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	HAL007015	A. BUILDING: _____ B. WING _____	C 08/26/2020

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with onsite visits on August 11, 2020 and August 14, 2020 and a desk review survey on August 11, 2020 through August 14, 2020, August 17, 2020 through August 21, 2020, and August 24, 2020 through August 26, 2020 and a telephone exit on August 26, 2020.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 5 staff sampled (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 04/01/11 as a medication aide (MA). -There was documentation of a health care personnel registry (HCPR) check for Staff C dated 09/10/08 with no substantiated findings. -There was no documentation of a HCPR check upon hire on 04/01/11. Telephone interview with Staff C on 08/18/20 at	D 137		

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10:05am revealed she had worked at the facility for 10 or more years, mostly as a MA but also as a personal care aide (PCA).

Telephone interview with the Executive Officer (EO) on 08/24/20 at 11:19am revealed:
-According to his records, Staff C was originally hired on 09/18/08 and terminated on 11/12/09.
-Staff C was rehired on 04/04/11.
-He did not know if a HCPR check was done for Staff C when she was rehired on 04/01/11.

Telephone interview with the Manager on 08/26/20 at 10:13am revealed:
-She was responsible for the personnel files.
-A former corporate Business Office Manager (BOM) was responsible for doing HCPR checks for staff upon hire.
-She was responsible for sending the former corporate BOM a copy of new hire applications so they BOM would know when a HCPR check was needed.
-The former BOM would let the Manager know if it was okay to hire a new staff person.
-Staff C worked with the facility in the past but was terminated and came back.
-She became the Manager in 2014 so she did not know if a HCPR check was done when Staff C was rehired in 2011.
-A HCPR check should have been completed on Staff C when she was rehired in 2011.
-She audited the personnel files about 2 years ago and she recalled asking the former BOM at that time about Staff C's HCPR check.
-The former BOM told her the computer had crashed and there should be a HCPR check in her file but he could not access it and he could not go back and redo because it would have been after she was rehired.
-The Executive Officer was currently responsible

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D 137	Continued From page 2 for doing HCPR checks. Telephone interview with the Interim Administrator on 08/26/20 at 1:05pm revealed: -The Manager was responsible for personnel files, including doing HCPR checks online and putting a copy in the personnel files. -The HCPR checks were supposed to be done as soon as a staff person was hired prior to the new staff working in the facility. -She could not locate any other HCPR checks for Staff C. -A HCPR check should have been done for Staff C when she was rehired in 2011.	D 137		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.	D 176		

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D 176	Continued From page 3 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related resident's rights, medication administration, and medication storage. The findings are: Interview with a medication aide (MA) on 08/11/20 at 10:42am revealed: -The Manager was responsible for overseeing the facility, but the Manager was out sick. -The facility did not have an acting Manager since the Manager was out sick had been out sick for two weeks. -She did not know who was in charge since the Manager was not there. -She guessed she was in charge since she was an MA and would be the Supervisor. -If an issue arose in the facility, the MA called the Manager. -If she was not able to reach the Manager, she did not know who to call. -She did not know how to get in contact with the Administrator or have a phone number to reach the Administrator. Telephone interview with the Administrator on 08/12/20 at 3:19pm revealed: -The Manager of the facility had been out sick for about two weeks. -The Manager was out and really sick on 08/11/20, but she was on-call for the facility. -If the staff needed anything, she expected the staff to call the Manager or her regarding their	D 176		

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questions.
-It had been brought to her attention on the morning of 08/12/20 by a family member that the previous Administrator's contact information was not readily available in the facility for the staff to contact her.
-She noted her contact information was not available for the staff at the facility on 08/12/20.
-She posted her contact information in the front office for staff on 08/12/20 before she left the facility.
-Prior to the COVID-19 outbreak at the facility, she came to the facility about once a week.
-Since the outbreak, she now came to the facility about two or three times a week.

Telephone interview with the Manager on 08/20/20 at 1:40pm revealed:
-She did not work at the facility from 08/01/20 through 08/16/20 because she was sick.
-Staff could call her if they had any questions, but the previous Administrator and the lead Supervisor oversaw the facility when she was out.
-When the lead Supervisor the Administrator were not available, then the Supervisors were in charge at the facility.
-The lead Supervisor was appointed Co-Manager by the previous Administrator last week.
-The new Co-Manager oversaw the facility until she returned to work on 08/17/20.

Interview with a personal care aide (PCA) on 08/14/20 at 11:20 AM revealed:
-Prior to 08/14/20 the facility Manager had been in charge if a facility staff needed assistance.
-If the staff at the facility needed assistance, they were to contact the Manager who was home sick.
-If the staff at the facility needed items or documentation completed by the Manager, a MA would go the Manager's house next door to the

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facility to pick-up or deliver items.
-The Administrator was to be called if facility staff were not able to reach the Manager by telephone.
-She was informed on 08/14/20 the person in charge of the facility would be a MA who had just been promoted to Co-Manager.

Interview with a MA on 08/14/20 at 4:00pm revealed:
-The Manager had been and was currently out sick.
-The MA on each shift was in charge of the facility.
-While the Manager was out sick the staff to call the Manager when they required assistance.
-If the staff could not reach the Manager they would leave a voicemail for the Manager.
-The Administrator was the Manager's supervisor.
-The Administrator had called the MA several times while the Manager was out sick to keep abreast of the facility.
-The Administrator no longer worked at the facility.
-The MA did not know who to contact if the staff required assistance.

Telephone interview with a MA on 08/18/20 at 10:05am revealed:
-She would call the Manager if there was an emergency and let the Manager know about it.
-She had not needed to call the Manager when the Manager was out sick.
-If staff needed something when the Manager was out sick, they could call the Administrator.
-The Administrator came to the facility when the Manager was out sick at least 2 or 3 times per week.
-The Administrator stayed a couple of hours up to a half day and sometimes stayed the whole day at the facility.

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-One of the staff started working as the Co-Manager last week and if staff needed something and the Manager was out, staff could call the Co-Manager.
-The Co-Manager lived about 8 minutes from the facility.

Telephone interview with a housekeeper/cook on 08/18/20 at 2:45pm revealed when the Manager was out sick, a MA was helping to supervise the staff at the facility and the MA later became the Co-Manager.

Review of an email from the Administrator dated 08/12/20 at 5:49pm revealed:
-She was leaving as of 08/12/20 and would not be involved with the facility any longer.
-She would send the (incomplete) plans of protection to the Interim Administrator to follow-up on.
-The Manager was to return to work at the facility on 08/17/20.
-A Co-Manager had been put in place at the facility until the Manager returned on 08/17/20.
-The name of the Co-Manager was not given.

Telephone interview with the Executive Officer on 08/13/20 at 8:43am revealed:
-He appointed an Interim Administrator from a sister facility to oversee the facility.
-The previous Administrator contacted him yesterday (08/12/20) and resigned from her position effective 08/12/20.
-The previous Administrator agreed to complete the requested plans of protection and he would follow-up with her regarding the plans of protection.
-He was not aware the previous Administrator had not completed or signed the requested plans of protection.

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-"It was unfortunate there was a communication gap" between the previous Administrator and him and she did not keep him informed of issues at the facility.

Telephone interview with the Administrator on 08/14/20 at 8:11am revealed:
-There was a communication barrier between staff.
-There had not been any supervision in the facility for a few weeks. "Staff does what they want."
-She had ownership in the company but does not have any 'say so.'
-She had not communicated any information to the manager/owner of the company regarding the health department guidance or other information from the health department.

Non-compliance was identified in the following rule areas:

1. Based on observations, interviews and record reviews, the facility failed to ensure staff documented on the medication administration records (MARs) the administration of medications immediately following the administration and not prior to the next residents administration of medication for 2 sampled residents (#4 and #5), during the initial facility tour on 08/11/20 and failed to ensure staff did not pre-chart medications for 4 of 8 sampled residents (#1, #2, #7, #8) during a medication pass on 08/14/20. [Refer to Tag D378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation).]

2. Based on interviews, observations 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

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D 176	Continued From page 8 (DHHS) were implemented and maintained when caring for residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors and staff, use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolated residents to designated areas; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and precautions to reduce the risk of transmission and infection including one resident (#3) who was previously COVID-19 negavitive being allowed to remain in a known COVID-19 positive room and failed report the resident's exposure to COVID-19 to his health care provider. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to ensure staff prepared medications for administration in accordance with the facility's policies and procedures as related to a medication aide failing to use the medication administration records (MARs) for guidance when preparing and administering sliding scale insulin for 2 sampled residents (#4, #5) observed during the initial tour of the facility on 08/11/20. [Refer to Tag D366 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).] _____ The Administrator, who was responsible for the total operations of the facility, failed to ensure responsibility for meeting and maintaining the rules and regulations governing residents' rights, health care, medication administration, and medication storage. The Administrator failed to ensure recommendations and guidance by the CDC, the NC DHHS, and the local Health Department (LHD) were implemented and maintained when caring for 22 residents during	D 176		

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D 176	Continued From page 9 the global Coronavirus (COVID-19) pandemic including lack of or improper screening of visitors and staff; improper use or lack of use of personal protective equipment (PPE) by staff and residents; not practicing social distancing and isolation of residents; not practicing infection control procedures and resulting in cross-contamination; not maintaining environmental cleanliness, including ensuring COVID-19 positive residents did not use the bathroom for non-COVID residents. The Administrator failed to ensure medication dosage were verified by review of the residents' medication administration records prior to administration and failed to ensure medications, including inhalers, eye drops, cough syrup, and topicals were stored under locked security when not directly supervised by MAs, resulting in a resident with dementia and a resident who was constantly disoriented standing by the unattended med cart and having access to the medications. The Administrator's failure to ensure rules and regulations were followed placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2020.	D 176		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

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D 338	Continued From page 10 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observations 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 (DHHS) were implemented and maintained when caring for residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors and staff, use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolated residents to designated areas; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and precautions to reduce the risk of transmission and infection including one resident (#3) who was previously COVID-19 negavitive being allowed to remain in a known COVID-19 positive room and failed report the resident's exposure to COVID-19 to his health care provider. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed: -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.	D 338		

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D 338	Continued From page 11 -Personnel should be screened for fever and symptoms of COVID-19 before starting each shift. -Screen residents daily for fever and symptoms of COVID-19. -All personnel should practice social distancing (remain at least six feet apart) when in common areas. -Implement social distancing among residents. -If COVID-19 is identified in the facility, resrll residents to their rooms. -Residents with known or suspected COVID-19 should be cared for using recommended PPE including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed: -Resident with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N95 is not available. -Facilities should be in communication with local health, state and federal public health partners and emergency preparedness partners to identify PPE needs and additional PPE supplies. -Facilities along with their health care coalitions, local and state health departments, and local and state partners should work together to develop strategies that identify and extend PPE supplies. So that recommended PPE will be available when needed most. -Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same health care personnel when interacting with more than one	D 338		

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patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e. COVID -19 patients residing in an isolation cohort).

Telephone interview with a county health department communicable disease supervisor on 08/13/20 at 1:06pm revealed:
-The COVID-19 outbreak began at the facility on 07/24/20 with one employee who tested positive when she went to her private health care provider.
-The local health department went to the facility and tested all the residents and staff on 07/27/20 which resulted in five residents and one staff being found positive for COVID-19.
-She called the county environmental health specialist on 07/28/20 and had the specialist to resend the previous COVID-19 guidance that was sent to the facility in March 2020.
-She told the Administrator on 07/28/20 that staff were to wear gowns, goggles, and N95 masks whenever they went into a COVID-19 positive room.
-COVID-19 positive residents needed to be isolated in their rooms and the facility needed to quarantine the other residents.
-Everyone at the facility needed to stay six feet apart and wear masks that covered their mouths and noses.
-Staff who tested positive for COVID-19 could not return to work for at least 10 days from the date of their tests and they had to be asymptomatic with no fever for 3 days.
-Staff who were negative for COVID-19 could continue to work.
-If it was possible, positive staff (asymptomatic) should be designated to work with positive residents and negative staff should work with negative residents.

