STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up and COVID-19 focused Infection Control survey with onsite visits on December 2, 2020 and December 3, 2020 and a desk review survey December 4, 2020 and December 7, 2020 to December 8, 2020 and a telephone exit on December 8, 2020.	{D 000}		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff B, and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -There was no job description for Staff A. -There was no hire date for Staff A. -There was no documentation of a Health Care Personnel Registry (HCPR) check being completed for Staff A. Interview with a Staff A on 12/03/20 at 3:51pm revealed:	D 137		

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-She was not sure exactly when she started working at the facility, but it was in September 2020.
-She did not know if or when a HCPR check was completed by the Administrator at this facility.

Interviews with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for personnel records.
-Staff A came from another facility, but she did not recall when Staff A started to work at this facility.
-She had not looked at Staff A's personnel record until today (12/03/20).
-She knew Staff A's required paperwork was not "up to date."
-She knew some required personnel records could transfer from one facility to another, but she was not sure what items.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 12/30/19.
-There was no documentation of a Health Care Personnel Registry (HCPR) check being completed for Staff B.

Telephone interview with Staff B on 12/03/20 at 4:41pm revealed he did not know if a HCPR check had been completed on him.

Interviews with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for personnel records.
-She thought Staff B had a HCPR check completed when Staff B first started.

3. Review of Staff D's personnel record revealed:
-There was no job description for Staff D.
-There was no hire date for Staff D.
-There was no documentation of a Health Care Personnel Registry (HCPR) check being

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D 137	Continued From page 2 completed on Staff D. Interview with Staff D on 12/02/20 at 9:20am revealed he cleaned at the facility three days a week for three hours. Interview with Staff D on 12/03/20 at 1:25pm revealed: -He started "volunteering" at the facility before Thanksgiving 2020. -If it was late at night, he might stay at the facility. -He had fallen asleep in the tv room in a chair. -He had been left alone with the residents but never long, "maybe" 30-45 minutes. -He did not know what a HCPR check was or if one had been completed on him. -No one had asked for his social security number. Interview with the Administrator on 12/03/20 at 2:55pm revealed: -She was responsible for personnel records. -Staff D was not an employee; "he just came by and was a friend of the family." -She had not completed a HCPR check on Staff D. The facility failed to ensure 3 of 4 sampled staff (Staff A, B and D) had a HCPR check completed prior to hire. This failure resulted in the facility not knowing if staff had substantiated findings on the HCPR which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 18, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY	D 137		

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D 137	Continued From page 3 22, 2021.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff, (Staff A, Staff B, and Staff D), had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -There was no job description for Staff A. -There was no hire date for Staff A. -There was no criminal background check completed for Staff A. Interviews with a Staff A on 12/03/20 at 11:33am and 3:51pm revealed: -She was not sure exactly when she started working at the facility, but it was in September 2020. -She did not know if a criminal background check had been completed when she started working at the facility. -She had not signed a criminal background release form since she started working at the facility.	D 139		

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Review of a resident's September 2020 medication administration record (MAR) revealed Staff A documented administering medications on 09/30/20.

Interviews with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for personnel records.
-Staff A came from another facility, but she did not recall when Staff A started to work at this facility.
-She had not looked at Staff A's personnel record until today (12/03/20).
-She knew Staff A's required paperwork was not "up to date."
-She knew some required personnel records could transfer from one facility to another, but she was not sure what items.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 12/30/19.
-Staff B's job description titled Fill in Relief Help was responsible for all responsibilities for total care of residents for periods up to 24-hours or less and assured proper administration of all medication and proper documentation.
-There was no criminal background check completed for Staff B.

Telephone interview with Staff B on 12/03/20 at 4:41pm revealed he thought he had a criminal background check, but "it was a while ago."

Interviews with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for personnel records.
-She knew Staff B needed a criminal background check and she asked a family member to assist her with this in January 2020.
-The family member had hired Staff B at a different facility, so she thought Staff B had a

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background check.
-She knew some required personnel records could transfer from one facility to another, but she was not sure what items.

3. Review of Staff D's personnel record revealed:
-There was no job description for Staff D.
-There was no hire date for Staff D.
-There was no criminal background check completed for Staff D.

Interview with multiple residents on 12//02/20 between 7:35am and 4:00pm revealed:
-Staff D worked at the facility.
-Staff D had been working "a couple of weeks."
-Staff D cleaned and cooked.
-Staff D slept in the living room at night.
-Sometimes Staff D was the only staff in the facility.

Interview with Staff D on 12/02/20 at 9:20am revealed he cleaned at the facility three days a week for three hours.

Interview with Staff D on 12/03/20 at 1:25pm revealed:
-He started "volunteering" at the facility before Thanksgiving 2020.
-He had requested a background check from the local police department "about" a week ago, but it had not come back yet.
-If it was late at night, he might stay at the facility.
-He had fallen asleep in the tv room in a chair.
-He had been left alone with the residents but never long, "maybe" 30-45 minutes.

Interview with the Administrator on 12/03/20 at 2:55pm revealed:
-Staff D was not an employee; "he just came by. He was a friend of the family."

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D 139	Continued From page 6 -She had not completed a criminal background check on Staff D. -She was not aware Staff D was staying overnight at the facility. -She was not aware Staff D had stayed alone at the facility with the residents. The facility failed to obtain a criminal background check for 3 of 4 sampled staff (Staff A, B and D). The facility's failure of not knowing if Staff A, B and D had a criminal record history was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on December 18, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2021.	D 139		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter.	D 176		

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D 176	Continued From page 7 The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related to infection control, medication administration, health care, discharge of residents, and staff qualifications. The findings are: Interview with the Administrator on 12/02/20 at 8:26am revealed: -There was a resident that had been admitted to the hospital and she did not know when he went to the hospital. -She thought he had been discharged from the hospital, but she did not know when. -She did not know where the resident currently was. Telephone interview with the Administrator on 12/07/20 at 11:05am revealed: -She did not know the hospice group or the day program one for one of the residents. -She did not recall what LHPS was; "oh that thing you do every three months". -She was not familiar with the rule area for self-administration of medications.	D 176		

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Telephone interview with the Administrator on 12/08/20 at 9:43am revealed:
-She was responsible for staff training and record keeping.
-She had a family member that helped her with "paperwork" and office work; the family member was an Administrator at another facility.
-She made sure all the residents had food, medication, were bathed and dressed, and had their personal care attended to.
-She ensured residents went to all their medical appointments and day programs.
-She went behind the staff to make sure everything related to resident care was done.
-She had meetings with the staff almost everyday to go over any changes in the facility or with the residents.
-She did not document her communication with residents, with physicians, families and staff because she just remembers them.

Noncompliance identified during the survey included:

1. Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff failing to use personal protective equipment (PPE) and practicing social distancing when not wearing a facemask as directed by CDC guidelines; no posted instructions for visitors at the entrance of the facility; to consistently screen residents, staff, or visitors upon entrance to the facility; not having a policy specific to COVID-19 infection prevention

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and control and no training or guidelines for staff to follow specific to COVID-19; failure to daily monitor residents for evidence of fever; and not providing soap for proper hand hygiene in two of the three resident bathrooms. [Refer to Tag D601 10A NCAC 13G .1801 Infection Prevention and Control Program (Type A2 Violation)].

2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 3 of 3 sampled residents (#1, #2, and #3) including an anti-psychotic medication, an eye drop used to treat glaucoma, a medication used to treat urine flow and a multi-vitamin (#3), a cream used to treat psoriasis (#2),a medication used to lower low-density lipoprotein (LDL) cholesterol and a medication used to lower and control blood sugars (#1). [Refer to Tag D358 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 2 of 2 sampled resident (Resident #1 and #3) regarding a missed appointment for an electroconvulsive therapy (ECT) procedure (#3) and follow up with the Cardiologist when the resident refused to wear compression stockings ordered for edema (#1). [Refer to Tag D273 10A NCAC 13G .0902(b) Health Care (Type B Violation)].

4. Based on interviews and record reviews, the facility failed to ensure 2 of 2 staff sampled (Staff A and B) who administered medications had completed their medication clinical skills competency validation prior to administering medications (Staff A and B) and completed the 5-hour and 10-hour medication aide training

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courses under the direction of a registered nurse or licensed pharmacist (Staff B) or successfully completed the required state examination (Staff B). [Refer to Tag D935 G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Standard Deficiency)].

5. Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 2 of 4 sampled staff (Staff A and D) prior to hire. [Refer to Tag D992 G.S. 131D-45 Examination and Screening for the Presence of Controlled Substances Required for Applicants for Employment in Adult Care Homes (Standard Deficiency)].

6. Based on interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff B, and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag D137 10A NCAC 13G .0407(a)(5) Other Staff Qualifications (Type B Violation)].

7. Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff, (Staff A, Staff B, and Staff D), had a criminal background check completed upon hire. [Refer to Tag D139 10A NCAC 13G .0407(a)(7) Other Staff Qualifications (Type B Violation)].

8. Based on interviews and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (Resident #3) related to an allergy medication and an anti-inflammatory medication that was brought to the facility at move-in but were not listed on the FL-2, and multiple medications that were administered post

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a hospital procedure with orders to contact the primary provider for clarification (#3). [Refer to Tag D344 10A NCAC 13F .1002(a) Medication Orders (Standard Deficiency)].

9. Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the Medication Administration Records (MAR) for 2 of 3 sampled residents (Resident #1 and #2). [Refer to Tag D367 10A NCAC 13G .1004(j) Medication Administration (Standard Deficiency)].

10. Based on observations, interviews, and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 2 of 3 residents sampled (Residents #2 and # 3) who were prescribed controlled substances. [Refer to Tag D392 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency)].

11. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 residents sampled (#1 and #2) who self-administered medications had orders to self-administer prescription medications that were kept in the residents' rooms including a an inhaler and giving the resident the glucometer to do his own finger stick blood sugar checks (#1); and a prescribed topical cream (#2). [Refer to Tag D375 10A NCAC 13G .1005(a) Self-Administration of Medications (Standard Deficiency)].

12. Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #3) was allowed to return to the facility after a hospital admission. [Refer to Tag D228 10A NCAC 13F .0702(d) Discharge of Residents

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D 176	Continued From page 12 (Standard Deficiency)]. _____ The Administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator. This failure to ensure medications were administered as ordered resulted in 3 residents not being administered medications as ordered, infection control procedures were not followed for COVID-19 including staff not wearing face masks, residents and visitors were not being screened, health care referral and follow-up was not provided for a procedure for a resident and compression stockings were not applied as ordered for a resident, and self-medication orders were not obtained for 2 residents who were self-administering medication, a resident was not provided a 30-day notice for discharge and staff qualifications were not completed for HCPR and background checks for staff who were providing care for the residents and medication training was not completed for staff who were administering medication, resulted in the substantial risk and neglect of the residents and constitutes an Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 8, 2020 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 07, 2021.	D 176		

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D 228	Continued From page 13	D 228		
D 228	10A NCAC 13F .0702 (d) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule: (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule; (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident; (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #3) was allowed to return to the facility after a hospital admission. The findings are: Review of the facility "Criteria For Client Discharge" Policy revealed: -The policy was not dated.	D 228		

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D 228	Continued From page 14 - It was the policy of this facility that every effort will be made, when problems are realized, to work with the client, his /her responsible person, social workers, case managers, and others to resolve the situation. However, in the instance where problems cannot be resolved or when they become unmanageable, the following shall constitute sufficient grounds for the discharge or client from the facility. -Threats of violence of actual violence towards self or another person within the facility or serious damage to the facility will be grounds for immediate discharge of a client from the facility and for the involvement of law enforcement personnel. -The safety of other individuals in the facility is endangered. -The health of other individuals in the facility is endangered as documented by a physician, physician's assistant, or a nurse practitioner. -If the client is admitted to the hospital for reasons that are detrimental to other clients or the clients' health, an immediate discharge will be implemented. -The discharge of a client will be done by written notification to the client, his/her responsible person, the department of social services, therapeutic agencies, and other applicable local service agencies and will allow 30-days for discharge or transfer. Review of Resident #3's current FL-2 dated 09/23/20 revealed: -Diagnoses included schizoaffective disorder, unspecified personality disorder, unspecified neurocognitive disorder, anemia chronic disease, osteoarthritis, seizures, glaucoma, and constipation. -Resident #3 wandered.	D 228		

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Review of Resident #3's Resident Register revealed:
-The resident was admitted to the facility on 10/17/20.
-There was no discharge or transfer information documented.
-The responsible party had not signed the discharge.

Review of Resident #3's Discharge Notice dated 11/13/20 revealed:
-The date of discharge was 11/13/20.
-The reason for discharge was Resident #3 did not comply with rules, threatened staff and other residents, did not comply with COVID-19 rules, manic behaviors due to medication refusals, staff and other residents felt unsafe, and concerned Resident #3 needed a higher and stricter level of care.
-Notification was documented as the Department of Social Services, Guardian, and Resident #3's mental health case manager.
-Planned discharge location was listed as Resident #3's guardian.
-The Administrator's signature was on the discharge notice.

Review of Resident #3's Incident and Accident Report dated 11/13/20 revealed:
-The report was completed by the Administrator.
-There was no time documented.
-Resident #3 left the facility without signing out.
-The police department was notified.
-The police department found Resident #3 while they were in-route to the facility.
-Resident #3 knew the rules and was underlined.

Telephone interview with a representative at the local police department on 12/08/20 at 9:08am revealed there were no incidents on file for

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Resident #3 between the dates of 10/07/20 and 11/15/20, but there was an event involving Resident #3 dated 11/08/20.

Review of Resident #3's police department's event reported dated 11/08/20 revealed:
-Call received at 7:31am Resident #3 left the facility without signing out.
-The Administrator reported Resident #3 had a history of walking to the local homeless shelter and police department while residing at another facility because Resident #3 loved to talk to people.
-At 7:42am Resident #3 was located walking back to the facility after going to the store.
-The event was documented as cleared at 7:54am.

Interview with the Administrator on 12/02/20 at 11:37am revealed she documented the incident involving the police department on Resident #3, but she had documented other incidents related to Resident #3 in his progress notes.

Review of Resident #3's Progress Note dated 10/20/20 revealed:
-Resident #3 would not stay away from other residents' doors asking for things or asking the residents to do things.
-Resident #3 was worrying the other residents.
-Resident #3 would say he was afraid of the other residents.
-The Administrator had asked Resident #3 to leave other residents alone.
-Resident #3 would not follow the rules.
-Resident #3's mental health case manager was notified Resident #3 would not follow the rules.

