on 08/17/20 at 2:02pm revealed:

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D 358	Continued From page 83 -The pharmacy did not fill the morphine sulfate for Resident #7 like they were supposed to in July 2020. -Hospice was supposed to send the prescription in mid-July to the pharmacy, but the pharmacy never received it. -A second prescription had to be obtained, and that it why it was not filled until 7/28/20. -She was aware that Resident #7 had missed doses on the days that she worked because the medication was unavailable. -When medications do not get delivered on time, the MA is responsible for contacting the pharmacy or the physician. -Resident #7 did not have any increased pain or behaviors related to missed pain medication. Telephone interview with the Administrator on 08/17/20 at 4:00pm revealed: -She was not aware that Resident #7 ran out of morphine sulfate in July 2020. -The MA was responsible to notify the HWN regarding medications that were unavailable for residents. b. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was a physician's order for hydralazine 50mg (to treat high blood pressure), take one tablet by mouth three times daily. Review of Resident #7's July 2020 electronic medication administration record (eMAR) revealed: -There was a computer-generated entry for hydralazine 50mg, take one tablet by mouth three times daily at 9:00am, 1:00pm, and 9:00pm. -Hydralazine was documented as not administered on 07/10/20 at 12:55pm, 07/13/20 at 1:06pm, 07/15/20 at 12:11pm, 7/20/20 at	D 358		

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D 358	Continued From page 84 1:18pm, 07/21/20 at 1:00pm, 07/22/20 at 1:36pm, 07/27/20 at 12:41pm, and 07/28/20 at 12:54pm. -The reason documented on the eMAR under "exceptions" was "waiting on refills from MD". -There was no documentation that the pharmacy or physician had been contacted regarding the medication being unavailable. -Hydralazine was not documented as administered at 1:00pm on 07/31/20 and there was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Review of Resident #7's August 2020 eMAR from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for hydralazine 50mg, take one tablet by mouth three times daily at 9:00am, 1:00pm, and 9:00pm. -Hydralazine was not documented as administered at 9:00am on 08/08/20 and at 1:00pm on 08/09/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of hydralazine 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth three times daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. -There was a blister pack of hydralazine 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth three times daily and a dispense date of 08/10/20. -There were 29 tablets remaining in the blister	D 358		

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pack.
-There was a blister pack of hydralazine 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth three times daily and a dispense date of 08/10/20.
-There were 29 tablets remaining in the blister pack.

Telephone interview with a first shift medication aide on 08/17/20 at 2:02pm revealed:
-The pharmacy did not fill the hydralazine like they were supposed to in July 2020.
-It was on cycle fill and should have been filled automatically each month.
-She was aware that he had missed a "few" doses at lunch time on days that she worked because the medication was unavailable.
-When medications do not get delivered on time, the MA is responsible for contacting the pharmacy or the physician.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 08/17/20 at 2:16pm revealed:
-The pharmacy was responsible for dispensing Resident #7's hydralazine.
-The pharmacy had dispensed a 30-day supply of hydralazine 50mg, take one tablet three times daily to Resident #7 on 06/01/20 to start on 06/10/20, a 31-day supply on 07/01/20 to start on 07/10/20, a 12-day supply on 07/28/20 from the previous pharmacy's computer system.
-They dispensed a 31-day supply on 07/31/20 to start 08/10/20 on the new system.
-They had switched over to a new computer system on 08/03/20.

Telephone interview with Resident #7's Hospice nurse on 8/14/20 at 1:20pm and 8/17/20 at

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D 358	Continued From page 86 1:07pm revealed: -She was not aware that he ran out of hydralazine in July 2020. -She had just started working with the resident on 07/27/20. -All other medications including hydralazine would have to be requested by the facility. Telephone interview with the Administrator on 08/17/20 at 4:00pm revealed: -She was not aware that Resident #7 ran out of his hydralazine in July 2020. -The MA was responsible to notify the HWN regarding medications that were unavailable for residents. c. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was an order for Biotene solution (to treat dry mouth), swish 15ml for 30 seconds and spit out twice daily. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Biotene solution 15ml, swish 15ml for 30 seconds and spit out twice daily. -Biotene solution was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed there was a bottle of Biotene solution with a computer-generated pharmacy label attached and the directions to swish 15ml for 30 seconds and spit out twice daily.	D 358		

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d. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was an order for bumetanide (to treat high blood pressure) 2mg, take one tablet by mouth twice daily.

