[External] Cadence Garner POC Revised

Heather Thomas <hthomas@cadencesl.com>

Tue 3/9/2021 10:00 AM

To: Nielsen, Tina B <tina.nielsen@dhhs.nc.gov>
Cc: Treva Whalen <twhalen@cadencesl.com>; Susan Stangroom <sstangroom@cadencesl.com>; Stacey Knox <sknox@allenflores.com>; Shelly Halleck <shalleck@allenflores.com>

1 attachments (3 MB)

Cadence Garner POC revised 3.8.2021.pdf;

Dear Ms. Nielsen,
Please find attached the revised and updated POC for Cadence Garner. If you have any questions don't hesitate to reach out anytime.

Have a great day.

Heather Thomas
Vice President of Operations- NC
Cadence Living
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Scottsdale, AZ 85253
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092215	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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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 12/30/20 and 01/04/21 and a desk review survey on 12/31/20 and 01/05/21 - 01/07/21, and a telephone exit on 01/07/21. On 01/12/21, the survey was reopened per the guidance from the supervisor and upper management, the desk review continued from 01/12/21 to 01/20/21, and a second telephone exit was done on 01/20/21.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure the facility was free of hazards as evidenced by storage of soiled furniture in a section of the hallway, toiletry items and a topical pain medication left unsecured in an unlocked and unoccupied resident room and bathroom and a unlocked laundry room accessible to all residents in a Memory Care Unit (MCU) including residents known to have dementia and/or wandering behaviors. The findings are:	D 079	D 079 – Community POC Response 1.The soiled furniture was immediately removed from the hallway on 1/4/21. The laundry room door was pulled closed and locked automatically. Personal items and medications were immediately removed from room C7. Housekeeping staff and personal care staff were re-educated on the importance of prompt removal of soiled items, that laundry room and janitorial closets must always remain locked in the secured units, and that all personal care items must be secured and out of residents' reach. 2. A new procedure has been developed to ensure that all soiled furniture or furniture awaiting donation/disposal will be stored in a secured/locked area inaccessible to residents. Maintenance, housekeeping and care staff will be educated on this procedure by 2/19/21. A new system for resident transitions has been created for verification of room readiness. The system will track room vacancies, personal item removal by	3/6/2021

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Reviewed + Accepted 03/09/21
Dria B Nielsen RN MSN

3-9-21

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D 079	Continued From page 1 Observation of the C hallway in the Memory Care Unit (MCU) beside room# C7 on 01/04/21 at 1:22pm revealed: -The hallway was assessible to the residents and separated from the remainder of the MCU by closed, double doors. -There were 4 chairs lined up beside one another against the left wall of the hallway blocking the rail on the wall. -The fourth chair had a set of wheelchair leg rests in the seat. Interview with the RCD on 01/04/21 at 1:59pm revealed: -The brown stains and build-up substance in the chairs located in the hallway appeared to be feces. -She thought the chairs were placed in the hallway the week prior. -Items were placed at the end of C-Hall until they could be addressed by the Maintenance Director. -The Maintenance Director was responsible for inspecting the furniture/equipment and fixing it if appropriate. -If the furniture could not be cleaned, then the Maintence director would dispose of it. Telephone interview with the Memory Care Director (MCD) on 01/06/20 at 12:59pm revealed she was not aware there were soiled chairs stored in the hallway in the MCU on the C hallway. Observation of the laundry room on the C hall of the MCU on 01/04/21 at 1:25pm revealed: -The unlocked laundry room was in a section of the hallway that was separated from the remainder of the MCU by closed, double doors and was accessible to the residents.	D 079	resident families, track completion of required repairs, and completion of terminal cleaning. Room assignment must be signed off by the ED/designee once room readiness has been verified. Rooms must remain locked during the readiness process. Community leadership will be trained on the new system and implementation will occur on 2/19/21. Housekeeping and care staff re-education and training will continue regarding maintaining the adult home in an uncluttered, clean, and orderly manner, free of all obstructions and hazards. Training was provided on 1/28/21 and will be provided again on 2/18/21. A Shift Supervisor and PCA responsibility checklist has been created to including rounding in all areas of the unit each shift to ensuring all empty rooms, laundry areas, janitorial closets, and any area that would be considered hazardous to residents are locked. Supervisors and PCAs will be trained for implementation on 2/18/21 and as needed for compliance. Department leadership will be re-educated on the community expectation that leadership round on all areas of their units at least daily when on duty to ensure that any potential resident hazards are immediately addressed.	