Review of Resident #3's Progress Note dated 10/30/20 revealed:

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D 228	Continued From page 17 -Resident #3 wanted to go outside at any time of the night to smoke a cigarette. -Resident #3 did not care who he woke up as long as he got his way. -The mental health case manager had reported Resident #3 played games, but these games were over. -Staff did not have time for the games Resident #3 was playing. -Staff did not know when to believe Resident #3 or not. -Staff were afraid of Resident #3. -Resident #3 lied and was not following the rules. Review of Resident #3's October 2020 and November 2020 medication administration records (MAR) revealed there were no refusals or other exceptions documented for any medications. Telephone interview with Resident #3's Guardian on 12/02/20 at 12:20pm revealed: -A medication aide (MA) from the facility contacted her on 11/16/20 to let her know Resident #3 had been sent to the hospital on 11/15/20 and Resident #3 would not be able to return to the facility. -She contacted the hospital discharge planner who told her the facility could not refuse to take Resident #3 back to the facility. -She talked to the Administrator on 11/18/20 who told her Resident #3 had walked to a store and asked the police to take him to the hospital. -She told the Administrator had she known Resident #3 was having "these" behaviors, it could have been addressed with Resident #3 through the mental health provider. -She had received no calls from the facility staff prior to 11/16/20 that Resident #3 was not "working out."	D 228		

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D 228	Continued From page 18 Interview with a resident on 12/02/20 at 9:29am revealed: -All the residents got along well. -He had not heard of anyone having any problems. -There was one named resident (#3) who was new and thought no one liked him. -Resident #3 could be annoying because Resident #3 would "go on and on" that no one liked him. -Resident #3 had been attacked at another facility and would say he was afraid it was going to happen again; he would assure the resident "everything was ok and not to worry." Interview with a second resident on 12/02/20 at 3:00pm revealed: -He got along with everyone at the facilty. -He had not heard anyone was afraid of any other residents. Interview with two other residents on 12/02/20 at 3:15pm revealed: -Everyone got along "good" at the facility. -Resident #3 was annoying at times but they were not afraid of him. -Resident #3 would say "no one likes me." -No one was afraid of Resident #3 but Resident #3 was afraid of other residents because of something that happened to him at another facility. -They had not heard any residents say they were afraid of Resident #3. Interview with a fifth resident on 12/02/20 at 3:17pm revealed: -All the residents got along. -He was not afraid of any of the other residents, "not even the two that were in the hospital." (two	D 228		

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D 228	Continued From page 19 residents were currently hospitalized). Interview with a MA on 12/03/20 at 11:53am revealed: -Resident #3 had expressed being afraid of other residents, "one minute he was okay and the next minute he would be nervous." -No residents were afraid of Resident #3. -Resident #3 needed to be reassured no one was going to "mess" with him. Interview with the Administrator on 12/03/20 at 3:04pm revealed: -She was told Resident #3 walked away from other facilities. -She did not want to admit Resident #3 and told her family member who had coordinated Resident #3's admission she did not think "it was going to work." -Resident #3 would stand at other residents' doors and the other residents would tell him to go away. -Resident #3 liked to have his way. -Resident #3 would leave the facility without signing out. -Someone from the hospital called, and she told them "Resident #3 could not come back to the facility." -She thought once a resident was admitted to the hospital, she did not have to them back. -She had not called Resident #3's primary care provider (PCP) about any changes in behavior because she did not know who to call. -Resident #3 was new to the facility (10/17/20) and she did not know who Resident #3's primary care provider was. -She had called Resident #3's mental health case manager about Resident #3's behaviors.(she did not recall the date).	D 228		

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Telephone interview with a second MA on 12/03/20 at 4:41pm revealed:
-He did not have any problems with Resident #3.
-He could not think of any other residents who had a problem with Resident #3.
-Resident #3 would take medications for him.

Telephone interview with Resident #3's mental health case manager on 12/04/20 at 11:03am revealed:
-He recalled only receiving one call related to Resident #3.
-The call received was on a weekend related to Resident #3 "walking away."
-Resident #3 was seen by mental health social workers and mental health nurses on a regular basis.
-He had sent a registered nurse to the facility (he did not recall the date) to evaluate Resident #3 after Resident #3 reported an incident that had occurred at his previous facility and had experienced an incontinence episode which was not normal behavior for Resident #3.

Review of the mental health nurses progress note dated 10/23/20 revealed:
-Resident #3 was educated on COVID-19 safe practices.
-Resident #3 reported compliance with medication administration.
-Staff agreed to call the mental health providers as needed for crisis intervention.

Review of the mental health nurses progress note dated 11/04/20 revealed:
-Resident #3 reported he was not coming out of his room because he was afraid the other residents did not like him.
-Resident #3 was afraid to shower because of an incident at a previous facility.

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-Resident #3 expressed increased anxiety, the mental health physician was contacted, and Resident #3 was started on anti-psychotic medication.

Review of the mental health social workers progress note dated 11/11/20 revealed:
-Resident #3 presented in a sad state and was depressed.
-Resident #3 discussed the incident of sexual assault at a previous placement and because of that was afraid to take a shower.
-Resident #3 was reassured by the facility staff he was safe at this facility.
-Resident #3 reported he was compliant with taking his medication.
-No recent behaviors were reported.

Review of the mental health peer support specialist's progress note dated 11/13/20 revealed:
-Upon arrival at the facility the peer support specialist was told Resident #3 had left the facility "about an hour ago" to go to a named store.
-Upon arrival at the store, Resident #3 was laying in the parking lot, was assessed, and had no injuries.
-Resident #3 reported he was not having "a good day."
-Support was provided and Resident #3 returned to the facility.

Second telephone interview with Resident #3's Guardian on 12/04/20 at 3:53pm revealed:
-She had not received a written thirty-day notice and she was required to have the discharge notice in writing.
-She did not understand why the Administrator would not take Resident #3 back because the resident went to the hospital with chest pain, not

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D 228	Continued From page 22 psychiatric problems. Telephone interview with Resident #3's mental health provider on 12/04/20 at 11:26am revealed: -No one from the facility had reached out to him about any changes in behavior for Resident #3. -He had seen Resident #3 at the facility on 11/03/20 and Resident #3 was outside with other residents and appeared to be interacting well with the other residents at the facility. -Assisted living was the appropriate level of care for Resident #3. Telephone interview with the Department of Social Services (DSS) Adult Home Specialist (AHS) on 12/07/20 at 12:54pm revealed: -She had not received a discharge notice on Resident #3 from the facility. -A hospital case manager contacted the DSS AHS on 11/25/20 related to Resident #3. -Resident #3 was medically stable and was ready for discharge back to the facility but the facility's refused to take him back. -She called the facility and talked to the facility's contracted nurse. -The contracted nurse reported Resident #3 was up all night, had bizarre behaviors, and was afraid of safety for the other residents. -The Administrator's family member was afraid if forced to take Resident #3 back, Resident #3 would hurt another resident, or another resident would hurt Resident #3; "his presence caused everyone to be on edge." Telephone interview with a social worker from the local hospital on 12/08/20 at 9:04am revealed: -He was Resident #3's case manager when the resident was admitted to the hospital on 11/15/20. -Resident #3 was admitted for medical reasons. -Resident #3 was ready to be discharged on	D 228		

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D 228	Continued From page 23 11/18/20. -Three attempts were made to the facility with no answer. -Resident #3's guardian was contacted and was told the facility refused to take Resident #3 back upon discharge from the hospital. -He tried to call the facility again on 11/20/20 and no one answered the telephone. -The county DSS was contacted on 11/25/20 due to the facility refusing to take Resident #3 back.	D 228		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 2 of 2 sampled resident (Resident #1 and #3) regarding a missed appointment for an electroconvulsive therapy (ECT) procedure (#3) and follow up with the Cardiologist when the resident refused to wear compression stockings ordered for edema (#1). The findings are: 1. Review of Resident #3's FL2 dated 09/16/20 revealed diagnoses included schizoaffective disorder, unspecified personality disorder, and an unspecified neurocognitive disorder.	D 273		

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Review of Resident #3's facility transfer list of medication dated 10/17/20 revealed:
-There was a hand-written note Resident #3 had an ECT scheduled for 10/21/20 with exclamation punctuation.
-Resident #3 should arrive at 8:00am to receive a COVID-19 test prior to ECT procedure. (ECT is a psychiatric treatment in which seizures in the brain are electrically induced in patients to provide relief from mental disorders).
-The list was signed by the medication aide (MA) from Resident #3's previous facility and co-signed by the MA for this facility.

Review of Resident #3's Progress Note dated 10/20/20 revealed:
-Resident #3 would not stay away from other residents' doors asking for things or asking the residents to do things.
-Resident #3 was worrying the other residents.
-Resident #3 would say he was afraid of the other residents.
-The Administrator had asked Resident #3 to leave other residents alone.
-Resident #3's mental health case manager was notified Resident #3 would not follow the rules.

Telephone interview with Resident #3's Guardian on 12/02/20 at 12:20pm revealed:
-She did not know Resident #3 had missed the ECT appointment scheduled for 10/21/20.
-She had received a call from a staff member from the ECT treatment center on 11/06/20 because the staff member had received a call from Resident #3's mental health case manager who reported Resident #3 had called himself "Jesus", was not getting along with other residents and had defecated on himself, and the Guardian was concerned because Resident #3 had never had this behavior before.

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-She called Resident #3's mental health case manager to determine the last time Resident #3 was seen by a mental health provider.
-The case manager reported Resident #3 had been seen on 11/04/20 and they were aware of the noted behaviors.
-She requested someone from the mental health provider go back out to see Resident #3 because she was concerned the resident may not be getting his medication as ordered.

Review of the mental health nurse's Progress Note dated 11/04/20 revealed:
-Resident #3 did not seem to be adjusting well.
-Resident #3 reported he had not eaten in 3 days.
-Resident #3 expressed increased anxiety, the mental health physician was contacted and Resident #3 was started on anti-psychotic medication.

Interview with the medication aide (MA) on 12/03/20 at 11:53am revealed:
-She admitted Resident #3 to the facility.
-She signed the facility transfer list of medication dated 10/17/20
-She "missed" seeing the note about Resident #3's ECT appointment.
-She had not contacted anyone about the missed appointment because she had "missed" seeing the appointment.

Interview with the Administrator on 12/03/20 at 3:04pm revealed:
-Resident #3 missed the ECT appointment scheduled for 10/21/20 because she did not know Resident #3 had an appointment.
-She received a call from a staff member at Resident #3's previous facility about the missed appointment and was told by the staff member how important the ECT was for Resident #3.

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-She was not the MA who admitted Resident #3, so she did not know Resident #3 had an appointment.
-The MA should have written Resident #3's appointment on the calendar.
-The MA had not worked in an assisted living facility before, so she did not know how things were done.
-"I need some training myself."
-An ECT appointment was re-scheduled for Resident #3 for 10/28/20 and Resident #3 went to the appointment.

Telephone interview with the staff member at the ECT treatment center on 12/04/20 at 1:56pm revealed:
-Resident #3 was scheduled for an ECT treatment every 4 weeks.
-Missing an ECT treatment was not life-threatening but was important to maintain stability.
-She had not been able to reach anyone at Resident #3's current facility for the appointment on 10/21/20.
-She could not speak to whether Resident #3's reported behaviors were related to the missed ECT treatment on 10/21/20, but she would have the ECT physician call on 12/04/20 to discuss.

Attempted telephone interview with the ECT physician on 12/04/20 at 1:56pm was unsuccessful.

Based on interviews Resident #3 was not available for interview.

2. Review of Resident #1's current FL-2 dated 02/27/20 revealed diagnoses included schizophrenia, cerebral ischemia, essential hypertension cardiomyopathy, chronic obstructive

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pulmonary disease, mental health disorder and hyperlipidemia unspecified.

Review of Resident #1's physician orders revealed:
-There was an order dated 09/15/20 for compression stockings apply daily in the morning and remove at bedtime.
-There was a second order dated 10/19/20 for compression stockings apply daily in the morning and remove at bedtime.

Review of Resident #1's physician notes revealed:
-There was note dated 09/15/20 for compression stockings daily while up.
-There was a note dated 10/01/20 Resident #1's bilateral lower extremity (BLE) had grade 2 edema.
-There was a note dated 10/08/20 Resident #1 had grade 3 pitting edema in his lower legs.
-There was a note dated 10/09/20 Resident #1 had continued grade 3 edema in his lower legs.
-There was a note dated 10/14/20 to get compression stocking and apply daily.
-There was a note dated 10/27/20 Resident #1 had trace BLE edema.
-There was a note dated 11/17/20 Resident #1's BLE had trace edema.
-There was a note dated 11/24/20 Resident #1 had grade 1 BLE edema.
-There was a note dated 12/01/20 Resident #1 had trace BLE edema.

Review of Resident #1's September 2020 medication administration record (MAR) revealed:
-There was a hand-written entry for compression stockings apply in the morning and remove at bedtime.
-There was a line drawn vertically between

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09/17/20 and 09/18/20 beside the entry; there was a handwritten note that read self-administer and was initialed by the Administrator.
-There was no documentation of application of the compression stockings for the month of September 2020.

Review of Resident #1's October 2020 MAR revealed:
-There was an entry for compression stockings apply in the morning then remove at bedtime scheduled on at 8:00am and off at 8:00pm; the entry time had a handwritten line drawn through the time and there was no other time noted.
-There was documentation the compression stockings were applied daily in the mornings but there was nothing documented for removal in the evening.

Review of Resident #1's November 2020 MAR revealed:
-There was an entry for compression stockings apply in the morning then remove at bedtime scheduled on at 8:00am and off at 8:00pm.
-There was documentation the compression stockings were applied daily in the mornings and removed at bedtime for the month of November 2020.

Review of Resident #1's December 2020 MAR revealed:
-There was an entry for compression stockings apply in the morning then remove at bedtime scheduled on at 8:00am and off at 8:00pm.
-There was a hand-written note beside the entry that read: please PRN (pro re nata; as needed) this order-[resident] does not put them on in the mornings; the note was dated 12/01/20 and was signed by the Administrator.
-There was no documentation the compression

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stockings had been applied for the month of December 2020.

Observation of Resident #1 on 12/02/20 at 12:20pm and 2:47pm revealed:
-He did not have on his compression stockings; he did not have any socks on.
-He had a pair of clean closed toe compression stockings in his top dresser drawer.

Observation of Resident #1 on 12/03/20 at 10:22am revealed he did not have on his compression stockings and did not have on any socks.

Interview with Resident #1 on 12/02/20 at 2:47pm revealed:
-He had compression stockings that he could apply with the help of another resident; staff did not help him apply his compression stocking.
-He struggled to apply his compression stockings alone.
-No one reminded him to apply his compression stockings; he remembered to apply them.
-He did not wear his compression stockings on the day they were washed.
-The staff knew when he had his compression stockings on because he "let them see them"; he would show them his ankle.
-His compression stockings came to his knees; the Registered Nurse (RN) from hospice was the only one that looked to see if the stockings were all the way up.
-He did not have them on that day because he "just did not want to put them on".
-The compression stockings felt like normal socks but a "little tighter"; the compression stockings did not hurt and were not uncomfortable to wear.
-He knew he needed to wear the compression

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stockings because they took the fluid off his legs and helped the fluid around his heart.
-He knew his legs would swell if he did not wear his compression stockings; but he still did not wear them every day.
-He did not have a reason why he did not wear his compression stockings daily; "I just do not wear them every day".

Interview with a resident on 10/03/20 at 10:22am revealed:
-He helped Resident #1 apply his compression stockings because the resident asked for his help.
-He helped Resident #1 by pulling them up because they were tight.
-The last time he helped apply Resident #1's compression stockings was a month ago.

Interview with a medication aide (MA) on 12/03/20 at 3:11pm revealed:
-Resident #1 applied his own compression stockings; he usually applied them in the morning after his shower.
-She thought Resident #1 was ordered compression stockings for the swelling in his legs and to help with circulation.
-Resident #1 was "pretty good" about applying and wearing his compression stockings until about a week ago.
-Resident #1 started to refuse to apply his compression stockings because he complained they were too tight.
-She never checked Resident #1 to see if he applied the stockings correctly; she could see them under his pant legs.
-She never notified the primary care provider (PCP) when Resident #1 refused to apply his compression stockings; she could have called the PCP.

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D 273	Continued From page 31 -She thought the Administrator had called the PCP when the resident refused to apply the compression stockings. Interview with the Administrator on 12/03/20 at 3:38pm revealed: -Resident #1 did not wear his compression stockings "half the time"; but "his legs look good". -She did not have Resident #1 pull up the bottom of his pants leg to see if his compression stockings were applied; she never checked to see if they were applied correctly. -She looked at Resident #1 every morning to see if he had his compression stockings on; she could see at the bottom of his pants because his pants were short, she could see when he did not have them on. -Resident #1 had an order for compression stockings for fluid buildup; the fluid was "down now" so he did not wear them. -She told Resident #1 when he needed to apply his compression stockings; she would tell him when she could see his legs were "looking bad and swollen" -She knew Resident #1 had not had his compression stockings on for the last week because he refused to wear them. -She did not notify anyone that Resident #1 was not applying his compression stockings or refused to wear them. Telephone interview with a representative from the hospice office on 12/07/20 at 10:58pm revealed: -The RN checked Resident #1 to see if his compression stockings were applied and would check for edema. -The RN would make a note in Resident #'s record if he did not have on his compression stockings.	D 273		

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-There was a note dated 10/20/20 from the RN she had to adjust Resident #1's compression stockings because they were not properly applied and were hanging off his toes and rolled down towards his ankles.