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-If it was not possible then the designated staff should be sure to change their PPE when they worked between the positive and negative residents.
-The local health department went to the facility again and tested all previously negative residents and staff on 08/05/20 which resulted in 6 residents and one staff being found positive for COVID-19.

Review of the facility's infection control policy revealed:
-The facility protocol was posted on the door. No visitors unless emergency crews were coming in.
-If anyone entered the building, they were asked if they had been out of the country or if a friend or family member had been out of the country or around anyone who had been sick within the last 2 weeks.
-Sign was posted on the door "WASH HANDS BEFORE ENTERING FACILITY".
-Staff were to take temperatures of staff and residents, and a record the results.
-Staff were to take temperatures of anyone entering the facility.
-Staff were supposed to wear gloves continuously and washes their hands frequently.
-All doorknobs, handrails, and all other surfaces in the facility were to be disinfected with a bleach and water mixture throughout the day.

1. Observation of the facility on 08/11/20 at 10:38am revealed:
-There was a sign posted on the top of the window of the front door of the facility that read, "Stop! Do not enter. Due to the dangers to the residents from exposure to the COVID-19 pandemic and per the North Carolina Department".
-There was a second sign posted on the bottom

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of the window of the front door of the facility that read, "of Health and Human Services, no visitors are allowed in the premises unless approved by the supervisor in charge. If you have any questions, please call the Manager and ask for the supervisor in charge.".
-There was a third sign posted on the window of the front door of the facility that read, "Please check with staff upon entering the building. Please sanitize your hands as you come in. If you have any respiratory symptoms, do not enter the facility. This is for the protection of our residents and staff. Thank you for understanding."
-There was a fourth sign posted on the window of the front door of the facility that read, "Attention All Visitors. To protect our residents at this time, if you meet any of the following criteria: 1. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat. 2. In the last 14 days, has been in contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with a respiratory illness. 3. International travel within the last 14 days to countries with sustained community transmission of COVID-19. For updated information on affected countries visit https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html. We ask that you not visit at this time. Thank you for your cooperation."
-The personal care aide (PCA) checked the temperatures of each survey team member using temporal thermometer upon entrance to the facility.
-The PCA did not perform the screening questions regarding respiratory symptoms, exposure to COVID-19, or international travel with the survey team and the survey team was allowed in the building without further screening.

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D 338	Continued From page 15 Observation of the facility on 08/14/20 at 11:05am revealed the PCA did perform temperature checks, but she did not perform the screening questions regarding respiratory symptoms, exposure to COVID-19, or travel with the survey team and the survey team was allowed in the building. Second observation of the facility on 08/14/20 at 2:10pm revealed the PCA did perform temperature checks, but she did not perform the screening questions regarding respiratory symptoms, exposure to COVID-19, or travel with the survey team and the survey team was allowed in the building. Review of the facility's COVID-19 policy dated 07/16/20 revealed: -Upon entrance to the facility, employees are asked "Screening Visitors" questions from the NCDHHS memo dated March 13, 2020. -Employee temperatures were taken. If the temperature exceeds 100.4, the employee would be sent home, asked to contact the local health department and isolate for 14 days. -No guests or family members would be allowed in the building unless there was an end of life situation or an emergent situation determined by the facility to necessitate the visit. -If there was justification for the visit, (staff) asked "Screening Visitors" questions and take their temperature. -If the visitor had a temperature or and/or answered yes to the questions, they were to be denied entrance. Interview with a medication aide (MA) on 08/14/20 at 3:22pm revealed: -Staff were screened for COVID-19 by	D 338		

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temperature checks only.
-The staff never answered any screening questions about COVID-19 symptoms, respiratory symptoms, possible exposure to COVID-19, or about their travel to other countries.
-The facility had not had any visitors so no there had not been any screening of visitors.
-If visitors were allowed in the facility, the visitors should have their temperature checked before being allowed in the facility just like the employees.

Telephone interview with a county health department communicable disease nurse on 08/12/20 at 8:47am revealed on 08/05/20 the facility did not ask her any COVID-19 related screening questions.

Review of the facility temperature log dated 08/14/20 revealed:
-There was documentation of temperatures for six staff members, including the Executive Officer, and two state survery team members.
-There was no documentation of responses to screenings for respiratory symptoms related to COVID-19 for any staff or state survey team members.

Interview with the Co-Manager on 08/14/20 at 2:45pm revealed:
-All visitors were supposed to be screened for COVID-19 by checking their temperatures and staff were supposed to ask all visitors the COVID-19 screening questions.
-The screening questions were hanging on the clipboard next to the door and staff should be using it when any visitors came in the facility.
-She did not understand why staff were not using the screening tool for COVID-19 since it was posted.

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D 338	Continued From page 17 -The employee's temperature check was documented on a log, but not the answers to the screening questions. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -The facility had not allowed visitors since March 2020 except for emergency medical service (EMS). -When staff came to work, they washed their hands, sanitized, masked down, put on gloves, and checked their temperatures. -She was told to document staff temperatures in March by the facility's home office and the health department. -There was no documentation for the screening questions asked to staff. Interview with the Administrator on 08/11/20 at 11:50am and 11:55am revealed: -The facility was not accepting visitors. -Staff were supposed to screen all visitors and staff by checking their temperatures and asking the COVID-19 screening questions. -She did not know why staff were only checking temperatures and not asking the screening questions. -Temperatures checks were documented on a log, but she was not sure about the documentation of the screening questions. -Staff was not supposed to work their shifts until their COVID-19 screening questions were completed. Telephone interview with the Interim Administrator on 08/19/20 at 10:20am revealed: -She expected for the staff to screen all visitors who came to the facility by taking their temperatures and asking the COVID-19 screening questions.	D 338		

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-The staff were supposed to be screened the same way when they entered the facility for work.
-The staff should document the screenings and temperature checks for visitors and staff in notebook located by the door.

Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed:
-The screening process for visitors consisted of taking the temperature and asking symptom questions.
-EMS were the only visitors allowed in the facility.
-EMS would wash their hands, put on a gown, mask and gloves when they entered the facility.
-She did not know why staff did not screen the survey team twice for respiratory symptoms when they entered the facility.

2 a. Observation of the front porch of the facility on 08/11/20 from 10:30am to 10:37am revealed:
-One male resident was sitting in a chair on the front porch of the facility, on the left side next to the front door, smoking a cigarette with his surgical mask tucked under his chin.
-At approximately 10:33am, a second male resident came out the facility, not wearing a mask on his face with the ends and loops of a mask visible between the rear of his head and his hoodie.
-The second resident carried a metal chair and positioned the chair approximately two to three feet in front of the first resident.
-The second resident slid his surgical mask down under his chin and began smoking his cigarette.
-At approximately 10:35am, a personal care aide (PCA) came out on the front porch of the facility and looked at the two residents smoking on the front.
-The PCA did not tell either of the two residents to social distance and went back inside the facility

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through the front door.

Second observation of the front porch of the facility on 08/14/20 from 10:45am to 10:48am revealed:
-A PCA and a male resident were sitting in chairs facing each other approximately three feet apart on the front porch.
-The male resident was wearing a mask.
-The PCA was not wearing a mask and was talking on her cellphone facing toward the resident.
-The PCA continued talking on the cellphone for approximately three minutes before going inside the facility.

Telephone interview with the county health department communicable disease supervisor on 08/13/20 at 1:06pm revealed:
-She advised the Administrator on 07/28/20 that everyone at the facility needed to stay six feet apart for social distancing.
-All residents and staff should wear masks covering their mouths and noses unless they were eating or drinking.

Review of the facility's COVID-19 policy dated 07/16/20 revealed:
-The facility would discuss social distancing with all employees and explain the need for them to stay healthy in order to work in the facility.
-Residents should always wear masks when outside their rooms and maintain a distance of six feet apart.

Telephone interview with a resident on 08/17/20 at 2:26pm revealed:
-Residents smoked on the porch in the back and sat close to each other "about three feet apart".
-"Some residents wore mask in the facility and

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D 338	Continued From page 20 some residents don't". Telephone interview with a second resident on 08/17/20 at 2:44pm revealed: -Residents who smoked outside in the back were about four feet apart from each other. -The resident sometimes smoked cigarettes that had been smoked previously by other residents in the facility. Telephone interview with a third resident on 08/17/20 at 1:23pm revealed: -Residents sometimes sat close together on the front porch and smoking area and smoked without social distancing. -Employees sometimes smoked with the residents and sat about three feet apart from each other when smoking. -The employees sometimes smoked cigarettes partially and then passed the cigarettes on to the residents to finish smoking. Telephone interview with a PCA on 08/18/20 at 9:10am revealed: -COVID-19 positive residents were not allowed to go outside to smoke -Staff always kept an eye on who was smoking. -Negative residents would go outside to smoke and they were six feet apart. -The smoking area was out back and there was a porch with chairs and picnic tables. -Staff kept all residents' cigarettes on the medication cart and residents were called by name and given one cigarette every hour. -Staff was supposed to stay with residents while they smoked. -Staff smoked in the same area as the residents. -If a resident asked her to borrow a cigarette, she told them no. -She had observed residents ask other residents	D 338		

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for cigarettes and she had observed resident's picking up cigarette butts and smoking them.
-She told the resident not to pick up cigarette butts and smoke them.

Telephone interview with a MA on 08/18/20 at 10:05am revealed:
-The residents could smoke on the side smoking porch that had chairs and there was also picnic tables out there.
-The residents were not supervised when they smoked but sometimes a staff person would go outside and smoke.
-COVID-19 positive residents did not go outside and smoke because smoking caused breathing problems.
-When negative residents went outside to smoke, they took their masks off and the chairs should be six feet apart.
-Some residents stood up to smoke and some walked around.
-Staff could see residents who were outside smoking through a window from the facility.
-Staff asked residents to spread out if they were sitting too close together.
-The residents' cigarettes were kept on the medication cart and residents were given 1 or 2 cigarettes every hour.
-Sometimes, residents would borrow or share cigarettes from each before the COVID-19 pandemic.
-She told residents not to share cigarettes and she had not seen the residents doing it now.

Telephone interview with a housekeeper/cook on 08/18/20 at 2:45pm revealed:
-COVID-19 positive residents were not allowed to go outside to smoke.
-Non-COVID-19 residents smoked outside the back door on the patio.

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D 338	Continued From page 22 -Staff did not go outside with the residents to smoke unless there was a resident in a wheel chair to make sure they were okay. -When residents went outside to smoke, they had to be at least 6 feet apart because their masks were not on while they were smoking. -There were not that many residents that smoked and they did not all go outside together because there were only 3 chairs out there. -Residents had tried to borrow cigarettes from her but she told them "no". -Residents did not share cigarettes because she told them not to so they would not "catch anything" from each other. -She had observed two residents who were roommates share a cigarette about a month ago but she had not seen them do it since then. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -Staff and residents were told to stay 6 feet apart while smoking. -Staff and residents were told to wear masks both inside and outside. -Residents were supposed to smoke in the back but they sometimes smoked on the front porch. -Staff and residents were not supposed to share cigarettes. -Some residents picked up cigarette butts off the ground and smoked them. -She had staff to check the smoke area for cigarette butts daily after she saw this happen. Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed: -Everyone must stay six feet apart. -Staff must wear masks and gowns. -A few residents went outside to smoke at a time. -She could not stop them from going out to smoke when they want to because it was their	D 338		

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right.
-She told residents not to share cigarettes.
-She wasn't sure if staff shared cigarettes with the residents.
-Sometimes residents do not have money to buy cigarettes.
-She told staff to pick up the cigarette butts off the ground so the residents could not pick them up and try to smoke them.

Interview with the MA on 08/11/20 at 10:41am and 10:48am revealed:
-The facility had residents with active cases of COVID-19 and the residents' rooms were identified by putting red stickers on the outside entrance of their room doors and their room doors were to remain closed.
-All residents and staff were supposed to wear masks that covered their mouths and noses.

