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THE CLINARD HOUSE	108 KATHLAND AVENUE THOMASVILLE, NC 27360

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{C 000}	Initial Comments The Adult Care Licensure Section completed a follow-up survey with an onsite visit on 02/09/21 and a desk review 02/10/21 through 02/11/21 with a telephone exit on 02/11/21.	{C 000}		
{C 171}	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff B and D) were competency validated by return demonstration for Licensed Health Support Professional (LHPS) task of transferring semi-ambulatory and ambulatory residents, feeding techniques for residents with swallowing problems, and applying and removing ace bandages. The findings are: Review of the quarterly Licensed Health Professional Support reviews for three residents revealed both residents required assistance with	{C 171}		

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{C 171}	Continued From page 1 transfers. Observations at on 02/09/21 between 8:00am and 11:00am revealed: -Three residents of the facility required assistance with ambulation and transfers. -Two of the three residents could not ambulate independently with a wheelchair. -Two of the residents required the assistance of two caregivers for transfers and toileting. -One resident required supervision and assistance with feeding on a honey thickened liquid diet. -One resident required an ace wrap to be applied to his foot. Interview with the Supervisor in Charge (SIC) on 02/09/21 at 9:00am revealed: -All four residents in the facility required assistance with transfers. -Three of the residents required the assistance of two care givers for transfers. -One resident required supervision and assistance with feeding on a honey thickened liquid diet. -One resident required an ace wrap to be applied to his foot. 1. Review of Staff B's, personal care aide (PCA), employee file revealed: -Staff B's date of hire was 12/14/20. -Staff B had an LHPS competency validation in the file signed and dated by a SIC on 12/15/20. -Staff B's LHPS competency validation was not signed by a licensed health professional support person. Telephone interview with Staff B on 02/10/21 at 2:20pm revealed: -Staff B was a PCA.	{C 171}		

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{C 171}	Continued From page 2 -Staff B was employed by the facility in December 2020, however could not remember the exact date of hire. -Staff B did not recall having her skills validation done by the facility nurse. -Staff B received her skills validation from the SIC working at the facility. Refer to telephone interview with the Business Office Manager (BOM) on 02/10/21 at 10:05am. Refer to the telephone interview with the Administrator on 02/10/21 at 3:00pm. 2. Review of Staff D's, Supervisor in Charge (SIC) employee file revealed: -Staff D was hired 08/18/20. -Staff D had no LHPS competency validation in the file. Telephone interview with Staff D on 02/10/21 at 9:40am revealed: -Staff D was employed by the facility until 11/11/19. -Staff D was rehired sometime in August 2020 she could not remember the exact date. -Staff D did not remember completing the skills validation LHPS check off by the facility nurse when she was hired. Refer to telephone interview with the Business Office Manager (BOM) on 02/10/21 at 10:05am. Refer to the telephone interview with the Administrator on 02/10/21 at 3:00pm. _____ Telephone interview with the Business Office Manager (BOM) on 02/10/21 at 10:05am revealed: -Today (02/10/21) the Owner informed her that	{C 171}		

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{C 171}	Continued From page 3	{C 171}		

the Registered Nurse (facility nurse) was responsible for checking off all the SICs and PCAs on LHPS skills.
-When she looked at the sign off on the LHPS skills for the staff she realized the SICs performed the validation of the skills.
-She did know a facility nurse was required to complete the LHPS validation of skills because the form stated a supervisor signature was required.

Telephone interview with the Administrator on 02/10/21 at 3:00pm revealed:
-The BOM and/or the Registered Nurse (facility nurse) was usually the ones responsible for ensuring all new staff had completed their LHPS competency validation.
-The facility nurse was a Registered Nurse and she's the one responsible for ensuring all new staff had completed their LHPS competency validation.
-He expected the BOM to review all the staff records and make sure they were complete.
-If the BOM found staff that required LHPS competency validation she was to bring it to the facility's nurse attention.
-The facility nurse was responsible for all staff training, including LHPS competency validation.
-He did not know the facility nurse did not complete the LHPS competency validations.
-The Owner did all the hiring of new staff and managed payroll.
-He did not personally review the staff records for completeness.
-The Owner was a previous Administrator with a license, and he thought she reviewed all staff records.

Attempted telephone interview with the facility nurse on 02/10/21 at 11:00am was unsuccessful.

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{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 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 A2 VIOLATION The Type A2 Violation was unabated. 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 Health Care, COVID-19 Infection Prevention and Control, Competency Validation for Licensed Health Professional Support Tasks, Licensed Health Professional Support and Examination and Screening for Controlled Substances.	{C 185}		

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{C 185}	Continued From page 5 The findings are: Interview with the Owner on 02/09/21 at 1:00pm revealed: -Her Administrator license had been suspended and she was no longer able to be involved with the daily operations of the facility. -She did not know the extent of the limitations put on her with the involvement of the residents and staff. -She was still committed to ensuring the best care by the staff of the residents and the health and safety of the residents. Telephone interview with the Business Office Manager (BOM) on 02/10/21 at 10:05am revealed: -The Administrator started in July 2020. -The Administrator's responsibility was the overall management of the facility. -The Administrator came to the office 3 or 4 days a week for an hour or two. -The Administrator had another full-time job. -The Owner was involved in the hiring of staff, payroll, financial operations, and implementing the COVID-19 policy. -Staff contacted the Owner when they had questions about policies and procedures. Telephone interview on 02/10/21 at 8:36am with the facility nurse revealed: -The Administrator was responsible for the overall operations of the facility, but the Owner often intervened. -The Administrator was in the office 3 or 4 days a week. -The Administrator had another full-time job. -The Owner was actively involved in the operations of the facility daily.	{C 185}		