Telephone interview with the MA/facility's transportation staff on 12/07/20 at 11:53am revealed:
-Resident #1's PCP had ordered the compression stockings for the fluid in his legs; his legs were swollen.
-He remembered Resident #1 had them on a couple of times when they were first ordered.
-Resident #1 applied the compression stockings when his legs were swollen but once the swelling went down, he would stop wearing them.
-He noticed Resident #1 never had his compression stockings on.
-He could look and see at the bottom of the resident's pants and could see the compression stockings were not on; Resident #1 did not wear any kind of socks.
-He did not notify the PCP when Resident #1 did not have the compression stockings on.
-He used to work as a MA at the facility but now he just transported residents to and from appointments.

Telephone interview with the hospice RN on 12/07/20 at 12:08pm revealed:
-Resident #1 could apply the compression stockings himself; she had shown him how to apply them.
-Resident #1 never had his compression stockings on; Resident #1 did not want to put them on.
-She checked Resident #1 for edema; he was on diuretics and he usually had trace edema when she saw him.

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D 273	Continued From page 33 -She would encourage Resident #1 to apply his compression stockings and when he did not have them on, she would apply them at her visits. -She visited Resident #1 at least once a week. Telephone interview with Resident #1's Cardiologist on 12/07/20 at 8:24am revealed: -She discontinued Resident #1's compression stocking at his in-person visit on 12/04/20 because the diuretics were working, and the swelling had gone down. -She was made aware Resident #1 was not wearing his compression stockings when he came in for in-person visits. -She would encourage Resident #1 to wear his compression stockings during his in-person visits. -She was not made aware Resident #1 was not wearing his compression stockings other than the in-person visits. _____ The facility failed to ensure a referral and follow up to meet the health care need for two residents including a scheduled ECT procedure was performed on Resident #3 every four weeks as ordered to maintain Resident #3's psychiatric stability. The resident missed the ECT procedure on 10/21/20 and the resident exhibited changes in his behavior. And failure to notify the Cardiologist of refusals to apply compression stocking for Resident #1 who had edema in his legs. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 8, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY	D 273		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (Resident #3) related to an allergy medication and an anti-inflammatory medication that was brought to the facility at move-in but were not listed on the FL-2, and multiple medications that were administered after a hospital procedure with orders to contact the primary provider for clarification (#3). The findings are: 1. Review of Resident #3's FL-2 dated 09/16/20 revealed: -Diagnoses included schizoaffective disorder, unspecified personality disorder, unspecified neurocognitive disorder, anemia chronic disease, osteoarthritis, seizures, glaucoma, and	D 344		

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constipation.
-There was an order for Famotidine (used to treat heartburn)10mg twice a day.
-There was an order for Aspirin 81mg (used to decrease the risk of blood clots) once a day.
-There was an order for Ativan (used to treat anxiety) 0.5mg twice a day.
-There was an order for Latanoprost eye drops (used to treat glaucoma) to administer one drop in both eyes at bedtime.
-There was an order for Levetiracetam (used to treat seizures) 500mg two tablets twice a day.
-There was an order for Loxapine Succinate (an anti-psychotic) 25mg three times a day.
-There was an order for Metoprolol Tartrate (used to treat high blood pressure) 25mg take ½ tablet twice a day.
-There was an order for Olanzapine (an anti-psychotic)10mg twice a day.
-There was an order for Trazodone 100mg (an antidepressant) take once a day at bedtime.
-There was an order for Vitamin D3 (a supplement) 1000IU take 2 tablets once a day.
-There was an order for Zoloft (an antidepressant) 50mg take 3 tablets once a day.

Review of Resident #3's subsequent FL-2 dated 09/23/20 revealed:
-There was an order for Famotidine 10mg twice a day.
-There was an order for Aspirin 81mg once a day.
-There was an order for Ativan 0.5mg twice a day.
-There was an order for Latanoprost eye drops to administer one drop in both eyes at bedtime.
-There was an order for Levetiracetam 500mg two tablets twice a day.
-There was an order for Loxapine Succinate 25mg three times a day.
-There was an order for Metoprolol Tartrate 25mg ½ tablet twice a day.

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-There was an order for Olanzapine 15mg twice a day.
-There was an order for Tamsulosin (used to treat improved urine flow in men) 0.4mg once a day.
-There was an order for Therems-M (a multi-vitamin) 27mg-0.4mg once a day.
-There was an order for Vitamin D3 50mcg 2 tablets once a day.
-There was an order for Zoloft 100mg once a day.

Review of Resident #3's facility transfer list of medication from his previous facility dated 10/17/20 revealed:
-There were 27 tablets of Claritin 10mg.
-There were 93 tablets of Zoloft 50mg.
-There were 120 tablets of Levetiracetam 500mg.
-There were 65 tablets of Loxapine 25mg.
-There were 58 tablets of Ativan 0.5mg.
-There were 59 tablets of Metoprolol 2mg.
-There were 27 tablets of Mobic (an anti-inflammatory)15mg.
-There were 59 tablets of Olanzapine 10mg.
-There were 60 tablets of Vitamin D3.
-There were 29 tablets of Trazadone 100mg.
-There were 30 tablets of Aspirin 81mg.
-There were 60 tablets of Pepcid 10mg.
-Latanoprost eye drops were listed with a note to contact Resident #3's primary care provider (PCP) to see if Resident #3 needed to continue the medication.
-There were no directions listed on the transfer list of medication.

Review of Resident #3's after-visit summary for an outpatient hospital summary dated 10/28/20 revealed:
-The resident had an Electroconvulsive therapy (ECT), (a psychiatric treatment in which seizures in the brain are electrically induced in patients to provide relief from mental disorders) procedure

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on 10/28/20.
-There was documentation this was Resident #3's current medication list and to take only the medications listed.
-Resident #3 was instructed to stop taking all medications not included on this list.
-If there were any questions regarding medications not on this list, please follow-up with Resident #3's healthcare provider.
-Aspirin 81mg once a day was listed.
-Vitamin D3 take 2 tablets (1000IU) once a day was listed.
-Famotidine 10mg twice a day was listed.
-Latanoprost 0.005% eye drops in both eyes at bedtime was listed.
-Levetiracetam 500mg take 2 tablets twice a day was listed.
-Lozapine 25mg three times a day was listed.
-Metoprolol Tartrate 25mg take ½ tablet twice a day was listed.
-Olanzapine 25mg take once a day at bedtime was listed; this was a change in current order.
-There was no entry for Ativan, Zoloft, Claritin, Mobic, and Trazadone.

Review of Resident #3's handwritten October 2020 medication administration records (MAR) revealed:
-There was an entry for Metoprolol Tartrate 2mg take ½ tablets twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 10/17/20-10/31/20.
-There was an entry for Vitamin D3 1000IU take two tablets once a day with a scheduled administration time of 8:00am; it was documented as administered 10/18/20-10/31/20.
-There was an entry for Loxapine Succinate 25mg take three times a day with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm; it was documented as administered

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D 344	Continued From page 38 10/17/20-10/31/20. -There was an entry for Levetiracetam 500mg take two tablets twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 10/17/20-10/31/20. -There was an entry for Zoloft 50mg take three tablets once a day with a scheduled administration time of 8:00am; it was documented as administered 10/18/20-10/31/20. -There was an entry for Claritin 10mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as administered 10/18/20-10/31/20. -There was an entry for Mobic 15mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as administered 10/18/20-10/31/20. -There was an order for Olanzapine 10mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 10/17/20-10/31/20. -There was an entry for Trazadone 100mg take one tablet once a day at bedtime with a scheduled administration time of 8:00pm; it was documented as administered 10/17/20-10/31/20. -There was an entry for Aspirin 81mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as administered 10/18/20-10/31/20. -There was an entry for Ativan 0.5mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 10/17/20-10/31/20. -There was an entry for Famotidine 10mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 10/17/20-10/31/20. Review of Resident #3's handwritten November 2020 MARs revealed:	D 344		

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D 344	Continued From page 39 -There was an entry for Metoprolol Tartrate 2mg take ½ tablets twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 11/01/20-11/14/20. -There was an entry for Vitamin D3 1000IU take two tablets once a day with a scheduled administration time of 8:00am; it was documented as administered 11/01/20-11/14/20. -There was an entry for Loxapine Succinate 25mg take three times a day with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm; it was documented as administered 11/01/20-11/14/20. -There was an entry for Levetiracetam 500mg take two tablets twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 11/01/20-11/14/20. -There was an entry for Zoloft 50mg take three tablets once a day with a scheduled administration time of 8:00am; it was documented as administered 11/01/20-11/14/20. -There was an entry for Claritin 10mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as administered 11/01/20-11/14/20. -There was an entry for Mobic 15mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as administered 11/01/20-11/14/20. -There was an order for Olanzapine 10mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 11/01/20-11/14/20. -There was an entry for Trazadone 100mg take one tablet once a day at bedtime with a scheduled administration time of 8:00pm; it was documented as administered 11/01/20-11/14/20. -There was an entry for Aspirin 81mg take one tablet once a day with a scheduled administration time of 8:00am; it was documented as	D 344		

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administered 11/01/20-11/14/20.
-There was an entry for Ativan 0.5mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 11/01/20-11/14/20.
-There was an entry for Famotidine 10mg take one tablet twice a day with a scheduled administration time of 8:00am and 8:00pm; it was documented as administered 11/01/20-11/14/20.

Review of Resident #3's pharmacy printed November 2020 MAR revealed the medication listed correlated with the FL-2 dated 09/16/20; there was no documentation on the MAR and the MAR was filed in Resident #3's record.

Interview with the Administrator on 12/02/20 at 11:37am revealed:
-She was not aware Resident #3 had multiple FL-2s at the time of admission.
-She did not know which FL-2 the admitting MA used to set up Resident #3's MARs.
-She was not familiar with what was in Resident #3's record because she was not the one who did the admission.
-She knew Resident #3 came to the facility with medications on hand, but she was not aware some of the medications on hand were not on the FL-2.
-She expected the MA to have compared the medications on hand with the FL-2 so she would know what to administer to Resident #3 and what had been discontinued.
-When Resident #3 came back to the facility from the hospital, the hospital discharge summary would be the current medication list for Resident #3.
-She had not looked at the hospital discharge summary or clarified the medication list.
-She had contacted the pharmacy (she did not

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D 344	Continued From page 41	D 344		

recall the date) because she wanted to get Resident #3's medications "straightened out."
-She could not recall why she called the pharmacy or what the problem was but thought it was because a medication did not come in to be administered.

Telephone interview with the Pharmacist with the facility's contract pharmacy on 12/02/20 at 3:45pm revealed:
-On 11/05/20, Resident #3's FL-2 dated 09/16/20 was received by fax at the pharmacy.
-When he contacted the facility, he was told Resident #3 did not need any medications.
-He was not aware of an FL-2 dated 09/23/20 for Resident #3 but would have clarified any medication changes.
-Latanoprost eye drops had not been dispensed for Resident #3.

Interview with the MA on 12/03/20 at 11:53am revealed:
-She admitted Resident #3 to the facility.
-She created Resident #3's October 2020 MAR based on the medications brought with Resident #3 at admission.
-She copied the medications from the October 2020 MAR to create Resident #3's November 2020 MAR.
-She compared the medications that Resident #3 brought into the facility to the FL-2 dated 09/16/20; she missed seeing there was no order for Claritin or Mobic.
-She had not contacted Resident #3's primary care provider (PCP) for clarification for the Latanoprost eye drops because she "missed" seeing the note about Resident #3's Latanoprost eye drops.
-She knew an order was needed before administering medication but had not contacted

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anyone for clarification because she had missed seeing it.
-She did not know there was a second FL-2 for Resident #3 dated 09/23/20 so she did not know there was an order for Tamsulosin or Therems-M.
-She was not working when Resident #3 returned from the hospital, so she did not see the discharge summary medication list.
-If she had known about the discharge summary medication list, she would have compared the list to the current medications and had any changes clarified.

Interview with the Administrator on 12/03/20 at 3:04pm revealed:
-She was working as the MA when Resident #3 returned from his ECT treatment and reviewed the discharge summary.
-She thought she faxed the discharge summary to the pharmacy.
-She did not receive a fax confirmation and did not contact the pharmacy to confirm the discharge summary had been received.
-She did not "think" anymore about it.
-She was not aware Claritin and Mobic had been administered to Resident #3 without an order since it was not listed on the FL-2.
-When Resident #3 had the medication at the time of admission and it was not on Resident #3's FL-2, the MA should have checked on it.
-It was concerning "they" were not doing their job.
-She did not know who Resident #3's PCP was or how to reach the PCP.

Telephone interview with Resident #3's PCP on 12/04/20 at 9:34am revealed:
-He had not received any communication related to Resident #3 from the current facility staff.
-He would have expected a call for clarification on the FL-2s and any other medication directives.

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-Resident #3 should be administered Claritin, Mobic, Therems-M, and Tamsulosin.
-Resident #3 should have continued receiving Latanoprost eye drops.

Telephone interview with Resident #3's mental health physician on 12/04/20 at 11:26am revealed:
-He was not aware Resident #3 had a discharge summary from the hospital after his ECT treatment with instruction to contact the provider to discuss medications that were not listed.
-He was not aware the order for Resident #3's Olanzapine was to be administered 25mg once a day at bedtime; if Resident #3 had been administered the Olanzapine 25mg he could have evaluated the effectiveness of the medication and made changes if needed.
-No one from the facility had contacted him to clarify what medications Resident #3 should continue to be administered.
-He would have expected the MA to reach out to him for clarification.

Telephone interview with a representative from the ECT office on 12/04/20 at 1:56pm revealed:
-Usually, a resident from a facility would have brought a copy of their current MAR to the ECT treatment so it could be compared to the medication list on file and changes made.
-Resident #3 did not have a current MAR with him for his ECT on 10/28/20.
-The discharge summary was not actual orders as it often was not comprehensive because a change may have not been transferred into the discharge summary.
-No one asked for clarification on the list that went back to the facility with Resident #3.

Based on interviews Resident #3 was not

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D 344	Continued From page 44 available for interview.	D 344		
{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 B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 3 of 3 sampled residents (#1, #2, and #3) including an anti-psychotic medication, an eye drop used to treat glaucoma, a medication used to treat urine flow and a multi-vitamin (#3), a cream used to treat psoriasis (#2),a medication used to lower low-density lipoprotein (LDL) cholesterol and a medication used to lower and control blood sugars (#1). The findings are: 1.Review of Resident #3's FL-2 dated 09/16/20 revealed diagnoses included schizoaffective disorder, unspecified personality disorder, unspecified neurocognitive disorder, anemia chronic disease, osteoarthritis, seizures, glaucoma, and constipation.	{D 358}		

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Review of Resident #3's resident register revealed Resident #3 was admitted to the facility on 10/17/20.

a. Review of Resident #3's FL-2 dated 09/16/20 revealed there was an order for Loxapine Succinate (an anti-psychotic) take three times daily.

Review of Resident #3's facility transfer list of medication dated 10/17/20 revealed there were 65 tablets of Loxapine 25mg.

Review of Resident #3's handwritten October 2020 medication administration records (MAR) revealed:
-There was an entry for Loxapine Succinate 25mg take three times a day with a scheduled administration time of 8:00am, 12:00pm, and 8:00pm.
-Loxapine was documented as administered 10/17/20-10/31/20 at 8:00am and 8:00pm.
-Loxapine was only documented on 10/17/20 at the 12:00pm dose.
-Loxapine was documented as administered 31 times out of 44 opportunities.
-There was no documentation Loxapine was administered at 12:00pm on 10/18/20-10/31/20.

Observation of Resident #3's medications on hand on 12/02/20 at 11:32am revealed there was a punch card labeled for Loxapine Succinate 25mg take one tablet three times a day with a dispense date of 10/15/20 for 60 tablets; there were 8 tablets available to be administered.