Review of Resident #6's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for bumetanide (to treat high blood pressure) 2mg, take one tablet by mouth twice daily.
-Bumetanide was not documented as administered at 9:00am on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of bumetanide 2mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.
-There was a second blister pack of bumetanide 2mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

e. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was a physician's order for calcium antacid chewable 500mg (to treat low calcium levels), take two tablets by mouth twice daily.

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D 358	Continued From page 88 Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for calcium antacid chewable 500mg, take two tablets by mouth twice daily. -Calcium antacid chewable was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of calcium antacid chewable 500mg with a computer-generated pharmacy label attached and the directions to chew two tablets by mouth twice daily and a dispense date of 08/10/20. -There were 29 tablets remaining in the blister pack. -There was a second blister pack of calcium antacid chewable 500mg with a computer-generated pharmacy label attached and the directions to chew two tablets by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. f. Review of Resident #'7's record revealed there was an order dated 06/10/20 for docusate sodium 100mg (to treat constipation), take one tablet by mouth twice daily. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for	D 358		

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docusate sodium 100mg, take one tablet by mouth twice daily.
-Docusate sodium 100mg was not documented as administered at 9:00am on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of docusate sodium 100mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.
-There was a second blister pack of docusate sodium 100mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

g. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was a physician's order for doxazosin 4mg (to treat high blood pressure), take one-half tablet by mouth twice daily.

Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for doxazosin 4mg, take one-half tablet by mouth twice daily.
-Doxazosin was not documented as administered at 9:00am on 08/08/20.
-There was no reason documented on the eMAR

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under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of doxazosin 4mg with a computer-generated pharmacy label attached and the directions to take one-half tablet (2mg) by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.
-There was a second blister pack of doxazosin 4mg with a computer-generated pharmacy label attached and the directions to take one-half tablet (2mg) by mouth twice daily and a dispense date of 08/10/20.
-There were 28 tablets remaining in the blister pack.

h. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was an order for duloxetine 30mg (to treat depression), take one tablet daily.

Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for duloxetine 30mg, take one tablet by mouth daily.
-Duloxetine was not documented as administered at 9:00am on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 91 -There was a blister pack of duloxetine 30mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. i. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was an order for duloxetine 60mg (to treat depression), take one tablet daily. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for duloxetine 60mg, take one tablet by mouth daily. -Duloxetine was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a bubble pack of duloxetine 60mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. j. Review of Resident #'7's current FL2 dated 05/29/20 revealed there was an order for metoprolol tartrate 50mg (to treat high blood pressure), one tablet by mouth twice daily. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from	D 358		

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D 358	Continued From page 92 08/01/20-08/13/20 revealed: -There was a computer-generated entry for metoprolol tartrate 50mg, take one tablet by mouth twice daily. -Metoprolol tartrate was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed: -There was a blister pack of metoprolol tartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. -There was a second blister pack of metoprolol tartrate 50mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth twice daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. k. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was a physician's order for oxycodone 5mg (to treat moderate pain), take two tablets by mouth every four hours. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for oxycodone 10mg, take one tablet by mouth every four hours. -Oxycodone was not documented as	D 358		

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administered at 8:00am on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed:
-There was a blister pack of oxycodone 10mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth every four hours and a dispense date of 08/07/20.
-There were 57 of 60 tablets remaining in the blister pack.
-There was a second blister pack of oxycodone 10mg with a computer-generated pharmacy label attached and the directions to take one tablet by mouth every four hours and a dispense date of 08/07/20.
-There were 30 of 30 tablets remaining in the blister pack.

l. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was an order for pantoprazole (to treat acid reflux) 40mg daily.

Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed:
-There was a computer-generated entry for pantoprazole 40mg, take one tablet daily.
-Pantoprazole was not documented as administered at 9:00am on 08/08/20.
-There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes.

Observation of Resident #7's medications available for administration on 08/13/20 at

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D 358	Continued From page 94 12:05pm revealed: -There was a blister pack of pantoprazole 40mg with a computer-generated pharmacy label attached and the directions to take one tablet daily and a dispense date of 08/10/20. -There were 28 tablets remaining in the blister pack. m. Review of Resident #'7s current FL2 dated 05/29/20 revealed there was an order for Spiriva 18mcg, inhale one capsule via hand held nebulizer once daily. Review of Resident #7's August 2020 electronic medication administration record (eMAR) from 08/01/20-08/13/20 revealed: -There was a computer-generated entry for Spiriva 18mcg, inhale one capsule via hand held nebulizer once daily. -Spiriva was not documented as administered at 9:00am on 08/08/20. -There was no reason documented on the eMAR under "exceptions" or in the electronic progress notes. Observation of Resident #7's medications available for administration on 08/13/20 at 12:05pm revealed there was a box of Spiriva 18mcg capsules with a computer-generated pharmacy label attached and the directions to inhale one capsule via hand held nebulizer once daily. Telephone interview with Resident #7's Hospice nurse on 8/14/20 at 1:20pm and 8/17/20 at 1:07pm revealed she was unaware that he had missed all morning medications on 08/08/20. Attempted interview with Resident #7 on 08/13/20 at 2:00pm was unsuccessful.	D 358		

