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	FCL029011	A. BUILDING: _____ B. WING _____	R-C 11/05/2020

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THE LYMAN HOUSE	900 KENREED DR THOMASVILLE, NC 27360

(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
C 000	Initial Comments The Adult Care Licensure Section and the Davidson County Department of Social Services conducted a follow-up survey, a complaint investigation and a COVID-19 focused Infection Control survey with onsite visits on 10/29/20 through 10/30/20, 11/02/20 through 11/04/20 and a desk review survey on 11/05/20, with a telephone exit on 11/05/20.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 12 sampled staff was tested upon hire for tuberculosis (TB) disease according to control measures from the Commission for Health Services. The findings are:	C 140		

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C 140	Continued From page 1 Review of personnel records revealed there was not a personnel record available for Staff L. Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed: -Staff L arrived in the facility and sat down at the dining room table where a resident was seated. -Staff L read to the resident and served her a beverage. -Staff L read to a second resident and played cards with him. -Staff L served the second resident a snack. Observation of the facility on 10/30/20 between 11:40am and 3:00pm revealed: -Staff L arrived in the facility and sat down to talk to a resident in the dining room. -Staff L played cards with a second resident. -Staff L cut up lunch meal items, prepared a plate and served a resident. Observation of the facility on 11/02/20 between 11:45am and 4:00pm revealed: -Staff L talked to 2 residents. -Staff L served the residents snacks and beverages. Interview with Staff L on 11/02/20 at 3:05pm revealed: -She "volunteered" at the facility for about 2 years. -She usually "volunteered" at the facility about 3 days a week. -She arrived at the facility between 11:00am and 12:00pm and usually left the facility between 2:00pm and 2:30pm. -She did devotional readings with the residents, engaged them with conversation, did activities with them, and served them food items and	C 140		

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C 140	Continued From page 2	C 140		

beverages.
-She did not remember if she had TB skin tests when she first started "volunteering" at the facility.

A second interview with Staff L on 11/04/20 at 2:21pm revealed:
-She did not think she was on the facility payroll; however, she received a bonus occasionally.
-She thought she last received a bonus in September 2020.

Interview with a personal care aide (PCA) on 11/02/20 at 3:16pm revealed:
-Staff L was in the facility about 3 days a week.
-She usually did activities with the residents.
-She also made residents plates during lunch and served the meal, snacks, and beverages to residents.

Interview with the facility nurse on 11/03/20 at 3:18pm revealed:
-The Business Office Manager (BOM) was responsible for maintaining personnel records.
-Staff L was considered a "volunteer" and came to the facility several days a week to do activities with the residents.
-She did not know if Staff L had a TB skin test or a personnel record.

Interview with the BOM on 11/03/20 at 4:45pm revealed:
-She was responsible for maintaining the personnel records.
-Staff L was supposed to complete activities and be interactive with residents.
-Staff L had the title of "volunteer", but she received financial compensation for the time she spent at the facility.
-Staff L had been coming to the facility for years, but she did not know for how long. She thought

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C 140	Continued From page 3 the time frame was greater than 3 years. -Staff L did not have a personnel record and there was no documentation of a TB skin test for Staff L. -She had not completed a TB skin test performed on Staff L because Staff L was "volunteering" at the facility. -She had no training for the BOM position. Interview on 11/03/20 at 3:30pm with the Administrator revealed: -The BOM was responsible for maintaining the personnel records. -He did not know Staff L did not have a TB skin test or a personnel record. -Staff L was considered a "volunteer" and not an employee. -Staff L was at the facility a few times each week to do "fun stuff" with the residents. -He did not know if Staff L received financial compensation for the time she spent in the facility.	C 140		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family 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 observations, record reviews and interviews, the facility failed to ensure 5 of 12 sampled staff (Staff L, C, D, F, and G) had no	C 145		

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C 145	Continued From page 4 substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to date of hire. The findings are: 1. Review of personnel records revealed there was not a personnel record available for Staff L. Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed: -Staff L arrived in the facility and sat down at the dining room table where a resident was seated. -Staff L read to the resident and served her a beverage. -Staff L read to a second resident and played cards with him. -Staff L served the second resident a snack. Observation of the facility on 10/30/20 between 11:40am and 3:00pm revealed: -Staff L arrived in the facility and sat down to talk to a resident in the dining room. -Staff L played cards with a second resident. -Staff L cut up lunch meal items, prepared a plate, and served a resident. Observation of the facility on 11/02/20 between 11:45am and 4:00pm revealed: -Staff L talked to 2 residents. -Staff L served the residents snacks and beverages. Interview with Staff L on 11/02/20 at 3:05pm revealed: -She had "volunteered" at the facility for about 2 years. -She usually "volunteered" at the facility about 3 days a week. -She arrived at the facility between 11:00am and	C 145		

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12:00pm and usually left the facility between 2:00pm and 2:30pm.
-She did devotional readings with the residents, engaged them with conversation, did activities with them, and served them food items and beverages.
-She did not know if the HCPR had been checked for findings when she first started "volunteering" at the facility.

Interview with a PCA on 11/02/20 at 3:16pm revealed:
-Staff L was in the facility about 3 days a week.
-She usually did activities with the residents.
-She also made residents plates during lunch and served the meal, snacks, and beverages to residents.

Interview with the facility nurse on 11/03/20 at 3:18pm revealed:
-The Business Office Manager (BOM) was responsible for maintaining personnel records.
-Staff L was considered a volunteer and came to the facility several days a week to do activities with the residents.
-She did not know if the HCPR had been checked for Staff L had or if she had a personnel record.

Interview with BOM on 11/03/20 at 4:45pm revealed:
-She was responsible for maintaining the personnel records.
-She knew HCPR checks were required for new employees.
-Staff L did not have a personnel record and there was no documentation the HCPR had been checked for Staff L.
-She had not checked the HCPR for Staff L because Staff L was "volunteering" at the facility.
-Staff L was supposed to complete activities and

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C 145	Continued From page 6 be interactive with residents. -Staff L had the title of "volunteer," but she received financial compensation for the time she spent at the facility. -Staff L had been coming to the facility for years, but she did not know for how long. She thought the time frame was greater than 3 years. -She had no training for the BOM position. Interview on 11/03/20 at 3:30pm with the Administrator revealed: -The BOM was responsible for maintaining the personnel records. -He did not know if the HCPR had been checked for Staff L or if Staff L had a personnel record. -Staff L was considered a "volunteer" and not an employee. -Staff L was at the facility a few times each week to do "fun stuff" with the residents. -He did not know if Staff L received financial compensation for the time she spent in the facility. Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm. Refer to interview with Administrator on 11/02/20 at 10:05am. 2. Review of Staff C, personal care aide's (PCA) personnel record revealed: -There was no hire date documented in the personnel record. -There was no documentation of a Health Care Personnel Registry (HCPR) check located for Staff C.	C 145		

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C 145	Continued From page 7 Attempted telephone interview with Staff C on 11/05/20 at 11:17am was unsuccessful. Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm. Refer to interview with the Administrator on 11/02/20 at 10:05am. 3. Review of Staff D, personal care aide's (PCA) personnel record revealed: -There was no hire date documented in the personnel record. -There was no documentation of a HCPR check located for Staff D. Telephone interview with Staff D on 11/05/20 at 9:40am revealed: -She was a PCA. -She had been working at the facility for about a month, however could not remember the exact date. -She was not sure if a HCPR check had been completed when she was hired. Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm. Refer to interview with the Administrator on 11/02/20 at 10:05am. 4. Review of Staff F, personal care aide's (PCA) personnel record revealed: -There was no hire date documented in the	C 145		

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C 145	Continued From page 8	C 145		

personnel record.
-There was no documentation of a HCPR check located for Staff F.

Telephone interview with Staff F on 11/05/20 at 3:40pm revealed:
-She was a PCA.
-She had been working at the facility for a couple of weeks, however could not remember the exact date.
-She was not sure if a HCPR check had been completed when she was hired.

Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am.

Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm.

Refer to interview with the Administrator on 11/02/20 at 10:05am.

5. Review of Staff G, personal care aide's (PCA) personnel record revealed:
-There was no hire dated documented in the personnel record.
-There was no documentation of a HCPR check located for Staff G.

Attempted phone interview with Staff G on 11/05/20 at 11:15am was unsuccessful.

Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am.

Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm.

Refer to interview with the Administrator on 11/02/20 at 10:05am.