Telephone interview with Resident #3's Guardian on 12/02/20 at 12:20pm revealed:
-She had received a call from the provider at Electroconvulsive therapy (ECT) (a psychiatric

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treatment in which seizures in the brain are electrically induced in patients to provide relief from mental disorders) treatment center that they had received a call from Resident #3's mental health case manager who reported Resident #3 had called himself "Jesus", was not getting along with other residents and had defecated on himself, and she was concerned because Resident #3 had never had this behavior before.
-She called Resident #3's mental health case manager to determine the last time Resident #3 was seen.
-The case manager reported Resident #3 had been seen on 11/04/20 and they were aware of the noted behaviors.
-She requested someone from the mental health team go back out to see Resident #3 because she was concerned the resident may not be getting his medication as ordered.

Review of the mental health nurse's Progress Note dated 11/04/20 revealed:
-Resident #3 did not seem to be adjusting well.
-Resident #3 reported he had not eaten in 3 days.
-Resident #3 expressed increased anxiety, the mental health physician was contacted and Resident #3 was started on anti-psychotic medication.

Telephone interview with Resident #3's mental health physician on 12/04/20 at 11:26am revealed:
-Loxapine was prescribed for Resident #3 to treat agitation and anxiety.
-He was not aware Resident #3 had not been administered the noon dose of Loxapine for 14 days.
-The noon dose would have had a calming effect and antipsychotic for Resident #3.
-Missing the noon dose could have affected

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{D 358}	Continued From page 47 Resident #3's behavior related to increased anxiety. -He expected Resident #3's Loxapine to be administered as ordered three times per day. -He started Resident #3 on Seroquel 25mg (an anti-psychotic) three times a day on 11/05/20 due to increased anxiety. Interview with the Administrator on 12/03/20 at 3:31pm revealed: -She saw the noontime entry on the November 2020 MAR and thought Resident #3 "must have a new order." -She administered the noon dose of Loxapine in November 2020. -She did not look back at Resident #3's October 2020 MAR to see the noon dose had been missed because she thought the noon dose was a new order in November 2020. -She had not administered Resident #3's Loxapine at noon in October 2020 because she did not know it was scheduled and had missed seeing the entry on the MAR. -She had not contacted Resident #3's mental health provider because she did not know the medication had been missed. Interview with a medication aide (MA) on 12/03/20 at 3:51pm revealed: -She administered Resident #3's noon dose of Loxapine. -She knew she administered Resident #3's noon dose of Loxapine because Resident #3 would always ask for it. -She did not know why there were extra pills of Loxapine on hand. Based on interviews Resident #3 was not available for interview.	{D 358}		

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{D 358}	Continued From page 48 b. Review of Resident #3's current FL-2 dated 09/23/20 revealed there was an order for Latanoprost Solution (eye drops used to treat glaucoma) 0.005% apply to both eyes at bedtime. Review of Resident #3's facility transfer list of medication from his previous facility dated 10/17/20 revealed: -Latanoprost Solution 0.005% was not available. -There was a hand-written note to contact Resident #3's primary care provider (PCP) to see if Resident #3 needed to continue this medication with exclamation punctuation. Review of Resident #3's handwritten October 2020 and November 2020 medication administration records (MAR) revealed there was no entry for Latanoprost Solution 0.005%. Review of Resident #3's pharmacy printed November 2020 MARs revealed there was an entry for Latanoprost Solution 0.005% once daily in both eyes with a scheduled administration time of 8:00pm; there was no documentation on the MAR and the MAR was filed in Resident #3's record. Observation of Resident #3's medications on hand on 12/02/20 at 11:32am revealed Latanoprost Solution 0.005% was not available to be administered. Telephone interview with the Pharmacist with the facility's contract pharmacy on 12/02/20 at 3:45pm revealed: -On 11/05/20, Resident #3's FL-2 dated 09/16/20 was received by fax at the pharmacy. -When he contacted the facility, he was told Resident #3 did not need any medications. -He was not aware of an FL-2 dated 09/23/20 for	{D 358}		

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Resident #3 but would have clarified any medication changes.
-Latanoprost eye drops had not been dispensed for Resident #3.

Telephone interview with Resident #3's PCP on 12/04/20 at 9:34am revealed:
-He had not received any communication related to Resident #3 from the current facility staff.
-He would have expected a call for clarification on Resident #3's FL-2s and any other medication directives.
-Resident #3 had a diagnosis of glaucoma and was prescribed Latanoprost eye drops to lower the intraocular pressure (Lowering high pressure inside the eye helps to prevent blindness).
-Resident #3 should have continued receiving Latanoprost eye drops and he was concerned without the medication Resident #3 would experience an exacerbation of the intraocular pressure.

Interview with the MA on 12/03/20 at 11:53am revealed:
-She admitted Resident #3 to the facility.
-She created Resident #3's October 2020 MAR based on the medications brought with Resident #3 at admission.
-She copied the medications from the October 2020 MAR to create Resident #3's November 2020 MAR.
-She compared the medications that Resident #3 brought into the facility to the FL-2 dated 09/16/20.
-She "missed" seeing the note about Resident #3's Latanoprost eye drops.
-She had not contacted Resident #3's PCP for clarification for the Latanoprost eye drops.

Interview with the Administrator on 12/02/20 at

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{D 358}	Continued From page 50 11:37am revealed: -She was not aware Resident #3 had multiple FL-2s at the time of admission. -She did not know which FL-2 the admitting MA used to set up Resident #3's MARs. -She was not familiar with what was in Resident #3's record because she was not the one who did the admission. -She knew Resident #3 came to the facility with medications on hand, but she was not aware some of the medications on hand were not on the FL-2. -She expected the MA to have compared the medications on hand with the FL-2 so she would know what to administer to Resident #3 and what had been discontinued. -When Resident #3 came back to the facility from the hospital, the hospital discharge summary would be the current medication list for Resident #3. -She had not looked at the hospital discharge summary or clarified the medication list. -She had contacted the pharmacy (she did not recall the date) because she wanted to get Resident #3's medications "straightened out." -She could not recall why she called the pharmacy or what the problem was but thought it was because a medication did not come in to be administered. Interview with the Administrator on 12/03/20 at 3:04pm revealed: -Resident #3 did not have any Latanoprost eye drops when he moved into the facility. -She did not know there was an order for Latanoprost eye drops. -When Resident #3 had the medication at the time of admission and it was not on Resident #3's FL-2, the MA should have checked on it. -She did not know who Resident #3's PCP was or	{D 358}		

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how to reach the PCP.
-It was concerning "they" were not doing their job.

Based on interviews Resident #3 was not available for interview.

c. Review of Resident #3's current FL-2 dated 09/23/20 revealed there was an order for Tamsulosin (used to treat improved urine flow in men) 0.4mg once a day.

Review of Resident #3's facility transfer list of medication from his previous facility dated 10/17/20 revealed there was no documentation related to Resident #3's Tamsulosin.

Review of Resident #3's handwritten October 2020 and November 2020 medication administration records (MAR) there was no entry for Tamsulosin 0.4mg.

Observation of Resident #3's medications on hand on 12/02/20 at 11:32am revealed Tamsulosin 0.4mg was not available to be administered.

Telephone interview with the Pharmacist with the facility's contract pharmacy on 12/02/20 at 3:45pm revealed:
-On 11/05/20, Resident #3's FL-2 dated 09/16/20 was received by fax at the pharmacy.
-When he contacted the facility, he was told Resident #3 did not need any medications.
-He was not aware of an FL-2 dated 09/23/20 for Resident #3 but would have clarified any medication changes.
-Tamsulosin 0.4mg had not been dispensed for Resident #3.

Telephone interview with Resident #3's PCP on

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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 52 12/04/20 at 9:34am revealed: -He had not received any communication related to Resident #3 from the current facility staff. -He would have expected a call for clarification on Resident #3's FL-2s and any other medication directives. -Resident #3 was prescribed Tamsulosin after the resident complained of straining to pass his urine and nocturnal frequent urination. -Resident #3 would have had an exacerbation of symptoms for all the missed medications and he expected the medications to have been administered as ordered. Interview with the MA on 12/03/20 at 11:53am revealed: -She admitted Resident #3 to the facility. -She created Resident #3's October 2020 MAR based on the medications brought with Resident #3 at admission. -She copied the medications from the October 2020 MAR to create Resident #3's November 2020 MAR. -She compared the medications that Resident #3 brought into the facility to the FL-2 dated 09/16/20. -She did not know there was a second FL-2 for Resident #3 dated 09/23/20 so she did not know there was an order for Tamsulosin. Interview with the Administrator on 12/02/20 at 11:37am revealed: -She was not aware Resident #3 had multiple FL-2s at the time of admission. -She did not know which FL-2 the admitting MA used to set up Resident #3's MARs. -She was not familiar with what was in Resident #3's record because she was not the one who did the admission. -She knew Resident #3 came to the facility with	{D 358}		

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{D 358}	Continued From page 53	{D 358}		

medications on hand, but she was not aware some of the medications on hand were not on the FL-2.
-She expected the MA to have compared the medications on hand with the FL-2 so she would know what to administer to Resident #3 and what had been discontinued.
-When Resident #3 came back to the facility from the hospital, the hospital discharge summary would be the current medication list for Resident #3.
-She had not looked at the hospital discharge summary or clarified the medication list.
-She had contacted the pharmacy (she did not recall the date) because she wanted to get Resident #3's medications "straightened out."
-She could not recall why she called the pharmacy or what the problem was but thought it was because a medication did not come in to be administered.

Interview with the Administrator on 12/03/20 at 3:04pm revealed:
-She did not know who Resident #3's PCP was or how to reach the PCP.
-It was concerning "they" were not doing their job.

Based on interviews Resident #3 was not available for interview.

d. Review of Resident #3's current FL-2 dated 09/23/20 revealed there was an order for Therems-M (a multi-vitamin) 27mg-0.4mg once a day.

Review of Resident #3's facility transfer list of medication from his previous facility dated 10/17/20 revealed there was no documentation related to Resident #3's Therems-M.

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{D 358}	Continued From page 54 Review of Resident #3's handwritten October 2020 and November 2020 medication administration records (MAR) revealed there was no entry for Therems-M 27mg-0.4mg. Observation of Resident #3's medications on hand on 12/02/20 at 11:32am revealed Therems-M 27mg-0.4mg was not available to be administered. Telephone interview with the Pharmacist with the facility's contract pharmacy on 12/02/20 at 3:45pm revealed: -On 11/05/20, Resident #3's FL-2 dated 09/16/20 was received by fax at the pharmacy. -When he contacted the facility, he was told Resident #3 did not need any medications. -Therems-M 27mg-0.4mg had not been dispensed for Resident #3. Telephone interview with Resident #3's PCP on 12/04/20 at 9:34am revealed: -He had not received any communication related to Resident #3 from the current facility staff. -He would have expected a call for clarification on the FL-2s and any other medication directives. -Resident #3 was prescribed Therems-M after labwork showed several low readings and it was decided an overall multi-vitamin would be effective; Therems-M should have been administered. -Resident #3 would have had an exacerbation of symptoms for all the missed medications and he expected the medications to have been administered as ordered. Interview with the MA on 12/03/20 at 11:53am revealed: -She admitted Resident #3 to the facility. -She created Resident #3's October 2020 MAR	{D 358}		

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{D 358}	Continued From page 55	{D 358}		

based on the medications brought with Resident #3 at admission.
-She copied the medications from the October 2020 MAR to create Resident #3's November 2020 MAR.
-She compared the medications that Resident #3 brought into the facility to the FL-2 dated 09/16/20.
-She did not know there was a second FL-2 for Resident #3 dated 09/23/20 so she did not know there was an order for Therems-M.

Interview with the Administrator on 12/02/20 at 11:37am revealed:
-She was not aware Resident #3 had multiple FL-2s at the time of admission.
-She did not know which FL-2 the admitting MA used to set up Resident #3's MARs.
-She was not familiar with what was in Resident #3's record because she was not the one who did the admission.
-She knew Resident #3 came to the facility with medications on hand, but she was not aware some of the medications on hand were not on the FL-2.
-She expected the MA to have compared the medications on hand with the FL-2 so she would know what to administer to Resident #3 and what had been discontinued.
-When Resident #3 came back to the facility from the hospital, the hospital discharge summary would be the current medication list for Resident #3.
-She had not looked at the hospital discharge summary or clarified the medication list.
-She had contacted the pharmacy (she did not recall the date) because she wanted to get Resident #3's medications "straightened out."
-She could not recall why she called the pharmacy or what the problem was but thought it

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{D 358}	Continued From page 56	{D 358}		

was because a medication did not come in to be administered.

Interview with the Administrator on 12/03/20 at 3:04pm revealed:
-She did not know who Resident #3's PCP was or how to reach the PCP.
-It was concerning "they" were not doing their job.

Based on interviews Resident #3 was not available for interview.

2. Review of Resident #2's current FL2 dated 03/12/20 revealed diagnoses included psoriasis, major depression, schizophrenia, hypertension, hyperlipidemia, vitamin D deficiency, and iron deficiency.

Review of Resident #2's primary care provider (PCP) progress note dated 08/27/20 revealed:
-Resident #2 complained of his psoriasis (a skin disease in which red, scaly patches form due to increased production of skin cells on some areas of the body) itching.
-There was documentation to start Resident #2 on Calcipotriene 0.005% (used to treat psoriasis) apply to psoriasis twice a day.

Review of Resident #2's October 2020 and November 2020 Medication Administration Record (MAR) revealed there was no entry for Calcipotriene cream.

Observation of Resident #2's medication on hand on 12/02/20 at 2:31pm revealed there was no Calcipotriene cream available to be administered.

Telephone interview with the pharmacist on 12/03/20 at 10:40am revealed:
-An electronic prescription was received from

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Resident #3's PCP for Calcipotriene 0.005% cream.
-They did not have the Calcipotriene cream available to be dispensed and the cream was ordered.
-When the Calcipotriene cream was delivered to the pharmacy it was not dispensed to the facility.
-No one from the facility had contacted the pharmacy to dispense Resident #2's Calcipotriene cream.

Telephone interview with Resident #2's PCP on 12/03/20 at 1:13pm revealed:
-Resident #2 had complained of his psoriasis itching so she ordered the Calcipotriene cream.
-She would have expected the medication to have been administered as ordered.
-No one had contacted her about the cream not being available to be administered.

Interview with Resident #2 on 12/02/20 at 3:00pm revealed:
-His itching had been worse "about a month ago" but was better now.
-He only had one cream he had used for the itching and presented a tube of Mometasone 0.1% cream. (steroid cream used to treat itching).

Interview with a medication aide (MA) on 12/03/20 at 11:33am revealed:
-She was not aware Resident #2 had an order for Calcipotriene cream.
-She did not start until September 2020 and the medication was not listed on Resident #2's MAR so she would not have known about the order.

Interview with the Administrator on 12/03/20 at 2:54pm revealed:
-Resident #2's PCP progress note would have been given to her by the transport staff.