Observation of the facility on 08/11/20 at 10:42am revealed:
-There was a resident sitting in the day room not wearing a mask across from a stationary fan that was blowing air from the day room out into and down the main hall.
-Another resident entered the day room who was not wearing a mask and walked passed a stationary fan that was blowing air.
-The second resident ambulated passed the MA, but the MA did not remind the resident to cover his face with his mask that hung under his chin.

Observation of a resident on 08/11/20 at 10:50am revealed:
-The resident was sitting in a wheelchair in the open doorway of his room and he was not wearing a mask.
-The resident was talking to two other residents who stood in the hallway approximately three feet

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from his doorway.
-The other two residents were wearing masks.
-There was no staff to advise the first resident to put on a mask or ask any of the residents to social distance.

Observation of the main hallway on 08/11/20 at 10:59am revealed a resident identified by staff as positive for COVID-19 ambulating in the hall without a mask.

Observation of a resident room on 08/11/20 at 11:20am revealed:
-A resident, whose room was identified as COVID-19 positive by a red sticker on the outside of his door, was sitting in his wheelchair in the room doorway with his mask attached only to his left ear and it was not covering his mouth or nose.
-The resident removed his mask.
-A MA, in the hallway, walked passed the resident, but did not tell the resident to put on his mask or close his room door.
-A PCA stopped and stood in the hallway looked at the resident sitting in the doorway of the room saw the resident was not wearing his mask.
-The PCA did not encourage the resident to put on his mask or close his room door.

Observation of another resident room on 08/11/20 at 11:26am revealed there was a red sticker on the outside the room door and the room door was completely open.

Observation on 08/14/20 at 3:30pm revealed another resident identified as COVID-19 positive ambulating in the main hall with a mask around his neck and not covering his mouth or nose.

Observation of the facility on 08/11/20 between11:33am and 11:39am revealed:

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D 338	Continued From page 25 -There was a red sticker on the door of a resident room and the room door was half partially open with a resident standing inside the opening of the door. -The resident exited from the room with his mask under his nose; crossed the hallway diagonally from his room and entered the common bathroom across from resident room. -At approximately 11:36am, the resident exited the common bathroom and returned to his room with his mask still under his nose and left his door opened halfway . -Staff was standing in the hallway by the resident room and did not ask the resident to put on his mask correctly when he exited or returned to his room. -At approximately 11:39am, staff prompted the resident to close his room door. Telephone interview with a county health department communicable disease nurse on 08/12/20 at 8:47am revealed: -She observed two male residents on 08/05/20, who had tested positive for COVID-19 on 07/30/20, in a shared resident room with the door fully opened to the facility's hallway. -One of the male residents left the room, without wearing a mask, and walked across the facility hallway to the bathroom. Telephone interview with a third resident on 08/17/20 at 1:23pm revealed: -The facility had not communicated any information to the residents regarding COVID-19. -There were no residents or staff wearing masks in the facility until about two weeks ago (not sure of date). -The staff had problems with at least two residents not wearing masks inside the facility who were positive for COVID-19.	D 338		

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D 338	Continued From page 26 Telephone interview with a third resident on 08/17/20 at 2:44pm revealed: -He was not aware of COVID-19 pandemic. -There were no residents or staff wearing masks in the facility until about two weeks ago (not sure of date). Telephone interview with a PCA on 08/18/20 at 9:10am revealed: -The residents started wearing masks the same time as staff, around May 2020 or June 2020. -Staff had to remind one or two residents to wear their masks. -One of the residents would sometimes wear the mask over his nose but not his mouth so staff would help him with the mask. Telephone interview with a MA on 08/18/20 at 10:05am revealed two residents had to be reminded to wear their face masks because the residents did not want to wear them. Telephone interview with a housekeeper/cook on 08/18/20 at 2:45pm revealed one resident did not like to wear face masks; she had put a mask on the resident this morning (08/18/20) and later he came back out of his room and the mask was off again. b. Observation of the hallway by a common bathroom across on 08/11/20 from 11:30am to 11:45am revealed: -One resident (who staff identified as COVID-19 positive) went inside the common bathroom at approximately 11:30am and left. -There was no cleaning of common bathroom by staff after the resident left. -The second resident (whom staff identified as COVID-19 positive) went inside the same	D 338		

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common bathroom at approximately 11:33am.
-There was no cleaning of common bathroom by staff before or after the second resident's use of the common bathroom exited.
-Two other residents (whom staff identified as COVID-19 negative) entered the same common bathroom between 11:35am and 11:45am.
-There was no cleaning of common bathroom by staff before or after each of the residents' use.

Review of the facility's COVID-19 policy dated 07/16/20 revealed:
-Facilities with COVID-19 cases bathrooms were to supposed to be cleaned ever hour.
-All staff were to assist with cleaning bathroom.

Telephone interview with the county health department communicable disease supervisor on 08/13/20 at 1:06pm revealed six residents tested positive for COVID-19 on 08/05/20.

Interview with the MA on 08/11/20 at 10:41am and 10:48am revealed:
-She and the PCA were the only two staff in the facility at the time.
-The housekeeper had just left on her break at 10:30am and would be back in an hour.

Second interview with the MA on 08/11/20 at 11:40am revealed:
-The housekeeper had car problems and had not returned from her break since leaving at 10:30am.
-The housekeeper was responsible to clean the bathrooms and the housekeeper would clean the bathrooms when she returned.
-She did not clean any of the bathrooms when the housekeeper was not at the facility.
-She did not know who was responsible to clean the bathrooms when the housekeeper was not

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there.

c. Observation of a personal care aide (PCA) on 08/11/20 from 10:44am to 10:47am revealed:
-She was wearing a blue disposable cloth gown, a KN95 mask, and gloves for personal protective equipment (PPE) inside the facility.
-She left the facility wearing her PPE at approximately 10:44am to deliver a fax to the facility's Manager who lived next door to the facility.
-The PCA returned to the facility at approximately 10:47am, but she did not change or disinfect any of the original PPE or perform any type of hygiene one she returned to the facility.

Telephone interview with the Interim Administrator on 08/19/20 at 10:20am revealed:
-If staff went outside wearing PPE, then the staff needed to take off the PPE when they come back inside the facility.
-The staff would need to put on new PPE after removing the previous PPE.
-Staff would need to put on new PPE to prevent cross contamination and spread of possible infections.

Second observation of the same PCA on 08/11/20 at 11:00am revealed:
-She entered a resident room, with a red sticker on the door the identified the room as COVID-19 positive, wearing her PPE and picked the urinary catheter up off the floor and placed on the rack on side of the bed.
-The PCA came out the room, removed her gloves, and threw them in the red trash can outside the entrance of the resident's room.
-The PCA applied a new pair of gloves without washing her hands or sanitizing her hands.
-The PCA had not changed her gown or

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disinfected her gown after leaving the resident's room.

Third observation of the same PCA on 08/11/20 at 11:38am revealed:
-The PCA pushed down the discarded PPE in the red trash can outside resident room #2 with her gloved right hand and her right arm extended down inside the red trash can approximately at her elbow.
-The PCA did not change her gloves or gown and walked halfway down the hallway of the facility.
-The PCA put her gloved hands inside the pockets of her uniform pants.
-The PCA began to assist a resident by grabbing the resident by his arm with her dirty gloves and walked with the resident back down the hallway toward the front door.

Interview with the PCA on 08/11/20 at 11:40am revealed:
-She washed her hands and changed her gloves after she picked up the urinary catheter bag from the floor in resident room #1.
-She washed her hands and changed her gloves after she pushed down the discarded PPE in the red trash can.
-She did not think she needed to change her gown because her arm did not touch anything inside the red trash can.
-She always either washed her hands or sanitized her hands with hand sanitizer any time she touched a resident or handled dirty items.
-She did not think that she needed to change any of PPE when she went outside because she just went to the Manager's front porch.

Observation of the staff inside the facility on 08/11/20 at 10:38am to 12:15pm revealed:
-The PCA and the MA both were wearing blue

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disposable cloth gowns, KN95 masks, and gloves.
-The PCA's gown was worn tied in the front and partially opened beginning mid-thigh to expose her uniform underneath.
-The MA's gown was worn tied in the back and had small tear approximately 1½ inch to the upper chest area.
-Neither staff were observed changing or disinfecting their cloth gowns after providing care providing care to both COVID-19 positive and COVID-19 negative residents including walking a resident in the hallway and administering medications.

Interview with the PCA on 08/11/20 at 11:40am revealed:
-She had used the same gown in the facility for two or three days with both COVID-19 negative and COVID-19 positive residents in the facility.
-She did not disinfect her gown between residents, but she changed her gloves and sometimes double gloved when she worked the COVID-19 positive residents.
-She took her blue gown home at night and washed it in hot water to disinfect.
-No one had given her instructions to do that; that was just how she cleaned her gown.
-She did not specify why she did not change her gown or used a different gown when she worked with COVID-19 positive residents.

Interview with the MA on 08/11/20 at 11:46am revealed:
-She sprayed her gown with disinfectant several times during her shift, but she could not specify when she disinfected her gown.
-She worked with both COVID-19 negative and positive residents on 08/11/20 and had not changed her gown or disinfected since the survey

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team arrived.
-She had not noticed the tear in her blue gown on 08/11/20.

Observation of the first resident bathroom on 08/11/20 at 10:50am revealed there was a hand dryer but there no paper towels in the bathroom.

Observation of the second resident bathroom on 08/11/20 at 10:52am revealed there was a hand dryer but there no paper towels in the bathroom.

Observation of the third resident bathroom on 08/11/20 at 11:40am revealed there was a hand dryer but there no paper towels in the bathroom.

Observation of the fourth resident bathroom on 08/11/20 at 11:25am revealed there was a hand dryer, no paper towels, no hand sanitizer, and no hand soap in the bathroom.

Observation of the second resident bathroom on 08/14/20 at 2:47pm revealed there was no hand soap or hand sanitizer

Observation of the fourth resident bathroom on 08/14/20 at 2:54pm revealed there was no hand soap or hand sanitizer.

Observation of the third resident bathroom, designated for COVID-19 positive residents, on 08/14/20 at 3:00pm revealed there was no hand soap or hand sanitizer.

Telephone interview with a housekeeper/cook on 08/18/20 at 2:45pm revealed:
-There was hand sanitizer in the hallways of the facility.
-They did not run out of soap or paper towels in the residents' bathrooms.

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D 338	Continued From page 32 Observation of the facility on 08/11/20 at 11:05am revealed: -A medication cart was at the end of the hallway across from the day room. -A resident, who tested positve for COVID-19 on 07/27/20, was observed performing a fingerstick without staff supervision. -The resident touched an alcohol swab pad, tissues, a cotton ball, located on the top of the medication cart with her ungloved hands. -The resident placed her used alcohol pad and used cotton ball on the top of the medication cart after she performed her fingerstick and then placed her glucometer inside a plastic bag located on top of the cart. -A MA came to medication cart and threw away the used alcohol pad and cotton ball and placed the bag that contained the resident's glucometer back inside the medication cart. -The MA did not disinfect the top of the medication cart. -The MA took out the resident's insulin from medication cart and drew the resident's insulin dosage; and the resident self-injected the insulin while the medication aide observed the injection. -The MA disposed of the resident's used insulin needle, removed her gloves, and sanitized her hands. -The MA removed a glove from a box located on top of the medication cart. -The MA slapped the glove on the top of the medication cart in the same area the resident's used alcohol pad and cotton ball were. -The MA applied her gloves and proceeded to draw insulin for a second resident, who was COVID-19 negative, and laid his insulin supplies on the top of the medication cart without disinfecting the medication cart.	D 338		

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Interview with the MA on 08/11/20 at 11:14am revealed:
-She did not think of the possibility of cross contamination because she thought the resident touched just her fingerstick supplies.
-She removed the used cotton ball and alcohol pad from the top of the medication cart, and she did not disinfect the top of the medication cart because it was just the first resident there.
-When she applied her new gloves, she forgot that she had not sanitized and proceeded to get the insulin ready for the second resident.
-She knew the top of medication cart should have cleaned the top of the medication cart before she proceeded to administer the next resident's insulin.