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C 145	Continued From page 9 Interview with the BOM on 11/05/20 at 10:34am revealed: -She was responsible for staff scheduling. -She and/or the facility nurse "were usually" responsible for staff hiring. -She was responsible for all new hire paperwork being completed, including HCPR checks. -She was unaware staff had been hired without HCPR checks. -She did not hire any of the new staff. Interview with the facility nurse on 11/05/20 at 1:23pm revealed: -She and/or the BOM "were usually" responsible for hiring staff. -She did not hire any of the new staff. -She was unaware staff had been hired without HCPR checks. Interview with the Administrator on 11/02/20 at 10:05am revealed: -He was not involved in the hiring of staff. -The BOM and/or the facility nurse"weare usually" responsible for hiring staff. -The BOM was responsible to make sure all employee paperwork was in order, including HCPR checks for new hires. -He was unaware that staff had not had HCPR checks upon hire. -He was unaware of who hired the new staff. No HCPR checkes wree completed during the survey. The facility failed to ensure a HCPR check was completed for Staff C, D, F, G and L prior to hire to verify there were no substantiated findings listed on the HCPR. This failure was detrimental to the welfare of the resident and constitutes a	C 145		

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C 145	Continued From page 10 Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 12 sampled staff (Staff L) had a criminal background check completed upon hire. The findings are: Review of personnel records revealed there was not a personnel record available for Staff L. Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed: -Staff L arrived in the facility and sat down at the dining room table where a resident was seated. -Staff L read to the resident and served her a beverage. -Staff L read to a second resident and played cards with him.	C 147		

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C 147	Continued From page 11 -Staff L served the second resident a snack. Observation of the facility on 10/30/20 between 11:40am and 3:00pm revealed: -Staff L arrived in the facility and sat down to talk to a resident in the dining room. -Staff L played cards with a second resident. -Staff L cut up lunch meal items, prepared a plate of food, and served a resident. Observation of the facility on 11/02/20 between 11:45am and 4:00pm revealed: -Staff L talked to 2 residents. -Staff L served the residents snacks and beverages. Interview with Staff L on 11/02/20 at 3:05pm revealed: -She had "volunteered" at the facility for about 2 years. -She usually "volunteered" at the facility about 3 days a week. -She arrived at the facility between 11:00am and 12:00pm and usually left the facility between 2:00pm and 2:30pm. -She did devotional readings with the residents, engaged them with conversation, did activities with them, and served them food items and beverages. -She did not remember signing a consent for a criminal background check and she did know if there was a criminal background check completed when she first started "volunteering" at the facility. A second interview with Staff L on 11/04/20 at 2:21pm revealed: -She did not think she was on the facility payroll; however, she received a bonus occasionally. -She thought she last received a bonus in	C 147		

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C 147	Continued From page 12 September 2020. Interview with a personal care aide (PCA) on 11/02/20 at 3:16pm revealed: -Staff L was in the facility about 3 days a week. -She usually did activities with the residents. -She also made residents plates during lunch and served the meal, snacks, and beverages to residents. Interview with the facility nurse on 11/03/20 at 3:18pm revealed: -The Business Office Manager (BOM) was responsible for maintaining personnel records. -Staff L was considered a "volunteer" and came to the facility several days a week to do activities with the residents. -She did not know if Staff L had a criminal background check completed or a personnel record. Interview with the BOM on 11/03/20 at 4:45pm revealed: -She was responsible for maintaining the personnel records. -She knew criminal background checks were required for new employees. -Staff L did not have a personnel record and there was no documentation Staff L had a criminal background check completed. -She had not requested a criminal background check for Staff L because Staff L was "volunteering" at the facility. -Staff L was supposed to complete activities and be interactive with residents. -Staff L had the title of "volunteer," but she received financial compensation for the time she spent at the facility. -Staff L had been coming to the facility for years, but she did not know for how long. She thought	C 147		

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C 147	Continued From page 13 the time frame was greater than 3 years. -She had no training for the BOM position. Interview with the Administrator on 11/03/20 at 3:30pm revealed: -The BOM was responsible for maintaining the personnel records. -He did not know if Staff L completed a criminal background check or had a personnel record. -Staff L was considered a "volunteer" and not an employee. -Staff L was at the facility a few times each week to do "fun stuff" with the residents. -He did not know if Staff L received financial compensation for the time she spent in the facility.	C 147		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by:	C 176		

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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
C 176	Continued From page 14 FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed cardio-pulmonary resuscitation (CPR) and choking management within the past 24 months for 2 of 10 (Staff F and G) sampled staff. The findings are: Review of the staffing schedule and staff CPR certifications for 10/19/20 to 11/01/20 revealed: There were 4 of 42 shifts when there was no staff member present in the facility that was trained in CPR within the past 24 months. 1. Review of Staff F, personal care aide's (PCA), personnel record revealed: -There was no hire date documented in the personnel record. -There was no documentation of past or current CPR certification for Staff F. Telephone interview with Staff F on 11/05/20 at 3:40 pm revealed: -She had been employed by the facility for about two weeks, but could not remember the exact date. -She never had any CPR training. Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34 am. Refer to telephone interview with facility nurse on 11/05/20 at 1:23 pm.	C 176		

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C 176	Continued From page 15 Refer to interview with Administrator on 11/02/20 at 10:05 am 2. Review of Staff G, personal care aide's (PCA), personnel record revealed: -There was no hire date documented in the personnel record. -There was no documentation of past or current CPR certification for Staff G. Attempted telephone interview with Staff G on 11/05/20 at 11:13 am was unsuccessful. Refer to telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34 am. Refer to telephone interview with facility nurse on 11/05/20 at 1:23 pm. Refer to interview with Administrator on 11/02/20 at 10:05 am. _____ Interview with the BOM on 11/05/20 at 10:34 am revealed: -She "was usually" responsible for staff scheduling. -She "was usually" responsible for staff hiring -She did not hire any of the new staff. -She was responsible for making sure all employee paperwork was in order for new staff. -The facility nurse was responsible for all training, including CPR. -She was not aware there was not a staff person on every shift with CPR certification. -There was no system in place to track staff qualifications. Interview with the facility nurse on 11/05/20 at 1:23 pm revealed: -She was responsible for all staff training,	C 176		

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C 176	Continued From page 16 including CPR. -She was unaware new staff had been hired without CPR training. -She was unaware there was not a staff person on every shift with CPR certification. -She was usually responsible for hiring along with the BOM. -She did not hire the new staff. Interview with the Administrator on 11/02/20 at 10:05 am revealed: -He was not involved the hiring of staff. -The BOM and/or the facility nurse "were usually" the ones responsible for hiring new staff. -The facility nurse was responsible for all staff training, including CPR. -He was unaware there was not a staff person on every shift with CPR certification. -He was unaware of the exactly who hired the new staff. _____ The facility failed to ensure at least one staff in the facility at all times had successfully completed CPR training within the last 24 months which placed the residents at risk for delay in life-saving measures if needed. This failure was detrimental to the health, safety and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/02/20 for this violation.	C 176		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be	C 185		

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C 185	Continued From page 17 responsible for the total operation of a family 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. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to other staff qualifications, training on cardio-pulmonary resuscitation, personal care and supervision, health care, medication administration, and infection prevention and control program. The findings are:	C 185		

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C 185	Continued From page 18 Interview with the Business Office Manager (BOM) on 11/04/20 at 1:13pm revealed: -The Administrator was responsible for the overall operations of the facility. -He was supposed to manage everything including what she and the facility nurse were doing. -The Administrator was not at the facility often. -The Administrator came to the office when she or the office facility nurse called for him to come. -The Administrator came to the office 3 to 4 days a week to see if anything needed to be signed and stayed for about an hour each time. Interview with the facility nurse on 11/04/20 at 1:27pm revealed: -The Administrator was responsible for maintaining the facility and for the overall operations of the facility. -If there were issues in the facility, she and the BOM tried to figure it out before they called the Administrator. -The Administrator came by the office 3 to 4 days a week around 12:00pm or 1:00pm and stayed for about an hour each time. -The Administrator placed her in charge when he was not at the facility or office. Telephone interview with a personal care aide (PCA) on 11/05/20 at 11:09am revealed: -When the Administrator first started work at the facility, he stopped by the facility to check in 3 to 4 times a week for about a month. -Now, she did not see the Administrator in the facility at all. -The Administrator went straight to the office when he came and stayed for about an hour. -She did not know what the Administrator's responsibilities were. -If she had an issue, she went to the BOM.	C 185		

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C 185	Continued From page 19 Interview with the Administrator on 11/05/20 at 1:15pm revealed: -He was responsible for overall management of the facility. -The BOM was responsible for criminal background checks and Health Care Personnel Registry checks, and for staff signing up for the cardio-pulmonary resuscitation classes but he was ultimately responsible. -The facility nurse was responsible for making sure all health care needs were met, correct and accurate medication administration and treatments, infection control including COVID-19, and completion of licensed health professional support tasks checkoff (The BOM ensured the checkoffs were in employee records.) but he oversaw all the facility nurse's responsibilities. -He came to the office during his lunch time, somewhere between 12:00pm and 2:00pm. -He sometimes came to the office after work during the week and sometimes on the weekend. -He went into the facility 2 to 3 times a week and stayed for 10 to 15 minutes. -"I just do a quick walk through. If I was at the facility full-time, I would go into the facility every day." Non-compliance was identified at violation levels in the following rule areas: 1. Based on observations, record reviews and interviews, the facility failed to ensure 5 of 12 sampled staff (Staff L, C, D, F, and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to date of hire. [Refer to Tag C0145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Type B Violation)].	C 185		

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C 185	Continued From page 20 2. Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed cardio-pulmonary resuscitation (CPR) and choking management within the past 24 months for 2 of 10 (Staff F and G) sampled staff. [Refer to Tag C 0176, 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Unabated Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to provide supervision by a staff (Staff L) for 1 of 3 sampled residents (#1) who had a fall resulting in a fractured hip. [Refer to Tag C0243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A2 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow up for 2 of 3 sampled residents who had swelling in her feet and needed to see a provider (Resident #3) and a resident who did not receive her medication when she was out of the faciltiy 3 days a week at dialysis (Resident #1). [Refer to Tag C0246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) with orders for a rapid-acting insulin and a proton pump inhibitor. [Refer to Tag C0330 10A NCAC 13G .1004(a) Medication Administration (Unabated Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by	C 185		