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D 358	Continued From page 95 Interview with the Health & Wellness Nurse (HWN) on 08/13/20 at 2:30pm revealed she was not aware that Resident #7's morning medications were not administered on 08/08/20. Attempted telephone interview with Resident #7's Physician on 08/14/20 at 2:20pm was unsuccessful. Refer to telephone interview with medication aide (MA) on 08/11/20 at 11:20am. Refer to interview with the HWD on 08/13/20 at 2:30pm. Refer to telephone interview with the lead MA on 08/17/20 at 10:23am. Refer to telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm. Refer to interview with the Administrator on 08/17/20 at 3:53pm. _____ Telephone interview with the personal care aide (PCA) on 08/11/20 at 3:55pm revealed: -During the past few weeks she had worked double shifts, first and second shifts, due to a staff shortage. -There were times during this period there was no MA in the SCU. -On 08/08/20 when she was working in the SCU and there was not a MA. -The residents did not receive their medications on first shift or second shift. -She contacted a MA that was not scheduled to work on the morning of 08/08/20. -The MA did not come into work on her day off.	D 358		

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D 358	Continued From page 96 -The staff responsible for scheduling was on vacation and she did not contact management. Telephone interview with a medication aide (MA) on 08/10/20 at 1:04pm revealed: -She worked primarily in the SCU as a MA. -At times, there was not a MA scheduled to work in the SCU. -The residents in the SCU would have to wait until the MA passing medications in the Assisted Living building had completed her medication pass. -The MA would then come down to the SCU building and pass medications to the residents. Telephone interview with another MA on 08/11/20 at 11:20am revealed: -She worked as a medication aide (MA) in the Special Care Unit (SCU). -The MAs float between the Assisted Living (AL) building and the SCU due to a staff shortage. -When the buildings share a MA, they had to hurry through the medication pass in each building. -Recently there were shifts residents did not receive all their medications. -She could not recall which dates this occurred. -The documentation where the MAs initial on the eMAR was blank and there was no note under "Exceptions" or the e-progress notes. Telephone interview with a second MA on 08/12/20 at 10:07am revealed: -The MAs work both the SCU and the Assisted Living communities. -If there was no MA in the SCU, the Assisted Living MA would go to the SCU community and administer medications. -The MA would administer medications to the Assisted Living residents, and when the medication pass was completed, she would	D 358		

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administer medications to the residents in the SCU.
-She received a call from the SCU staff on 08/08/20 requesting she come in to administer medications to the SCU residents.
-There was no MA scheduled for the SCU community.
-She did not know why the MA assigned to the Assisted Living community did not administer medications to the SCU residents after the Assisted Living medication pass was completed.
-It was her day off and she did not come in to the facility.
-She did not know if anyone else was contacted.
-She did not contact management.

Telephone interview with the lead MA on 08/17/20 at 10:23am revealed:
-She worked as a MA in the AL community.
-She had also been the staff scheduler for the MAs and PCAs, staffing both the AL and SCU communities for the past month.
-If there was a callout or staff did not report for their shift, she would notify management and get coverage from in house staff or a staffing agency.
-She also reviewed the eMARs on the AL community and reported to the Health and Wellness nurse if there was no documentation a medication had been administered.
-She would contact the MA to determine the cause of the missed medication documentation and report to the Health and Wellness nurse.
-She did not complete any Medication Incident Reports.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 08/17/20 at 2:45pm revealed:
-The facility was on a monthly cycle fill for scheduled medications.

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-The cycle fill medications were delivered to the facility prior to the next month's cycle date.
-The cycle date for the new month was to begin on the 10th of each month.
-A thirty- or thirty-one-day supply of the medications was filled in blister packs to be administered at the beginning of the new cycle.
-Medications, except for controlled substances, that were unused from the previous month could be kept in the facility or returned to the pharmacy.
-There was no tracking mechanism for medications returned to the pharmacy that were not controlled substances.
-As needed (PRN) medications were filled when requested by the facility staff.
-Insulin vials and Flex Pens were also filled when requested by the facility staff.