Review of county environmental health guidelines utilized by the facility revealed:
-Staff should clean all touchable surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tables, and bedside tables daily, or as needed.
-Staff should clean any surfaces that may have blood, body fluids, and/or secretions or excretions on them.

Observation of a MA on 08/14/20 at 11:39am revealed:
-The MA prepared to go inside a resident room to administer medication to a resident who was COVID-19 positive.
-She was wearing a KN95 mask, blue gauze gown, and gloves for PPE.
-She removed the blue gauze gown and laid it top of her medication cart.
-She put on a yellow disposable gown and went inside the COVID-19 positive and administered medication to the resident inside the room.
-She came outside of the resident room and

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stood outside the doorway of the room.
-She removed the yellow disposable gown and her gloves and discarded them in the red trash can in the hallway next to the door.
-She picked up the blue gauze gown from the top of the medication cart and she put the blue gown so that it tied in the front.
-She touched the ties of the front of gown; dropped the gown ties, reached over on the medication cart and sanitized her hands with the hand sanitizer on the top of the medication cart.
-She then secured the ties on the blue gauze gown.
-She did not change her blue gauze gown or disinfect her medication cart.
-She administered oral medications to another resident while wearing the same blue gauze gown.

Interview with the MA on 08/14/20 at 11:42am revealed:
-Her blue gauze gown was still clean because she sanitized her hands before she tied the gown.
-She did not need to disinfect the medication cart since she only touched the blue gown on top of the medication cart.
-She knew how to prevent cross contamination because she had driven a school bus before and she "kept the bus clean so she and the kids did not get sick".
-Her blue gown "was clean and her medication cart was not contaminated".

Telephone interview with a resident on 08/17/20 at 1:23pm revealed:
-The staff recently started wearing masks and gowns in the facility within the last week or so (not sure of date).
-Staff did not start wearing PPE inside the facility until the most recent COVID-19 cases started

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(end of July 2020 beginning of August 2020).
-He observed staff leave COVID-19 positive residents' room and not wash their hands (not sure of date).
-He had to tell a MA about touching his bag with glucometer after she had not cleaned her hand after she had worked with a resident who was COVID-19 positive (unable to specific the date).
-The MA got mad and walked away from him when he spoke up.
-It concerned that the MAs sometimes did not change their gloves between working with residents or practice good hygiene.
-He washed his hand frequently, used hand sanitizer, stayed in his room in order to keep from getting infected with COVID-19.
-"I am doing what I can to stay alive."

Telephone interview with a second resident on 08/17/20 at 2:26pm revealed sometimes staff did not remove their PPE when they left out of residents' room who were positive for COVID-19 before administering medication before administering to negative residents.

Telephone interview with a PCA on 08/18/20 at 9:10am revealed:
-When performing personal care tasks for COVID-19 positive residents, staff wore double gloves, double gowns, double masks, and they put on face shields.
-Some gowns were blue and some were plastic.
-After staff come out of a room with a COVID-19 positive resident, they took off all PPE, threw it away, washed/sanitized hands, and then they "suit back up".
-She went to the staff bathroom located at the front of the facility to remove her PPE after leaving a resident's room by walking down the hall, through the facility, with the used PPE still

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on.
-She either took a plastic bag with new PPE with her to the staff bathroom or she had another staff bring new PPE to her.
-She then put on her new PPE in the staff bathroom.
-For COVID-19 negative residents, staff wore a single layer of PPE.
-Staff used the same gown with COVID-19 negative residents but changed gloves between the negative residents.
-The facility also had booties for staff's shoes, and they started wearing booties after their first COVID-19 positive case.
-Staff started wearing full PPE around May 2020 or June 2020 for the protection of staff and residents.

Telephone interview with a PCA on 08/18/20 at 3:35pm revealed:
-Staff had been using PPE "going on a month" at the facility.
-Staff wore gowns, gloves, and masks.
-They had N95 masks and white plastic gowns now.
-The Administrator said they could wash and re-use the gowns, but she did not say how many times they could wash and re-use the gowns.
-She used her gowns two times.
-She wiped down the gown with bleach water every time she came out of a COVID-19 positive resident's room.
-They had a spray bottle of bleach water on the housekeeping cart and she walked to the locked housekeeping closet and got the bleach water.
-The locked closet was near the staff bathroom at the front of the facility, so she had to walk all the way down the hallway with the used gown on to get the bleach water.
-Once she cleaned the gown, she would go to a

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non-COVID-19 resident's room and she would follow the same process to clean the gown once she left that room.
-She would use the same gown a second day before she threw it away.
-She washed the blue gown at night in her washing machine at home with hot water and bleach and on the third day, she used a new gown.
-She changed masks every time she went into a different resident's room and she threw the used masks away.
-She re-used face shields by wiping them down with bleach water every time she came out of a resident's room.
-When she got home, she would clean the face shield again.
-She used a face shield for about 3 days before replacing it.
-She changed gloves every time she worked with a resident.

Telephone interview with the Manager on 08/26/20 at 10:15am revealed:
-Staff changed their PPE and put on new PPE after working with a COVID-19 positive resident.
-Staff should wear double sets of PPE gear when working with COVID-19 positive residents.
-Staff should take off everything when they come out of a COVID-19 room, clean their face shield, and put on new PPE.
-Staff was in PPE when she came to the Manager's house and should have changed her PPE once she returned to the facility and sanitized her hands.
-Staff should be practicing good hand hygiene and cleaning surfaces as needed in the facility.

Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed:

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-Staff should change gowns, gloves, and masks immediately and dispose of them when working with a COVID-19 positive resident.
-Staff should wash their hands when they leave each resident's room.
-If staff wore double PPE such as 2 masks, 2 gowns, they should take off everything when they leave the positive COVID-19 room and dispose of it, disinfect the face shield with alcohol.
-If staff pushed trash down with their hand, they must remove all their PPE, wash hands, clean the face shield, and put on new PPE.
-Staff should not wear ripped gowns.
-They should change their gown, gloves, and masks whenever their PPE becomes dirty or torn.
-Staff should be washing or sanitizing their hands and sanitizing areas with bleach water as need to prevent cross contamination.

d. Review of the facility COVID-19 Policy and Procedure Update as of 07/16/20 for employees seeking access to the facility revealed if positive, employees should isolate for 10 days and have 3 days with no fever (with no fever-reducing medication).

Review of the county environmental health guidelines for Coronavirus revealed staff with COVID-19 should comply with work exclusion (as determined by employer occupational health and state/local health department) until they are no longer deemed infectious.

Telephone interview with the county health department communicable disease supervisor on 08/13/20 at 1:06pm revealed a staff and five other residents tested positive for COVID-19 on 07/27/20 and the end of their isolation date was 08/08/20.

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Second telephone interview with the county health department communicable disease supervisor on 08/25/20 at 12:05pm revealed:
-The staff was tested for COVID-19 on 07/27/20 but reported that she started having symptoms on 07/26/20.
-The staff had 10-day isolation period from the date that she reported having symptoms.
-The last day of her 10-day isolation period would have been 08/06/20.
-If the staff's symptoms improved, and she had no fever for three days without taking medications; then she could return to work before her 10 days.
-The staff could only work with COVID-19 positive resident only and she could not perform and personal care when she returned to work.
-She told this to the Administrator (time not specified) about the staff returning to work at the facility.
-She understood the facility needed the staff to return to work because other staff who were out sick because they were positive.

Review of the facility's MARs for 08/04/20 revealed the staff documented that she administered medications for all residents during first shift at the facility which included both COVID-19 positive and COVID-19 negative residents.

Telephone interview with the staff on 08/25/20 at 2:28pm revealed:
-She lost her sense of smell and taste on 07/26/20, but she did not know it was a symptom of COVID-19.
-She got tested for COVID-19 on 07/27/19 and her test came back positive.
-She never had any other symptoms and her sense of taste and smell returned after five or six

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days.
-The health department staff told her she could come back on 08/05/20 after they spoke with the Administrator.
-The Administrator wanted her to come back to work because so many staff were out sick.
-She could perform any personal care with the residents at the facility.
-She returned to work and she administered medications to all the residents without any assistance from other staff.
-She administered medications to both COVID-19 positive and COVID-19 negative residents.

Telephone interview with the Manager on 08/26/20 at 10:15am revealed:
-She was out sick when the staff returned to work.
-She only knew what the staff told her that the health department said the staff could come back to work and administer medications, but she could not provide personal care to the residents.
-The staff and the previous Administrator had worked out with the county health department when the staff should return to work.

Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed:
-The Manager kept track of COVID-19 positive staff and the date they should return to work.
-Staff should not come back to work prior to the 14-day isolation period.
-The Manager told her the 14-day isolation period policy came from the health department and PCP.
-If staff has COVID-19 symptoms they must stay home and get tested.
-If staff is asymptomatic but tests positive for COVID-19 they can return to work in 14 days.
-She did know the a staff returned to work early

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and was working with COVID-19 positive and negative residents.
-That arrangement was made with the previous Administrator.

3. Observation of the facility's supply of personal protective equipment (PPE) on 08/11/20 revealed there were 10 white cloth gowns, 20 disposable masks, and 35 face shields.

Observation of the facility's supply of PPE on 08/14/20 revealed there were 6 blue cloth gowns, 15 blue plastic disposable gowns, 6 KN95 masks, 70 disposable masks, 80 face shields, and 15 pairs of goggles located in the Manager's office and 8 disposable blue gowns were the PPE stations on the facility's main hallway.

Review of county environmental health summary notes revealed:
-The Administrator reported the facility was lacking gowns, hand sanitizer, and eye protection on 08/13/20, but the facility had placed an order for the supplies.
-The county environmental health section offered the Administrator enough personal equipment supplies (PPE) until the facility's order arrived and another request was placed through the county website for supplies.

Telephone interview with the county health department communicable disease supervisor on 08/13/20 at 1:06pm revealed:
-The Administrator called her on 08/13/20 and reported that the facility needed gowns and hand sanitizer.
-She reached out to a local source in the county to get the PPE for the facility who said that they would get the gowns for the facility.