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C 185	Continued From page 21 the Centers for Disease Control (CDC) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE), staff not maintaining a social distance of 6 feet from residents when not appropriately wearing PPE, and no screening of staff and visitors [Refer to Tag C061 10A NCAC 13G. 1700 Infection Prevention and Control (Type A2 Violation)]. The failure of the Administrator to ensure staff had a Health Care Personnel Registry (HCPR) checks were completed upon hire which resulted in the facilty not knowing if staff had any substantiated finding on the HCPR; at least one staff person was on the premises at all times who had completed an accredited course on cardio-pulmonary resuscitation and choking management within the last 24 months resulting in residents placed at risk for a delay in life-saving measures if needed; staff provided supervision which resulted in a resident falling and sustaining a fractured hip and the need for surgery (#1); referral and follow up for a resident who had swelling in her feet and needed to see a provider (#3); a resident who did not receive her medication when she was out of the faciltiy 3 days a week at dialysis which could result in pain, weeping skin, and increased edema in her feet and ankles (#3) a resident not receiving insulin and pantoprazole which could result in hypoglycemia and gastric upset (#1); and failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) were implemented and maintained to provide protection of the residents during the	C 185		

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C 185	Continued From page 22 global coronavirus (COVID-19) pandemic.This failure resulted in substantial risk of physical harm and neglect to residents which constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/03/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 05, 2020	C 185		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision by a staff (Staff L) for 1 of 3 sampled residents (#1) who had a fall resulting in a fractured hip. The findings are: Observation of the facility on 11/02/20 between 2:45pm and 3:45pm revealed: -There was a screeching noise coming from the bedroom area. -Staff L and a personal care aide (PCA) were standing in the kitchen area. -There was no other staff in the facility.	C 243		

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C 243	Continued From page 23 -The PCA did not know what the noise was or where it was coming from. -The PCA found Resident #1 on the floor in the bathroom. -Staff L left the facility to go get help from the medication aide (MA). -Other staff came to the facility to assist and Emergency Medical Services (EMS) services were called. -Resident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living, impaired functional mobility, balance, gait, and endurance, physical debility. -Resident #1 was semi-ambulatory. Review of Resident #1's care plan dated 07/25/20 revealed: -Resident #1 required limited assistance with toileting, ambulation, and transfer. -Resident #1 required a 1 person assist with transfers and ambulation. Review of Resident #1's local hospital admission report dated 11/02/20 revealed: -Resident #1 was admitted to the hospital after a fall at the facility. -There was documentation Resident #1 was trying to get onto the toilet using a walker and accidentally fell onto the floor. -Resident #1 denied any dizziness or lightheadedness. -Resident #1 complained of right hip pain, but she denied any loss of consciousness or head injury. -Resident #1 had skin tears to her right elbow and right leg	C 243		

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C 243	Continued From page 24 -Resident #1's emergency department diagnoses included fall, right hip pain, closed fracture of right hip, and end stage renal disease. -Resident #1 had surgery on her right hip on 11/04/20. Review of Resident #1's staff communication notes for August, September, and October 2020 revealed there was no documentation of a fall. Interview with a personal care aide (PCA) on 11/02/20 at 2:58pm revealed: -Staff L assisted Resident #1 to the bathroom and once Resident #1 got into the bathroom, Staff L closed the door. -She did not know the Staff L had taken Resident #1 to the bathroom. -She found Resident #1 on the floor in the bathroom and her right elbow and right lower leg were bleeding. -She did not know if Resident #1 hit her head. -EMS was called to the facility to assess Resident #1. Interview with Staff L on 11/02/20 at 3:05pm revealed: -The PCA had taken a resident to the bathroom when Resident #1 told her she needed to go to the bathroom "quick." -The PCA was walking the other resident back to a chair in the family room as Resident #1 independently got up from her chair in the living room and walked to the bathroom with her walker. She walked behind Resident #1 as she walked to the bathroom. -Once Resident #1 got to the bathroom, she did not assist Resident #1 with getting onto the toilet, but she closed the door to give Resident #1 privacy. -After closing the bathroom door, she walked to	C 243		

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the kitchen.
-While in the kitchen, she heard Resident #1 screaming, but thought it was another resident making sounds.
-She went to check on Resident #1, following the PCA and Resident #1 had fallen in the bathroom.
-She observed Resident #1 laying in front of the toilet in a fetal position with her head pointing towards the tub.
-She did not go all the way in the bathroom, so she could not tell if Resident #1 was bleeding or not.
-Resident #1 told her that when she went to pull her pants down, she fell.
-She had been volunteering at the facility for about 2 years and visited about 3 days a week.
-She did devotions and activities with the residents and sometimes served the residents food.
-She had previously assisted residents to the bathroom in emergency situations, but she did not provide any other type of personal care.
-No one told her she could not assist residents to the bathroom.

A second interview with the PCA on 11/02/20 at 3:16pm revealed:
-Resident #1 ambulated independently with a walker, but she needed supervision.
-She assisted Resident #1 with ambulating by standing behind her and placing a hand on her back to prevent a fall.
-Sometimes she put her finger into the back waist of her pants to help guide her.
-When Resident #1 went to the bathroom, she took her walker into the bathroom with her.
-Resident #1 did not need any assistance with getting on the toilet, but she always stayed in the bathroom with her to make sure she got up and down from the toilet okay and to the sink to wash

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her hands.
-She had not known Resident #1 to fall in the facility before.
-Staff L normally did activities with the residents and helped make meal plates.
-During her shift, the Staff L assisted residents to the bathroom if she was busy doing something else.
-She did not know if Staff L had any type of training.

Interview with a second PCA on 11/02/20 at 5:21pm revealed:
-Resident #1 needed to be supervised during ambulation and while using the bathroom.
-She usually walked behind Resident #1 as she ambulated to the bathroom and stayed in the bathroom with her.
-Sometimes Resident #1 needed assistance getting up and down from the toilet and with pulling her pants up and down.

Interview with Resident #1's responsible party on 11/03/20 at 1:49pm revealed:
-Resident #1 did well with ambulating and transferring on her own, but there were times when she made a misstep.
-Resident #1 was admitted to the hospital with a fractured pelvis after the falling on 11/02/20.
-Resident #1 would be scheduled for surgery to implant screws and replace a hip joint.
-Resident #1 had not had any other recent falls.

Interview with the facility nurse on 11/03/20 at 3:18pm revealed:
-She was not at the facility, but she was told by staff Resident #1 fell on 11/02/20.
-She heard Resident #1 say over the phone that she hit her head.
-Resident #1 did not want to go to the hospital,

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C 243	Continued From page 27 but the Administrator talked to Resident #1's family member and called 911. -Staff L should not have taken any of the residents to the bathroom. -"She knew not to leave her there unattended." -The PCA should have been attending to Resident #1. Interview with the Administrator on 11/03/20 at 3:33pm revealed: -Residents were expected to be checked on at least every hour and taken to the bathroom when needed. -He expected staff to keep a close eye on residents. -Staff L was at the facility to do "fun stuff" with the residents, but not to provide personal care. -He would not have expected Staff L to take Resident #1 to the bathroom. -He did not know Staff L had assisted residents to the bathroom prior to 11/02/20. -Staff L could get residents a glass of water or tea, but nothing other than that. _____ The facility failed to provide supervision to Resident #1 by a volunteer who left the resident unsupervised in the bathroom resulting in the resident having an unwitnessed fall, sustained a fractured hip and needed surgery. This failure resulted in substantial risk for physical harm and neglect to residents which constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/03/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 5, 2020.	C 243		

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C 246	Continued From page 28	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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, record reviews, and interviews, the facility failed to ensure referral and follow up for 2 of 3 sampled residents who had swelling in her feet and needed to see a provider (Resident #3) and a resident who did not receive her medication when she was out of the faciltiy 3 days a week at dialysis (Resident #1). The findings are: 1. Review of Resident #3's current FL2 dated 07/31/20 revealed diagnoses included vascular dementia, hypertension, ataxia, and acute respiratory failure. Observation of Resident #3 on 11/03/20 at 1:43pm revealed: -Resident #3 was sitting in a chair in the living room. -Resident #3 had swelling in both ankles and feet with her right foot and ankle being a little more swollen than the left. -Resident #3 had indentions in her ankles where the top of her socks were placed on her lower legs. Review of Resident #3's staff communication notes for August, September, October, and November 2020 revealed there was no	C 246		

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C 246	Continued From page 29 documentation regarding swelling in Resident #3's feet. Review of Resident #3's record revealed there was no documentation of swelling in Resident #3's feet. Interview with a personal care aide (PCA) on 11/03/20 at 1:42pm revealed: -She did not think Resident #3 had any swelling in her feet. -After looking at Resident #3's feet, she noticed swelling in both feet and ankles with more swelling in her right foot and ankle. Interview with a PCA on 11/04/20 at 2:51pm revealed: -She had not noticed any swelling in Resident #3's feet and ankles. -If she had noticed any swelling, she would have told a medication aide (MA) and the MA would have told the nurse. Interview with the facility nurse on 11/04/20 at 11:38am revealed: -Staff reported to her about a month ago that Resident #3 had swelling in her legs. -She told staff to prop Resident #3's legs up on a pillow and put her in a recliner. -If Resident #3 was not in her wheelchair, she was in her recliner. -She notified Resident #3's previous primary care provider (PCP) of Resident #3's swelling when it was reported to her about a month ago, but she did not document the contact with the PCP. -Staff had not reported to her and she did not know Resident #3 had any current swelling in her feet and ankles. -She did not complete skin assessments for residents unless staff told her one needed to be	C 246		

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C 246	Continued From page 30	C 246		

completed.
-She had not completed a skin assessment for Resident #3.
-Resident #3 did not have a current PCP to report the swelling to, but she would make a note for the incoming PCP who was scheduled to be at the facility on 11/09/20.
-If staff reported to her that swelling in Resident #3's feet and ankles became extreme prior to seeing a PCP, she would have to send Resident #3 out to the local hospital to be assessed.
-She would look at Resident #3's feet and ankles and if elevation would take care of the swelling, if not, she would send resident out of the facility for medical care because there was no one to write orders at this time.