Interview with the Health & Wellness Nurse (HWN) on 08/13/20 at 2:30pm revealed:
-She was responsible for physician's orders and medications in the community.
-She supervised the MAs and the PCAs.
-The MAs refer to the eMARs for the administration of medications.
-She printed and reviewed a Variance report detailing medications that have been missed.
-If the initials of the MA were not documented for the administration of a medication, with no exception noted, it was captured on the Variance report as a missed medication.
-She was printing this report several times a week.
-Recently she only got a chance to print this report weekly because she was preoccupied with many other responsibilities given to her since the Special Care Coordinator (SCC) resigned.
-She did not print a variance report until today (08/13/20).
-The last time she printed the variance report was

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the week prior to 08/01/20.
-She did not know all the residents on the SCU was not administered and of their medications on 08/08/20 until today (08/13/20) when she was asked to print the report.
-She expected the SCU and AL to be staffed with a MA so all the residents would receive all their medications.
-The staff was instructed to contact management if there was a staff shortage.
-She would come in to the facility to assist or find a replacement for the MA.
-She was not contacted by the staff to inform her there was no MA on SCU on 08/08/20 to administer medications.
-Occasionally, the MA on the AL building would come down to the SCU and pass the medications if there was a callout.
-She did not know why the AL MA was not contacted to administer the medications on 08/08/20.

Interview with the Administrator on 08/17/20 at 3:53pm revealed:
-The HWN was responsible for physician's orders and medications in the community.
-The HWN supervised the MAs and the PCAs.
-The supervisor in charge (SIC) submitted a staffing schedule each week to the HWN.
-If there was a callout or a staff person did not report for their shift, the MA on the shift would call the scheduler.
-The scheduler was on vacation from 07/23/20 through 08/12/20.
-If the scheduler was unavailable, the staff should call the HWN or the Administrator.
-The HWN printed and reviewed a Variance report detailing medications that had been missed.
-She had not been reviewing the report as

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D 358	Continued From page 100 scheduled since the SCC position was vacant. -She would have seen the omission when she printed the Variance report. -She expected anyone of the staff that knew there was not a MA available to pass medications on 08/08/20 to call management. -She did know the residents missed all their medications 08/08/20 until today (08/13/20). -There was not a member of the management team assigned on call for the weekends, but all the management team was accessible by telephone. -The staff failed to communicate the problem. _____ The facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents. In addition the facility neglected to give any medications to 15 of 15 residents residing in the Special Care Unit who did not receive any medication on 08/08/20, and two residents on the Assisted Living side who missed all morning medications on 08/08/20 and 08/09/20. This failure resulted in substantial risk of neglect and harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 16, 2020.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the	D 465		

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residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to ensure minimum staff were present to meet the needs of Special Care Unit (SCU) residents for 23 of 48 shifts sampled for 16 days from 07/10/20 to 08/08/20.

The findings are:

Review of NCDHHS Emergency Staffing Recommendations during the COVID-19 pandemic revealed:
-Staff who test positive for COVID-19 will be unable to work until they meet the criteria for returning to work. This can cause sudden staffing shortages at a time when extra work is required to control the outbreak.
-Facilities should prepare for the possibility of staffing shortages and have a concrete plan with specific steps to take if they do need additional staff.
-The following options should be considered for emergency staffing:
-Allowing caregivers that are positive but asymptomatic to staff areas dedicated to caring for positive residents [while wearing appropriate personal protective equipment (PPE)].

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-Contacting temporary staffing agencies
-Contacting other sister agencies for temporary staffing support
-Contacting local hospitals for temporary staffing support
- If all these options have been exhausted and additional staffing is still needed, your local health department can request emergency staff from the state. Emergency staffing requests typically take several days to fill. Facilities should begin searching for additional staff as soon as staff are tested rather than waiting for test results to come back, so these emergency staffing requests can be filled if necessary.

Staffing and emergency staffing policies were requested on 06/30/20 at 9:05am and on 07/01/20 at 10:28am but none were provided.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living (AL) with a capacity of 100 beds and a Special Care Unit (SCU) with a capacity of 25 beds.

Review of the Resident Bed List Report dated 07/09/20 revealed:
-There was a SCU census of 25 residents.
-The required staff hours for third shift was 20 hours.