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{C 185}	Continued From page 6 -The Administrator found out resident care issues from the Owner. -The Administrator was not actively involved in the care of the residents because the Owner took on daily operations of the facility. Telephone interview on 02/11/21 at 3:30pm with the Administrator revealed: -He was "supposed to be" responsible for the overall management of the facility. -In July 2020 he agreed to place his license on the wall for the facility to remain open. -He worked another full-time job and could not visit the facility daily. -He did his best over the last few months to go into the facility 3-4 times a week. -Because the Owner was limited on the amount of her involvement with the operations of the facility it created a "weird dynamic" between them. -Because of the "weird dynamic" the staff continued to pursue leadership by the Owner, and this created breaks in communications from the staff to him. -He expected the staff to communicate with him, but they did not, instead the staff go to the Owner. -The Owner was still involved in financial operations of the facility, the hiring, training of the staff and implementing the COVID-19 recommendations.. -The facility struggled with keeping staff, a facility nurse, and facility provider. -He found out about staff grievances, nursing care issues, and facility providers concerns about resident care after the facts or incidents were communicated with the Owner and the Owner handled the situations. Non-compliance was identified in the following rule areas:	{C 185}		

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{C 185}	Continued From page 7 1. Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 4 residents during the global Coronavirus (COVID-19) pandemic as related to testing of residents and staff for COVID-19, cohorting residents who tested positive for COVID-19, reporting positive case of COVID-19 to the local health department, and staff not removing required personal protective equipment (PPE) appropriately after providing care to residents who had been placed in quarantine. [Refer to Tag C0612, 10A NCAC 13G .1701(a)(b) Infection Prevention and Control Program (Type A2 Violation)]. 2. Based on observation, interviews and record reviews, the facility failed to ensure referral and follow-up for a neurology consult and a missed medication for 1 of 3 sampled residents (Resident #2). [Refer to Tag C0246, 10A NCAC 13G .0902(b) Health Care (Standard Deficiency)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (Staff B, and D) were competency validated by return demonstration for Licensed Health Support Professional (LHPS) task of transferring semi-ambulatory and ambulatory residents, feeding techniques for residents with swallowing problems, and applying and removing ace bandages. [Refer to Tag C0171, 10A NCAC 13G. 0504(a) Competency Validation for Licensed Health Professional Support (Standard Deficiency)].	{C 185}		

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{C 185}	Continued From page 8 4. Based on observation, record reviews and interviews the facility failed to assure quarterly licensed health professional support (LHPS) evaluations had been completed by an appropriate licensed professional for 3 of 3 sampled residents with LHPS tasks of transferring semi-ambulatory and ambulatory residents (#1, #2 & #3), feeding techniques for residents with swallowing problems (#2), and applying and removing ace bandages (#3). [Refer to Tag C0252, 10A NCAC 13G. 0903(a) Competency Validation for Licensed Health Professional Support (Standard Deficiency)]. 5. Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled staff (Staff D) were screened for controlled substances prior to hire. [Refer to Tag C0992, G.S. 131D-45 Examination and Screening for controlled substances. (Standard Deficiency)]. _____ The failure of the Administrator to ensure the management, operations, and policies and procedures of the facility were implemented to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 4 residents during the global Coronavirus (COVID-19) pandemic increased the risk for the residents to contract COVID-19, health care referral and follow up for a neurology consult and missed medications, the residents' licensed health professional support evaluations were completed quarterly, and proper staff qualifications related to controlled substance screening at hire, and validation for LHPS task which placed the residents at substantial risk for harm. This failure put the residents at risk for serious physical harm and neglect with	{C 185}		

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{C 185}	Continued From page 9 constitutes an A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/25/21 for this violation.	{C 185}		
{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: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for acute and routine health care needs for 1 of 3 sampled residents related to notifying the physician regarding a neurology consult, and medication that was unavailable for administration (Resident #2). The findings are: Review of Resident #2 current FL2 dated 11/19/20 revealed: -Diagnoses included Huntington's disease, migraines, and history of falls. -There was an order for Trintellix 20mg (to treat depression), once daily. a. Review of Resident #2's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Trintellix 20mg once daily at 12:00pm. -There was documentation Trintellix 20mg was not administered 9 of 31 opportunities from 01/01/21-01/31/21.	{C 246}		

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{C 246}	Continued From page 10 -The documented reason medication was not administered was "waiting on medications, nurse notified". Interview with the pharmacist at the contracted pharmacy on 02/11/21 at 2:03pm revealed: -The order for Resident #2's for Trintellix 20mg once daily was received 11/19/20 with 12 months of refills. -Resident #2's Trintellix 20mg was on a cycle fill and dispensed by the first of every month. -Resident #2's Trintellix 20mg was dispensed with a month supply on 12/29/20, and 01/29/21. -On 01/15/21 there was a verbal request placed from the facility for additional tablets to be sent to the facility until the next cycle fill was delivered on 01/29/21. -The staff administering the Trintellix 20mg can reorder it through the eMAR system. -The pharmacy would dispense enough of the medication until the next refill date. -Trintellix was a medication used to treat severe depression. -Trintellix could not be stopped abruptly because Resident #2 could experience severe depressive behaviors, dementia, and suicidal thoughts. Telephone interview with the supervisor in charge (SIC) on 02/10/21 at 1:26pm revealed: -She knew Trintellix 20mg was unavailable for administration for Resident #2. -The Trintellix 20mg was not delivered by the pharmacy at the beginning of the month of January 2021. -She told the facility nurse on 12/30/20 when the delivery tote arrived at the facility. -The facility nurse was out of work sick when Resident #2 missed her Trintellix. -She told the Business Office Manager (BOM). -When the facility nurse returned to work on	{C 246}		