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{D 358}	Continued From page 58 -She did not recall seeing Resident #2's order for Calcipotriene cream; "she could not remember back that far." -She did not have a system in place to track orders. 3. Review of Resident #1's current FL-2 dated 02/27/20 revealed diagnoses included schizophrenia, cerebral ischemia, essential hypertension cardiomyopathy, chronic obstructive pulmonary disease, mental health disorder and hyperlipidemia unspecified. a. Review of Resident #1's physician orders dated 10/06/20 revealed: -There was an order for Nexlizet (a medication used to lower low-density lipoprotein (LDL) cholesterol) 180mg-10mg take one tablet daily. -There was no documentation of an order to discontinue the Nexlizet. Review of Resident #1's pharmacy dispensing records from October 2020 to December 2020 revealed Nexlizet was not dispensed. Review of Resident #1's October 2020 medication administration record (MAR) revealed Nexlizet was not on the MAR. Review of Resident #1's November 2020 MAR revealed: -There was an entry for Nexlizet 180/10mg take 1 tablet once daily with a scheduled administration time of 8:00am. -Nexlizet was documented as administered 31 times from 10/01/20-10/31/20. Review of Resident #1's December 2020 MAR revealed: -There was an entry for Nexlizet 180/10 mg take	{D 358}		

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{D 358}	Continued From page 59 1 tablet once daily with a scheduled administration time of 8:00am. -Nexlizet was documented as administered on 12/01/20 and 12/02/20. Observation of Resident #1's medications on hand on 12/03/20 at 2:16pm revealed there was no Nexlizet 180/10 mg available for administration. Interview with the Administrator on 12/03/20 at 4:30pm revealed: -She did not know why the Nexlizet was signed off on the MAR when it was not available for administration; she guessed she just "followed suit" and signed on all the medication on the MAR. -The insurance company would not pay for the Nexlizet; she did not inform the primary care physician (PCP) the medication was not being administered. -She thought the pharmacy would call the PCP but she did not know if the call to the PCP was made. -She did not know if the PCP was aware Resident #1 was not receiving the Nexlizet as ordered. -She thought she had made a note in Resident #1's record about the insurance denial to pay for the medication. -She would have to call the PCP to get a discontinuation order for Resident #1's Nexlizet. Telephone interview with the pharmacist from the facility's contracted pharmacy on 12/03/20 at 4:09pm revealed: -There was an order for Nexlizet 180/10mg take one tablet once daily for Resident #1 dated 10/06/20, but it was never dispensed. -Resident #1's insurance denied payment for the order for Nexlizet on 10/06/20.	{D 358}		

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{D 358}	Continued From page 60 -The pharmacy had left a message with the PCP's office on 10/06/20 to inform them the Nexlizet was not covered by Resident #1's insurance. -The facility was informed of the insurance company's denial for payment on the Nexlizet on 10/06/20. -The pharmacy usually tried to get all medications approved for payment or get another medication ordered from the PCP. -The pharmacy never heard anything back from he PCP or the facility concerning the Nexlizet. Telephone interview with Resident #1's PCP on 12/08/20 at 8:28am revealed: -She ordered the Nexlizet for Resident #1 because his last lab results dated 09/28/20 showed his LDLs were 214. -Nexlizet was ordered to help lower Resident #1's low-density lipoprotein (LDL) cholesterol and assist with his cardio vascular disease. -She was concerned that Resident #1 did not receive the Nexlizet but there was nothing she could do when insurance denied payment for medications. -She wrote a new order for another medication for Resident #1 when her nurse told her about the Nexlizet; she was informed four days ago (12/04/20); she did not know who had notified her office. b. Review of Resident #1's record revealed there was a physician's order for Victoza (an injectable medication used to treat type 2 diabetes) 18mg/3ml inject 0.6mg subcutaneous (SQ) once a day for one week; then inject 1.2mg every day. Review of Resident #1's dispensing records from the facility's contracted pharmacy from October 2020 to December 2020 revealed two Victoza	{D 358}		

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{D 358}	Continued From page 61 18mg pens were dispensed on 10/06/20. Review of Resident #1's October 2020 medication administration record (MAR) revealed: -There was a handwritten entry to inject 0.6mg once daily for 7 days scheduled at 8:00am; there was nothing noting the medication that was to be injected. -The medication was documented as administered 7 times from 10/06/20 to 10/12/20, then there was a note stop 10/12/20 discontinue. -There was no entry or documentation of administration of Victoza 18mg on the MAR. Review of Resident #1's November 2020 MAR revealed: -There was an entry for Victoza 18mg inject 0.6mg SQ once daily for 7 days scheduled at 8:00am; there was a hand drawn wavy line across the administration dates beside the entry. -There was an entry for Victoza 18mg inject 1.2mg SQ once daily scheduled at 8:00am; there was a hand drawn wavy line across the administration dates beside the entry. -There was no documentation Victoza was administered for the month of November 2020. Review of Resident #1's December 2020 MAR revealed: -There was an entry for Victoza 18mg inject 0.6mg SQ once daily for 7 days scheduled at 8:00am; there was a hand drawn wavy line across the administration dates beside the entry. -There was an entry for Victoza 18mg inject 1.2mg SQ once daily scheduled at 8:00am; there was a hand drawn wavy line across the administration dates beside the entry. -There was no documentation Victoza was administered for the month of December 2020.	{D 358}		

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{D 358}	Continued From page 62 Observation of Resident #1's medication on hand on 12/03/20 at 2:16pm revealed there were two Victoza 18mg pens available for administration. Interview with a medication aide (MA) on 12/03/20 at 2:54pm revealed: -She was told by the Administrator the primary care physician (PCP) discontinued Resident #1's Victoza when he went to his last appointment; she did not remember the date. -Resident #1 was started on the Victoza and then it was canceled; the Administrator told her the PCP was just trying him out on the Victoza. Telephone interview with a representative from the facility's contracted pharmacy on 12/03/20 at 11:50am revealed: -There were two Victoza 18mg pens dispensed on 10/06/20. -There was an order Victoza 18mg/3ml inject 0.6mg once a day for one week; then inject 1.2mg every day. -The Victoza was used to help control blood sugar levels and could result in increased blood sugar levels if not taken correctly. -The two Victoza pens should have had the 7 doses when administered at 0.6mg and then had about 25 doses when administered at 1.2mg. Telephone interview with Resident #1's PCP on 12/03/20 at 11:58am revealed: -Resident #1 had a diagnoses of type 2 diabetes mellitus. -Resident #1 was ordered the Victoza 18mg with other medications in a layered effort to get his blood sugar levels lowered -Resident #1 had an active order for Victoza 18mg administered at 1.2mg injected once daily. -The Victoza was a step-up medication and was ordered to begin at a lower dose of 0.6mg once	{D 358}		

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daily for 7 days and then increase to the higher dose.
-Resident #1's A1C was 7 in June 2020 and had increased to 9 in September 2020 (An A1C test is a blood test that reflects your average blood glucose levels over the past 3 months. An A1C level below 5.7 percent is considered normal); Resident #1 last appointment was 10/06/20.
-She expected the order for Victoza 18mg inject 1.2mg to have been followed as ordered.
-She had not been notified by the facility that Resident #1 was not administered his Victoza.
-She needed to know if Resident #1 was not administered the Victoza because she needed to know if the change in his medication was working.

Interview with Resident #1 on 12/03/20 at 8:10am revealed:
-He did not get an injection for his diabetes; he did at one time but not anymore.
-He could not recall when he used to get an injection for his diabetes, and he did not know his injections for diabetes stopped.

Interview with the Administrator on 12/03/20 at 3:52pm revealed:
-Resident #1's Victoza was not discontinued; it was only ordered for few days; she documented the administration for seven days on the MAR.
-She did not know why the Victoza was only ordered to be administered for 7 days; "they [PCP] just stopped it".
-He had not been administered the Victoza since it was documented as administered on the October 2020 MAR.

Telephone interview with the Administrator on 12/08/20 at 9:27am revealed:
-She did not know until 12/08/20 that Resident #1

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{D 358}	Continued From page 64 had a current order for Victoza 1.2mg inject once daily. -She thought Resident #1 was "done" with the Victoza; she thought the order was for only 7 days. -She saw the two entries for the Victoza on the November 2020 and December 2020 MARs but thought the pharmacy made an error and repeated the order twice on the MAR. -She thought the second entry was a duplicate of the first entry; she did not read the second entry. -She drew the line across the administration dates on the MAR next to the Victoza entries. _____ The failure of the facility to ensure the adminstration of medications and treatments to three residents including a resident (#1) who had a history of heart desease and type 2 diabetes that was not administered a cholesterol lowering medication and was not administered a medication to lower blood glucose levels. A resident (#3) who had a history of anxiety was not administered the noon dose of ordered anti-anxiety medication which resulted in Resident #3 having increased anxiety and having to have an additional anxiety medication prescribed, he was also not administered a multi-vitamin, a medication used to treat glaucoma and a urine retention medication. A resident (#2) was allowed to self-administer a cream to treat psoriasis, and then complained of increased itching, was prescribed an additional cream used to treat psoriasis, which was never ordered for the resident. These failures were detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on December 8,	{D 358}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

(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 65 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2021 .	{D 358}		
{D 367}	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the Medication Administration Records (MAR) for 2 of 3 sampled residents (Resident #1 and #2).	{D 367}		

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{D 367}	Continued From page 66 The findings are: 1. Review of Resident #2's current FL2 dated 03/12/20 revealed diagnoses included psoriasis, major depression, schizophrenia, hypertension, hyperlipidemia, vitamin D deficiency, and iron deficiency. a. Review of Resident #2's current FL-2 dated 03/12/20 revealed there was a medication order for Mometasone 0.1% cream apply topically to the affected area daily (a topical cream used to treat redness, swelling, itching and inflammation, and discomfort of various skin conditions). Review of Resident #2's October 2020 Medication Administration Record (MAR) revealed: -There was an entry for Mometasone 0.1% cream apply topically to the affected area with a scheduled administration time of 8:00am. -Mometasone 0.1% was documented as administered at 8:00am from 10/01/20-10/31/20. Review of Resident #2's November 2020 MAR revealed: -There was an entry for Mometasone 0.1% cream apply topically to the affected area with a scheduled administration time of 8:00am. -Mometasone 0.1% was documented as administered at 8:00am from 11/01/20-11/31/20. Observation of medication on hand on 12/02/20 at 2:31pm revealed a plastic bag with a pharmacy label with a dispense date of 11/24/20 that contained a full tube of Mometasone 0.1% cream. Interview with Resident #2 on 12/03/20 at 3:00pm revealed: -The resident presented a tube of Mometasone	{D 367}		

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{D 367}	Continued From page 67	{D 367}		

Cream he had in his dresser drawer.
-The tube did not have a pharmacy label and was not in a bag labeled from the pharmacy.
-He used the cream every day.
-The medication aide (MA) did not apply the cream.
-The Administrator gave him the tube of Mometasone and when he needed more, he would tell the Administrator.
-He applied the cream to his elbow and back after he took a bath.
-No one had told him he could not have the Mometasone in his room without a physician's order.

Interview with a MA on 12/03/20 at 11:33am revealed:
-She had not administered Resident #2's Mometasone cream since she started to work at the facility in September 2020.
-She missed seeing the Mometasone cream on Resident #2's MAR but she had documented she had administered the cream.
-She compared the resident's medications at the first of the month to make sure they matched the MARs, but she did not look at the MARs every day when she administered the medication.
-She initialed all of Resident #2's current medications listed on the MARs because she knew there had been no changes.

Interview with the Administrator on 12/03/20 at 2:54pm revealed:
-When she administered medication, she handed Resident #2 the tube of Mometasone cream and allowed the resident to "get out how much he wanted to put on his spots."
-She documented administering Resident #2's medication because she knew the cream had been administered.

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{D 367}	Continued From page 68 b. Review of Resident #2's current FL2 dated 03/12/20 revealed there was an order for Lisinopril 40mg to administer two tablets daily (used to treat high blood pressure). Review of Resident #2's September 2020 MAR revealed: -There was an entry for Lisinopril 40mg administer two tablets daily with a scheduled administration time of 8:00am. -Lisinopril was documented as administered at 8:00am from 09/01/20-09/30/20. Review of Resident #2's October 2020 MAR revealed: -There was no entry for Lisinopril 40mg administer two tablets daily. -There was no documentation Lisinopril 40mg had been administered. Review of Resident #2's November 2020 MAR revealed: -There was an entry for Lisinopril 40mg administer two tablets daily with a scheduled administration time of 8:00am. -Lisinopril was documented as administered at 8:00am from 11/01/20-11/31/20. Observation of medication on hand on 12/02/20 at 2:31pm revealed: -There was a punch card for Lisinopril 40mg with a dispense date of 11/24/20. -Each bubble contained 2 tablets of Lisinopril 40mg. -There were 28 of 30 tablets available to be administered. Telephone interview with the pharmacist from the facility's contracted pharmacy on 12/03/20 at	{D 367}		

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{D 367}	Continued From page 69 10:40am revealed: -He did not know why there was no entry on Resident #2's September 2020 MAR for Lisinopril 40mg. -Reviewing the order history showed there were no medication refills for the October 2020 dispensing and a new prescription had been requested from Resident #2's primary care provider (PCP). -The MARs were printed off at the end of September 2020 which would have been in-between the old prescription and the new prescription being keyed in and this would be the only reason he could think of for the Lisinopril not being listed on Resident #2's October 2020 MAR. -No one from the facility had called about Resident #2's Lisinopril not being listed on the October 2020 MAR. -The MA could have written in the Lisinopril on Resident #2's MAR. -Lisinopril 40mg was dispensed 10/01/20, 10/26/20, and 11/24/20 for a 30-day supply each dispensing. Interview with a MA on 12/03/20 at 11:33am revealed: -She did not recall not seeing an entry for Resident #2's Lisinopril on the October 2020 MAR. -She knew she administered Resident #2's Lisinopril because the medication was on-hand; she missed documenting it on the MAR. Interview with the Administrator on 12/03/20 at 2:54pm revealed: -She did not recall Resident #2's Lisinopril not being listed on the October 2020 MAR. -She looked at the MAR when she administered medication, "She tried to do it every time." -"She did not know how she missed it."	{D 367}		

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{D 367}	Continued From page 70 -She thought Resident #2's Lisinopril was administered, but not documented. Refer to the telephone interviw with the Administrator on 12/08/20 at 9:14am. 2. Review of Resident #1's current FL-2 dated 02/27/20 revealed diagnoses included schizophrenia, cerebral ischemia, essential hypertension cardiomyopathy, chronic obstructive pulmonary disease, mental health disorder and hyperlipidemia unspecified. Review of Resident #1's physician's order revealed there was an order dated 10/06/20 for Nexlizet (a medication used to lower cholesterol) 180mg-10mg take one tablet daily. Review of Resident #1's pharmacy dispensing records from October 2020 to December 2020 revealed Nexlizet was not dispensed. Review of Resident #1's October 2020 medication administration record (MAR) revealed there was no entry for Nexlizet. Review of Resident #1's November 2020 MAR revealed: -There was an entry for Nexlizet 180/10mg take 1 tablet once daily with a scheduled administration time of 8:00am. -Nexlizet was documented as administered 31 times daily from 11/01/20-11/30/20. Review of Resident #1's December 2020 MAR revealed: -There was an entry for Nexlizet 180/10 mg take 1 tablet once daily with a scheduled administration time of 8:00am. -Nexlizet was documented as administered on	{D 367}		

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{D 367}	Continued From page 71 12/01/20 and 12/02/20. Observation of Resident #1's medications on hand on 12/03/20 at 2:16pm revealed there was no Nexlizet 180/10 mg available for administration. Interview with Resident #1 on 12/02/20 at 8:16am revealed he knew he took medication for his blood pressure and to help his heart, but he did not know exactly what he took. Interview with the medication aide (MA) on 12/03/20 at 2:41pm revealed: -She popped all of Resident #1's tablets out of the cards and into a cup for him to take. -She signed the MAR after she administered all the medication to Resident #1. -She did not know why she did not compare the MAR to the medication label. -She knew she should check the MAR to the medication label for accuracy. Interview with the Administrator on 12/03/20 at 4:30m revealed: -She did not know why the Nexlizet was signed off on the MAR when it was not available for administration. -She guessed she just "followed suit" and documented administering any medication on the MAR. -She did not notice Resident #1 did not have the Nexlizet all that time she documented the medication as administered. -She documented her initials next to the dates where other staff had documented initials for medication administration. Refer to telephone interviw with the Administrator on 12/08/20 at 9:14am.	{D 367}		

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{D 367}	Continued From page 72 Telephone interview with the Administrator on 12/08/20 at 9:14am revealed: -She prepared the new medication adminstration record (MAR) every month for each resident. -She looked at the current MAR and compared it to the next month's MAR sent from the pharmacy. -She looked for changes in medication administration times, discontinued medications that might still be on the MAR and looked at the dosages. -She looked at the MAR once a month and looked for missed administrations and she looked at medication on hand to be sure there was enough medication available for administration. -She expected the staff to look at the MAR to ensure they were administering the correct medication to the correct resident at the correct dosage and time. -Staff should not sign the MAR until after they had administered the medication.	{D 367}		
{D 375}	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	{D 375}		

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{D 375}	Continued From page 73 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 residents sampled (#1 and #2) had orders to self-administer prescription medications that were kept in the residents' rooms including an inhaler and giving the resident the glucometer to do his own finger stick blood sugar checks (#1); and a prescribed topical cream (#2). The findings are: Review of the facility's Self-Administration Medication policy revealed: -The policy was not dated. -A physician's order was required for a resident to self-administer medication. -Residents had the right to self-administer their own medication if competent. -If the medication was kept in the resident's room, it must be kept in a safe and secure place out of sight from other residents and visitors. -The medication was to be recorded on the MAR, but staff should not initial or sign that they had administered the medication. -Staff had the responsibility to monitor the resident and contact the physician if there was a change in the residents physical or mental behavior. -If the physician was not available, the pharmacist, nurse, or administrator was to be contacted. 1. Review of Resident #2's current FL2 dated 03/12/20 revealed: -Diagnoses included psoriasis, major depression,	{D 375}		

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{D 375}	Continued From page 74	{D 375}		

schizophrenia, hypertension, hyperlipidemia, vitamin D deficiency, and iron deficiency.
-There was a medication order for Mometasone 0.1% cream apply topically to the affected area daily (a topical cream used to treat redness, swelling, itching and inflammation, and discomfort of various skin conditions).
-There was no order to self-administer the Mometasone cream.