Review of the Employee Time Detail dated 07/09/20 revealed there were 19 staff hours provided on the third shift, a shortage of 1.0 hours.

Review of the Resident Bed List Report dated 07/10/20 revealed:
-There was a SCU census of 25 residents.
-The required staff hours for first shift was 25

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hours.
-The required staff hours for second shift was 25 hours.
-The required staff hours for third shift was 20 hours.

Review of the Employee Time Detail dated 07/10/20 revealed:
-There were 22.06 staff hours provided on the first shift, a shortage of 2.94 hours.
-There were 21.05 staff hours provided on the second shift, a shortage of 3.95 hours.
-There were 11.00 staff hours for provided on the third shift, a shortage of 9.0 hours.

Review of the Resident Bed List Report dated 07/11/20 revealed:
-There was a SCU census of 25 residents.
-The required staff hours for first shift was 25 hours.
-The required staff hours for second shift was 25 hours.
-The required staff hours for third shift was 20 hours.

Review of the Employee Time Detail dated 07/11/20 revealed:
-There were 21.00 staff hours provided for first shift, a shortage of 4.00 hours.
-There were 14.66 staff hours provided for the second shift, a shortage of 10.34 hours.
-There were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.

Review of the Resident Bed List Report dated 07/12/20 revealed:
-There was a SCU census of 25 residents.
-The required 20 staff hours on third shift was 20 hours.

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Review of the Employee Time Detail dated 07/12/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 11.00 hours.

Review of the Resident Bed List Report dated 07/13/20 revealed:
-There was a SCU census of 25 residents.
-The required staff hours for second shift was 25 hours.
-The required staff hours for third shift was 20 hours.

Review of the Employee Time Detail dated 07/13/20 revealed:
-There were 20.16 staff hours provided for the second shift, a shortage of 4.84 hours.
-There were 17.25 staff hours provided on the third shift, a shortage of 2.75 hours.

Review of the Resident Bed List Report dated 07/14/20 revealed:
-There was a SCU census of 24 residents.
-The required staff hours for second shift was 24 hours.
-The required staff hours for third shift was 19.2 hours.

Review of the Employee Time Detail dated 07/14/20 revealed:
-There were 20.10 staff hours provided for the second shift, a shortage of 3.90 hours.
-There were 16.9 staff hours provided on the third shift, a shortage of 2.30 hours.

Review of the Resident Bed List Report dated 07/15/20 revealed:
-There was a SCU census of 21 residents.
-The required staff hours for second shift was 21 hours.

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D 465	Continued From page 105 -The required staff hours for third shift was 16.8 hours. Review of the Employee Time Detail dated 07/15/20 revealed: -There were 19.08 staff hours provided on the second shift, a shortage of 1.92 hours. -There were 9.00 staff hours provided on the third shift, a shortage of 7.8 hours. Review of the Resident Bed List Report dated 07/16/20 revealed: -There was a SCU census of 22 residents. -The required staff hours for third shift was 17.60 hours. Review of the Employee Time Detail dated 07/16/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 8.6 hours. Review of the Resident Bed List Report dated 07/17/20 revealed: -There was a SCU census of 22 residents. -The required staff hours for third shift was 17.60 hours. Review of the Employee Time Detail dated 07/17/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 8.6 hours. Review of the Resident Bed List Report dated 07/18/20 revealed: -There was a SCU census of 21 residents. -The required staff hours for third shift was 16.8 hours. Review of the Employee Time Detail dated 07/18/20 revealed there were 9.00 staff hours	D 465		

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provided on the third shift, a shortage of 7.8 hours.

Review of the Resident Bed List Report dated 07/19/20 revealed:
-There was a SCU census of 21 residents.
-The required staff hours for third shift was 16.8 hours.

Review of the Employee Time Detail dated 07/19/20 revealed there were 9.00 staff hours provided on the third shift, a shortage of 7.8 hours.

Review of the Resident Bed List Report dated 07/20/20 revealed:
-The census was 20 residents.
-The required staff hours for second shift was 20.0 hours.
-The required staff hours for third shift was 16.0 hours.

Review of the Employee Time Detail dated 07/20/20 revealed:
-There were 15.50 staff hours provide on the second shift, a shortage of 4.50 hours.
-There were 9.25 staff hours provided on the third shift, a shortage of 6.75 hours.

Review of the Resident Bed List Report dated 07/22/20 revealed:
-The census was 18 residents.
-The required staff hours for first shift was 18 hours.
-The required staff hours for third shift was 16 hours.