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D 079	Continued From page 2 -The door to the laundry room was in a fully opened position with the items in the room visible from the doorway. -There was an enclosed device labeled as a "chemical laundry dispenser", positioned on the wall with an unlocked lid. -Inside the laundry dispenser, there was a solid white substance. Observation of the bathroom in an unoccupied room (room #C7, on the C hall of the MCU) on 01/04/21 at 1:03pm revealed: -The bathroom in the unoccupied room (room #C7) was separated by closed, double doors. -There was an opened 22-ounce container of baby cornstarch powder with approximately ½ of the powder remaining with labeled directions for external use only and do not apply to broken or irritated skin, stored on the side of the sink. -There was a container of a liquid perineal cleanser with a former resident ' s name handwritten on the container, stored on the side of the sink. -There was a 16-ounce bottle of a liquid body and shampoo wash with labeled directions for external use only and avoid contact with eyes, stored on the side of the sink. -There was a bottle of liquid mouthwash stored on the side of the sink. Observation of an unoccupied room (room #C7, on the C hall of the MCU) on 01/04/21 at 1:19pm revealed: -The unoccupied room was in a section of the hallway that was separated from the remainder of the MCU by closed, double doors. -The entrance room door was in an opened position. -There was a plastic container in the top of the closet in the room used to store toiletry items.	D 079	Room sweeps on the memory care units will be assigned to care staff and conducted weekly to ensure personal care items, medications, cleaners, and other hazardous materials are not stored accessible to residents in their rooms. Hazardous items found will be either secured or returned to the resident's family. Staff will be training on the room round process on 2/18/21, with 2/19/21 implementation. The community has added auto closing arms to both memory care laundry room doors to ensure doors remain secure. An electronic keypad for the doors will be purchased and installed on the laundry room doors on the secured memory care unit to ensure that laundry room doors are always secured while allowing staff easy access to the area when completing laundry. Keypad and auto closing features will be installed upon delivery and staff will be immediately trained on keypad use. 3. The ED or designee will round twice weekly for four weeks to ensure all empty rooms and areas containing hazards are secured, preventing resident access. 25% of occupied resident rooms will be spot checked to ensure compliance with weekly Room Sweeps. Rounding will continue weekly for 2 additional months. Results will be reviewed for staff compliance, trends, and patterns and reported through QA. The QA Committee make on-going recommendations.	

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D 079	Continued From page 3 -There was a 16-ounce tube of toothpaste without a lid, with approximately 1/4th of the toothpaste remaining with a former resident's name handwritten on the tube. -There were labeled instructions if more of the toothpaste used for brushing was accidentally swallowed, get medical help or contact a Poison Control Center right away. -There were at 3 more smaller tubes of toothpaste that had been opened and were stored in the plastic container. -There was a 100gram tube of Voltaren gel, labeled as prescription only, topical use only with approximately 3/4th of the medication remaining. (Voltaren gel is a topical pain medication used to relieve pain, swelling, and joint stiffness caused by arthritis). -There were labeled directions not to use the Voltaren gel in eyes. -There was a 2-ounce bottle of skin moisturizer. -There was a 3.5-ounce bottle of cold cream cleanser and make up remover with approximately ½ of the cream remaining. -There were labeled warning directions for external use only, if product got into the eyes, rinse thoroughly. -There were two containers of antiperspirant (one in a solid stick form and the other as a liquid roll on). -There were four worn toothbrushes with one of the toothbrushes stored inside an enclosed holder with a former resident's name written in the holder. Observation behind the closed double doors on the C hallway of the Memory Care Unit (MCU) on 01/04/21 at 1:58pm revealed: -A male resident was observed ambulating in the hallway passing the soiled chairs stored in the hallway, the unoccupied resident room# C7 and	D 079	Shift Supervisor and PCA Shift Checklists will be reviewed by the department supervisor, RSC, and/or ED weekly for 3 months through 5/19/21. Results will be reviewed for compliance, trends and patterns reported through QA for on-going recommendations. 4. All corrective measures will be implemented by 3/6/21/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends and patterns.	