Observation of Resident #3 on 10/29/20 between 10:15am and 2:30pm revealed Resident #3 sat in her wheelchair at the dining room table for the majority of the day.

A second interview with the facility nurse on 11/04/20 at 3:42pm revealed:
-She looked at Resident #3's feet and ankle and there was nonpitting edema.
-Resident #3's toes were a little discolored due to poor vascular circulation.
-If Resident #3 had a PCP, she would have contacted the PCP to inform of the Resident #3's swelling and place her on the PCP's schedule to be seen.
-Because Resident #3 did not have a PCP at this time, she would wait until 11/09/20 for Resident #3 to be seen.
-She did not feel the swelling in Resident #3's feet and ankles warranted any immediate medical attention.
-She did not know how long the swelling in Resident #3's feet and ankles had been going on,

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C 246	Continued From page 31 but without medical treatment, Resident #3 could experience pain, weeping, and increased edema. Telephone interview with a PCA on 11/05/20 at 11:09am revealed: -She reported swelling in Resident #3's feet and ankles in September 2020 and reported it to the facility nurse. -She noticed swelling in Resident #3's feet and ankles this morning and reported it to the facility nurse. -The facility nurse told her that she was aware of the swelling and to make sure Resident #3's feet were elevated. -She normally put Resident #3 in a reclining chair with her feet up. -Sometimes staff kept Resident #3 at the dining room table because she got out of bed late and Resident #3 would sit in her wheelchair at the dining room table for breakfast and lunch. -When swelling was identified and reported to the facility nurse, it should have been documented in the staff communication notes. Telephone interview the Administrator on 11/05/20 a t1:15pm revealed: -He did not know Resident #3 had swelling in her feet and ankles. -Resident #3 did not currently have a PCP, but if she needed care, she would be sent to urgent care or the emergency room. -The previous PCP came to the facility once a week and was last in the facility a few weeks ago. -Staff gave the previous PCP a list of residents who needed to be seen, but he didn't know if Resident #3 was seen regarding swelling in her feet and ankles. Interview with a representative from Resident #3's previous PCP's office on 11/05/20 at 2:14pm	C 246		

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C 246	Continued From page 32 revealed: -There was no documentation the facility reported to the PCP's office in August, September, or October 2020 Resident #3 had swelling in her feet and ankles. -There was no documentation in any of the previous PCP's notes from August, September, or October 2020 that swelling in Resident #3's feet and ankles was addressed. Based on observations, record reviews and interviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living, impaired functional mobility, balance, gait, endurance and physical debility. -There was an order for Humalog injections 100mL inject 3 units three times a day before meals and hold for blood sugar (BS) of 60 or less (A rapid-acting insulin used to lower elevated BS levels). Review of Resident #1's after visit summary with a medical specialist dated 03/02/20 revealed diagnoses included type 2 diabetes mellitus. a. Review of Resident #1's physician's orders revealed: -There was a physician's order dated 04/28/20 to discontinue the morning dose of Humalog. -There was a physician's order dated 05/15/20 for Humalog 100mL inject 6 units with lunch and dinner. -There was a physician's order dated 08/21/20 to hold Humalog if BS was less than 100.	C 246		

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C 246	Continued From page 33 Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2020 revealed: -There was an entry for lispro (Humalog) insulin injection 100/ml inject 6 units twice a day with lunch and dinner hold for BS less than 100 scheduled for administration at 12:00pm and 5:00pm. -Lispro was not administered for 12 of 28 opportunities in October due to "Out of Facility." -Resident #1's BS ranged from 69 to 312 on the days when insulin was administered at 12:00pm. -Resident #1's BS ranged from 170 to 368 on the days when insulin was not administered at 12:00pm. Interview with the facility nurse on 10/29/20 at 1:39pm revealed: -"Out of Facility" meant that Resident #1 was out of the facility. -Resident #1 went out of the facility to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually returned to the facility before 3:00pm so she told the medication aide (MA) to administer Resident 1's 2:00pm medications when she returned from dialysis. -Resident #1 did not receive her 12:00pm dose of Lispro because it was scheduled during the time she was out of the facility at dialysis. Interview with Resident #1 on 10/29/20 at 3:53pm revealed: -She went to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left the facility at 10:00am and returned to the facility between 2:30pm and 3:00pm on dialysis days. -Staff administered her medication prior to her going to dialysis and when she returned from dialysis.	C 246		

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-There was no medication sent with her when she went to dialysis and the nurses at dialysis did not administer medication to her.
-She did not know if she had medication scheduled to be administered while she was out of the facility.

Interview with a MA on 10/30/20 at 2:10pm revealed:
-Resident #1 went out of the facility to dialysis 3 days a week.
-Resident #1's 12:00pm dose of lispro was not administered when Resident #1 was out of the facility at dialysis.
-She documented "Out of Facility" when Resident #1 did not receive her 12:00pm dose of insulin due to being at dialysis.
-She did not know if dialysis was able to administer medication to Resident #1.
-The facility nurse knew Resident #1 was not getting scheduled medication when she was at dialysis.
-She did not know if Resident #1's primary care provider (PCP) had been contacted regarding the missed doses of insulin.
-The facility nurse was responsible for contacting Resident #1's PCP.

Interview with a second MA on 11/03/20 at 10:53pm revealed:
-She did not administer the 12:00pm dose of lispro to Resident #1 when she was out of the facility at dialysis.
-She had been told by the facility nurse to just mark on the eMAR that Humalog was not administered and document the reason as "Out of Facility."
-The facility nurse was responsible for following up with physicians.
-She did not know if Resident #1's PCP had been

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C 246	Continued From page 35 made aware Resident #1 was not receiving insulin as ordered when she was out of the facilty at dialysis. Interview with the facility nurse on 11/03/20 at 11:29am revealed: -She knew Resident #1 was not receiving lispro as ordered at 12:00pm when she went to dialysis. -She had not talked to Resident #1's previous PCP regarding Resident #1 not receiving lispro when she was out of the facility. -When there were residents who went to dialysis, it got too confusing for the MAs when medications and medication times were changed. -Dialysis did not allow the facility to send medications with Resident #1. Interview with a representative at Resident #1's dialysis center on 10/05/20 at 2:05pm revealed: -Resident #1 came to dialysis 3 days a week on Tuesdays, Thursdays and Saturdays. -The dialysis center did not administer any medication to their patients other than Tylenol and antibiotics and those would have to be ordered by the dialysis physician. -Residents could take their own medication if they brought it with them to dialysis. -The dialysis staff had not noticed Resident #1 to have any signs or symptoms of hyperglycemia or hypoglycemia. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -He did not know Resident #1 had medication scheduled for administration during the time she was out of the facility at dialysis. -He expected medication to be administered as ordered. Interview with a representative from Resident #1's	C 246		

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C 246	Continued From page 36 previous PCP's office on 10/05/20 at 2:14pm revealed: -Resident #1 had an order for Humalog 6 units twice daily at lunch and dinner. -There was no documentation the PCP was notified Resident #1 was not getting Humalog on the days she went to dialysis. b. Review of Resident #1's current FL2 dated 01/24/20 revealed there was an order for Pantoprazole 40mg 1 tablet twice daily (a proton pump inhibitor used to treat acid reflux). Review of Resident #1's after visit summary with a medical specialist dated 03/02/20 revealed diagnoses included end stage renal disease, type 2 diabetes mellitus, hypertension, dyslipidemia, and anemia. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2020 revealed: -There was an entry for pantoprazole 40mg 1 tablet twice daily scheduled for administration at 6:30am and 11:30am. -Pantoprazole 40mg was not administered for 12 of 28 opportunities in October due to "Out of Facility." Interview with the facility nurse on 10/29/20 at 1:39pm revealed: -"Out of Facility" meant that Resident #1 was out of the facility. -Resident #1 went out of the facility to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually returned to the facility before 3:00 so she told the MA to administer Resident 1's 2:00pm medications when she returned from dialysis. -Resident #1 did not receive her 11:30am dose of	C 246		