Review of the Employee Time Detail dated 07/22/20 revealed:
-There were 16 staff hours provide on the first

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shift, a shortage of 2.0 hours.
-There were 11.50 staff hours provided on the second shift, a shortage of 6.5 hours.

Review of the Resident Bed List Report dated 08/02/20 revealed:
-The census was 15 residents.
-The required staff hours for third shift was 12 hours.

Review of the Employee Time Detail and staff schedule dated 08/02/20 revealed:
-There was no MA scheduled for second shift.
-There were 9.45 staff hours provided on the third shift, a shortage of 2.55 hours.

Review of the Resident Bed List Report dated 08/08/20 revealed the census was 15 residents.

Review of the Employee Time Detail and staff schedule dated 08/08/20 revealed:
-There was no MA scheduled for first shift.
-There was no MA scheduled for second shift.

Telephone interview with a third shift medication aide (MA) on 08/06/2020 at 2:42pm revealed:
-She was the only assigned MA on third shift for the facility from 11:00pm until 7:00am.
-She was responsible for ensuring the SCU personal care aides (PCAs) were on the unit.
-She was responsible for administering PRN medication to SCU residents on third shift.
-She was responsible for responding to incidents or accidents involving SCU residents on third shift.
-The SCU was usually staffed with one or two PCAs on third shift.
-In July 2020, there were numerous occasions of only one PCA being schedule on third shift in the SCU.

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-In July 2020, the Health & Wellness Nurse (HWN) instructed her to inform the third shift SCU PCA that the PCA would be responsible for 25 residents on third shift.
-The HWN instructed her to instruct SCU PCA's to contact the third shift MA as needed if there was an incident or accident on the unit.
-When only one SCU PCA was on the unit, the HWN instructed her to inform the SCU PCA to only perform incontinence care 'the best you can.'
-When only one SCU PCA was on the unit, the HWN instructed her to tell PCA staff not to get residents up and ready in the morning until first shift PCA staff came in to help.
-She worked an eight-hour shift, six to seven days per week on third shift at the facility.
-She spent a cumulative one-hour total on the SCU unit during third shift, she spent the additional seven shift hours on the assisted living unit.
-The facility had been utilizing temporary, outside agency care staff up until approximately June 2020 due to insufficient facility staff.
-She had been informed by the former Special Care Coordinator (SCC), that the facility was no longer utilizing healthcare staffing agency care staff for the SCU.

Telephone interview with a third shift PCA on 08/05/2020 at 5:30pm revealed:
-She worked as a third shift PCA on the SCU.
-She had been working in the SCU starting in June 2020.
-Around 07/09/2020, there were 25 SCU residents.
-On 07/11/2020 and 07/12/2020, there were 25 SCU residents and she was the only PCA on the unit for third shift.
-On 07/11/2020 and 07/12/2020, the third shift MA was on the SCU unit for about one-hour total

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between 11:00pm and 7:00am.
-She was not aware of any incidents or accidents occurring with SCU residents on 07/11/2020 or 07/12/2020.
-There were one or two SCU residents that preferred to ambulate and were active during third shift, requiring increased supervision.
-On the third shifts she worked alone, the MA from the assisted living unit would come check-in with her and had instructed her not to get residents out of bed in the morning and to provide bedside personal care as much as possible and to check residents for incontinence every 2-hours.
-She was not sure who maintained the scheduling of SCU staff.
- "There definitely wasn't enough staff in the SCU on third shift for 25 residents in July."

Telephone interview with a first and second shift PCA on 08/14/2020 at 12:19pm revealed:
-She began working both first and second shift in the SCU to fill in for shift vacancies in July 2020.
-On 07/10/2020, she worked first and second shift with on the SCU with one MA providing care for 25 residents.
-From 07/12/2020 until approximately 07/22/2020, there were occasions she was the only PCA on the SCU unit for first or second shifts with a MA occasionally on the unit.
-In July 2020, there were occasions of the SCU having one PCA and no MA for up to 25 SCU residents.
-She had asked the HWN and facility Administrator about staffing to resident census sometime in late July and the facility Administrator informed her due to a decrease in SCU resident census, there was no need to maintain two PCA's on the SCU unit for first and second shifts.