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D 079	Continued From page 4 the opened door leading to the laundry room and toward the facility's exit door at the end of the hallway. -The male resident ambulated to the exit door at the end of the hallway and after being prompted, was redirected by the Resident Care Director (RCD) away out of the hallway behind the closed double doors. Interview with the RCD on 01/04/21 at 1:59pm revealed: -The male resident seen in the hallway went into this section of the hallway a lot to look out the exit door's window. -The laundry room should always be locked. -There were residents who resided on the MCU with dementia and/or wandering behaviors. -Chemicals were stored in the laundry room that could be harmful if ingested. -Room# C7 had been used for residents who needed end of life care. -The RCD was not aware that Room# C7 had not been deep cleaned. -Room# C7 had not been occupied for a couple of weeks. -Housekeeping was responsible for the cleaning of residents' rooms after discharge. -She was not aware that there were toiletry items or topical medications stored in residents' rooms and the bathroom. -Medications were stored on the locked medication cart. -Toiletry items were stored in the locked storage closet near the nurses' station. -The RCD locked the door to room# C7, locked the laundry room door, and would notify the Maintenance Director of the furniture in the hallway. Telephone interview with the Memory Care	D 079		

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D 079	Continued From page 5 Director (MCD) on 01/06/20 at 12:59pm revealed: -The laundry room should always be locked. -She was not aware there was an unlocked resident room and bathroom with toiletries including tubes of toothpaste, cornstarch, perineal cleanser, body wash, shampoo, mouth wash skin creams, antiperspirant, a topical pain medication left unsecured in the bathroom and closet of the room. -She thought housekeeping had cleaned this area and removed all items. -She last monitored this area on C hall in the MCU around 12/14/20. -There should not have been any toiletries or topical pain medications left unsecured and accessible to any of the residents. -The MCU had a lockable cabinet space to keep all the residents' toiletry items locked and secured. -She attempted to limit exposure to different areas of the facility when residents were testing positive for COVID-19 and had assigned a named staff to ensure all areas on C hall were cleaned; however she had not monitored the area behind the double doors because no residents were assigned to those resident rooms. -Staff were responsible not to prohibit and redirect any residents from entering that section of the hallway behind the double doors. -She was not aware a male resident went back in this area of the hallway. -The male resident observed walking in the area of the hallway behind the double doors on 01/04/20 was at risk for ingesting liquids that were undrinkable (dangerous to consume). -The male resident was a wanderer and at risk for picking up items, picking up a shower product thinking the product was something to drink because of his diagnosis cognitive limitations. -Residents in the MCU always needed to be	D 079		

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D 079	Continued From page 6 monitored to keep the residents safe. Telephone interview with one of the primary care providers (PCPs) for the facility on 01/06/21 at 8:05am revealed: -She was the PCP for the male resident observed in the hallway of the facility on C Hall in the MCU on 01/04/21. -She had concerns if any of the residents' in the MCU had accessibility to any chemicals. -The male resident would pick up different items, had dementia and would not understand the importance of not touching items or use an item he picked up that could potentially harm him. Telephone interview with the Administrator on 01/05/21 at 3:32pm revealed: -The facility had a hazard policy. -He would attempt to locate the policy and provide a copy. At the time of exit on 01/07/21, the facility's hazard policy was not provided. Interview with the Administrator on 01/04/21 at 4:50pm revealed: -He expected staff to ensure all areas of the facility were free of hazards. -Re-education would be done with all staff to ensure all hazards were secured and not accessible to residents in the MCU. Based on observations, record reviews, and interviews the male resident observed on the C hall of the MCU was not interviewable. Attempted telephone interview with the Maintenance Director was unsuccessful on 01/05/21 and 01/06/21.	D 079		