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D 338	Continued From page 42 Interview with the personal care aide (PCA) on 08/11/20 at 11:40am revealed: -She had used the same gown in the facility for two or three days with both COVID-19 negative and COVID-19 positive residents in the facility. -She had to take her gowns home to wash them because the facility had run out of gowns the previous week. -Sometimes, there was not enough gowns at the facility and staff had to wear gowns longer than they needed to be worn. -She thought the Administrator had brought a package of gowns to the facility on 08/10/20, but she did not change her gown when she came to work on 08/11/20. Interview with a medication aide (MA) on 08/11/20 at 11:46am revealed: -She worked on 08/07/20 day shift and there were no gowns available in the building at the end of her shift. -There was a problem at the facility with staff not having enough gowns to wear. -She normally wore the blue gown for two or three days, but she had this blue gown longer because there were no gowns in the facility when she last worked on 08/07/20. -When the gown supply was low in the facility, she took her gown home and kept it in her car. -She did not know about the new supply of gowns the Administrator brought to the facility on 08/10/20 because no one told her about the new gowns. Interview with the Administrator on 08/11/20 at 11:50am revealed: -A supply of gowns was kept in the office and had always been available for staff. -She did not know why staff were reporting they had no gowns.	D 338		

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D 338	Continued From page 43 -Her expectation was that staff were to wear goggles, facemask, gloves and gowns. -Staff were not to take gowns home. Telephone interview with a second MA on 08/20/20 at 2:06pm revealed: -She wore a blue gown for about 2 days because she had not seen any more at the facility, so she took the gown home and washed it out on high heat. -She did not currently have any concerns about PPE supply because the facility had "plenty" now. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -The facility had a supply of gowns and gloves in a closet with more PPE in her office. -The PCAs were responsible for replenishing the PPE for staff to use on the residents. -The MA and the Manager checked to ensure PPE was restocked (how often was not specified). -The previous administrator brought gowns and let staff know they were there. -She had never seen the facility without gowns. Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed: -The facility's supply PPE was low prior to her arrival at the facility. -She has taken PPE to the facility 2 times since she has been the Interim Administrator. -She stated there is PPE in the Manager's office but was not locked. -There were 2 tables in the hall with PPE on them and a nightstand with gloves, masks, gowns, and sanitizer. -The Manager told staff where the PPE was kept in the office.	D 338		

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D 338	Continued From page 44 4. Review of Resident #3's current FL2 dated 04/01/20 revealed: -Diagnoses included diabetes mellitus II, epilepsy, schizophrenia paranoid, mental retardation, hypertension, kidney disease, and hyperlipidemia. -The resident was semi-ambulatory. Interview with a personal care aide (PCA) on 08/14/20 at 11:20am revealed: -Resident #3 had not been identified as positive for COVID-19 and had been residing in one room. -Between 07/31/20 and 08/01/20 Resident #3 had ambulated into a COVID-19 positive room. -When she arrived for work, she was not informed by the off-going staff Resident #3 had ambulated into a room with a positive COVID-19 resident. -She was informed by Resident #3 the night shift medication aide (MA) on 07/31/20 had directed Resident #3 to remain in the COVID-19 positive room. -Resident #3 next informed her the Co-Manager and a second PCA had directed him to stay in the COVID-19 positive room. -She left Resident #3 in the COVID-19 positive room with the COVID-19 positive resident. Interview with a MA on 08/14/20 at 3:20pm revealed: -She started working at 11:00pm on 7/31/20 and observed Resident #3 in the room of a COVID-19 positive resident. -She had not been informed by the off-going staff Resident #3 was COVID-19 positive or had been placed in the COVID-19 positive room with a COVID-19 positive resident. -She was told by Resident #3 the Co-Manager had spoken with the Manager and he was to remain in the room of the COVID-19 positive resident.	D 338		

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-She left Resident #3 in the room with the COVID-19 positive resident as she did not ask the Co-Manager but assumed Resident #3 was COVID -19 positive.

Telephone interview with the Co-Manager on 08/20/20 at 12:49pm revealed:
-Resident #3 would try to make himself sick by getting close to other sick residents so that Resident #3 could leave the facility.
-Resident #3 tested negative for COVID-19 on 07/27/20.
-She worked 3:00 pm til 11:00 pm on 07/31/20.
-Shortly after midnight she was notified at home by the third shift MA that Resident #3 was lying on the bed in a COVID-19 positive room.
-Resident #3 was wearing a mask under his chin exposing his nose and mouth.
-Resident #3 was lying 3 feet from the COVID-19 positive resident.
-She did not know how long Resident #3 had been in the room.
-She contacted the primary care provider (PCP).
-The PCP advised her to leave Resident #3 in the COVID-19 resident room due to exposure.
-Resident #3 tested positive for COVID-19 on 08/05/20.

Telephone interview with the mental health registered nurse on 08/24/20 at 10:12am revealed:
-The last office visit for Resident #3 was on 05/19/20 via telephone.
-She was not notified of Resident #3 entering a COVID-19 resident room on 07/31/20 by facility staff.

Telephone interview with Resident #3's family members on 08/24/20 at 1:50pm revealed:
-They were both considered responsible parties.

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-They were not aware of Resident #3 entering the COVID-19 positive resident room on 07/31/20.
-They were made aware on 08/07/20 by a MA that Resident #3 tested positive for COVID-19 on 08/05/20.

Telephone interview with the Clinical Director of the office of Resident #3's PCP on 08/24/20 at 11:44am revealed:
-She was the person the facility notified if any information needed to be given to the PCP.
-She did not have any documentation of any incidents regarding Resident #3 being found in a COVID-19 positive room.
-She expected the facility to remove Resident #3, who was negative for COVID-19, from the COVID-19 positive resident's room.
-She expected the facility to isolate Resident #3 and arrange for Resident #3 to be tested for COVID-19.

Telephone interview with the PCP on 08/24/20 at 3:23pm revealed:
-He was made aware on 08/24/20 of Resident #3 entering a COVID-19 positive resident room by a staff member.
-If he had been notified, he would have expected the facility to remove Resident #3, who was negative for COVID-19, from the COVID-19 positive residents' room.
-He expected the facility to isolate Resident #3 and arrange for Resident #3 to be tested for COVID-19.

Telephone interview with the Interim Administrator on 08/25/20 at 2:00pm revealed:
-Resident #3 was found in a COVID-19 positive resident room around 12:30am on 07/31/20 by a MA.
-Staff called the Co-Manager who advised them

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to leave the resident in the COVID-19 positive resident room due to exposure.
-The PCP was not notified by staff on 07/31/20.
-The Interim Administrator would have advised staff to remove Resident #3 from the COVID-19 positive resident room, isolate the resident, and test the resident for COVID-19.
-When staff had questions after-hours they should call the Manager, the Co-Manager, or the Interim Administrator.

Telephone interview with the Co-Manager on 08/25/20 at 2:45pm revealed:
-Resident #3 was in the living room when she finished her shift at 11:00pm on 07/30/20.
-The MA found Resident #3 in the COVID-19 positive resident room at 12:30am.
-Resident #3 stated the Co-Manager put him in that room but the Co-Manager stated she did not place Resident #3 in that room.
-She notified the Manager the next morning on 08/01/20.
-The Manager told her to "use your best judgement" on whether or not to leave Resident #3 in a COVID-19 positive resident room.

Telephone interview with the Mental Health Provider (MHP) on 08/25/20 at 3:01pm revealed:
-Resident #3 missed his regularly scheduled appointment on 08/19/20 due to hospitalization.
-The most recent doctor's notes for Resident #3 were from the last visit on 05/19/20.
-Resident #3 exhibited attention-seeking behaviors.
-Resident #3 was prescribed medications for mental health conditions.
-He was not notified of Resident #3 entering the COVID-19 positive resident room.
-He would expect the staff to notify the PCP and follow through with instructions given.

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D 338	Continued From page 48 -He would have advised the staff to remove Resident #3 from the COVID-19 positive resident room, isolate the resident, and test the resident immediately for COVID-19. Telephone interview with the Interim Administrator on 08/26/20 at 9:04am revealed: -There is a process for contacting the PCP after hours and on weekends. -We have called the answering service and they call us right back. -Staff should have looked in the chart for the PCP information in order to notify the PCP and follow through with instructions. Telephone interview with Resident #3 on 08/26/20 at 9:31am revealed Resident #3 was not interviewable. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -She received a telephone call from the co-Manager on 08/01/20. -She thought Resident #3 had been exposed to the COVID-19 positive resident for at least 45 minutes. -She would have taken the resident out of the COVID-19 positive resident room and put the resident in a separate room. -Staff should have called the PCP that night or the health department the next day. -Resident #3 tested positive for COVID-19 on 08/05/20. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the	D 338		

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D 338	Continued From page 49 COVID-19 pandemic in which multiple residents residing in the facility were diagnosed with COVID-19. The facility's failure placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2020	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure staff prepared medications for administration in accordance with the facility's policies and procedures as related to a medication aide failing to use the medication administration records (MARs) for guidance when preparing and administering sliding scale insulin	D 358		

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D 358	Continued From page 50 for 2 sampled residents (#4, #5) observed during the initial tour of the facility on 08/11/20. The findings are: 1. Review of the facility's medication administration policy revealed the community's staff shall ensure that medication is taken properly and, in the quantities, prescribed. a. Review of Resident #4's current FL-2 dated 06/30/20 revealed: -Diagnoses included diabetes, schizophrenic disorder, dementia, hypertension, hyperlipidemia, depression, and insomnia. -There was a physician order for fingerstick blood sugars checks four times a day; resident may perform her own fingersticks and insulin injections with staff monitoring. -There was a medication order for Humulin R-100 units insulin sliding scale administer 5 units for blood sugar reading between 201-250, administer 10 units for blood sugar reading between 251 - 300, administer 15 units for blood sugar readings between 301-350, and blood sugar readings greater than 351 give 20 units and call the physician if needed. Observation of the facility on 08/11/20 at 11:05am during the initial tour revealed: -A medication cart was at the end of the hallway across from the day room. -The medication administration book (MAR) was laying on a table in the day room. -The medication aide (MA) drew up insulin for Resident #4 and a dose of insulin was administered to Resident #4 at approximately 11:08am. -The MA did not verify Resident #4's insulin dosage with her MAR prior to its administration.	D 358		

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D 358	Continued From page 51 Interview with the MA, who failed to review Resident #4's insulin dosage, on 08/11/20 at 11:20am revealed: -She did not keep the MAR book on the cart when administering medications. -The MAR book was in the day room, not on the medication cart. -She did not refer to the MARs when preparing or administering medications to residents. -She remembered Resident #4 as on sliding scale insulin. -She did not need to refer to the MAR for Resident #4 as she knew the correct amount of insulin Resident #4's was to receive for her sliding scale from her memory. -She did not refer to Resident #4's MARs prior to administering sliding scale insulin to Resident #4. -She knew the correct dose of insulin to give to Resident #4 based on her memory of Resident #4's sliding scale. Telephone interview with the MA, who failed to review Resident #4's insulin dosage, on 08/20/20 at 2:07pm revealed: -She was cleaning the medication cart during the 11:30am medication pass on 08/11/20. -She did not "grab the MAR book" because she was cleaning the cart. -She monitored the fingerstick readings for Resident #4 during her 11:30am medication pass. -Resident #4's insulin dosage had not changed; and she drew up the resident's insulin dosage from what she "remembered her sliding scale was supposed to be". Refer to interview with a second MA on 08/14/20 at 3:22pm. Refer to telephone interview with the	D 358		

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D 358	Continued From page 52 Administrator on 08/12/20 at 3:19pm. Refer to telephone interview with the Manager on 08/26/20 at 10:15am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm. b. Review of Resident #5's current FL-2 dated 01/02/20 revealed: -Diagnoses included diabetes, schizophrenia, hypertension, hyperlipidemia, gastroesophageal reflux disease, and chronic constipation. -There was a physician order for fingerstick blood sugars checks three times a day with meals; resident may perform his own fingersticks and insulin injections with staff monitoring. -There was a medication order for Humulin R-100 units insulin sliding scale administer 5 units for blood sugar reading between 201-250, administer 10 units for blood sugar reading between 251-300, administer 15 units for blood sugar readings between 301-350, and blood sugar readings greater than 351 give 20 units and call the physician if needed. Observation of the facility on 08/11/20 at 11:05am during the initial tour revealed: -A medication cart was at the end of the hallway across from the day room. -The MAR book was laying on a table in the day room. -Resident #5 came up and stood to the left of the medication cart and performed his fingerstick. -The MA drew up an insulin dosage for Resident #5 and a dose of insulin was administered to Resident #5 at approximately 11:11am -The MA did not verify Resident #5's insulin dosage with his MAR prior to its administration.	D 358		

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D 358	Continued From page 53 Interview with the MA, who failed to review Resident #5's insulin dosage, on 08/11/20 at 11:20am revealed: -She did not keep the MAR book on the cart when administering medications. -The MAR book was in the day room, not on the medication cart. -She did not refer to the MARs when preparing or administering medications to residents. -She remembered Resident #5 as on sliding scale insulin. -She did not need to refer to the MAR for Resident #5 because she knew the correct amount of insulin Resident #5's was to receive for his sliding scale from her memory. -She did not refer to Resident #5's MARs prior to administering his sliding scale insulin. -She knew the correct dose of insulin to give to Resident #5 based on her memory of Resident #5's sliding scale. Telephone interview with the MA, who failed to review Resident #5's insulin dosage, on 08/20/20 at 2:07pm revealed: -She was cleaning the medication cart during the 11:30am medication pass on 08/11/20. -She did not "grab the MAR book" because she was cleaning the cart. -She monitored the fingerstick readings for Resident #5 during her 11:30am medication pass. -Resident #5's insulin dosage had not changed; and she drew up the resident's insulin dosage from what she "remembered his sliding scale was supposed to be". Refer to interview with a second MA on 08/14/20 at 3:22pm. Refer to telephone interview with the Administrator on 08/12/20 at 3:19pm.	D 358		