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C 246	Continued From page 37 pantoprazole because it was scheduled during the time she was out of the facility at dialysis. Interview with Resident #1 on 10/29/20 at 3:53pm revealed: -She went to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left the facility at 10:00am and returned to the facility between 2:30pm and 3:00pm on dialysis days. -Staff administered her medication prior to her going to dialysis and when she returned from dialysis. -There was no medication sent with her when she went to dialysis and the nurses at dialysis did not administer medication to her. -She did not know if she had medication scheduled to be administered while she was out of the facility. Interview with a MA on 10/30/20 at 2:10pm revealed: -Resident #1 went to dialysis 3 days a week. -Resident #1's 11:30am dose of pantoprazole was not administered when Resident #1 was out of the facility at dialysis. -She documented "Out of Facility" when Resident #1 did not receive her 11:30am dose of pantoprazole due to being at dialysis. -She did not know if dialysis was able to administer medication to Resident #1. -The facility nurse knew Resident #1 was not getting scheduled medication when she was at dialysis. -She did not know if Resident #1's primary care physician (PCP) had been contacted regarding the missed doses of pantoprazole. -The facility nurse was responsible for contacting Resident #1's PCP.	C 246		

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C 246	Continued From page 38 Interview with a second MA on 11/03/20 at 10:53pm revealed: -She did not administer the 11:30am dose of pantoprazole to Resident #1 when she was out of the facility at dialysis. -She had been told by the facility nurse to just mark on the eMAR that pantoprazole was not administered and document the reason as "Out of Facility." -The facility nurse was responsible for following up with physicians. -She did not know if Resident #1's PCP had been made aware Resident #1 was not receiving pantoprazole as ordered when she was out of the facilty at dialysis. Interview with the facility nurse on 11/03/20 at 11:29am revealed: -She knew Resident #1 was not receiving pantoprazole as ordered at 11:30am when she went to dialysis. -She had not talked to Resident #1's previous PCP regarding Resident #1 not receiving pantoprazole when she went to dialysis. -When there were residents went to dialysis, it got too confusing for MAs when medications and medication times were changed. -Dialysis did not allow the facility to send medications with Resident #1. -Resident #1 did not currently have a PCP. Interview with a representative at Resident #1's dialysis center on 10/05/20 at 2:05pm revealed: -Resident #1 came to dialysis 3 days a week on Tuesdays, Thursdays and Saturdays. -The dialysis center did not administer any medication to their patients other than Tylenol and antibiotics and those would have to be ordered by the dialysis physician. -Residents could take their own medication if they	C 246		

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C 246	Continued From page 39 brought it with them to dialysis. -The dialysis staff have not noticed Resident #1 to have any signs or symptoms of heartburn. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -He did not know Resident #1 had medication scheduled for administration during the time she was out of the facility at dialysis. -He expected medication to be administered as ordered. Interview with a representative from Resident #1's previous PCP's office on 10/05/20 at 2:14pm revealed: -Resident #1 had an order for pantoprazole 40mg 1 tablet twice daily. -There was no documentation the PCP was notified Resident #1 was not getting Pantoprazole when she was out of the facility at dialysis. -She was not the provider and could not provide possible outcomes for Resident #1 due to not receiving the pantoprazole as ordered. _____ The facility failed to ensure referral and follow up for 2 of 3 sampled residents (Resident #3 and #1) regarding a resident who had swelling in her feet and ankles, placed the resident at risk for pain, weeping skin, and increased edema in her feet and ankles (#3); a resident who was not administered humalog insulin and pantoprazole when she was out of the facility at dialysis 3 days a week which could result in hypoglycemia and gastric upset. This 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 10/29/20.	C 246		

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C 246	Continued From page 40 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020.	C 246		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) with orders for a rapid-acting insulin and a proton pump inhibitor. The findings are: Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living, impaired functional mobility, balance, gait, and endurance, physical debility.	C 330		

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C 330	Continued From page 41 -There was an order for Humalog injections 100mL inject 3 units three times a day before meals and hold for blood sugar (BS) of 60 or less (A rapid-acting insulin used to lower elevated BS levels). Review of Resident #1's after visit summary with a medical specialist dated 03/02/20 revealed diagnoses included type 2 diabetes mellitus. a. Review of Resident #1's physician's orders revealed: -There was a physician's order dated 04/28/20 to discontinue the morning dose of Humalog. -There was a physician's order dated 05/15/20 for Humalog 100mL inject 6 units with lunch and dinner. -There was a physician's order dated 08/21/20 to hold Humalog if BS was less than 100. Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2020 revealed: -There was an entry for Lispro (Humalog) insulin injection 100/ml inject 6 units twice a day with lunch and dinner hold for BS less than 100 scheduled for administration at 12:00pm and 5:00pm. -Lispro was not administered for 12 of 28 opportunities in October due to "Out of Facility." -Resident #1's normal BS ranged from 69 to 312. -Resident #1's BS ranged from 170 to 368 on the days when insulin was not administered at 12:00pm. Observation of medication available for adminstration for Resident #1 on 10/30/20 revealed: -Humalog insulin pen 100ml was available on the medicatication cart.	C 330		

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C 330	Continued From page 42 -The instructions on the medication label were to administer 6 units twice daily with lunch and dinner. Hold for BS if 60 or less. -There were 5 pens dispensed by the pharmacy on 08/05/20 and there were 3 pens remaining. Interview with the facility nurse on 10/29/20 at 1:39pm revealed: -"Out of Facility" meant that Resident #1 was out of the facility. -Resident #1 went out of the facility to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually returned to the facility before 3:00 so she told the medication aide (MA) to administer Resident 1's 2:00pm medications when she returned from dialysis. -Resident #1 did not receive her 12:00pm dose of Lispro because it was scheduled during the time she was out of the facility at dialysis. Interview with Resident #1 on 10/29/20 at 3:53pm revealed: -She went to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left the facility at 10:00am and returned to the facility between 2:30pm and 3:00pm on dialysis days. -Staff administered her medication prior to her going to dialysis and when she returned from dialysis. -She did not receive inslin when she returned from dialysis. -There was no medication sent with her when she went to dialysis and the nurses at dialysis did not administer medication to her. -She did not know if she had medication scheduled to be administered while she at dialysis. Interview with a MA on 10/30/20 at 2:10pm	C 330		

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C 330	Continued From page 43 revealed: -Resident #1 went out of the facility to dialysis 3 days a week. -Resident #1's 12:00pm dose of Lispro was not administered when Resident #1 went to dialysis. -She documented "Out of Facility" when Resident #1 did not receive her 12:00pm dose of insulin due to being at dialysis. -She did not know if staff at the dialysis clinic was able to administer medication to Resident #1. -The facility nurse knew Resident #1 was not getting scheduled medication when she was at dialysis. Interview with a second MA on 11/03/20 at 10:53pm revealed: -She did not administer the 12:00pm dose of Lispro to Resident #1 when she was out of the facility at dialysis. -She had been told by the facility nurse to just mark on the eMAR that Humalog was not administered and document the reason as "Out of Facility." Interview with the facility nurse on 11/03/20 at 11:29am revealed: -She knew Resident #1 was not receiving Lispro as ordered at 12:00pm when she went to dialysis. -She had not talked to Resident #1's PCP regarding Resident #1 not receiving Lispro when she was out of the facility. -When there were residents who received dialysis, it gets too confusing when you start changing medications and medication times. -The dialysis center did not allow the facility to send medications with Resident #1. Telephone interview with a representative at Resident #1's dialysis center on 10/05/20 at 2:05pm revealed:	C 330		

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C 330	Continued From page 44 -Resident #1 came to dialysis 3 days a week on Tuesdays, Thursdays and Saturdays. -The dialysis center did not administer any medication to their patients other than Tylenol and antibiotics and those would have to be ordered by the dialysis physician. -Residents could take their own medication if they brought it with them to dialysis. -The dialysis staff have not noticed Resident #1 to have any signs or symptoms of hyperglycemia or hypoglycemia. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -The facility nurse was responsible for training MAs and was responsible for correct and accurate medication administration and treatments. -He did not know Resident #1 had medication scheduled for administration during the time she was out of the facility at dialysis. -He expected medication to be administered as ordered. Telephone interview with a representative from Resident #1's previous PCP's office on 10/05/20 at 2:14pm revealed: -Resident #1 had an order for Humalog 6 units twice daily at lunch and dinner. -Humalog was used to treat diabetes. -There was no documentation the PCP was notified Resident #1 was not getting Humalog when she was out of the facility at dialysis. b. Review of Resident #1's current FL2 dated 01/24/20 revealed there was an order for Pantoprazole 40mg 1 tablet twice daily (a proton pump inhibitor used to treat acid reflux). Review of Resident #1's electronic Medication	C 330		

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C 330	Continued From page 45 Administration Record (eMAR) for October 2020 revealed: -There was an entry for pantoprazole 40mg 1 tablet twice daily scheduled for administration at 6:30am and 11:30am. -Pantoprazole 40mg was not administered for 12 of 28 opportunities in October due to "Out of Facility." Observation of medication available for adminstration for Resident #1 on 10/30/20 revealed: -Pantoprazole 40mg was available on the medicatication cart. -The instructions on the medication label were to administer 1 tablet daily. -A quantity of 31 tablets of pantoprazole 40mg were dispensed by the pharmacy on 10/01/20 and their was 1 tablet remaining. Interview with the facility nurse on 10/29/20 at 1:39pm revealed: -"Out of Facility" meant that Resident #1 was out of the facility. -Resident #1 went out of the facility to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually returned to the facility before 3:00pm so she told the MA to administer Resident 1's 2:00pm medications when she returned from dialysis. -Resident #1 did not receive her 11:30am dose of pantoprazole because it was scheduled during the time she was out of the facility at dialysis. Interview with Resident #1 on 10/29/20 at 3:53pm revealed: -She went to dialysis on Tuesdays, Thursdays, and Saturdays. -She usually left the facility at 10:00am and returned to the facility between 2:30pm and	C 330		