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D 465	Continued From page 110 Confidential telephone interview with a MA revealed: -The facility had been understaffed since May 2020. -On first shift, the facility staffed two MA's and one or two PCA's for the assisted living unit. -On third shift, the facility occasionally staffed one MA and one care aide for the assisted living unit in July 2020. -She did not know who was responsible for scheduling staff. -The facility had been utilizing an outside healthcare agency staff to fill vacancies in the schedule up until approximately May or June 2020. -The SCU was staffed by one PCA on third shift and utilized one MA on third shift that was responsible for the entire facility. Telephone interview with a housekeeper & PCA on 08/14/2020 at 11:05am revealed: -She had been hired as a SCU housekeeper on or about July 17, 2020. -On her first day working on the SCU, she had been scheduled to be the SCU housekeeper, but she was asked by the HWN to assisted with performing resident personal care due to understaffing. -On her second day working on the SCU, she was scheduled to be a PCA and perform housekeeping, she worked approximately four hours as a PCA and four hours as a housekeeper on 07/18/2020. -She had been performing housekeeping and PCA duties on first and second shift during July and August 2020. -Sometimes there was only one PCA and MA on first and second shifts in July 2020 for approximately 25 residents.	D 465		

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Telephone interview with a lead MA on 08/11/2020 at 11:49am revealed:
-She was responsible for scheduling assisted living unit staff in July 2020.
-She scheduled staff according to pre-set staff schedules and tried to fill schedule vacancies with available facility staff.
-The schedule was shared with the HWN and the Administrator for review.
-Staff were expected to contact facility management if they planned to call-out before there scheduled shift.
-She was not responsible for scheduling healthcare agency staff to fill schedule vacancies; this was the responsibility of the HWN or the Administrator.
-She was responsible for scheduling the third shift MA to work on the assisted living unit.
-She was not responsible for scheduling SCU staff.

Telephone interview with a former SCC on 08/05/2020 at 1:12pm revealed:
-She had been working as the SCC since January 2020.
-She had been responsible for scheduling SCU staff through mid-July 2020.
-At the end of June 2020, the Administrator instructed her to no longer schedule healthcare agency staff to fill SCU staffing schedule gaps and only schedule facility staff for all shifts.
-She had informed the HWN and the Administrator on multiple occasions in July 2020 about the SCU being understaffed to the resident census and was not provided any additional staffing resources to address the staffing shortage.
-She had been instructed by the Administrator to include the third shift assisted living unit MA towards the SCU third shift care aide staffing

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requirements and utilize one to two PCA's on third shift when available.
-The third shift MA "spent very little time in the unit during third shift because she had a lot of responsibilities on the assisted living unit."

Telephone interview with the HWN on 08/13/20 at 2:30pm revealed:
-The staff had been instructed to contact management if there was a staff shortage.
-She would contact a staffing agency to send personnel or she would come in to the facility to assist.
-She had not been contacted by the staff that there was no MA on SCU on 08/08/20.
-Occasionally, the MA on the AL building would come down to the SCU and pass the medications if there was a callout.
-She did not know why the AL MA was not contacted to pass the medications on 08/08/20.
-Her expectation was the SCU would be staffed with an MA and residents would receive the medications as prescribed by their physicians.

Telephone interview with the HWN on 08/14/2020 at 1:07pm revealed:
-She was responsible for assuring MA and PCA's met the healthcare and personal care needs of residents.
-She was not responsible for scheduling SCU staff prior to August 2020.
-Staff scheduling for the SCU was the responsibility the former Memory Care Manager (MCM).
-She was aware the SCU was to be staffed with two PCA's and one MA on first and second shifts when the census was 25.
-She was not aware if the facility third shift MA counted as care staff hours on the assisted living unit and SCU schedules.

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-She expected the third shift MA to occasionally check-in with the SCU PCAs during third shift and respond to incidents or accidents and administer PRN medications to SCU residents.
-She did not know how many hours the third shift MA spent on the SCU during third shift.
-The facility attempted to utilize a healthcare staffing agency in the past to fill schedule vacancies but around May 2020, the agency was unable to fulfill all the schedule vacancies for the SCU and assisted living unit.
-The facility attempted to utilized facility staff since May 2020, to fill all schedule vacancies to the best of their ability.