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{C 246}	Continued From page 11 01/12/21 she called the pharmacy and the Trintellix was delivered. -She was told not to reorder medications through the eMAR system by the facility nurse and the Owner. -If she reordered medications through the eMAR system only one dose would be sent to the facility. -She did not call Resident #2's Nurse Practitioner (NP). -The facility nurse was responsible for follow up with the NP. Telephone interview with the Business Office Manager on 02/11/21 at 11:23am revealed: -The facility nurse was responsible for contacting Resident #2's NP when Resident #2's medications were not available. -She could not recall being told Resident #2's Trintellix was not available in January 2021. Telephone with the facility nurse on 02/11/21 at 8:30am revealed: -When she returned to work on 01/12/21 she had a notice from the SIC that Resident #2's Trintellix was not available. -The SIC told her Resident #2's Trintellix was not in the delivery tote when it was delivered. -She called the pharmacy and had the Trintellix delivered on 01/12/21. -She did not know Resident #2 missed her Trintellix 9 times in January 2021. -She usually ran a medication discrepancy report but did not have time in January 2021. -She did not call Resident #2's NP because she learned Resident #2's NP stopped seeing residents at the facility when she returned to work on 01/12/21. Telephone interview with Resident #2's NP on	{C 246}		

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{C 246}	Continued From page 12 02/11/21 at 8:00am revealed: -He began practicing as Resident #2's NP on 02/03/21. -He did not know Resident #2's Trintellix was not available in January 2021. Telephone interview with Resident #2's previous NP on 02/11/21 at 9:40am revealed: -She expected the facility nurse or the Administrator to notify her if there were issues with Resident #2 getting her medications. -Her last visit with Resident #2 was on 01/05/21. -She did not know about Resident #2's Trintellix. -The facility nurse was not present when she visited on 01/05/21. -She stopped seeing residents the first week of 01/05/21, but Resident #2 had enough Trintellix refills. -The SIC should have contacted her or the Administrator when Resident #2 did not receive her Trintellix in 48 hours. Review of Resident #2's caregiver notes revealed there was no documentation Resident #2's Trintellix was not available or Resident #2's NP was contacted. Telephone interview with the Administrator on 02/11/21 at 3:30pm revealed: -He did not know Resident #2's Trintellix was not available in January 2021. -He expected the facility nurse to review the eMARs medication discrepancies and call the NP. -Resident #2 did not have a NP available in January because the Owner was pursuing another facility NP. -Resident #2's NP stopped seeing residents at the facility because she was not happy that the facility nurse was not available when she made	{C 246}		

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{C 246}	Continued From page 13 visits to the facility on two different occasions. -The facility nurse did not speak up and bring the issue to his attention. b. Review of Resident #2's physician orders dated 12/15/20 revealed an order to continue to pursue a neurology consult for management of her Huntington's disease as the resident's former neurologist has retired. Telephone interview with the supervisor in charge (SIC) on 02/10/21 at 1:26pm revealed: -She did not know Resident #2 had an order for a neurology consult. -The facility nurse was responsible for arranging neurology consults. Telephone with the facility nurse on 02/11/21 at 8:30am revealed: -She knew Resident #2 had an order for a neurology consult on 12/15/20. -When she resigned her position as facility nurse on 02/08/21 Resident #2 had not seen a neurologist. -She depended on the Business Office Manager (BOM) to schedule all of the residents' appointments and coordinate with the facility transporter to get them to their scheduled appointments. -She gave the order to the BOM to schedule the appointment. -She followed up with the BOM each time Resident #2 saw her NP because the NP asked about the appointment. -She did not know why Resident #2 had not seen a neurologist. Telephone interview with the BOM on 02/11/21 at 11:23am revealed: -She did not know Resident #2 had an order for a	{C 246}		

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{C 246}	Continued From page 14	{C 246}		

neurology consult on 12/15/20.
-She called outside providers like dialysis and the wound clinic to schedule the residents' appointments.

Telephone interview with Resident #2's NP on 02/11/21 at 8:00am revealed:
-He began practicing as Resident #2's NP on 02/03/21.
-He did not know Resident #2's had an order for a neurology consult.
-He did not see any notes in Resident #2's record of a visit to a neurologist.
-When he saw Resident #2 on 02/03/21 he agreed Resident #2 required management by a neurologist because her Huntington's disease was worsening.

Telephone interview with Resident #2's previous Nurse Practitioner (NP) on 02/11/21 at 9:40am revealed:
-She expected the facility nurse or the Administrator to notify her if there were issues with Resident #2 getting her neurology consult.
-Her last visit with Resident #2 was on 01/05/21.
-She ended her practice at the facility at the beginning of January 2021, but Resident #2 still had not seen a neurologist.
-She did not think the facility nurse attempted to call to get Resident #2 an appointment.
-The order she wrote on 12/15/20 for the neurologist consult was not the first time she wrote for a referral for Resident #2 to see a neurologist.