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C 330	Continued From page 46 3:00pm on dialysis days. -Staff administered her medication prior to her going to dialysis and when she returned from dialysis. -There was no medication sent with her when she went to dialysis and the nurses at dialysis did not administer medication to her. -She did not know if she had medication scheduled to be administered while she was at dialysis and she did not know if pantoprazole was administered to her when she returned to the facility. Interview with a medication aide (MA) on 10/30/20 at 2:10pm revealed: -Resident #1 went out of the facility to dialysis 3 days a week. -Resident #1's 11:30am dose of pantoprazole was not administered when Resident #1 was out of the facility at dialysis. -She documented "Out of Facility" when Resident #1 did not receive her 11:30am dose of pantoprazole due to being at dialysis. -She did not know if dialysis was able to administer medication to Resident #1. -The facility nurse knew Resident #1 was not getting scheduled medication when she was at dialysis. -She did not know if Resident #1's primary care physician (PCP) had been contacted regarding the missed doses of pantoprazole. -The facility nurse was responsible for contacting Resident #1's PCP. Interview with a second MA on 11/03/20 at 10:53pm revealed: -She did not administer the 11:30am dose of Lispro to Resident #1 when she was out of the facility at dialysis. -She had been told by the facility nurse to just	C 330		

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C 330	Continued From page 47	C 330		

mark on the eMAR that pantoprazole was not administered and document the reason as "Out of Facility."

Interview with the facility nurse on 11/03/20 at 11:29am revealed:
-She knew Resident #1 was not receiving pantoprazole as ordered at 11:30am when she went to dialysis.
-She had not talked to Resident #1's PCP regarding Resident #1 not receiving pantoprazole when she was out of the facility.
-When there were residents who received dialysis, it got too confusing for MAs when medications and medication times were changed.
-Dialysis did not allow the facility to send medications with Resident #1.

Telephone interview with a representative at Resident #1's dialysis center on 10/05/20 at 2:05pm revealed:
-Resident #1 came to dialysis 3 days a week on Tuesdays, Thursdays and Saturdays.
-The dialysis center did not administer any medication to their patients other than Tylenol and antibiotics and those would have to be ordered by the dialysis physician.
-Residents could take their own medication if they brought it with them to dialysis.
-The dialysis staff have not noticed Resident #1 to have any signs or symptoms of heartburn.

Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed:
-The facility nurse was responsible for training MAs and was responsible for correct and accurate medication administration and treatments.
-He did not know Resident #1 had medication scheduled for administration during the time she

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C 330	Continued From page 48 was out of the facility at dialysis. -He expected medication to be administered as ordered. Telephone interview with a representative from Resident #1's previous PCP's office on 10/05/20 at 2:14pm revealed: -Resident #1 had an order for pantoprazole 40mg 1 tablet twice daily. -There was no documentation the PCP was notified Resident #1 was not getting Pantoprazole when she was out of the facility at dialysis. -She was not the provider and could not provide possible outcomes for Resident #1 due to not receiving the pantoprazole as ordered. _____ The facility failed to ensure medications were administered as ordered for Resident #1 who was not administered humalog insulin which result in elevated blood sugar as high as 367 and could result in gastric upset. This failure was detrimental to the health, safety and welfare of the resident which constitutes an Unabated Type B Violation. _____ The facility provided Plan of Protection in accordance with G.S. 131D-34 on 10/29/20.	C 330		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family 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.	C 367		

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C 367	Continued From page 49 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the retrievable record of controlled substances were maintained and reconciled accurately with the documented receipt and administration of an anti-anxiety medication for 1 of 2 sampled resident (#1). The findings are: Review of Resident #1's current of FL-2 dated 01/24/20 revealed diagnoses included fall, impaired mobility, impaired functional mobility, balance, gait and endurance, and physical debility. Review of Resident #1's physician orders dated 03/30/20 revealed an order for alprazolam (a Scheduled IV controlled substance used to treat anxiety) 0.5mg one tablet twice a day. Review of Resident #1's July 2020 electronic Medication Administration Record (eMAR) and controlled substance count sheets (CSCS) revealed: -There was an entry for alprazolam 0.5mg 1 tablet at bedtime, scheduled at 9:00am and 9:00pm. -There was documentation alprazolam 0.5mg was administered from 07/01/20 to 07/31/20 at 9:00am and 9:00pm daily. -Review of Resident #1's CSCS for alprazolam 0.5mg revealed there was a CSCS with a beginning quantity of 62 alprazolam 0.5mg with a label dated 05/13/20 and documented as signed out at 9:00am and 9:00pm from 07/01/20 at 9:00pm to 07/31/20 at 9:00pm with a remaining quantity of 0 tablets.	C 367		

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C 367	Continued From page 50 Review of Resident #1's August 2020 eMAR and CSCS revealed: -There was an entry for alprazolam 0.5mg i tablet at bedtime, scheduled at 9:00am and 9:00pm. -There was documentation alprazolam 0.5mg was administered from 08/01/20 to 08/31/20 at 9:00am and 9:00pm daily. -There was a CSCS with a beginning quantity of 62 alprazolam 0.5mg with a label dated 07/27/20 and documented as signed out at 9:00am and 9:00pm from 08/01/20 at 9:00am to 08/31/20 at 9:00am with a remaining quantity of 0 tablets. Review of Resident #1's September 2020 eMAR revealed: -There was an entry for alprazolam 0.5mg one tablet at bedtime, scheduled at 9:00am and 9:00pm. -There was documentation alprazolam 0.5mg was administered from 09/01/20 to 09/30/20 at 9:00am and 9:00pm daily. -There was a CSCS with a beginning quantity of 62 alprazolam 0.5mg with a label dated 09/01/20 and documented as signed out at 9:00am and 9:00pm from 09/01/20 at 9:00pm to 10/01/20 at 9:00am with a remaining quantity of 0 tablets. Review of Resident #1's October 2020 eMAR revealed: -There was an entry for alprazolam 0.5mg one tablet at bedtime, scheduled at 9:00am and 9:00pm. -There was documentation alprazolam 0.5mg was administered from 10/01/20 to 10/31/20 at 9:00am and 9:00pm daily. -There was a CSCS with a beginning quantity of 60 alprazolam 0.5mg with a label dated 10/01/20 and documented as signed out at 9:00am and 9:00pm from 10/01/20 at 9:00pm to 10/31/20 at	C 367		

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C 367	Continued From page 51 9:00am with a remaining quantity of 0 tablets Review of Resident #1's November 2020 eMAR revealed: -There was an entry for alprazolam 0.5mg one tablet at bedtime, scheduled at 9:00am and 9:00pm. -There was documentation alprazolam 0.5mg was administered on 11/01/20 at 9:00am and 9:00pm and 11/02/20/20 at 9:00am. -There was a CSCS with a beginning quantity of 60 alprazolam 0.5mg with a label dated 11/01/20 and documented as signed out at 9:00am and 9:00pm from 10/31/20 at 9:00pm to 11/02/20 at 9:00am with a remaining quantity of 56 tablets. Review of the facility's packing slips sent by the contracted pharmacy with medications dispensed revealed: -There was a packing slip dated 06/05/20 documenting alprazolam 0.5mg quantity of 62 tablets sent to the facility. -The packing slip was approved by the facility nurse at the time and dated as processed on 06/23/20. Review of the contracted inventory returns report from 10/01/19 to 11/04/20 revealed there was no documentation for the return of 62 alprazolam 0.5mg tablets dispensed on 06/05/20. Observation of Resident #1's medication on hand on 11/03/20 at 3:40pm revealed there were 56 alprazolam 0.5mg tablet remaining on a bubble pack card of 60 tablets labeled for dispensed on 11/01/20. Based on observation, interview and record review there were 62 doses of alprazolam 0.5mg tablets dispensed on 06/05/20 missing with no	C 367		

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C 367	Continued From page 52 accounting for disposition. Telephone interview with a representative from the facility contracted pharmacy on 11/05/20 at 10:48 am revealed: -The pharmacy routinely dispensing medication in bingo style bubble card packaging. -Resident #1's alprazolam 0.5mg twice a day was dispensed on 05/13/20 for 62 tablets, on 06/05/20 for 62 tablets, on 07/27/20 for 62 tablets, on 09/01/20 for 60 tablets, 10/01/20 for 60 tablets, and 11/01/20 for 60 tablets. -The pharmacy included CSCS sheets indicating the dispensed quantity, and date of dispensing with columns for documenting administration for each quantity dispensed to assist the facility with tracking administration or disposition of the alprazolam 0.5mg. -There was documentation for return of 62 doses of alprazolam 0.5mg tablets dispensed on 06/05/20 for Resident #1. Telephone interview with the Administrator on 11/05/20 at 1:14pm revealed: -The facility nurse was in charge of ensuring medications were administered as ordered. -The facility nurse was responsible to monitor all medications, including controlled medications, for inventory control, and records of administration and return or destruction/disposition. -The facility nurse should have a CSCS for each time Resident #1's alprazolam 0.5mg was dispensed with documentation for administration available for review. -He did not audit the residents' controlled drugs administration. Telephone interview with the facility nurse on 11/05/20 at 3:21pm revealed: -She became the facility nurse in July 2020.	C 367		