Telephone interview with the facility Administrator on 8/17/2020 at 3:19pm revealed:
-She assigned a lead MA to be responsible for scheduling AL unit staff in July 2020.
-The former SCC had been responsible for scheduling SCU staff in July 2020.
-She and the HWN were responsible for scheduling SCU staff in August 2020.
-She did not know a MA was not scheduled on the SCU on or about 8/8/2020 for first and second shifts.
-She did not know the SCU residents' medications were not administered on 08/08/2020 until 08/16/2020 when it was brought to her attention.
-She did not audit the staffing the staff assignments and staff hours for the SCU.
-She was aware the AL unit maintained approximately 75 residents per day in July and August 2020 and the SCU maintained approximately 25 residents per day until the third or fourth week of July 2020.
-She did know the third shift MA had been placed on the SCU schedule to work on the SCU.
-She expected the third shift MA to float between

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the assisted living unit and SCU.
-She expected the third shift MA to be on the SCU unit for a total of four hours per shift.
-She expected the SCU to be staffed with two PCA's on third shift.
-She was not aware the SCU had been staffed with one PCA on numerous occasions in July 2020.
-She expected staff, to update staff schedules when a scheduled staff called-out, was placed on leave, or a schedule vacancy was filled with a healthcare agency staff.
-When staff called out sick the lead MA and/or the HWN was expected to be notified, so they could find a replacement or take the assignment themselves.
-On 08/08/20 the staff on duty failed to notify someone on the management team that they did not have enough staff to administer medications.
-She did not routinely contact the facility when she was not onsite to check for adequate staffing, she expected the staff to contact management when staffing issues occurred.

Attempted telephone interviews with contract staffing agency manager on 08/14/20 at 12:05pm and 08/17/20 at 11:05am were unsuccessful.

Attempted telephone interview with contract staffing agency human resources 08/17/20 at 11:15am were unsuccessful.

Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights.

Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration.

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The facility failed to ensure the minimum number staff were always present to meet the needs of

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D 465	Continued From page 115 residents residing in the Special Care Unit (SCU) for 23 of 48 shifts sampled for 16 days from 07/10/20 to 08/08/20. The facility's failure resulted in a lack of adequate staff on the unit to supervise and administer medications for dementia residents was detrimental to the health, welfare, and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 August 13, 2020 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2020.	D 465		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were free from physical abuse and neglect related to Personal Care and Other Staffing, Resident Rights, Medication Administration, and Special Care Unit Staff. The findings are: 1. Based on record reviews and interviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents residing in the Assisted Living (AL) unit for 22 of 54 shifts sampled for 18 days between	D914		

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D914	Continued From page 116 07/10/20 and 08/13/20. The facility's failure resulted in a lack of adequate staff on the unit to administer medications was detrimental to the health, welfare, and safety of the residents. [Refer to Tag 0188 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type B Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to maintain the guidelines and recommendations established by the CDC, LHD, and NC DHHS for infection prevention and transmission during the COVID-19 pandemic related to the improper usage of disinfectants in order to effectively eliminate the coronavirus; not screening staff or resident temperatures and not providing reliable thermometers to do so; allowing COVID positive residents and COVID negative residents to dine and gather in common areas without any regard for social distancing; not cohorting COVID positive residents and COVID negative residents into separate rooms when there was potential to do so; staff not donning the appropriate PPE when necessary and also not donning PPE correctly when indicated; and not testing staff or retesting COVID negative residents as instructed all of which resulted in 11 residents residing in the facility diagnosed with COVID-19, 1 hospitalization, 2 deaths, and 3 staff diagnosed with COVID-19. These failures resulted in serious harm and neglect. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 6 of 7 sampled residents (Residents #2, #3, #4, #5, #6 and #7), including several medications to control blood sugar, a medication to control blood pressure, a	D914		

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D914	Continued From page 117 medication for nerve pain, an anticoagulant, mood stabilizers, a medication for cholesterol and an overactive bladder (Resident #5); medications for bipolar disorder and a mood stabilizers (Resident #3); medications to treat depression, dementia, chronic pain, cholesterol, to control blood sugar, to control blood pressure, and a mood stabilizer (Resident #4), medications for pain, anxiety, acid reflux, and high blood pressure (Resident #2), medications for pain, anxiety and high blood pressure (Resident #6), and medications for pain control, high blood pressure, depression, and respiratory issues (Resident #7). In addition, the facility failed to ensure 15 out of 15 residents, residing in the Special Care Unit, received their medication on 08/08/20, and two residents on the Assisted Living community received their medications on 08/08/20 and 08/09/20. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure the minimum number staff were always present to meet the needs of residents residing in the Special Care Unit (SCU) for 23 of 48 shifts sampled for 16 days from 07/10/20 to 08/08/20. The facility's failure resulted in a lack of adequate staff on the unit to supervise and administer medications for dementia residents was detrimental to the health, welfare, and safety of the residents. [Refer to Tag 0465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].	D914		