Review of Resident #2's caregiver notes revealed no documentation Resident #2's neurology consult appointment was attempted.

Telephone interview with the Administrator on

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{C 246}	Continued From page 15 02/11/21 at 3:30pm revealed: -He did not know Resident #2's did not have a neurology consult scheduled. -He expected the facility nurse to notify him if there was an issue getting Resident #2 to a neurologist.	{C 246}		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers, up to and including	C 252		

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C 252	Continued From page 16 a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph); (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or	C 252		

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C 252	Continued From page 17 (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations had been completed by an appropriate licensed professional for 3 of 3 sampled residents with LHPS tasks of transferring semi-ambulatory and ambulatory residents (#1, #2 & #3), feeding techniques for residents with swallowing problems (#2), and applying and removing ace bandages (#3). The findings are: 1. Review of Resident #1's current FL2 dated 11/09/20 revealed: -Diagnoses included dementia, Parkinson's disease, osteoarthritis, and neuropathy. -Resident #1 was non-ambulatory and required a wheelchair for ambulation. Review of Resident #1's Resident Register revealed she was admitted to the facility on 01/14/19. Review of Resident #1's record revealed there was documentation of a LHPS assessment completed 10/30/20 which included assistance for a non-ambulatory resident. Observation of Resident #1 on 02/09/21 at 8:45am revealed Resident #1 required assistance of two persons to get out of bed.	C 252		

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C 252	Continued From page 18 Interview with the personal care aide (PCA) on 02/09/21 at 8:40am revealed: -Resident #1 was not ambulatory. -Resident #1 required two-person assistance to get out of bed to her wheelchair. Interview with the Supervisor in Charge (SIC) on 02/09/21 at 9:00am revealed: -Resident #1 required two-person assistance to get out of bed to her wheelchair. -The facility nurse completed all LHPS assessments. -She did not know when the facility nurse last completed Resident #1's LHPS assessment. Based on observation, interviews, and record review, it was determined Resident #1 was not interviewable. Refer to telephone interview with the facility nurse on 02/11/21 at 8:30am. Refer to telephone interview with the Administrator on 02/11/21 at 3:30pm. 2. Review of Resident #2's current FL2 dated 11/19/20 revealed: -Diagnoses included Huntington's disease, migraines, and history of falls. -Resident #2 was semi-ambulatory with a wheelchair. Review of Resident #2's Resident Register revealed she was admitted to the facility on 07/03/19. Review of Resident #2's record revealed there was documentation of a LHPS assessment completed 10/30/20 which included assistance for semi-ambulatory or non-ambulatory resident.	C 252		

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C 252	Continued From page 19 Review of Resident #2's care plan dated 02/02/21 revealed other LHPS tasks included resident #2 is a two person assist with ambulation, and honey thickened liquids with meals. Observation on 02/09/21 at 9:38am revealed: -Resident #2 received transfer assistance by the Supervisor in Charge (SIC) and personal care aide (PCA) to her wheelchair in her room. -Resident #2 was assisted to the table. -Resident #2 required her food cut up and her liquids honey thickened. Interview with the personal care aide (PCA) on 02/09/21 at 8:40am revealed: -Resident #2 required two-person assistance to get out of bed to her wheelchair. -Resident #2 required assistance and supervision when she ate because she had difficulty swallowing. -Resident #2 required all her liquids she drank thickened. Interview with the Supervisor in Charge (SIC) on 02/09/21 at 9:00am revealed: -Resident #2 required two-person assistance to get out of bed to her wheelchair. -Resident #2 required assistance and supervision when she ate because she had difficulty swallowing. -Resident #2 required all her liquids she drank honey thickened. -The facility nurse completed all LHPS assessments. -She did not know when the facility nurse last completed Resident #2's LHPS assessment. Based on observation, interviews, and record review, it was determined Resident #2 was not	C 252		

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C 252	Continued From page 20 interviewable. Refer to telephone interview with the facility nurse on 02/11/21 at 8:30am. Refer to telephone interview with the Administrator on 02/11/21 at 3:30pm. 3. Review of Resident #3's current FL2 dated 11/09/20 revealed: -Diagnoses included dementia with behaviors, hypertension, and traumatic subdural hemorrhage. -Resident #3 was semi-ambulatory with a walker. Review of Resident #3's record revealed there was documentation of a LHPS assessment completed 10/30/20 which included assistance for semi-ambulatory or non-ambulatory resident. Review of Resident #3's care plan dated 02/02/21 revealed other LHPS tasks included resident #3 is a two person assist with ambulation, ensure resident has an ace wrap on under his blue pressure boot. Observation on 02/09/21 at 9:38am revealed: -Resident #3 received transfer assistance by the Supervisor in Charge (SIC) and personal care aide (PCA) to his wheelchair in his room. -Resident #3 wore an ace bandage on his foot. Interview with the personal care aide (PCA) on 02/09/21 at 8:40am revealed: -Resident #3 required two-person assistance to get out of bed to his wheelchair. -Resident #3 wore an ace bandage on his foot under a blue pressure relief boot. Refer to telephone interview with the facility nurse	C 252		