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C 367	Continued From page 53 -She had been sorting and reorganizing the facility's records since she came to the facility. -All controlled medications were stored in the facility's medication cart under double lock with the pharmacy provided CSCS being located in a binder on top of the cart. -Residents' completed CSCS sheets were stored centrally in the business office. -The facility nurse at the time documented receipt of 62 alprazolam 0.5mg on 06/05/20. -She could not find Resident #1's CSCS for 62 alprazolam 0.5mg tablets dispensed on 06/05/20 documenting administration or disposition of the medication. -She was unable to locate 62 tablets of alprazolam 0.5mg tablets dispensed by the contracted pharmacy in a bingo style bubble card for Resident #1 on the medication cart or in any overstock storage. -She had been auditing controlled drugs received for residents since she came to the facility in July 2020. -The medication aides were responsible to conduct shift counts of controlled drugs since she started in July 2020. -She did not know Resident #1 had 62 tablets of alprazolam 0.5mg that had no accounting for administration or disposition.	C 367		
C 601	10A NCAC 13G .1701 (a) (b) Infection Prevention and Control Program 10A NCAC 13G .1701 Infection Prevention and Control Program (a) In accordance with Rule .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	C 601		

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C 601	Continued From page 54 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 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) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding infection prevention and control practices to reduce the risk of transmission and infection as related to staff inappropriately wearing face masks, staff not maintaining a social distance of 6 feet from residents when not appropriately wearing face masks, and no screening of staff and visitors. The findings are: Review of the Center for Disease Control (CDC) guideline for the prevention and spread of the Coronavirus (COVID-19) disease in long-term care facilities revealed personnel should always wear a face mask while in the facility. Review of the CDC guidelines for use of facemasks revealed COVID-19 is transmitted	C 601		

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through droplet, therefore the mouth and nose are to be completely covered when wearing a face mask to prevent contamination and transmission of COVID-19.

Review of the CDC guidelines for Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities updated 05/29/20 revealed:
-Personnel should wear a face mask at all times while they are in the facility.
-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 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) before starting each shift/when they enter the building.
-Designate one or more facility employees to ensure all residents have been asked daily about fever and symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea).
-Educate residents and personnel about COVID-19.
-Post signage at all entrances to provide information about current visitation policies or restrictions and to remind visitors and personnel not to enter the building if they have a fever or symptoms consistent with COVID-19.

Review of the facility's Emergency COVID-19 Rules for Family Care Homes dated 10/23/20 revealed the facility should ensure the following policies and procedures are established and

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C 601	Continued From page 56 implemented consistent with the federal CDC guidelines: proper use of PPE; procedures for screening visitors and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working. Observation of the outside of the facility on 10/29/20 at 9:00am revealed: -The entrance to the facility was unlocked and there was a sign posted which read, "Notice to Visitors: The Almost Home Group Residences are Currently Closed to Visitors." Please call the owner if you have any questions. Thanks!" -There was no signage posted at the entrance to remind visitors and personnel not to enter the building if they have a fever or symptoms consistent with COVID-19. Observation of the facility upon entrance on 10/29/20 at 9:01am revealed: -A personal care aide (PCA) was present in the facility, but she did not screen the surveyor for fever or with screening questions. -The surveyor asked the PCA about screening for temperature and screening questions and the PCA took the surveyors temperature. -The PCA did not record the surveyor's temperature. Interview with the PCA on 10/29/20 at 9:02am revealed: -No visitors were allowed in the facility. -There was no screening process for health care professionals who entered the facility. -Staff were not screened with temperatures or screening questions when they entered the facility.	C 601		

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C 601	Continued From page 57 -She had been told to wash her hands when she entered the facility, but she had not been told staff and visitors, including health care personnel (HCP), needed to be screened upon entrance to the facility. -She had not had any COVID-19 training since March 2020. -Staff and residents had been previously tested for COVID-19 and there had been no positive cases. Observation of the facility on 10/29/20 between 9:13am and 9:15am revealed: -A medication aide (MA) was preparing medication on the medication cart to administer to a resident and she was not wearing a face mask. -The MA administered medication to a resident and was not wearing a face mask. -The housekeeper entered the facility wearing a face mask, but she was not screened. Interview with the MA on 10/29/20 at 2:41pm revealed: -She had not had any Infection Control training related to COVID-19 since March 2020. -She learned about COVID-19 through the news and her parents. -To help prevent COVID-19, the facility staff disinfected shared medication equipment, wheelchairs, walkers and staff wore facemasks. -Residents temperatures were taken once daily, but they were not asked any screening questions. -There was no screening process for staff or visitors, including HCP. -A few months ago, when there was a suspected case of COVID-19, staff were required to take their temperatures when they entered the facility and then every 2 hours. -The temperature checks for staff stopped when	C 601		

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the suspected case of COVID-19 was negative.
-There had not been any positive cases of COVID-19 for staff or residents in the facility.
-She has not been told she needed to take temperatures of visitors, including HCP, or ask screening questions.
-Face masks should be worn with the strings around the ears and covering the nose and mouth.
-She wore her face mask down below her nose and mouth sometimes because she had to breathe.
-She thought she had her face mask on and worn appropriately when she administered medication to the resident earlier in the day on 10/29/20.
-There was ample supply of face masks in the facility.

Observation of the facility on 10/29/20 at 2:46 revealed:
-There were about 40 face masks located at the entrance of the facility and about 40 face masks located on the medication cart.
-There was also a supply of gloves available.

Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed:
-A "volunteer" arrived in the facility and sat down at the dining room table where a resident was seated.
-The "volunteer" was not wearing a face mask and staff did not take her temperature or ask screening questions.
-The "volunteer" left the facility and came back in with her face mask on, but she still was not screened with a temperature or screening questions.
-The "volunteer" read to the resident and served her a beverage, read to a second resident and played cards with him, and served the second

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resident a snack all with her face mask below her nose and loose enough to expose her mouth.

Interview with the "volunteer" on 10/29/20. At 11:28am revealed:
-She had been volunteering at the facility for about 3 days a week for about 2 years.
-She had not had any COVID-19 training at the facility.
-She washed her hands often and wore a face mask to help prevent the spread of COVID-19.
-She was supposed to wear her face mask to cover her nose and mouth, but sometimes the face mask slipped down.
-"Sometimes I have to pull my face mask down to breathe a little bit. When you breathe out you are breathing out carbon dioxide and when you have a face mask on, you breathe it back in and I don't like that."
-When she entered the facility on the morning of 10/29/20, she was not wearing a face mask because she left the face mask in her purse.
-Sometimes the staff took her temperature when she entered the facility, but she could not remember when her temperature was last taken.
-Staff did not ask her any screening questions when she entered the facility.
-She did not think she came in contact with anyone with COVID-19 because she only went to the facility, to bible college where there were only 10 people, and then she went straight home.

Interview with the facility nurse on 10/29/20 at 1:13pm revealed:
-She had been working at the facility since July 2020.
-There had been no infection control training regarding COVID-19 provided to staff since she had been working at the facility and there had not been any COVID-19 training provided to new

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hires.
-Staff checked residents' temperatures and vital signs daily.
-If a resident exhibited signs and symptoms of COVID-19, she would test the resident then isolate the resident to his or her room and quarantine the whole house.
-If a staff exhibited any signs or symptoms of COVID-19, the staff should contact the facility nurse before coming in for work.
-The staff would be directed to get testing and would not be allowed to return to work until there was a negative test.
-She was not sure if staff temperatures were being checked when they entered the facility.
-There should have been a sheet in the sign-in notebook to document the temperatures, but she did not know if it was there nor not.
-Staff were not screened with questions for COVID-19, but staff had to wear a face mask.
-When HCP entered the facility, they had to wear a face mask and wash their hands.
-HCP did not have their temperatures taken nor were they asked screening questions because "If I walk into a local store and I'm not asked a million questions, then I don't expect to be questioned when I walk into work."

Observation of the facility on 10/30/20 at 12:15pm and 12:30pm revealed:
-A MA was preparing medication at the medication cart and had her face mask below her nose and fitting loosely around her mouth.
-The MA checked the blood sugar of a resident who did not have a face mask on.

Interview with the MA on 10/30/20 at 2:10pm revealed:
-She had not been provided any training by the facility regarding COVID-19.