Review of Resident #2's record revealed there was no documentation of a "Self-Administration of Medication Assessment" and no physician's order to self-administer medications.

Review of Resident #2's October 2020 Medication Administration Record (MAR) revealed:
-There was an entry for Mometasone 0.1% cream apply topically to the affected area with a scheduled administration time of 8:00am.
- Mometasone 0.1% was documented as administered at 8:00am from 10/01/20-10/31/20.

Review of Resident #2's November 2020 MAR revealed:
-There was an entry for Mometasone 0.1% cream apply topically to the affected area with a scheduled administration time of 8:00am.
- Mometasone 0.1% was documented as administered at 8:00am from 11/01/20-11/30/20.

Observation of Resident #2's medication on hand on 12/02/20 at 2:31pm revealed a plastic bag with a pharmacy label with a dispense date of 11/24/20 that contained a tube of Mometasone 0.1% cream.

Observation of a medication for Resident #2 on 12/03/20 at 3:00pm revealed:

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{D 375}	Continued From page 75 -The residenthad a tube of Mometasone Cream he kept in his dresser drawer. -The tube did not have a pharmacy label and was not in a bag labeled from the pharmacy. Interview with Resident #2 on 12/03/20 at 3:00pm revealed: -He used the cream every day. -The medication aide (MA) did not apply the cream. -The Administrator gave him the tube of Mometasone and when he needed more, he would tell the Administrator. -He applied the cream to his elbow and back after he took a bath. -No one had told him he could not have the Mometasone in his room without a physician's order. Telephone interview with the pharmacist with the facility's contracted pharmacy on 12/03/20 at 10:40am revealed: -There was no self-administer order on file for Resident #2's Mometasone cream. -If a self-administer order was received for the cream, it would be noted on the resident's MAR. Telephone interview with Resident #2's primary care provider (PCP) on 12/03/20 at 1:13pm revealed: -She had not ordered Resident #2's Mometasone cream to be self-administered. -If Resident #2 was self-administering his Mometasone cream, she expected a MA to observe and make sure Resident #2 applied the cream correctly. Interview with a MA on 12/03/20 at 11:33am revealed: -She had not administered Resident #2's	{D 375}		

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{D 375}	Continued From page 76	{D 375}		

Mometasone cream since she started to work at the facility in September 2020.
-She had not given Resident #2 a tube of Mometasone cream because she had not seen a self-administer order.
-Resident #2 had not asked her for Mometasone cream.

Interview with the Administrator on 12/03/20 at 2:54pm revealed:
-When she administered medication, she handed Resident #2 the tube of Mometasone cream and allowed the resident to "get out how much he wanted to put on his spots."
-She was not aware Resident #2 had a tube of Mometasone cream in his room.
-She did not "think" Resident #2 had an order to self-administer the Mometasone cream.
-She knew Resident #2 needed a self-administer order to keep the tube of Mometasone cream in his room.

2. Review of Resident #1's current FL-2 dated 02/27/20 revealed diagnoses included schizophrenia, cerebral ischemia, essential hypertension cardiomyopathy, chronic obstructive pulmonary disease (COPD), mental health disorder and hyperlipidemia unspecified.

Review of Resident #1's record revealed there was no documentation of a "Self-Administration of Medication Assessment" and no physician's order to self-administer medications.

a. Review of Resident #1's current FL-2 dated 02/27/20 revealed:
-There was an order for albuterol Sul HFA (a medication used to treat difficulty breathing due to COPD) 90mcg, inhale 2 puffs every four hours as needed for shortness of breath.

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{D 375}	Continued From page 77 -There was no order for self-administration. Observation of Resident #1's medication on hand on 12/03/20 at 2:16pm revealed there was an albuterol 90mcg inhaler in a red sleeve with a dispense date of 09/16/20 and the counter read 20. Review of dispensing records from the facility's contracted pharmacy from September 2020 to December 2020 revealed albuterol HFA 90mcg was dispensed on 09/16/20; no other albuterol inhalers had been dispensed during those months. Observation of Resident #1's room on 12/02/20 at 7:55am revealed: -There was an albuterol inhaler in a gray sleeve on the resident's nightstand. -The counter on the inhaler was zero. Second observation of Resident #1 on 12/02/20 at 9:40am revealed: -Resident #1 was short of breath and audible wheezing could be heard approximately 10 feet away. -Resident #1 took an inhaler out of his pocket and administered three quick puffs. Interview with Resident #1 on 12/02/20 at 7:55am revealed: -He had the inhaler for use when he "could not catch" his breath. -He used the inhaler when he "needed it" which was about 2 to 3 times a day. -He kept the inhaler with him because if it was kept in the office [medication room] he would not be able to get to it when he needed it. -He kept the inhaler in his pocket when he left the facility.	{D 375}		

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{D 375}	Continued From page 78 -He kept the inhaler on his nightstand when he was in the facility. Second interview with Resident #1 on 12/03/20 at 4:34pm revealed: -He used the inhaler when he was out of breath and it helped after he took it. -He had a Registered Nurse (RN) show him how to use it before he was admitted to the facility. -He took 2 puffs 2 to 6 times a day; he did not think that was too much. -He knew the inhaler was working because he could feel the "oxygen" spraying into his mouth; there was no taste. -The inhaler he currently was using was only a month old and was still working. -He had used the inhaler one time that day. -He did not know anything about the counter on the inhaler, but he knew the inhaler was still working because he could breath better after he used it that morning. -He would go to the Administrator to get a new inhaler if the one he was using was empty. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 12/07/20 at 10:01am revealed; -Resident #1's albuterol inhaler would be empty if the counter indicated a zero. -The resident would not get any medication out of the inhaler and would not get any relief. -There were 200 puffs per albuterol inhaler. Telephone interview with a staff at Resident #1's day program on 12/07/20 at 11:36am revealed Resident #1 told her he had an inhaler with him to use but she never saw him use the inhaler. Telephone interview with the facility's transportation staff/MA on 12/07/20 at 11:58am	{D 375}		

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{D 375}	Continued From page 79	{D 375}		

revealed:
-Resident #1 had an inhaler that he kept in his pocket; he had seen Resident #1 use the inhaler.
-Resident #1's breathing was always labored.
-He had seen Resident use the inhaler "a lot"; Resident #1 used the inhaler a couple of times a day at his discretion.

Telephone interview with Resident #1's primary care provider (PCP) on 12/08/20 at 8:28am revealed:
-Resident #1 did not have an order to self-administer his albuterol inhaler, but he could use the inhaler on his own.
-She did not know if he should have a self-administer order to keep the inhaler because he could possibly over use the inhaler.
-The facility staff should offer Resident #1 the inhaler if they noticed he needed help breathing.

Telephone interview with the Administrator on 12/07/20 at 11:31am revealed:
-Resident #1 had an albuterol inhaler when he was first admitted to the facility.
-Resident #1 had an "emergency" albuterol inhaler in the medication room and the order was for as needed.
-Resident #1 had used the emergency inhaler that morning and the night before; he used the emergency inhaler 2 to 3 times a week.
-Resident #1 could always come to her or a MA if he needed to use the emergency inhaler.
-She did not know he had an inhaler and she did not know how he got one; he might have had it for a long time.
-She did not think he should have an inhaler for self-administering because he would use them up too fast.
-She was concerned Resident #1 was trying to use an empty inhaler because the inhaler would

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{D 375}	Continued From page 80	{D 375}		

not help when he needed it.
-She would take the inhaler away from him that day.

b. Review of Resident #1's current FL-2 dated 02/27/20 revealed:
-There was an order for daily finger stick blood sugar checks (FSBS).
-There was not an order for self-administration.

Observation of Resident #1's glucometer on 12/02/20 at 3:49pm revealed there was a dark brownish red finger print and smears on the top of the glucometer.

Interview with Resident #1 on 12/02/20 at 8:16am revealed:
-He took his on FSBS checks in the morning; "I stick myself".
-He went into the medication room and the medication aide (MA) would give him a container with his glucometer kit inside.
-He took the glucometer and put the "tabs into the machine" himself.
-He stuck himself with a lancet.
-The MA would look at the glucometer reading and write down the number in the book.

Interview with a MA on 12/03/20 at 3:11pm revealed:
-Resident #1 came to the medication room and took a box that had his glucometer and supplies were in so he could do his FSBS.
-Resident #1 did his FSBS in the medication room; sometimes she watched him but not each time.
-She did not give him instructions on how to use the glucometer; it looked like he did the FSBS correctly.
-Resident #1 gave her the used lancet and the

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test strip to dispose of; then he put the glucometer back into the box.
-Resident #1 did not clean the glucometer after every use; there were alcohol prep pads in the box with his glucometer and supplies.
-Resident #1 would show her the reading from the glucometer and she would document the number in the medication administration record (MAR).
-She always thought she should do the FSBS check for Resident #1, but she never said anything to anyone.
-Resident #1 had done his own FSBS since she had been there and that was why she never did it for him or said anything.
-She did not know anything about a self-administration order for Resident #1's FSBS checks.

Telephone interview with Resident #1's primary care provider (PCP) on 12/03/20 at 11:58am revealed:
-She did not give Resident #1 an order to self-administer his FSBS checks.
-She did not know if she would give Resident #1 an order to self-administer his FSBS checks because she did not know if Resident #1 could check his FSBS himself.
-She did not know if Resident #1 did the FSBS himself.
-She would like to watch Resident #1 do a FSBS check before she would give an order to self-monitor or self-administrator a FSBS check.
-Resident #1 would need to be reminded to do his FSBS if he had a self-administer order.

Telephone interview with the Administrator on 12/02/20 at 1:30pm revealed:
-Resident #1 had always done his own FSBS; he was doing his own FSBS checks before he was

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{D 375}	Continued From page 82 admitted to the facility. -Resident #1 knew how to do his FSBS checks; she watched him do the FSBS checks. -She did not watch every time he did his FSBS. -She did not worry about cleaning Resident #1's glucometer because she did not know it had gotten dirty or possibly had blood on it.	{D 375}		
{D 392}	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 2 of 3 residents sampled for an anti-anxiety medication (Resident #2 and #3). Review of the facility's controlled substance policy revealed: -The medication aide (MA) who administered a narcotic medication should document the date, time patient name, dose and signature on the Controlled Substance Count Sheet (CSCS). -At the change of shift, the off going and incoming MA should count the narcotic medication for any discrepancies. -Any discrepancies should be resolved and documented before the outgoing MA leaves the facility.	{D 392}		

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{D 392}	Continued From page 83 1. Review of Resident #2's current FL-2 dated 03/12/20 revealed: -Diagnoses included major depression, schizophrenia, hypertension, hyperlipidemia, vitamin D deficiency, psoriasis and iron deficiency. -There was a medication order for Klonopin 1mg (a controlled substance used to treat anxiety) one tablet at bedtime. Review of Resident #2's October 2020 Medication Administration Record (MAR) revealed: -There was an entry for Clonazepam 1mg (generic for Klonopin) at bedtime with a scheduled administration time of 8:00pm. -Clonazepam 1mg was documented as administered at 8:00pm from 10/01/20-10/31/20. Review of Resident #2's October 2020 CSCS revealed: -The form was developed by the facility staff and had a blank for the resident name, drug, medication route, dose, and frequency that were completed for Resident #2 for Clonazepam 1mg at bedtime. -There was a column for the amount received, received by, and date for the dispensed medication, but there was no documentation for Resident #2's Clonazepam 1mg. -There were columns for quantity, date, time (am/pm), amount given, amount left, signature, amount wasted, and witness. -The date column was completed for the dates of 10/01/30-10/31/20. -The time column had pm circled for the dates of 10/01/20-10/31/20. -The amount given column was completed for 1 tablet from 10/01/20-10/31/20.	{D 392}		

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{D 392}	Continued From page 84 -There was a signature for the dates from 10/01/20-10/27/20, 10/29/20, and 10/31/20. -There was no signature on 10/27/20 and 10/30/20. -The column for the amount left was blank for the dates of 10/01/20-10/31/20. -There was no quantity documented from 10/01/20-10/31/20. Review of Resident #2's November 2020 (MAR) revealed: -There was an entry for Clonazepam 1mg at bedtime with a scheduled administration time of 8:00pm. -Clonazepam 1mg was documented as administered at 8:00pm from 11/01/20-11/31/20. Review of Resident #2's November 2020 CSCS revealed: -There was documentation for Resident #2 for Clonazepam 1mg at bedtime. -There was no documentation in the column for the amount received, received by, and date. -There were columns for quantity, date, time (am/pm), amount given, amount left, signature, amount wasted, and witness. -The date column was completed for the dates from 11/01/30-11/31/20. -The time column had pm circled for the dates from 11/01/20-11/23/20, and 11/26/20-11/31/20. -The amount given column was completed for 1 tablet from 11/01/20-11/23/20, and 11/26/20-11/31/20. -There was a signature for the dates of 11/01/20-11/23/20, and 11/26/20-11/31/20. -There was no signature for 11/24/20 and 11/25/20. -The column for the amount left was blank for the dates from 11/01/20 -11/31/20. -There was no quantity documented from	{D 392}		

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{D 392}	Continued From page 85 11/01/20-11/31/20. Review of Resident #2's December 2020 (MAR) revealed: -There was an entry for Clonazepam 1mg at bedtime with a scheduled administration time of 8:00pm. -Clonazepam 1mg was documented as administered at 8:00pm on 120/01/20. Review of Resident #2's December 2020 CSCS revealed: -There was documentation for Resident #2 for Clonazepam 1mg at bedtime. -There was no documentation in the column for the amount received, received by, and date. -There were columns for quantity, date, time (am/pm), amount given, amount left, signature, amount wasted, and witness. -The date column was completed for the date of 12/01/30. -The time column had pm circled for the date of 12/02/20. -The amount given column was completed for 1 tablet for the date of 12/01/20. -There was a signature for the date of 12/01/20. -The column for the amount left was blank for the date of 12/01/20. -There was no quantity documented. Observation of Resident #2's medications on hand on 12/02/20 at 2:31pm revealed: -There was a punch card for Clonazepam 1mg dispensed on 11/02/20 for 30 tablets. -There were 9 of 30 tablets available for administration. Refer to the telephone interview with the pharmacist at the facility's contracted pharmacy on 12/03/20 at 10:40am.	{D 392}		

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{D 392}	Continued From page 86 Refer to the interview with the medication aide (MA) on 12/03/20 at 11:23am. Refer to the interview with the Administrator on 12/03/20 at 4:17pm. 2. Review of Resident #3's current FL-2 dated 09/23/20 revealed: -Diagnoses included schizoaffective disorder, unspecified personality disorder, unspecified neurocognitive disorder, anemia chronic disease, osteoarthritis, seizures, glaucoma, and constipation. -There was an order for Ativan 0.5mg (anti-anxiety medication) take one tablet twice daily. Review of Resident #3's October 2020 Medication Administration Record (MAR) revealed: -There was an entry for Ativan 0.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Ativan 0.5mg was documented as administered at 8:00am from 10/18/20-10/31/20. -Ativan 0.5mg was documented as administered at 8:00pm from 10/17/20-10/31/20. -Ativan was documented as administered 29 times. Review of Resident #3's October 2020 Controlled Substance Count Sheet (CSCS) revealed: -The form was developed by the facility staff and had a blank for the resident name, drug, medication route, dose, and frequency that were completed for Resident #3 for Ativan 0.5mg at 8:00am and 8:00pm. -There was a column for the amount received, received by, and date for the dispensed	{D 392}		

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medication, but there was no documentation for Resident #3's Ativan.
-There were columns for quantity, date, time (am/pm), amount given, amount left, signature, amount wasted, and witness.
-The date column was completed for the dates of 10/17/30-10/31/20.
-The time column had am on one row for the am dose and the pm on the next row; am and pm were circled for the dates of 10/17/20-10/31/20.
-The amount given column was completed for 1 tablet from 10/17/20-10/29/20 for both the am and pm dose.
-There was no signature for the dates of 10/30/20 pm dose and 10/31/20 am dose.
-There was a signature for the dates from 10/17/20-10/27/20, 10/29/20, and 10/31/20.
-The column for the amount left was blank for the dates of 10/17/20-10/31/20.
-There was no quantity documented from 10/17/20-10/31/20.
-Ativan was documented as administered 27 times.