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D 358	Continued From page 54 Refer to telephone interview with the Manager on 08/26/20 at 10:15am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm. _____ Interview with a second MA on 08/14/20 at 3:22pm revealed she kept the MAR book with her when she performed medication administration to verify the resident's medication orders prior to medication administration because that was the facility's policy and how she verified medication dosages prior to administration. Telephone interview with the Administrator on 08/12/20 at 3:19pm revealed: -She watched the MA on 08/12/20 and "caught the MA administering medications to the residents without verifying the medication orders". -She told the MA she had to use the MAR book to verify the medication orders prior to medication administration. -She did not know the MA was not verifying the resident's medications in the MAR book prior to medication administration until 08/12/20. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -The MAs were supposed to match the medications with the residents' MARs when administering medications then pop it in the medication cup. -The MAs were not supposed to give medicines from memory including insulin. Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed: -Staff brought the MAR book down the hall on the medicine cart and passed medicines to residents	D 358		

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D 358	Continued From page 55 in each room. -Staff were supposed to review the MAR book to verify the correct doses were given prior to administering medications for each resident. _____ The facility failed to ensure medication staff used the medication administration records (MARs) for guidance when preparing and administering sliding scale insulin for two residents (#4 and 5) to ensure correct dosages prior to administration of the insulin based on the residents' blood sugar readings. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection on 08/19/20 and 09/11/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2020.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	D 366		

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

Based on observations, interviews and record reviews, the facility failed to ensure staff documented on the medication administration records (MARs) the administration of medications immediately following the administration and not prior to the next residents administration of medication for 2 sampled residents (#4 and #5), during the initial facility tour on 08/11/20 and failed to ensure staff did not pre-chart medications for 4 of 8 sampled residents (#1, #2, #7, #8) during a medication pass on 08/14/20.

The findings are:

1. Review of the facility's medication administration policy revealed the staff person administering medication is responsible for charting the drug immediately after administration on the resident's medication administration record (MAR).

a. Review of Resident #4's current FL-2 dated 06/30/20 revealed:
-Diagnoses included diabetes, schizophrenic disorder, dementia, hypertension, hyperlipidemia, depression, and insomnia.
-There was a physician order for fingerstick blood sugars checks four times a day; resident may perform her own fingersticks and insulin injections with staff monitoring.
-There was a medication order for Humulin R-100 units insulin sliding scale administer 5 units for blood sugar reading between 201-250, administer 10 units for blood sugar reading between 251 -

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300, administer 15 units for blood sugar readings between 301-350, and blood sugar readings greater than 351 give 20 units and call the physician if needed.

Observation of the facility on 08/11/20 at 11:05am during the initial tour revealed:
-Resident #4 performed her fingerstick by the medication cart in the hallway with supplies left on top of the medication cart.
-The medication aide (MA) drew up insulin for Resident #4 and a dose of insulin was administered to Resident #4 at approximately 11:08am.
-Another resident came up and stood to the left of the medication cart and performed his fingerstick.
-The MA drew up an insulin dosage for the other and a dose of insulin was administered to the other resident at approximately 11:11am.
-The MA did not document Resident #4's insulin administration on her MAR prior to administering insulin to the second resident.
-The MA proceeded down the hallway without documenting Resident #4's insulin administration.

Review of the Resident #4's August MARs on 08/11/20 at 11:17am revealed there was no documentation of the Resident #4's fingerstick or insulin dosage.

Interview with the MA, who failed to document Resident #4's insulin administration, on 08/11/20 at 11:20am revealed she did not document medications immediately after administering or assisting residents to administer their medications.

Observation of the facility on 08/11/20 at 11:54am revealed there was no documentation of Resident #4's insulin administration or fingerstick in the

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D 366	Continued From page 58 MAR book from 11:08am. Telephone interview with the MA, who failed to document Resident #4's insulin administration, on 08/20/20 at 2:07pm revealed she did not document the administration of the insulin or the fingerstick for Resident #4 until after she finished cleaning the medication cart and retrieved the MAR book from the day room (time not specified). Refer to interview with a second MA on 08/14/20 at 3:22pm. Refer to telephone interview with a third MA on 08/18/20 at 10:05am. Refer to telephone interview with the Administrator on 08/12/20 at 3:19pm. Refer to telephone interview with the Manager on 08/26/20 at 10:15am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm. b. Review of Resident #5's current FL-2 dated 01/02/20 revealed: -Diagnoses included diabetes, schizophrenia, hypertension, hyperlipidemia, gastroesophageal reflux disease, and chronic constipation. -There was a physician order for fingerstick blood sugars checks three times a day with meals; resident may perform his own fingersticks and insulin injections with staff monitoring. -There was a medication order for Humulin R-100 units insulin sliding scale administer 5 units for blood sugar reading between 201-250, administer 10 units for blood sugar reading between 251-300, administer 15 units for blood sugar	D 366		

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readings between 301-350, and blood sugar readings greater than 351 give 20 units and call the physician if needed.

Observation of the facility on 08/11/20 at 11:05am during the initial tour revealed:
-Resident #5 came up and stood to the left of the medication cart and performed his fingerstick.
-The MA drew up an insulin dosage for Resident #5 and a dose of insulin was administered to Resident #5 at approximately 11:11am
-The MA did not document the insulin administration for Resident #5 on his MAR after it was administered.
-The MA proceeded down the hallway without documenting Resident #5's insulin administration.

Review of the Resident #5's August 2020 MARs on 08/11/20 at 11:17am revealed there was no documentation of the Resident #5's fingerstick or insulin dosage.

Interview with the MA who failed to document Resident #4's insulin administration, on 08/11/20 at 11:20am revealed she did not document medications immediately after administering or assisting residents to administer their medication.

Observation of the facility on 08/11/20 at 11:54am revealed there was no documentation of Resident #5's insulin administration or fingerstick in the MAR book from 11:11am.

Telephone interview with the MA, who failed to document Resident #5's insulin administration, on 08/20/20 at 2:07pm revealed she did not document the administration of the insulin or the fingerstick for Resident #5 until after she finished cleaning the medication cart and retrieved the MAR book from the day room (time not

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D 366	Continued From page 60 specified). Refer to interview with a second MA on 08/14/20 at 3:22pm. Refer to telephone interview with a third MA on 08/18/20 at 10:05am. Refer to telephone interview with the Administrator on 08/12/20 at 3:19pm. Refer to telephone interview with the Manager on 08/26/20 at 10:15am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm. _____ Interview with a second MA on 08/14/20 at 3:22pm revealed: -Staff should document all medication administration and treatment in the residents' MARs immediately after they were completed. -She documented after each resident's medication administration because that is what she was taught to do. Telephone interview with a third MA on 08/18/20 at 10:05am revealed: -When she passed medications, she documented her initials on the MARs at different times but mostly when she was administering medications. -She sometimes waited to document the administration of medications until the end of the medication pass. -She was aware the MARs were supposed to be initialed when observing the resident take the medication and prior to the next resident. -If something happened while she was administering medications and she had to stop to do something else, she would go back later and	D 366		

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document on the MARs.

Telephone interview with the Administrator on 08/12/20 at 3:19pm revealed:
-She watched the MA on 08/12/20 and "caught the MA not documenting after performing the medication administration" with the residents.
-She told the MA she had to immediately document on the residents' MARs after the residents were administered the medications.
-She did not know the MA was not documenting after medication administration until 08/12/20.

Telephone interview with the Manager on 08/26/20 at 10:15am revealed the staff were supposed to document medication administration in the MAR book after it was completed for each resident.

Telephone interview with the Interim Administrator on 08/26/20 at 1:02 pm revealed:
-Staff brought the MAR book down the hall on the medicine cart and passed medicines to residents in each room.
-Staff were supposed to pass medicines and sign the MAR book immediately.
-The MAR book should not have been left at the end of the hall and documentation should have been entered after all medications were given.

2. Review of the facility's medication administration policy revealed the staff person administering medication is responsible for charting the drug immediately after administration on the resident's medication administration record (MAR).

a. Review of Resident #7's current FL-2 dated 01/02/20 revealed diagnoses included diabetes, paranoid schizophrenia, hypertension, arthritis,

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chronic obstructive pulmonary disease, and asthma.

Review of Resident #7's physician's orders dated 07/02/20 revealed an order for Lorazepam 0.5mg take ½ tablet once daily with lunch (Lorazepam is a medication used to treat anxiety and sleep disorders).

Observation on 08/14/20 at 11:14am during the morning medication pass revealed the Co-Manager initialed Lorazepam as administered on the Medication Administration Record (MAR) and narcotic log prior to the actual administration for Resident #7.

Refer to interview with the Co-Manager on 08/14/20 at 2:45pm.

Refer to interview with a Medication Aide (MA) on 08/14/20 at 3:22pm.

Refer to telephone interview with the Interim Administrator on 08/19/20 at 10:20am.

b. Review of Resident #8's current FL-2 dated 04/01/20 revealed diagnoses included diabetes, schizoaffective disorder, hypertension, hyperlipidemia, and mild mental retardation.

Review of Resident #8's physician's orders dated 07/02/20 revealed an order for Lorazepam 0.5mg take 1 tablet once daily as needed for acute/breakthrough agitation.

Observation on 08/14/20 at 11:26am during the morning medication pass revealed the Co-Manager initialed Lorazepam as administered on the MAR and narcotic log prior to the actual administration for Resident #8.

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D 366	Continued From page 63 Refer to interview with the Co-Manager on 08/14/20 at 2:45pm. Refer to interview with a MA on 08/14/20 at 3:22pm. Refer to telephone interview with the Interim Administrator on 08/19/20 at 10:20am. c. Review of Resident #2's current FL-2 dated 10/01/19 revealed diagnoses included diabetes, schizophrenia, hypertension, mild mental retardation, and gastroesophageal reflux disease. Review of Resident #2's physician's orders dated 07/02/20 revealed an order for Lorazepam 0.5mg take 1 tablet every morning and at lunch. Observation on 08/14/20 at 11:39am during the morning medication pass revealed the Co-Manager initialed Lorazepam as administered on the MAR and narcotic log prior to the actual administration for Resident #2. Refer to interview with the Co-Manager on 08/14/20 at 2:45pm. Refer to interview with a MA on 08/14/20 at 3:22pm. Refer to telephone interview with the Interim Administrator on 08/19/20 at 10:20am. d. Review of Resident #1's current FL-2 dated 01/02/20 revealed diagnoses included paranoid schizophrenia. Review of Resident #1's physician's orders dated 07/02/20 revealed orders for Tramadol 50mg - 2	D 366		

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D 366	Continued From page 64 tablets four times a day, Famotidine 20mg - 1 tablet four times a day, Tylenol 325mg - 2 tablet four times a day, and Reglan 5mg - 1 tablet four times a day (Tramadol and Tylenol are medications used to relieve pain. Famotidine and Reglan are medications used to treat gastroesophageal reflux disease). Observation on 08/14/20 at 11:48am during the morning medication pass revealed the Co-Manager initialed Tramadol, Famotidine, Tylenol, and Reglan as administered on the MAR and Tramadol on the narcotic log prior to the actual administration for Resident #1. Refer to interview with the Co-Manager on 08/14/20 at 2:45pm. Refer to interview with a MA on 08/14/20 at 3:22pm. Refer to telephone interview with the Interim Administrator on 08/19/20 at 10:20am. _____ Interview with the Co-Manager on 08/14/20 at 2:45pm revealed: -She did not see the problem with pre-documenting on the MARs or narcotic log because she always watched the residents take their medications. -She sometimes documented before she administered medications and sometimes after she administered medications. -It depended on when she remembered, but she always documented on the residents' MARS when she administered medications. -She was taught to document on the MARs after medications were administered to the residents. Interview with a MA on 08/14/20 at 3:22pm	D 366		