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C 252	Continued From page 21 on 02/11/21 at 8:30am. Refer to telephone interview with the Administrator on 02/11/21 at 3:30pm. _____ Telephone interview with the facility nurse on 02/11/21 at 8:30am revealed: -She was responsible for completing all the residents care plans. -She did not complete the residents' LHPS tasks assessments. -Another facility nurse who no longer worked at the facility was completing the LHPS tasks assessments until she left in November 2020. -She did not know the residents' LHPS tasks assessments were not completed. -She was very limited on how much she could get done for the residents. Telephone interview with the Administrator on 02/11/21 at 3:30pm revealed: -He did not know the residents' LHPS tasks assessments were not completed since October 2020. -The facility nurse was responsible for completing the LHPS tasks assessments. -He expected the facility nurse to find time to complete all her job responsibilities.	C 252		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and	C 612		

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C 612	Continued From page 22 procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was unabated. TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 4 residents during the global Coronavirus (COVID-19) pandemic as related to testing of residents and staff for COVID-19, notifying the local health department when one or more staff and residents tested positive for COVID-19, cohorting staff to work with residents who tested positive for COVID-19, not removing required personal protective equipment (PPE) appropriately after providing care to residents who had been placed in quarantine.	C 612		

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C 612	Continued From page 23 The findings are: Review of the Center for Disease Control (CDC) recommended infection prevention and control practices when caring for a patient with suspected or confirmed COVID-19 infection dated 12/14/20 revealed: -A single new case of COVID-19 infection should be considered an outbreak. -Perform viral testing of all residents as soon as there is a new confirmed case. -Testing identifies infected residents quickly to assist in their clinical management and allow rapid implementation of infection prevention and control (IPC) interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent transmission. -After initially performing viral testing of all residents in response to an outbreak, the CDC recommends repeat testing to ensure there are no new infections among residents and staff and that transmission has been terminated. -Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days since the most recent positive result. -The facility should identify a space in the facility that could be dedicated to the care for residents with confirmed COVID-19 and identify Health Care Personal (HCP) who will be assigned to work with the COVID-19 care unit when it is in use. -Cohort COVID-19 positive residents with dedicated staff in one area and COVID-19 negative residents with dedicated staff in a separate area. -Residents with known or suspected COVID-19 should be cared for using recommended personal	C 612		

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protective equipment (PPE) including eye protection (goggles or face shield), gloves, gown, and a N95 respirator or face mask (if a respirator is not available).
-If a gown is available, a gown should be worn for activities where splashes or sprays were anticipated, or high-contact resident care activities.
-High contact activities include transferring, dressing, showering, changing linens and providing toileting assistance.
-PPE must be donned correctly before entering the isolation unit if cohorting.
-PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas.
-PPE must be removed slowly and deliberately in a sequence that prevents self-contamination.
-Position a trash can near the exit inside the resident's room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
-Staff who are expected to use PPE should receive training on selection and use of PPE, including demonstrating competency with putting on and removing PPE in a manner to prevent self-contamination.

Review of the NC DHHS What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care (LTC) Settings dated September 4, 2020 revealed:
-Follow current CDC guidance for testing of residents in LTC settings.
-One case of COVID-19 in LTC setting is a serious public health concern. If one laboratory-confirmed COVID-19 case is identified along with other cases of acute respiratory illness within two incubation periods (28 days) in the

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same long-term care facility, a COVID-19 outbreak might be occurring.
-Notify your local health department a confirmed or suspected case of COVID-19 in a resident or staff of an LTC facility should be immediately reported to your local health department (LHD) for the county in which your facility is located.
-Your LHD will guide you on patient placement, cohorting of patients and staff, and environmental cleaning.
-Check CDC guidance for the most up-to-date infection prevention recommendations for long-term care settings.
-Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff (i.e. the same staff interact with symptomatic residents and residents who test positive for COVID-19 on an ongoing basis, and do not interact with uninfected residents).

Review of the facility's Infection Control policy dated 12/30/20 revealed:
-Disposable respirators and face masks should be removed and discarded after exiting the resident's room or care area.
-Perform hand hygiene after removing the face mask.
-Put on a gown upon entry to a resident's room or care area, remove and discard the gown in a dedicated container for waste before leaving the resident's room.
-Infection prevention should be frequent, consistent, and supportive instead of punitive.
-Teach concepts repeatedly and in different ways to ensure that everyone understands and implements infection prevention practices.
-Check learning after education session using quizzes, return demonstration, and other

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methods.
-There was no protocol for cohorting staff and residents at the facility.

1. Review of the facility census and the actual laboratory results of COVID-19 testing provided by the facility revealed:
-The week of 01/20/21-01/27/21, the census was 4 residents, 1 resident tested positive, 3 residents tested negative, and no residents were hospitalized.
-The week of 01/28/21-02/04/21, the census was 4 residents, 1 resident tested positive (same resident tested positive previously), 3 residents were not documented as tested, and no residents were hospitalized.
-The week of 02/05/21-02/10/20, no residents were tested for COVID-19.

Review of the facility's staff spreadsheet of completed COVID-19 testing revealed:
-The week 01/20/21-01/24/21, 4 staff tested negative and 6 staff were not documented as tested for COVID-19.
-The week of 01/28/21-02/04/21, 4 staff tested negative and 6 staff were not documented as tested for COVID-19.
-The week of 02/05/21-02/10/20, no staff was tested for COVID-19.
-No staff who previously tested negative for COVID-19 were retested weekly.