Review of Resident #3's November 2020 (MAR) revealed:
-There was an entry for Ativan 0.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-Ativan 0.5mg was documented as administered at 8:00am from 11/01/20-11/14/20.
-Ativan 0.5mg was documented as administered at 8:00pm from 11/01/20-11/14/20.
-There were exceptions documented from 11/15/20-11/31/20 with the reason listed as the hospital.
-Ativan was documented as administered 28 times.

Review of Resident #3's November 2020 CSCS

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{D 392}	Continued From page 88 revealed: -The form was developed by the facility staff and had a blank for the resident name, drug, medication route, dose and frequency that were completed for Resident #3 for Ativan 0.5mg at 8:00am and 8:00pm. -There was no documentation in the column for the amount received, received by, and date. -There were columns for quantity, date, time (am/pm), amount given, amount left, signature, amount wasted, and witness. -The date column was completed for the dates of 11/01/20-11/14/20. -The time column had am on one row for the am dose and the pm on the next row; am and pm were circled for the dates of 11/01/20-11/14/20. -The amount given column was completed for 1 tablet from 11/01/20-11/14/20 for both the am and pm dose. -The column for the amount left was blank for the dates of 11/01/20-11/14/20. -There was no quantity documented from 11/01/20-11/14/20. -Ativan was documented as administered 28 times. Observation of Resident #3's medications on hand on 12/02/20 at 11:32am revealed: -There was a punch card for Ativan 0.5mg dispensed on 10/16/20 for 60 tablets. -There were 2 of 60 tablets available for administration. Review of Resident #3's facility transfer list of medication revealed: -Resident #3 transferred to the facility with the punch card for Ativan 0.5mg dispensed on 10/16/20 for 60 tablets. -Resident #3 had 58 of 60 tablets available at the time of admission to the facility.	{D 392}		

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{D 392}	Continued From page 89 Based on interviews and record reviews it was determined Resident #3 was not interviewable Refer to the telephone interview with the pharmacist at the facility's contracted pharmacy on 12/03/20 at 10:40am. Refer to the interview with the medication aide (MA) on 12/03/20 at 11:23am. Refer to the interview with the Administrator on 12/03/20 at 4:17pm. _____ Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/03/20 at 10:40am revealed: -The CSCS was sent every month for all residents who had medication classified as controlled. -He was not aware the MA was not documenting on the CSCS log provided. -He was not aware the MA was not documenting the quantity on hand for controlled medication. -He did not "routinely" look at the control logs when he completed the medication quarterly reviews. Interview with the MA on 12/03/20 at 11:23am revealed: -She administered controlled substance medication. -She did not count the controlled medication at this facility; "I did at the facility I used to work at." -She knew controlled medication should be counted and documented at each administration. -She followed what was "being done at this facility." -She had not talked to anyone about the controlled medication counts.	{D 392}		

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{D 392}	Continued From page 90 -She thought because it was an assisted living "maybe it was different." Interview with the Administrator on 12/03/20 at 4:17pm revealed: -She administered controlled substance medication. -She did not count the controlled substance each time she administered medication. -She did not document the number of controlled substances before or after the administration of a controlled substance. -She knew the MA was supposed to document the beginning quantity and remaining quantity; she learned it "a long time ago." -She recently took a refresher course for medication administration, and "we went over that." (she did not recall the date) -She had not started completing the CSCS logs "that way" because "I wanted to start it with a new pack." -She had not talked to any other MAs about the way to complete CSCS logs.	{D 392}		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and	D 601		

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procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff failing to use personal protective equipment (PPE) and practicing social distancing when not wearing a facemask as directed by CDC guidelines; no posted instructions for visitors at the entrance of the facility; to consistently screen residents, staff, or visitors upon entrance to the facility; not having a policy specific to COVID-19 infection prevention and control and no training or guidelines for staff to follow specific to COVID-19; failure to daily monitor residents for evidence of fever; and not providing soap for proper hand hygiene in two of the three resident bathrooms.

The findings are:

Review of the CDC guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities last updated 11/20/20

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revealed:
-Health care personnel should always wear a facemask while they are in the facility.
-Health care personnel should practice social distancing.
-All health care personnel should be screened at the beginning of their shift by actively checking their temperatures for fever and screening for other symptoms of COVID-19; and document the absence of those symptoms.

Review of the CDC guidelines for hand hygiene for the prevention and spread of the coronavirus disease in LTC facilities last updated 05/17/20 revealed:
-The CDC recommends using alcohol based hand rub (ABHR) with 60-95% alcohol in healthcare settings.
-Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom.

Review of the Centers for Disease Control (CDC) recommendations for cleaning and disinfection during the global pandemic (COVID-19) revealed:
-Clean surfaces using soap and water to reduce the number of germs, dirt and impurities on the surface. Then use of a disinfectant to kill the germs on the surfaces.
-Practice routine cleaning of high touched surfaces; more frequent cleaning and disinfection may be required based on level of use.
-High touch surfaces include: tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc.

Review of the NC DHHS guidelines for the core principles of COVID-19 infection prevention for larger residential settings, with seven or more beds, last updated on 10/16/20 revealed:

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D 601	Continued From page 93 -Staff should use the appropriate personal protective equipment (PPE) when providing resident care. -Facility should screen all staff daily for temperature check, presence of symptoms, and known exposure to COVID-19. -Post signage at all entrances and leave notices for contract service providers at all entrances. -Provide information about current visitation policies or restrictions. -Remind visitors and personnel not to enter the building if they have fever or symptoms consistent with COVID-19. -Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building. -Send visitors and personnel home if they have a fever (temperature of 100.0 oF or greater) or symptoms consistent with COVID-19. 1. Observation of the entrance to the facility on 12/02/20 at 7:32am revealed: -There was a sign posted on the door that read "Please wear facemask"; there was no other signage on the door. -A facility staff could be seen inside the facility through the window of the kitchen; the staff was not wearing a facemask. Observations of the facility staff on 12/02/20 at 9:20am revealed he was still not wearing a mask. Observation of a resident on 12/02/20 at 2:24pm revealed he got out of a van and the driver did not have a facemask on; the resident was wearing a facemask.	D 601		

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D 601	Continued From page 94 Observation of the facility on 12/03/20 at 10:09am revealed the Administrator was in the resident dining room and did not have on a facemask. Observation of a medication aide (MA) on 12/03/20 at 12:44pm revealed she was working in the kitchen preparing food and she had her facemask under her chin; her nose and mouth were not covered. Observation of the resident television room on 12/03/20 at 1:25pm revealed: -There was a staff sitting in the room without a facemask on and was not social distancing from the two residents that were also sitting in the television room. -He carried the mask in his hand when he went outside of the facility. Interview with a staff on 12/02/20 at 7:32am revealed he had not been told by anyone to wear a facemask while inside the facility. Interview with a resident on 12/02/20 at 7:37am revealed: -He walked to the store but always wore a mask. -Staff did not wear masks in the facility. Interview with a second resident on 12/02/20 at 7:45am revealed: -He went to the store every other day. -He wore a mask when he was in the store. -Staff did not wear a mask in the facility. Interview with a third resident on 12/02/20 at 7:46am revealed the staff did not wear facemasks while working inside the facility. Interview with a forth resident on 12/02/20 at 7:48am revealed:	D 601		

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-He wore a mask when he went to the store; a couple of times a month.
-Staff did not wear masks in the facility.

Interview with a fifth resident on 12/02/20 at 8:04am and 10:45am revealed:
-Staff did not wear facemasks when they worked inside the facility; one staff wore a facemask when they took him to his physician's appointments.
-He wore a facemask in the car on the way to a physician's appointment and while at the appointment but did not wear a facemask in the car on the way home.
-He went to a local store that day to buy a few things; he did not have a facemask to wear to the store because he lost it.
-No one said anything to him about not wearing a facemask while at the store.

Interview with a sixth resident on 12/02/20 at 2:36pm revealed:
-He went to work two days a week and he attended a day program on the other three days of the week.
-He went to the store on his own when he wanted.
-He always wore a facemask when he left the facility; he had his own cloth facemasks that he washed with his clothes.
-He did not pay attention to the driver of the van he rode in to go to his day program; everyone riding in the van wore facemasks.
-Staff wore facemasks when they were in the medication room with him, but staff did not wear facemasks anywhere else while in the facility.

Interview with a seventh resident on 12/02/20 at 3:00pm revealed:
-He went to a day program on Monday,

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Wednesday and Friday.
-He wore a mask at the day program.
-Staff at the facility did not wear masks.

Interview with the MA on 12/03/20 at 12:47pm revealed:
-She worked a 24-hour shift two days a week.
-She wore a mask when she was around the residents.
-She did not wear a facemask when she worked in the kitchen or when she was in the office because she was alone in those areas.
-She and the residents wore facemasks when she transported residents to any appointments.
-The only thing she knew to do to prevent COVID-19 was to take temperatures, to wear a facemask, use hand sanitizer and practice social distancing.
-The Administrator had only told her to wear a facemask when around the residents and that was all; she had not had any COVID-19 focused infection prevention and control training.
-The residents all had facemasks; some of the residents had their own cloth facemask and some had the ones the facility had given them.
-The residents could come to her and request a facemask if they needed another one; the residents had been told to wear a facemask when they are in the local community.

Interview with the Administrator on 12/02/20 at 9:19am revealed:
-She told the staff and residents in March 2020 about wearing a facemask, to clean and sanitize more often and to wash their hands more often.
-She told staff to wear a facemask when they were close to a resident or when they were providing resident care.
-She allowed the staff to pull their facemask down below their mouth and nose when they were not

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around residents because the staff said they could not breathe with a facemask on.
-Staff worked 24 hour shifts and could not wear a facemask the entire time they were at work; she did not require staff to wear a facemask because they worked a 24-hour shift.
-She did not have a rule requiring the facility staff to wear a facemask.
-Visitors were required to wear a mask when they visited the facility.
-The residents could "come and go freely"; they could go to the local store if they wanted too.
-She told the residents to sign out and to wear a facemask when they left the facility; sometimes the residents would forget to wear their facemask.
-She provided facemask to the residents; they could ask her for a facemask if they needed one.
-There were four residents that left the facility to attend day programs; the programs required the residents to wear facemask.

2. Observation of the facility upon entrance on 12/02/20 at 7:33am revealed:
-There was a facility staff in the kitchen washing dishes and could be seen through the facility door.
-The staff working in the kitchen instructed the survey team to enter the facility but did not come to the door; the door was unlocked.
-The facility staff did not screen the survey team for fever or with a screening questionnaire.
-There was no signage posted at the entrance to instruct visitors about screening prior to entering the facility.

Observation of a resident on 12/02/20 at 10:38pm revealed the resident entered the facility and did not have his temperature taken by anyone; he had a shopping bag from a local store in his

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D 601	Continued From page 98 hands. Observation of the facility on 12/02/20 at 2:24pm revealed the survey team was not screened or checked for a fever upon reentry to the facility. Observation of a resident on 12/02/20 at 2:24pm revealed: -He got out of a van and he was wearing a facemask. -The resident's temperature was not taken when he entered the facility. -He went into his room and did not wash his hands or use hand sanitizer. Observation of the facility on 12/02/20 at 3:05pm revealed: -An inspector from the local health department (LHD) entered the facility and walked through the kitchen and into the resident hallway. -The inspector from the LHD introduced herself to the Administrator and informed the Administrator she was there for a sanitation inspection. -The LHD inspector asked the Administrator if she needed to be screened. -The Administrator took the inspector's temperature and documented it in a log book; the Administrator did not ask the LHD inspector any screening questions. Observation of the facility on 12/03/20 at 10:09am revealed: -The Administrator was in the resident dining room and she did not screen the survey team for symptoms of COVID-19 or check them for a fever. -A resident entered the facility and the Administrator took his temperature but did not document it in the log book.	D 601		

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D 601	Continued From page 99 Observation of a facility staff on 12/03/20 at 10:28am revealed he had a facemask on and checked his own temperature but did not document anywhere. Observation of the facility on 12/03/20 at 11:08am revealed: -A facility staff and a resident returned from a physician's appointment. -The staff and the resident were not checked for fever and moved about the facility without washing their hands or using hand sanitizer. Interview with a resident on 12/02/20 at 7:45am revealed: -He went to the store every other day. -No one ever checked his temperature at the facility. Interview with a second resident on 12/02/20 at 7:46am revealed: -His temperature was not taken every time he left the facility and returned. -Sometimes he walked to a local store and did not have his temperature taken when he returned from the store. -Staff took his temperature when he returned from a physician's appointment. Interview with a third resident on 12/02/20 at 7:48am revealed: -He went to the store a couple of times a month. -No one checked his temperature at the facility. Interview with a forth resident on 12/02/20 at 8:04am revealed: -His temperature was taken and documented in a book by a staff when he returned from a physician's appointment. -He went to a day program two to three times a	D 601		

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week; when he returned from the day program his temperature was not taken.

Interview with a fifth resident on 12/02/20 at 2:36pm revealed:
-He went to work two days a week and he attended a day program on the other three days of the week.
-He went to the store on his own when he wanted.
-His temperature was never taken at the facility by anyone and he did not take his own temperature.

Interview with a sixth resident on 12/02/20 at 3:00pm revealed:
-He went to a day program on Monday, Wednesday and Friday.
-The staff at the day program took his temperature, but the staff at the facility did not take his temperature.

Interview with the MA on 12/03/20 at 12:47pm revealed:
-She worked a 24-hour shift two days a week.
-Visitors were stopped at the door and their temperatures were taken, there was hand sanitizer and the visitors needed to wear a facemask.
-She considered a visitor to be anyone that did not live in the facility; the survey team were also visitors.
-She did not know why she did not screen or check the survey team for temperatures when they arrived; she thought they would be "okay" because she thought the survey team did something to check before they came into the facility.
-Staff were supposed to stop visitors at the door for screening and temperature checking.

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D 601	Continued From page 101 -Visitors should stop at the door; there was no signage at the door to instruct visitors as to what to do; "a sign at the door would help". -Some visitors would stop at the door and some would come into the facility looking for her. -Families were not allowed to come inside the facility; she did not know of any family that came inside for visitation. -Residents' were required to have their temperatures taken when they returned from leaving the facility; it was the staff's responsibility to take the residents temperatures upon return. -Residents were free to go into the community for day programs and to visit or shop in local stores; their temperatures were not always taken when they returned. -The residents' temperatures should have been taken every time they went into the community. Interview with the Administrator on 12/02/20 at 9:19am revealed: -The only precautions the facility followed regarding visitors was to take temperatures and a screening questionnaire. -Visitors had been allowed to come into the facility for about the last month; a visitor was anyone that did not live at the facility or was not a staff. -Visitors were required to have their temperature taken by a staff. -There was one resident that had two visitors at a time come to see him in his room. -She allowed residents to go into the community with family members or other visitors; the resident and the visitors were screened when they returned to the facility. -The residents could "come and go freely"; they could go to the local store if they wanted too. -There were four residents that left the facility to attend day programs.	D 601		

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-The residents that went to day programs were supposed to have their temperatures checked by staff when they returned from their day programs; she did not know if they always had their temperatures done.