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D 366	Continued From page 65 revealed: -Staff should document all medication administration and treatment in the residents' MARs immediately after they completed administration. -She documented after each resident's medication administration because that is what she was taught to do. -She did not think it was right to pre-document on the residents' MARS or narcotic logs. Telephone interview with the Interim Administrator on 08/19/20 at 10:20am revealed: -She did not know about the Co-Manager pre-documenting when administering medications. -She took over as the Administrator on 08/14/20. -Staff should not be pre-documenting on the MARs during medication administration. _____ The facility failed to ensure staff documented the administration of medications immediately after they were given for two residents (#4, #5) during the initial tour and staff pre-documented medication administration for 4 residents (#1, #2, #7, #8) including narcotics, pain-relievers, and an acid reflex medication during a medication pass which was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection on 08/19/20 and 09/11/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2020.	D 366		

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D 378	Continued From page 66	D 378		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were under locked security related to inhalers, eye drops, barrier cream, and cough syrup that were left unsecured on top of the medication cart in the hallway of the facility without direct physical supervision and accessible to at least one resident who had a history of dementia and disorientation and one resident who was identified as constantly disoriented and related to the medication cart keys that were left unattended and unsupervised on the top of the medication cart. The findings are: 1. Review of the facility Medication Storage policy/procedure revealed: -Maintain security of medications during medication administration. -Assure medication room/cart/cabinet is locked when not in use.	D 378		

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D 378	Continued From page 67 -Do not put keys on top of cart under the MAR book. -Do not put keys in a cubby hole on the medication cart. -Medications are to be stored in a locked area, unless the medications are under the direct supervision of staff. -Direct supervision means the cart is in sight and the staff person can get to the cart quickly, if necessary. -Medication room/cart/cabinet is locked when not in use. -Unless the medication storage area is under the direct supervision of staff, the medication area including carts is to be locked. -When a medication care is not being used, it should be stored in a locked area or stored in an area where it is under the supervision of staff. Observation of the facility on 08/11/20 from 11:10am to 11:44am revealed: -A resident who has dementia and a history of disorientation was standing at the left end of the medication cart located in the main hall between the day room and the nurses' station. -The Medication Aide (MA) was observed in the hallway and entered the nurses' station from the main hall doorway. -Observation of the cart was blocked by a wall between the cart and the nurses' station. -A second resident who was identified as being constantly disoriented ambulated to the cart and then stood at the right side of the medication cart. -On the top of the medication cart were three inhalers, a container of eyedrops;a tube of barrier cream was on the left ledge of the medication cart. -The MA walked from the side hall beside the nurses' station, entered the main hall from the side hallway and ambulated to the medication	D 378		

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cart.
-The MA opened the medication drawer without unlocking the medication cart.
-The MA was observed in the day room.
-A set of medication cart keys was on the top of the medication cart.
-The MA was not present at the medication cart or within sight of the cart.
-The medication cart was left unobserved and unattended.

Observation of the facility on 08/14/20 at 3:38pm revealed:
-The medication cart was in the main hallway outside the day room.
-The mediction cart was left unobserved and unattended by the MA sitting with her back to the cart in the day room and subsequently while she worked in the facility office.
-A tube of barrier cream was on an open shelf on the left side of the medication cart.
-The MA was not present at the medication cart or within sight of the cart.

Refer to telephone interview with a personal care aide (PCA) on 08/18/20 at 9:10am.

Refer to telephone interview with a second MA on 08/18/20 at 10:05am.

Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm.

2. Observation of the facility during 11:30am medication pass on 08/14/20 from 11:09am to 11:50am revealed:
-There was a house stock 118 milliliter (ml) bottle of cough syrup that contained 118 milliliter (ml) on top of the medication cart.
-There was a tube of barrier cream on the left

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ledge of the medication cart.
-Neither medications were secured while the Co-Manager completed the 11:30am medication pass.
-The Co-Manager called a resident who has dementia and a history of disorientation to the medication cart in the hallway to perform her fingerstick and insulin injection.
-The Co-Manager had to leave the medication cart to get more insulin for the resident from the refrigerator in the medication closet approximately midway down the hall.
-The Co-Manager locked the medication cart; the cough syrup and barrier cream were left unsecured on the medication cart when the Co-Manager left the medication cart at 11:31am.
-There was no one there to supervise the resident or monitor the medication cart with the unsecured medications while the Co-Manager was gone.
-The Co-Manager returned to the medication cart with the resident's insulin at approximately 11:34am.
-The Co-Manager opened the medication cart and resumed preparing for the resident's insulin injection.

Second observation of the facility on 08/14/20 at 2:44pm revealed:
-The cough syrup and barrier cream were still in the same spots originally noted at 11:09am on top of the medication cart.
-The medication cart was parked in the hallway across the hall from the day room by the front door.
-The medication cart was locked and there were no residents in the hallway where the medication cart was.

Review of the facility's medication storage policy revealed medications are to be stored in a locked

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area, unless the medications are under the direct supervision of staff.

Interview with the Co-Manager on 08/14/20 at 2:45pm revealed:
-Medications were never left out on the medication cart unsecured.
-If a medication was left out on top of the medication cart, the medication cart was always within her sight.
-She had not noticed the cough syrup, or the barrier cream had been left unsecured on top of the medication cart.
-The barrier cream was probably left out of the medication cart that morning because they had a few residents who were incontinent, and the residents requested to use the barrier cream, so the staff just kept it on the ledge of the medication cart.
-The cough syrup was part of the house stock and she probably kept it on top of the medication cart just in case a resident had a cough or a sniffle.
-Both the cough syrup and the barrier cream were supposed to locked in the medication cart or the medication storage room.
-The facility did not have any problem with any residents who were disoriented or who would disturb medications that may be unsecured on the medication cart.

Interview with a MA on 08/14/20 at 3:22pm revealed:
-Medications were supposed to be secured and locked in the medication cart or in the medication closet.
-Medications were not supposed to be left on top of the medication cart.
-She did not know why the cough syrup had been left on top of the medication cart.

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D 378	Continued From page 71 -She thought that another staff member may have been left the barrier cream out on the medication cart after they used the barrier cream. Telephone interview with the Interim Administrator on 08/19/20 at 10:20am revealed: -She did not know anything about any problems with medications being left unsecured on the medication cart. -She took over as the Administrator on 08/14/20. -Staff should make sure that all medications were secured in the medication cart. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -The medication cart was always locked. -Staff should not have left house stock medicines on top of the cart because a resident may have taken it. Refer to telephone interview with a personal care aide (PCA) on 08/18/20 at 9:10am. Refer to telephone interview with a second MA on 08/18/20 at 10:05am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:02pm. _____ Telephone interview with a PCA on 08/18/20 at 9:10am revealed the medication cart was parked near the staff office during the day when not being used and she had not seen any medications left unattended on the cart. Telephone interview with a second MA on 08/18/20 at 10:05am revealed: -She did not leave medications on top of the medication cart; she put them back where they belonged.	D 378		

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D 378	Continued From page 72 -Some house stock medications were kept in the bottom of the medication cart and some were kept in a medication cabinet. -No medications were stored on top of the medication cart. Telephone interview with the Interim Administrator on 08/26/20 at 1:02pm revealed: -Medicines, including house stock, should be stored in the locked medicine cart at all times. -There was no reason to leave medicines on top of the medicine cart. _____ The facility failed to ensure medications were maintained under locked security or under direct supervision of staff in charge of medication administration by leaving medications unsecured on the medication cart in the hallway of the facility on at least two separate occasion, including one occasion when at least one resident with a diagnosis of dementia, and a second occasion when a resident identified as constantly disoriented, were left unsupervised and had access to unsecured medications and by leaving the medication cart keys unattended on the top of the medication cart. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection on 08/19/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2020.	D 378		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents	D 454		

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D 454	Continued From page 73 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the responsible persons for 2 of 2 sampled residents (#3, #6) within 24 hours for illnesses that required emergency medical evaluations and resulted in hospitalizations. The findings are: 1. Review of Resident #3's current FL2 dated 04/01/20 revealed: -Diagnoses included diabetes mellitus II, epilepsy,	D 454		

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schizophrenia paranoid, mental retardation, hypertension, kidney disease, and hyperlipidemia.
-The resident was semi-ambulatory.

Review of Resident #3's care plan dated 04/01/20 revealed:
-The resident was oriented.
-The resident was forgetful and needed reminding.
-The resident needed assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident used a walker as needed.

Review of Resident #3's resident register dated 06/05/15 revealed the name and telephone numbers for two family members as contact persons.

Review of a hospital discharge summary for Resident #3 dated 08/20/20 revealed:
-Resident #3 was admitted to the hospital on 08/10/20 and discharged from the hospital on 08/20/20.
-The diagnoses were acute kidney injury, COVID-19, hypernatremia, chronic kidney disease stage 3, and left leg swelling.

Telephone interview with Resident #3's family members on 08/24/20 at 1:50pm revealed:
-They handled Resident #3's affairs.
-They were not notified Resident #3 was in the hospital.
-They had been calling the facility but the staff would not give them any information on the resident.
-They got in touch with the Manager on 08/11/20.
-She told them Resident #3 went to the hospital on 08/10/20.
-They were not notified the last few times

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D 454	Continued From page 75 Resident #3 went to the hospital. Telephone interview with the MA on 08/25/20 at 2:28pm revealed: -She notified a family member of Resident #3's hospitalization but could not recall the date of notification. -She thought the previous Administrator and Co-Manager notified someone. Telephone interview with the Manager on 08/26/20 at 10:15am revealed: -She usually called the family when a resident was sent to the hospital. -She was not working on 08/10/20 so she gave the contact person's telephone number to the MA and instructed the MA to call the family. Telephone interview with the Interim Administrator on 08/25/20 at 2:00pm revealed: -The MA and the Manager were responsible for notifying contact persons when a resident was hospitalized. -The notification to the resident's contact person should be done as soon as the resident leaves the facility. -Resident #3's contact persons were not notified when he was sent out the hospital. 2. Review of Resident #6's current FL-2 dated 04/01/20 revealed diagnoses included schizophrenia, diabetes, hypertension, obesity, hyperlipidemia. Review of the Resident Register for Resident #6 revealed: -Resident #6 was admitted to the facility on 06/26/12. -Resident #6's family member was his responsible person.	D 454		

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D 454	Continued From page 76 Review of Resident #6's hospital discharge summary visit notes revealed Resident was hospitalized from 08/08/20 through 08/17/20 due to COVID-19, acute encephalopathy, and Type II diabetes mellitus. Telephone interview with a family member of Resident #6 on 08/24/20 at 11:57am revealed: -She had an problem with the facility about a week and half ago when she found out the facility failed notify her when Resident #6 was admitted to the hospital. -She received a phone call from a medication aide (MA) at the facility, on either 08/11/20 or 08/12/20, that Resident #6 had been admitted to the hospital on 08/08/20 because he was unresponsive. -The family member was upset because the MA told her that Resident #6 had COVID-19. -The MA told that the second MA was supposed to have notified her the same day that Resident #6 was hospitalized. -She called and spoke with the Administrator on 08/12/20 and the Administrator explained that she had been away from the facility. -She did not think it was right that the responsible person was not notified when Resident #6 was hospitalized. Attempted telephone interviews with the MA who called Resident #6's responsible person was unsuccessfully on 08/25/20 at 2:53pm and 08/26/20 at 10:08am. Telephone interview with the second MA on 08/25/20 at 2:28pm revealed: -She was not the MA who worked on 08/08/20 when Resident #6 was sent to the hospital. -She called Resident #6's family member	D 454		

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(responsible person) on 08/10/20 after the Administrator instructed her to contact his family member.
-Resident #6's family member (responsible person) was very upset because they were noted notified the day Resident #6 went into the hospital.