Telephone interview with the Owner of the facility on 02/09/21 at 11:00am revealed:
-Two residents had tested positive for COVID-19 in two different facilities she owned since 01/06/21.
-One resident tested positive for COVID-19 on 01/20/21 in this facility.
-Several staff tested positive for COVID-19 or

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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 612	Continued From page 27 developed symptoms of COVID-19 since 01/06/21, but she did not know the exact number. -She thought the CDC guidelines that recommended she test all the residents and staff every two weeks since September 2020, and this is what she was doing. -The LHD Nurse provided resources for testing, obtaining PPE, and staffing shortages in October 2020 when the Administrator and staff first tested positive for COVID-19. -She told the LHD Nurse there was one resident who tested positive for COVID-19 when the nurse came to the facility to administer COVID-19 vaccines on 02/01/21. -The LHD told her they were not available to provide testing for all the staff and residents. -She struggled with obtaining a lab vendor to complete COVID-19 testing and found one the second week of January 2021. -Another agency shipped 60 test kits to the facility the week of 01/20/21-01/27/21. -She did not test all the residents and staff weekly for COVID-19. -She told staff to stay home if they had signs or symptoms of COVID-19 or tested positive for COVID-19. -She struggled with keeping enough staff at work to provide care to all the residents in all 3 facilities. -The staff was reluctant to get tested. -Staff reported they were refused outside testing unless they had signs or symptoms of COVID-19. -She did not understand it to be necessary according the CDC guidelines to test all the negative staff and residents weekly because there was only one resident who tested positive in the facility for COVID-19. -She thought testing of all the staff and residents only needed to occur every other week.	C 612		

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C 612	Continued From page 28 Telephone interview with a Registered Nurse (RN) from the local health department (LHD) on 02/10/21 at 1:45pm revealed: -When she visited the facility on 01/04/21 to administer the residents' first doses of COVID-19 vaccines the Owner told her there were no residents had tested positive for COVID-19. -On 02/01/21, she returned to administer the residents' second dose of COVID-19 vaccine. -On 02/01/21, the Owner told her one resident in another facility under her ownership tested positive for COVID-19 on 01/06/21 at dialysis and was hospitalized. -On 02/01/21, the Owner told her one resident in this facility tested positive for COVID-19 on 01/20/21 and remained on quarantine. -On 02/01/21, she was not told any staff that tested positive or exhibited symptoms in the last month. -If the Owner reported two or more cases of residents or staff who tested positive for COVID-19 she would have recommended all negative residents and staff test twice weekly if possible, but at least weekly, for 14 days until no new COVID-19 positive cases were identified. -She offered guidance and resources for testing and the Owner informed her COVID-19 testing was being done. -She did not know how often the staff and residents were being tested for COVID-19. -The Owner told her the staff were reluctant about getting weekly COVID-19 testing. -She did not know the Owner had difficulty obtaining COVID-19 test kits or a vendor to result the COVID-19 tests. -The LHD assisted the facility with testing in October 2020. Telephone interview with a personal care aide (PCA) on 02/10/21 at 2:20pm revealed:	C 612		

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C 612	Continued From page 29 -On 01/17/21, she tested positive for COVID-19 after she went to emergency room for shortness of breath, fatigue, and body aches. -She notified management of her COVID-19 test results and she was told to remain home for 10 days. -She was not tested at the facility during the outbreak. Telephone interview with another PCA on 02/11/21 at 8:00am revealed: -She was sick the third week of January 2020 with cold symptoms, low grade temperature, and fatigue. -She was told by management to remain home from work for 10 days. -She was tested for COVID-19 at the facility when she returned to work on 02/04/21. -The COVID-19 test on 02/04/21 was the only time she was tested for COVID-19 in January 2021 and February 2021. Telephone interview with another PCA on 02/11/21 at 12:30pm revealed: -She was tested on 01/28/21 for COVID-19 by the facility nurse. -Her COVID-19 test was negative. -She was not tested weekly or every other week. -This was the only COVID-19 test she received in January 2021 and February 2021. Telephone interview with a supervisor in charge (SIC) on 02/11/21 at 10:00am revealed: -The facility nurse administered a COVID-19 test to her on 01/05/21 but the test had to be discarded because it remained in the refrigerator too long. -She tested negative for COVID-19 on 01/26/21. -The only time she was tested for COVID-19 was 01/26/21.	C 612		

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C 612	Continued From page 30 -Two residents in another facility on the property tested positive in the month of January 2021. -One of the residents in the other facility on the property tested positive for COVID-19 on 01/06/21 when she went to dialysis and was sent to the hospital from dialysis. -The other resident tested positive for COVID-19 at the hospital around 01/31/21 and recently passed away. -Two staff who worked in all the facilities with all the residents tested positive for COVID-19 the first and second week of January 2021, she did not know the exact dates. Confidential staff telephone interview on 02/10/21 at 10:15am revealed: -The facility nurse and the Owner administered the COVID-19 testing. -Not all the residents and staff were tested for COVID-19 in the last month between 01/06/21-02/10/21. -The third shift staff in all of facilities under the ownership was never tested one time in January 2021 and February 2021. -If the third shift staff tested for COVID-19 they obtained testing on their own after they became symptomatic. Telephone interview with the Facility Nurse 02/11/21 at 8:52am revealed: -She was asked to administer COVID-19 testing the week of 01/04/21. -When she was out of work the week following (01/04/21), the COVID-19 tests were not sent to the lab vendor and were discarded. -She asked the Owner about additional COVID-19 testing after the tests were thrown away, and the Owner told her the vendor was no longer going to perform the COVID-19 testing for free.	C 612		