Telephone interview with the Administrator on 12/07/20 at 1:15pm revealed:
-Staff should have screened and taken the temperatures of the survey team each time they entered the facility and when they returned from lunch on the same day.
-She considered the survey team to be visitors and when she saw the survey team she thought the medication aide (MA) had screened the team.
-She should have checked to log to see if the survey team was screened and she did not ask if the survey team had been screened.
-The staff that was on duty should check visitors and the log book to insure visitors have been screened.
-She did not want the visitors to screen themselves, she wanted the staff to perform the screening of visitors.
-She did not have signage posted at the entry instructing visitors to stop for screening prior to entering the facility.

3. Review of the facility's policy for infection control and prevention on 12/02/20 at 9:19am did not include policies specific to the prevention and control of COVID-19 in the facility.

Interview with the medication aide (MA) on 12/03/20 at 12:47pm revealed:
-The only thing she knew to do to prevent COVID-19 was to take temperatures, to wear a facemask, use hand sanitizer and practice social distancing.
-The Administrator had only told her to wear a

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facemask when around the residents and that was all.
-The Administrator had not told her anything about hand hygiene and she was not familiar with the term frequently touched surfaces.
-She had not seen or been shown a policy for COVID-19 infection prevention and control.
-She tried to encourage the residents to wash their hand after they used the bathroom, and when they returned from being outside the facility and after they smoked.
-She encouraged the residents to use hand sanitizer when they returned to the facility from outside and before they ate.
-She relied on the Administrator to update her on recommendations related to COVID-19.

Interview with the Administrator on 12/02/20 at 9:19am revealed:
-She did not have a policy specifically for COVID-19 prevention or control; she did not know she needed to have a policy for COVID-19.
-She told the staff and residents about wearing a facemask, to clean and sanitize more often and to wash their hands more often in March 2020.
-She did not know the staff needed any training or information specifically related to COVID-19; she thought the annual infection control training was all that was needed.
-She did not have a plan in place if a facility staff or a resident received a positive COVID-19 test result; she had not thought about a plan.
-She thought she could send any residents to the hospital if they received a positive result from a COVID-19 test; she did not know what to do if a resident with a positive test result could not go to the hospital.
-She had not instructed staff to self-monitor for symptoms of COVID-19; she did not think about instructing the staff she thought the staff should

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know to self-monitor for symptoms.
-There were four residents that left the facility to attend day programs; the programs required the residents to wear
-She did not know what frequently touched surfaces meant or what frequently touched surfaces were.
-She did not get updated information from NCDHHS and she did not refer to the Centers for Disease Control (CDC) web site for guidance or updated information for long term care facilities.
-She was not familiar with 10A NCAC 13F .1801 Infection Prevention and Control dated 10/23/20.
-She would develop a policy for the facility that would include COVID-19 focused infection prevention and control.

4. Interview with six residents on 12/02/20 between 7:37am and 3:00pm revealed no one checked their temperature at the facility.

Interview with the medication aide (MA) on 12/03/20 at 12:47pm revealed residents' temperatures were not being taken or documented to monitor for COVID-19 symptoms.

Interview with the Administrator on 12/02/20 at 9:19am revealed:
-The facility was not taking daily temperatures of residents or monitoring for symptoms of COVID-19.
-She did not know that was something she needed to do; she thought it was just for visitors.

5. Observation of three resident bathrooms at 8:12am revealed there was soap in only one of the bathrooms for residents to use when they washed their hands.

Interview with a resident on 12/02/20 at 8:10am

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D 601	Continued From page 105 revealed: -There was no soap in the bathroom to wash his hands with. -He just used water and did without soap. -There had not been soap in the bathroom for about a month. -He knew to wash his hands after going to the bathroom. Interview with a second resident on 12/02/20 at 2:36pm revealed: -There was no soap in the resident bathrooms to wash his hands. -He just rubbed his hands together under the water and used his own hand sanitizer later. Interview with the medication aide (MA) on 12/03/20 at 12:47pm revealed: -She worked a 24-hour shift two days a week. -The Administrator had not told her anything about hand hygiene. -She knew hand hygiene included washing hands by using soap and warm water and "to sing the ABC song". -She tried to encourage the residents to wash their hands after they used the bathroom, and when they returned from being outside the facility and after they smoked. -She encouraged the residents to use hand sanitizer when they returned to the facility from outside and before they ate. -She worked two days a week and checked the bathrooms for soap when she cleaned them on the days she worked. -She did not know soap was not available in each resident bathroom; there was usually soap in each bathroom. Interview with the Administrator on 12/02/20 at 9:19am revealed:	D 601		

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D 601	Continued From page 106 -She had told the residents they should keep their hands clean and to wash their hands every time they went to the bathroom, before they eat and when they return from the store. -She told the residents to use hand sanitizer if they could not wash their hands. -She checked on the resident bathrooms every two to three days to be sure they were clean and had hand soap. -She had checked the bathrooms two days ago, 11/30/20 and there was liquid soap in all three bathrooms; she was "surprised" someone had not complained about there not being soap. -Staff should be checking the bathrooms for soap every day. _____ The facility failed to implement and maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which staff did not wear facemasks within the facility; staff did not screen the residents, visitors, or themselves daily; no COVID-19 focused infection control policy, and not providing soap in the resident bathrooms to maintain proper hand hygiene during the global pandemic. The facility's failure to complete staff and visitor screening, properly use facemasks, not monitoring the residents daily for symptoms related to COVID-19, and not providing hand soap for hand hygiene placed the residents at increased risk for transmission and infection from COVID-19, resulted in substantial risk and neglect to residents. This failure constitutes a Type A2 Violation. _____ A plan of protection was provided by the facility in	D 601		

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D 601	Continued From page 107 accordance with G.S. 131D-37 on December 8, 2020 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 07, 2021.	D 601		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, health care, and staff qualifications. The findings are: 1. Based on interviews, and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff B, and Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag D137 10A NCAC 13G .0407(a)(5) Other Staff Qualifications (Type B Violation)]. 2. Based on record reviews and interviews, the	{D912}		

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{D912}	Continued From page 108	{D912}		

facility failed to ensure 3 of 4 sampled staff, (Staff A, Staff B, and Staff D), had a criminal background check completed upon hire. [Refer to Tag D139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)].

3. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 2 of 2 sampled resident (Resident #1 and #3) regarding a missed appointment for an electroconvulsive therapy (ECT) procedure (#3) and follow up with the Cardiologist when the resident refused to wear compression stockings ordered for edema (#1). [Refer to Tag D273 10A NCAC 13G .0902(b) Health Care (Type B Violation)].

4. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered to 3 of 3 sampled residents (#1, #2, and #3) including an anti-psychotic medication, an eye drop used to treat glaucoma, a medication used to treat urine flow and a multi-vitamin (#3), a cream used to treat psoriasis (#2),a medication used to lower low-density lipoprotein (LDL) cholesterol and a medication used to lower and control blood sugars (#1). [Refer to Tag D358 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].

5. Based on interviews and record reviews, the facility failed to ensure 2 of 2 staff sampled (Staff A and B) who administered medications had completed their medication clinical skills competency validation prior to administering medications (Staff A and B) and completed the 5-hour and 10-hour medication aide training courses under the direction of a registered nurse or licensed pharmacist (Staff B) or successfully

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{D912}	Continued From page 109 completed the required state examination (Staff B). [Refer to Tag D935 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)].	{D912}		
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 observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to infection prevention and control program and management of facilities. The findings are: 1. Based on observation, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related infection control, medication administration, health care, appropriate resident discharge, and ensuring staff qualifications were completed. [Refer to Tag D176 10A NCAC 13F .0601 Management of Facilities (Type A2 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the	D914		

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D914	Continued From page 110 North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff failing to use personal protective equipment (PPE) and practicing social distancing when not wearing a facemask as directed by CDC guidelines; no posted instructions for visitors at the entrance of the facility; to consistently screen residents, staff, or visitors upon entrance to the facility; not having a policy specific to COVID-19 infection prevention and control and no training or guidelines for staff to follow specific to COVID-19; failure to daily monitor residents for evidence of fever; and not providing soap for proper hand hygiene in two of the three resident bathrooms. [Refer to Tag D601 10A NCAC 13G .1801 Infection Prevention and Control Program (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration.	D935		

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D935	Continued From page 111 b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 2 staff sampled (Staff	D935		

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D935	Continued From page 112 A and B) who administered medications had completed their medication clinical skills competency validation prior to administering medications (Staff A and B) and completed the 5-hour and 10-hour medication aide training courses under the direction of a registered nurse or licensed pharmacist (Staff B) or successfully completed the required state examination (Staff B). The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 12/30/19. -Staff B's job description titled Fill in Relief Help was responsible for all responsibilities for total care of residents for periods up to 24-hours or less and assured proper administration of all medication and proper documentation. -There was no documentation Staff B had passed the written medication aide (MA) exam. -There was no documentation Staff B completed the 5, 10, or 15-hour medication administration training course and no documentation of the MA employment verification form. -There was no documentation Staff B completed the medication clinical skills competency validation. Interview with multiple residents on 12/02/20 between 7:35am and 4:00pm revealed: -Staff B had worked "a couple of times" recently (they could not recall the dates). -Staff B administered medication when he was working. -There was no other staff in the facility when Staff B was working. Interview with an outside provider on 12/02/20 at 3:45pm revealed:	D935		

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D935	Continued From page 113 -He was at the facility on 11/24/20. -Staff B was at the facility on 11/24/20 in the am. -The Administrator was not at the facility. Telephone interview with Staff B on 12/03/20 at 4:41pm revealed: -He did not work at the facility; he had not worked at the facility in a long time. -When he worked at the facility he cooked, cleaned and assisted some residents with bathing. -He did not have any problems administering medication to a named resident. -He would pour the medication from a cup into the resident's hand. -The Administrator would leave medication in cups with the residents names on each cup in the office; the office was double locked. -The time the medication was scheduled to be administered was not written on the cups, but he knew what time to administer the medication. -He knew medications were documented on the medication administration record (MAR); he had documented on the MAR (he did not recall when). -He had only worked 2 days in the last few months. -He worked 12-hours one day and 24-hours one day (he did not recall the dates). Second telephone interview with Staff B on 12/03/20 at 4:41pm revealed: -He took a medication administration class at a local pharmacy, maybe 4-5 months ago. -He had not documented on the MARs in over a year. -He quit passing medications (he did not recall the date) because he needed to take the MA test. -He did not document on the MARs because he did not administer medication. -He was currently at the MA testing site to take	D935		

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D935	Continued From page 114	D935		

the MA test so he could administer medication because he did not want to "get anyone in trouble."

Review of a resident's November 2020 MAR revealed Staff B had not documented administering medications.

Interview with the Administrator on 12/03/20 at 2:55pm revealed:
-Staff B stayed with the residents during Thanksgiving but she did not recall the exact days.
-Staff B was a fill-in relief worker.
-Staff B cooked, cleaned, and provided personal care for the residents.
-Staff B did not administer medication.
-She did not know why anyone would say Staff B had administered medication.
-Staff B took the medication administration class but did not pass the MA exam.
-She did not know Staff B's 5, 10, or 15-hour medication administration training course certificate was not in the employee record.

Review of the North Carolina MA testing registry on 12/03/20 revealed Staff B failed the written MA exam in October 2020.

2. Review of Staff A's personnel record revealed:
-There was no documentation of Staff A's job description at the facility.
-There was no documentation of Staff A's hire date at the facility.
-Staff A completed the 15-hour training on 02/05/19.
-Staff A completed the medication clinical skills competency validation on 02/11/19.
-There was no documentation of a medication clinical skills competency validation being

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completed when Staff A began working at this facility in September 2020.
-There was no documentation Staff A passed the written medication aide (MA) exam.

Interview with a Staff A on 12/03/20 at 11:33am and 3:51pm revealed:
-She was not sure exactly when she started working at the facility, but it was in September 2020.
-She had taken the MA exam and passed the exam years ago (she did not recall the date).
-She had not demonstrated medication administration to a registered nurse (RN) for completion of a medication clinical skills competency checklist since she began employment in September 2020.

Review of the North Carolina MA testing registry on 12/03/20 revealed Staff A passed the written MA exam on 05/16/16.

Review of a resident's September 2020 and October 2020 medication administration record (MAR) revealed Staff A documented administering medications on 09/30/20.

Interview with multiple residents on 12/02/20 between 7:35am and 4:00pm revealed Staff A administered medication when she was on duty.

Interviews with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for employee records.
-Staff A came from another facility but she did not recall when Staff A started to work at this facility.
-She had not looked at Staff A's employee record until today (12/03/20).
-She knew Staff A's required paperwork was not "up to date."

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D935	Continued From page 116 -She knew Staff A needed to have an RN complete the medication clinical skills validation. -Staff A had not signed a job description for this facility. -She thought Staff A had passed the MA exam and thought a copy was in Staff A's employee record. -She knew some required employee records could transfer from one facility to another, but she was not sure what items. [Refer to Tag D358 10A 10A NCAC 13G .1004 Medication Administration (Type B Violation).] [Refer to Tag D367 10A NCAC 13G .1004j Medication Administration (Standard Deficiency).] [Refer to Tag D392 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency).] [Refer to Tag D375 10A NCAC 13G .1005(a) Self-Administration of Medications (Standard Deficiency).] [Refer to Tag D344 10A NCAC 13G .1002(a) Medication Orders (Standard Deficiency).] _____ The facility failed to ensure medication aides had completed the minimum medication standards for 2 of 3 sampled staff who were administering medications to residents which included completing the required validation for medication clinical skills competency (Staff A and Staff B) and completion of a 5-hour or 10-hour medication aide training course and had not successfully passed a written state medication administration test within 60 days of hire (Staff B). The facility's failure placed the residents at risk for medication errors and was detrimental to the health, safety, and well-being of the residents and	D935		

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D935	Continued From page 117 constitutes a Type B Violation. _____ The facility provided a plan of protection (POP) in accordance with G.S. 131D-34 on 12/23/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2021.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency,	D992		

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and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 2 of 4 sampled staff (Staff A and D) prior to hire.

The findings are:

1. Review of Staff A's personnel record revealed:
-There was no documentation of Staff A's job description.
-There was no documentation of Staff A's hire date at the facility.
-There was an examination and screening for the presence of controlled substances dated 2018.
-There was no documentation of an examination and screen for the presence of controlled substance being completed when Staff A began working in September 2020.

Interview with a Staff A on 12/03/20 at 11:33am and 3:51pm revealed she had not been asked to do a drug screen since she started working at the facility.

Interview with the Administrator on 12/03/20 at 10:38am and 2:35pm revealed:
-She was responsible for employee records.
-Staff A came from another facility, but she did not recall when Staff A started to work at this facility.
-She had not looked at Staff A's employee record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001103	A. BUILDING: _____ B. WING _____	R 12/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

(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
D992	Continued From page 119 until today (12/03/20). -She knew Staff A's required paperwork was not "up to date." -She had not completed an examination and screen for the presence of controlled substance on Staff A. -She knew some required employee records could transfer from one facility to another, but she was not sure what items. 2. Review of Staff D's personnel record revealed: -There was no documentation of Staff D's job description at the facility. -There was no documentation of Staff D's hire date at the facility. -There was no documentation of an examination and screen for the presence of controlled substance on Staff D. Interview with Staff D on 11/02/20 at 9:20am revealed he cleaned at the facility three days a week for three hours. Interview with Staff D on 12/03/20 at 1:25pm revealed: -He started "volunteering" at the facility before Thanksgiving 2020. -No one had asked him to do a drug screen. Interview with the Administrator on 12/03/20 at 2:55pm revealed: -Staff D was not an employee, "he just came by. He was a friend of the family." -She had not completed an examination and screen for the presence of controlled substance on Staff D.	D992		