Telephone interview with the Manager on 08/26/20 at 10:15am revealed:
-She usually called the family when a resident was sent to the hospital.
-She was not working the day Resident #6 was sent out the hospital, so she was not sure who contacted his family member (responsible person).

Telephone interview with the Administrator on 08/12/20 at 3:19am revealed:
-Resident #6's family member contacted her on 08/12/20 regarding not being notified when the Resident #6 was hospitalized.
-It was the responsibility of the second medication aide who was worked the shift when Resident #6 was sent to the hospital to notify his responsible party or family.
-She did not know Resident #6's responsible party had not been notified until the family member called her to complain.

Telephone interview with the Interim Administrator on 08/25/20 at 2:00pm revealed:
-The medication aide (MA) and the Manager were responsible for notifying contact persons when a resident was hospitalized.
-The notification to the resident's contact person should be done as soon as the resident leaves the facility.

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D912	Continued From page 78	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews of staff and residents, the facility failed to ensure provision of adequate and appropriate care and services to residents regarding medication storage, medication administration, and management and other staff. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure staff documented on the medication administration records (MARs) the administration of medications immediately following the administration and not prior to the next residents administration of medication for 2 sampled residents (#4 and #5), during the initial facility tour on 08/11/20 and failed to ensure staff did not pre-chart medications for 4 of 8 sampled residents (#1, #2, #7, #8) during a medication pass on 08/14/20. [Refer to Tag D378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation).] 2. Based on observation, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules related resident's rights, medication administration, and medication storage. [Refer to	D912		

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D912	Continued From page 79 Tag D176 10A NCAC 13F .0601(a) Management of Facilities (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to ensure staff prepared medications for administration in accordance with the facility's policies and procedures as related to a medication aide failing to use the medication administration records (MARs) for guidance when preparing and administering sliding scale insulin for 2 sampled residents (#4, #5) observed during the initial tour of the facility on 08/11/20. [Refer to Tag D366 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure residents were free of neglect and harm as related to residents' rights regarding the facility adhering to infection control guidelines during the Coronavirus pandemic. The findings are: 1. Based on interviews, observations 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 (DHHS) were implemented and maintained when caring for residents during the global Coronavirus	D914		

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D914	Continued From page 80 (COVID-19) pandemic as related to screening of visitors and staff, use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolated residents to designated areas; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and precautions to reduce the risk of transmission and infection including one resident (#3) who was previously COVID-19 negavitive being allowed to remain in a known COVID-19 positive room and failed report the resident's exposure to COVID-19 to his health care provider. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).]	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934		

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D934	Continued From page 81	D934		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide mandatory, annual state approved infection prevention training in accordance with the instructions and requirements as related to skills demonstration, guided student practice and return demonstration with skills check-offs for 3 of 3 medication aides (A, B, C) sampled that had been employed for more than one year.

The findings are:

Review of the Instructor's Manual for the State Approved Infection Control Training Course revealed:
-Return demonstration describes what a student must do to indicate ability to apply what is learned.
-The student is to demonstrate skills for handwashing, hand rub with alcohol based product and the application and removal of gloves.
-If actual demonstration of use of mask and/or gown is not possible, the student should be able to verbalize the application and removal of mask and gown.
-Each skill must be demonstrated by the instructor.

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D934	Continued From page 82 -Guided student practice is a vital component of skill acquisition and is best done right after skill demonstration. -Skill check-offs are held after demonstration and student practice have taken place. -The adult care home is responsible for maintaining the documentation of the training and completed skill sheets in the staff's file. 1. Review of Staff A's personnel record revealed: -Staff A was hired on 11/30/17 as a medication aide (MA). -There was a certificate with a male pharmacist's electronic signature for the state infection control training course for Staff A dated 01/24/20. -There were no skills check-off sheets for the state approved infection control training. Telephone interviews with Staff A on 08/20/20 at 2:06pm and 08/25/20 at 2:28pm revealed: -She had worked at this facility since 2017 as a MA. -She was not sure but she thought she had the state approved infection control training last year but she could not recall the date. -Staff had to watch videos during the training and the female instructor talked with them. -The instructor asked the class questions and staff had to take a written test. -No male instructor had trained staff on infection control. -She was not certain if the training she had was the state infection control course because they did most trainings on the computer and watched videos but she could not remember them all. -She did not recall having state approved infection control training in 2020. Refer to telephone with the Co-Manager on 08/25/20 at 3:31pm.	D934		

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D934	Continued From page 83 Refer to telephone interviews with the Manager on 08/24/20 at 9:45am and 08/26/20 at 10:13am. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/20 at 1:43pm. Refer to telephone interviews with a nurse from a contracted teaching service on 08/26/20 at 8:20am and 9:34am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:05pm. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 03/01/18 as a medication aide (MA). -There was a certificate with a pharmacist's electronic signature for the state infection control training course for Staff B dated 01/24/20. -There were no skills check-off sheets for the state approved infection control training. Telephone interview with Staff B on 08/21/20 at 11:43am revealed: -She had worked at the facility for a total of 6 years, since February 2014. -She became a MA around April 2015. -She did the state annual infection control training in January 2020. -A nurse showed them a video and asked them questions. -They discussed handwashing and how to clean and disinfect. -They all did handwashing and she thought they put on and took off gloves during the training but she was not sure. -She did not recall any demonstration, guided practice, or return demonstration of putting on or	D934		

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taking off gowns and masks.
-She did not recall a male pharmacist doing any training on infection control at the facility.

Refer to telephone with the Co-Manager on 08/25/20 at 3:31pm.

Refer to telephone interviews with the Manager on 08/24/20 at 9:45am and 08/26/20 at 10:13am.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/20 at 1:43pm.

Refer to telephone interviews with a nurse from a contracted teaching service on 08/26/20 at 8:20am and 9:34am.

Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:05pm.

3. Review of Staff C's personnel record revealed:
-Staff C was hired on 04/01/11 as a medication aide (MA).
-There was a certificate with a pharmacist's electronic signature for the state infection control training course for Staff C dated 01/24/20.
-There were no skills check-off sheets for the state approved infection control training.

Telephone interview with Staff C on 08/18/20 at 10:05am revealed:
-She had worked at the facility for 10 or more years, mostly as a MA but also as a personal care aide (PCA).
-She had infection control training but she could not remember the last time it was done.
-She did not recall having any recent infection control training.

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D934	Continued From page 85 Telephone interview with the Executive Officer (EO) on 08/24/20 at 11:19am revealed: -According to his records, Staff C was originally hired on 09/18/08 and terminated on 11/12/09. -Staff C was rehired on 04/04/11. Refer to telephone with the Co-Manager on 08/25/20 at 3:31pm. Refer to telephone interviews with the Manager on 08/24/20 at 9:45am and 08/26/20 at 10:13am. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/20 at 1:43pm. Refer to telephone interviews with a nurse from a contracted teaching service on 08/26/20 at 8:20am and 9:34am. Refer to telephone interview with the Interim Administrator on 08/26/20 at 1:05pm. _____ Telephone with the Co-Manager on 08/25/20 at 3:31pm revealed: -Staff had the state annual infection control training at the facility on 01/24/20. -They used a computer training with videos provided by the facility's contracted pharmacy. -There was also a female instructor (did not know her name) who came to the facility and had a class for about 1 and ½ hours. -She went over bloodborne pathogens, handwashing, and how to disinfect surfaces. -Staff practiced handwashing and each had to demonstrate handwashing. -They printed certificates from the computer training provided by the pharmacy. -She did not know if the female instructor provided any certificates.	D934		

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D934	Continued From page 86 Telephone interviews with the Manager on 08/24/20 at 9:45am and 08/26/20 at 10:13am revealed: -She was responsible for the personnel files and setting up in-services and training for staff. -They usually did the state annual infection control training for staff each year in January. -The facility had a training company they used previously but they stopped coming so she talked with the pharmacy around the beginning of January 2020 about setting up some training. -The male pharmacist did not come to the facility and do the training but he knew about it. -A nurse who worked at the pharmacy and did licensed health professional support (LHPS) reviews and other training at the facility did their annual state infection control training in January 2020. -The nurse was at the facility doing LHPS reviews so she asked the nurse about doing the infection control training while she was at the facility. -The nurse did a class with a video and went over it briefly. -The video was about 30 minutes long, they had a discussion, and answered questions. -The nurse used slides on the computer and went over proper procedures for bloodborne pathogens. -The nurse did not demonstrate anything and the nurse did not observe the staff demonstrate any infection control tasks. -No return demonstration skills set check offs were completed for any staff. -That was the way they had always done the infection control training, with no return demonstrations. -There was no sign-in sheet for staff and no documentation was left at the facility by the nurse. -She thought the nurse may have sent a list of	D934		

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names of staff to the pharmacy.
-Staff had to do computer training by themselves, take a test, and then they could print their certificates.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/24/20 at 1:43pm revealed:
-The pharmacy developed an online program using the state approved infection control course a couple of years ago.
-The pharmacy's online training program did not include the required hands-on part of the state approved infection control course, including the clinical skills sets for return demonstration of infection control tasks.
-The facility was supposed to get their nurse to do the hands-on part of the training, including the demonstrations, guided practice, and return demonstration check offs.
-This was discussed with facility staff in the past when they started using the pharmacy's online training course.
-He could not recall which staff but it was probably a previous Administrator since there had been a lot of staff turnover at the facility.
-The certificate had his electronic signature because when the staff completed the online course and took a test at the end of the course, it would automatically generate the certificate if they passed the computerized test.
-He was not aware the facility was not getting a nurse to complete all of the requirements of the hands-on portion of the infection control course as required.
-The pharmacy did not employ nurses but they had different training vendors they could recommend to the facility as resources for nurse trainers.
-He realized now that his electronic signature on

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D934	Continued From page 88 the state annual infection control certificates was misleading as it appeared he had done the complete state annual infection control training himself and that staff had completed the entire course, classroom and hands-on. Telephone interviews with a nurse from a contracted teaching service on 08/26/20 at 8:20am and 9:34am revealed: -She provided back-up licensed health professional support (LHPS) reviews for the facility. -The facility Manager asked her about doing infection control training one day while she was on-site at the facility doing LHPS reviews sometime around the first part of February 2020. -She had taught the state approved infection control training course in the past but she did not come to the facility that day prepared to do the training because she was not asked about it prior to her visit. -For that reason, she did not feel comfortable saying the participants received training on everything they were supposed to in the training course in February 2020. -It was "probably a hit or miss thing" and incomplete. -She did not keep a roster of staff who attended and she did not sign anything or leave certificates because they already had certificates signed by the pharmacist on 01/24/20. -She would prefer to do the entire training course herself and she always used the required state annual infection control course available online on the state's website when she did the entire training course. -She usually went over disinfecting, handwashing, gloves, and masks verbally. -She went over information about shingles, flu shots, and different types of bacteria.	D934		

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D934	Continued From page 89 -She usually got staff to wash their hands, use hand sanitizer, and put on and take off gloves. -She was aware of the clinical skills sets for return demonstration required in the course but she did not do the skills sets with staff in February 2020 because she did not come to the facility prepared to do the training. -If she had done return demonstration for all of the skills sets, she would have left copies for the facility's files. Telephone interview with the Interim Administrator on 08/26/20 at 1:05pm revealed: -The Manager was responsible for personnel files and making sure training classes are done. -The Manager was responsible for making sure staff completed the state annual infection control training course as required. -She was not aware the state annual infection control training was not completed in accordance with the course requirements in January and February 2020. -She spoke with staff at the facility's contracted pharmacy yesterday (08/25/20) and she had a nurse trainer coming to the facility to redo the state annual infection training course for staff as required.	D934		