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C 612	Continued From page 31 -The Owner said "she would handle" COVID-19 testing at that point and she no longer performed any of the COVID-19 tests. -She did not test all staff and residents weekly for COVID-19. -Not all the residents and staff were tested weekly or every other week. -She tested negative for COVID-19 the week of 01/20/21, and this was the only time she was tested at the facility. Interview with the Administrator on 02/09/21 at 9:15am revealed: -He did not know any residents were still on quarantine for suspected or confirmed COVID-19. -The Owner contacted the LHD at least every week in the last month to facilitate COVID-19 vaccines. -The facility nurse and the Owner were responsible for monitoring and testing all the staff and residents for COVID-19. -The Owner took over responsibility for managing the facility's COVID-19 infection prevention program. -The facility staff were expected to follow all the guidelines from the CDC and LHD. -The Owner was responsible for reporting all COVID-19 positive staff and residents to the LHD. -He did not know how many staff tested positive for COVID-19. -He depended on the Owner to report all positive COVID-19 cases of resident and staff to the LHD. Telephone interview with the Owner on 02/10/21 at 10:30am revealed: -She did her best to follow all CDC, NC DHHS, LHD guidance on testing residents and staff but she found them "ambiguous". -She reached out to a community resource who sent 60 test kits and a lab vendor the week of	C 612		

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C 612	Continued From page 32 01/20/21. -The facility nurse and she attempted to test all residents and staff every other week after two residents tested positive. -She did not think it was necessary to test all the staff and residents every week because there was only one resident who tested positive in this facility. -She knew one staff tested positive on 01/18/21 and heard about other staff who tested positive. -She did not report any staff COVID-19 positive test results to the LHD. -She did not report any staff demographics to the LHD after she heard they tested positive for COVID-19. -She would locate all the COVID-19 test results by end of the day tomorrow (02/11/21). Additional documentation of staff and residents COVID-19 test results was requested and not provided prior to exit of the facility on 02/11/21. 2. Interview with the Supervisor in Charge on 02/09/21 at 8:45am revealed: -There was one resident who was quarantined since she tested positive for COVID-19 on 01/20/21. -She was assigned to administer all medications to all 4 of the residents in the facility. -She was responsible for assisting the personal care aide (PCA) when needed with all the residents who tested negative for COVID-19 and the resident who tested positive for COVID-19. -She and the PCA assisted all the residents with their personal care needs such as toileting, transferring, bathing, and linen changes. -A float staff either a SIC or PCA came during their shift from another facility under the same ownership located within a block from this facility to assist them with all the residents' personal care	C 612		

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C 612	Continued From page 33 needs. Interview with the PCA on 02/09/21 at 9:45am revealed: -There was no staff designated to care for only the COVID-19 positive or only the COVID-19 negative residents. -She was responsible for assisting all the residents who tested negative for COVID-19 and the resident who tested positive for COVID-19. -The SIC and her assisted all the residents with their personal care needs such as toileting, transferring, bathing, and linen changes. -A float staff would come from another facility to relieve them for lunch or assist them with the COVID-19 positive and negative residents. Telephone interview with a PCA on 02/10/21 at 2:20pm revealed she provided personal care services to two COVID-19 positive residents, and all the residents' who tested negative for COVID who resided in two different facilities. Telephone interview with another PCA on 02/11/21 at 8:00am revealed: -She provided personal care services to both residents who tested positive for COVID-19 in all the facilities and all the residents who tested negative for COVID-19 in all the facilities. -Staff was not assigned to care for only the residents' who tested positive for COVID-19 or the residents' who tested negative for COVID-19. Telephone interview with a SIC on 02/11/21 at 10:00am revealed: -She floated as a SIC or PCA between all 3 facilities on the property. -Staff was not designated to the residents' that tested positive for COVID-19 and the residents' that tested negative to COVID-19.	C 612		

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C 612	Continued From page 34 Confidential staff telephone interview on 02/10/21 at 10:15am revealed: -There was staff assigned each shift to work in all three facilities as a float person to assist with residents' medication administration or personal care needs such as transfers, toileting, feeding, and bathing. -The extra staff could assist with personal care, medication administration, or relieve them for their lunch and dinner breaks. -During first and second shift there was two additional staff (SIC or PCA) who were assigned in the facility from one of their other two facilities and they were called "floaters". -On third shift there was one or two "floaters" available to float among all three facilities as a SIC to assist a PCA assigned to the facility. Telephone interview with the Owner of the facility on 02/09/21 at 11:00am revealed: -One or two staff were scheduled as floaters between all the facilities each shift to assist the staff in each facility with the residents' personal care such as bathing, toileting, transfers, and medication administration. -Staff was not designated to care for residents who tested positive for COVID-19 and for residents who tested negative for COVID-19. -There was one resident in this facility who tested positive for COVID-19 on 01/20/21. -There was one resident in another facility who tested positive for COVID-19 on 01/06/21. 3. Observations upon entry into the facility on 02/09/21 between 8:30am and 10:00am revealed: -The surveyor was greeted by a Supervisor-in-Charge (SIC) and a personal care aide (PCA) upon entry. -The SIC entered the room of a resident who had	C 612		

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tested positive for COVID-19 wearing a gown, goggles, mask, and gloves.
-The SIC exited the resident's room wearing the same gown, goggles, mask, and gloves.
-The SIC walked down the hallway leading away from the resident's room to the kitchen and removed the same gown, goggles, and gloves.
-The SIC arrived in the kitchen with the same gown, goggles, and gloves rolled up together in her right hand.
-The SIC placed the same gown and goggles on the kitchen counter where there were two dinner plates, drinking glasses, and eating utensils.
-The SIC went to the medication cart and proceeded to remove items from the drawers and the top of the medication cart.
-After prompting, the SIC moved the gown and goggles from the kitchen counter and placed them on top of a book shelf containing five large binders.
-The SIC discarded the gown, goggles and gloves into a trash receptacle and returned to the medication cart without washing her hands.