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C 601	Continued From page 61 -There was no screening in for staff or visitors, including HCP, prior to 10/29/20. -Staff had only been told to wear a face mask and wash their hands. -Face masks should cover the nose and mouth. -She knew her face mask was below her nose when she checked the resident's blood sugar earlier on 10/30/20. -She wore her face mask below her nose because her glasses fogged up and she could not see. Observation on 11/02/20 between 9:00am and 5:00pm revealed: -The Administrator came in to the facility one time. -The Administrator entered the facility and walk through the family room where a resident was sitting and towards the hallway leading to the resident rooms. Observation of the facilty on 11/03/20 between 9:00am and 5:00pm revealed: -The Administrator entered the facility and walked through the dining room and into the living room where a resident was sitting. -The Administrator had a brief interaction with the resident sitting in the living room. Interview with the Administrator on 11/04/20 at 10:34am revealed he had tested on 11/04/20 and tested positive for COVID-19. Interview with the facility nurse on 11/04/20 at 11:52pm revealed: -She would be responsible for testing residents and staff and for also contacting the LHD. -Her plan was to ask the Administrator if he had been in the facility within the last week and to test residents and staff who may have been exposed.	C 601		

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C 601	Continued From page 62 -She had 33 COVID-19 test kits available in the office. -There were 3 residents in the facility, and she would need 25 tests if she were to test all staff including herself and the Business Office Manager. Observation of the facility office on 10/04/20 at 12:53pm revealed: -The facility nurse contacted the local health department (LHD) and placed the phone on speaker. -The facility nurse told the nurse at the LHD a staff had tested positive for COVID-19. -The nurse from the LHD advised the facility nurse she would need to test residents and staff who were exposed to the COVID-19 positive staff. -The LHD nurse advised the facility nurse that every resident exposed would need to quarantine for 14 days form 11/03/20 with 11/17/20 being the last day of quarantine. -The LHD nurse advised the facility nurse that if HCP were exposed, but have no symptoms, they were still able to work because they were considered essential, but staff would need to wear full personal protective equipment (PPE) consisting of gloves, N-95 face masks, face shields, and gowns. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -The facility nurse was responsible for the infection control program at the facility. -He knew some of the CDC guidelines, but not all of them. -He did not know about the recommendations regarding staff and visitor screenings and staff wearing face masks while in the facility. -Sometimes he saw staff with their face masks on	C 601		

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C 601	Continued From page 63 while other times he saw staff with their face masks off. -He wore his facemask 99% of the time unless he forgot to put it on. _____ The facility failed to adhere the Centers for Disease Control (CDC) guidelines for COVID-19 including recommendations for use of face masks for staff; staff not maintaining a social distance of 6 feet from residents when not appropriately wearing face masks, and no screening of staff and visitors. The facility's failure placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ A plan of protection was provided by the facility in accordance with G.S. 131D-37 on 10/29/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 5, 2020.	C 601		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to other staff qualifications,	C 912		

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C 912	Continued From page 64 training on cardio-pulmonary resuscitation, management and other staff, personal care and supervision, health care, and medication administration. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure 5 of 12 sampled staff (Staff L, C, D, F, and G) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to date of hire. [Refer to Tag C0145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure at least one staff was on the premises at all times who had completed cardio-pulmonary resuscitation (CPR) and choking management within the past 24 months for 2 of 10 (Staff F and G) sampled staff. [Refer to Tag C 0176, 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Unabated Type B Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to other staff qualifications, training on cardio-pulmonary resuscitation, personal care and supervision, health care, medication administration, and infection prevention and control program. [Refer to Tag C0185, 10A NCAC 13G .0601(a) Management And Other Staff (Type A2 Violation)].	C 912		

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C 912	Continued From page 65 4. Based on observations, interviews and record reviews, the facility failed to provide supervision by a staff (Staff L) for 1 of 3 sampled residents (#1) who had a fall resulting in a fractured hip. [Refer to Tag C0243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A2 Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow up for 2 of 3 sampled residents who had swelling in her feet and needed to see a provider (Resident #3) and a resident who did not receive her medication when she was out of the faciltiy 3 days a week at dialysis (Resident #1). [Refer to Tag C0246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) with orders for a rapid-acting insulin and a proton pump inhibitor. [Refer to Tag C0330 10A NCAC 13G .1004(a) Medication Administration (Unabated Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's 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 record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to infection prevention and control program.	C 914		

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C 914	Continued From page 66 The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE), staff not maintaining a social distance of 6 feet from residents when not appropriately wearing PPE, and no screening of staff and visitors. [Refer to Tag C061 10A NCAC 13G. 1700 Infection Prevention and Control (Type A2 Violation)].	C 914		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for 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	C992		

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	FCL029011	A. BUILDING: _____ B. WING _____	R-C 11/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C992	Continued From page 67 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, 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 observations, record reviews and interviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire for 4 of 12 sampled staff, (Staff L, C, D, and E). The findings are: 1. Review of personnel records revealed there was not a personnel record available for Staff L. Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed: -Staff L arrived in the facility and sat down at the dining room table where a resident was seated. -Staff L read to the resident and served her a beverage. -Staff L read to a second resident and played cards with him. -Staff L served the second resident a snack.	C992		

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C992	Continued From page 68 Observation of the facility on 10/30/20 between 11:40am and 3:00pm revealed: -Staff L arrived in the facility and sat down to talk to a resident in the dining room. -Staff L played cards with a second resident. -Staff L cut up lunch meal items, prepared a plate, and served a resident. Observation of the facility on 11/02/20 between 11:45am and 4:00pm revealed: -Staff L talked to 2 residents. -Staff L served the residents snacks and beverages. Interview with Staff L on 11/02/20 at 3:05pm revealed: -She had "volunteered" at the facility for about 2 years. -She usually "volunteered" at the facility about 3 days a week. -She arrived at the facility between 11:00a and 12:00pm and usually left the facility between 2:00pm and 2:30pm. -She had not been asked to complete an examination and screening for controlled substances when she first started "volunteering" at the facility. A second interview with Staff L on 11/04/20 at 2:21pm revealed: -She did not think she was on the facility payroll; however, she received a bonus occasionally. -She thought she last received a bonus in September 2020. Interview with a personal care aide (PCA) on 11/02/20 at 3:16pm revealed: -Staff L was in the facility about 3 days a week. -She usually did activities with the residents.	C992		

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C992	Continued From page 69 -She also made residents meal plates during lunch and served the meal, snacks, and beverages to residents. Interview with the facility nurse on 11/03/20 at 3:18pm revealed: -The Business Office Manager (BOM) was responsible for maintaining personnel records. -Staff L was considered a "volunteer" and came to the facility several days a week to do activities with the residents. -She did not know if there had been n examination and screening for controlled substances for Staff L. Interview with the BOM on 11/03/20 at 4:45pm revealed: -She was responsible for maintaining the personnel records. -She knew an examination and screening for controlled substances was required for new employees. -Staff L did not have a personnel record and there was no documentation an examination and screening for controlled substances had been completed for Staff L. -She had not initiated an examination and screening for controlled substances for Staff L because Staff L was "volunteering" at the facility prior to her hire. -Staff L was supposed to complete activities and be interactive with residents. -Staff L had the title of "volunteer," but she received financial compensation for the time she spent at the facility. -Staff L had been coming to the facility for years, but she did not know for how long. She thought the time frame was greater than 3 years. Interview on 11/03/20 at 3:30pm with the	C992		

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C992	Continued From page 70 Administrator revealed: -The BOM was responsible for maintaining the personnel records. -He did not know if an examination and screening for controlled substances had been completed for Staff L or if Staff L had a personnel record. -Staff L was considered a "volunteer" and not an employee. -Staff L was at the facility a few times each week to do "fun stuff" with the residents. -He did not know if Staff L received financial compensation for the time she spent in the facility. Refer to interview with the Administrator on 11/02/20 at 10:05pm. Refer telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with the facility nurse on 11/05/20 at 1:23pm. 2. Review of Staff C, personal care aide (PCA) personnel record revealed: -There was no hire date was documented in the personnel record. -A controlled substance screening consent form was not located in the personel record. -A controlled substance screening was not located in the personnel record. -A personnel record could not be located for Staff C. Attempted telephone interview with Staff C on 11/05/20 at 11:17am was unsuccessful. Refer to interview with the Administrator on 11/02/20 at 10:05pm.	C992		

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C992	Continued From page 71 Refer telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with the facility nurse on 11/05/20 at 1:23pm. 3. Review of Staff D, personal care aide (PCA) employee file revealed: -There was no hire date documented in the employee file. -A controlled substance screening consent form was not located in the personnel record. -A controlled substance screening was not located in the personnel record. -A controlled substance screening could not be located for Staff D. Telephone interview with Staff D on 11/05/20 at 9:40am revealed: -Had been employed by the facility for month, however could not remember the exact date. -She did not recall if a controlled substance screening had been done. Refer to interview with the Administrator on 11/02/20 at 10:05pm. Refer telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with the facility nurse on 11/05/20 at 1:23pm. 4. Review of Staff E, personal care aide (PCA) personnel record revealed: -There was no hire date documented in the employee file. -A controlled substance screening consent form was not located in the personnel record.	C992		

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C992	Continued From page 72 -A controlled substance screening was not located in the personnel record. -A controlled substance screening could not be located for Staff E. Attempted telephone interview with Staff E on 11/05/20 at 9:55am was unsuccessful. Refer to interview with the Administrator on 11/02/20 at 10:05pm. Refer telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am. Refer to telephone interview with the facility nurse on 11/05/20 at 1:23pm. _____ Interview with the Administrator on 11/02/20 at 10:05am revealed: -He was not involved in the hiring of staff. -The BOM and/or the facility nurse were usually the ones responsible for hiring new staff. -The facility nurse and/or the BOM were responsible for ensuring employees had all needed screenings, including controlled substance screening. -He was unaware staff had been hired without controlled substance screening. -He was unaware of exactly who hired the new staff. Telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am revealed: -She and/or the facility nurse were usually responsible for staff hiring. -She did not hire the new staff. -She was responsible for making sure all employee paperwork was in order for new staff. -She and/or the facility nurse usually did the	C992		

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C992	Continued From page 73 controlled substance screenings. -She was not aware that staff had been hired without controlled substance screening. Telephone interview with the facility nurse on 11/05/20 at 1:23pm revealed: -She, along with the BOM, "were usually" responsible for hiring staff. -She and/or the BOM usually did the controlled substance screening of staff. -She was unaware staff had been hired without a controlled substance screening. -She did not hire any of the new staff.	C992		