Interview with the SIC on 02/09/21 at 8:45am revealed:
-She wore PPE into the resident's room on quarantine because when she administered medications the residents sometimes needed help with toileting or sitting up to take her medications.
-She was not planning to reuse the goggles and gown but that she planned to discard them in the trash but there was no trash receptacle for them in the resident's room.
-She was trained by the facility nurse on how to put on and remove PPE.
-She watched a video on putting on and removing PPE.
-She did not perform a return demonstration

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related to how she would put on or remove PPE, and discard.
-She "forgot" to wash her hands when she put the PPE in the trash.
-All the staff brought their PPE into the kitchen to throw it into the trash.
-There was never trash receptacles placed in the residents' rooms to discard PPE.

Interview with the PCA on 02/09/21 at 9:45am revealed:
-She watched a video and the facility nurse put on and remove PPE.
-She did not perform a return demonstration for the facility nurse.
-She wore PPE to transfer, toilet, and bathe the resident on quarantine.
-There was not a trash can in the resident's room to discard PPE.
-She would wear her PPE to the bathroom located at end of the hallway and throw it in the trash.
-Afterwards she would wash her hands in the sink in the bathroom.

Interview with the Administrator on 02/09/21 at 9:15am revealed:
-The LHD and other community services assisted the facility in obtaining a large shipment of PPE.
-The staff was trained on appropriate donning and doffing of PPE in the last month by the facility nurse.
-The SICs and PCAs were expected to appropriately take off PPE, discard it in the trash can, and wash their hands to prevent the spread of COVID-19.
-The staff was asked to sign a COVID-19 prevention policy after watching a video on PPE with the facility nurse.
-The staff was not asked to perform a return

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C 612	Continued From page 37 demonstration on donning and doffing PPE for the facility nurse. -He expected the facility nurse to make sure the staff understood how to properly use PPE and wash their hands. _____ The failure of the facility to adhere to the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) recommendations and guidance regarding testing of residents and staff for COVID-19, notifying the local health department when one or more staff and residents tested positive for COVID-19, cohorting staff to work with residents who tested positive for COVID-19 only, not removing required personal protective equipment (PPE) appropriately after providing care to residents who had tested positive for COVID-19 placed the residents at increased risk for transmission and infection from COVID-19. The facility's failure resulted in risk for serious neglect and serious physical harm and constitutes an A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/10/21 for this violation.	C 612		
{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 observations, interviews and record	{C 912}		

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{C 912}	Continued From page 38 reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Infection Prevention and Control. The findings are: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 4 residents during the global Coronavirus (COVID-19) pandemic as related to testing of residents and staff for COVID-19, notifying the local health department when one or more staff and residents tested positive for COVID-19, cohorting staff to work with residents who tested positive for COVID-19, not removing required personal protective equipment (PPE) appropriately after providing care to residents who had been placed in quarantine.[Refer to Tag 0612 10A NCAC 13G .1701, Infection Prevention and Control (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 Health Care, COVID-19 Infection Prevention and Control, Competency Validation for Licensed Health Professional Support Tasks, Licensed Health Professional Support and Examination and Screening for Controlled Substances.[Refer to Tag C0185 10A	{C 912}		

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{C 912}	Continued From page 39 NCAC 13G .0601(a) Management and Other Staff (Type A2 Violation)].	{C 912}		
{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 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	{C992}		

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{C992}	Continued From page 40 examination and screening. This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to ensure 1 of 3 sampled staff (Staff D) was screened for controlled substances prior to hire. The findings are: Review of Staff D's, Supervisor in Charge (SIC) employee file revealed: -Staff D was hired 08/18/20. -A controlled substance screening result dated 07/17/19. Telephone interview with Staff D on 02/10/21 at 9:40am revealed: -She was employed by the facility until 11/11/19 and quit. -She was rehired sometime in August 2020 she could not remember the exact date. -She did not recall if a controlled substance screening had been done. Telephone interview with the Business Office Manager (BOM) on 02/10/21 at 10:05am revealed: -She began working for the facility in November 2020. -The Owner and or the facility nurse interviewed and hired all the staff. -She and/or the facility nurse were usually the ones responsible for hiring new staff. -Staff D was hired before she was hired as the BOM. -She did not know until today (02/10/21) that all staff rehired at the facility was required to complete a controlled substance screening.	{C992}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL029012	A. BUILDING: _____ B. WING _____	R 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C992}	Continued From page 41 Telephone interview with the Administrator on 02/10/21 at 3:00pm revealed: -The Owner hired all staff employed at the facility. -He did not know Staff D did not have a controlled substance screening upon rehire in August 2020. -He expected the Owner or the facility nurse to complete all drug screenings for new and rehired employees. Telephone interview with the Owner on 02/10/21 at 12:30pm revealed: -She did all the hiring of staff. -Because Staff D was a previous employee, she did not complete her control substance screening. -She did not know it was required when staff was rehired.	{C992}		