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D 079	Continued From page 7 The facility failed to ensure hazards were secure including a laundry room used to store chemicals; a topical pain medication, liquid and solid toiletries; and unclean furniture including a chair soiled with stains left accessible to all residents including one resident who was known to walk in that area of the hallway frequently, had dementia and/or wandering behaviors and would not understand the importance of not touching items or use an item he picked up that could potentially harm him. The facility's failure was detrimental to the health and safety of the residents which constitutes a Type B Violation The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 06, 2021	D 079		
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 ensure 1 of 6 sampled staff (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) in accordance with G.S. 131 E-256 upon	D 137	D 137 – Community POC Response 1.The North Carolina Health Care Personnel Registry for Staff B was re-printed to ensure date verification was included on the document. 2.All active staff employee records were audited to ensure that all staff had North Carolina Health Care Personnel Registry (HCPR) checks, that included the print date prior to the prospective employee's start date. Any variances will be corrected by reprinting the Registry information to ensure that the print date was included on the document.	3/6/2021

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D 137	Continued From page 8 hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 12/16/20 as a medication aide (MA). -There was no documentation of a HCPR check upon hire. Interview with Staff B on 12/30/20 at 5:15am revealed: -She was hired as a MA. -She had only worked at the facility for 7 days. -She worked third shift as a MA and floated on all the halls. Telephone interview with the Business Office Manager (BOM) on 01/07/21 at 11:08am revealed: -She was responsible for the HCPR checks for the staff. -She could not find the original document with the date of the HCPR check prior to hire. -She printed one on 01/07/21 when she could not find the original. -She would continue to look for the original document and would fax to the survey team when she located it. Upon exit, no further documentation was received.	D 137	3. All prospective staff HCPR checks will be audited by the ED prior the employee start date to ensure the HCPR has been completed and contains the print date. Auditing will continue through 5/19/21. Results will be reviewed for staff compliance, trends and patterns and reported through the QA Committee for recommendations. Active employee files will be audited by the BOD quarterly for 1 year to ensure HCPR verification has been completed and the verification document includes the print date. Results will be reviewed for staff compliance, trends and patterns and reported through the QA Committee for recommendations. 4. All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more	D 188		

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D 188	Continued From page 9 shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the	D 188	D 188 – Community POC Response 1. The staff on duty at the time of survey and the Activities Director were immediately re-educated on the need to always maintain minimum staffing levels (including breaks and assigned duties that take staff of the unit). First shift staff were also provided immediate re-education. 1/6/21. Additional staff re-education was completed on 1/7/21. The RSC was re-educated on required staff on 2/19/21. 2. Shift Supervisors were re-educated on the requirements for staffing based on census. The minimum staffing requirements have been posted at each Nurses Stations as a reminder for Shift Supervisors, who are responsible for obtaining coverage due to unexpected absences. The ED or designee will be notified of staffing changes and planned coverage via text after the Daily Assignment Sheet has been posted. Anytime coverage has not been obtained, the ED/designee will be notified and a member of the leadership team will report to the facility to assist with coverage when needed to ensure adequate minimal staffing is maintained until additional coverage can be found. Staff will be trained on this process on 2/18/21, and the process will be implemented on 2/19/21.	3/6/2021

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D 188	Continued From page 10 facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility with a census of 24 - 28 were met for 3 of 8 shifts sampled from 11/16/20-11/20/20 and 4 of 10 shifts sampled from 12/12/20 -12/13/20, 12/18/20 and 12/25/20. The findings are: Review of the facility's current license revealed: -The license was effective 12/01/19 - 12/31/20. -There had been a change of ownership on 12/01/19. -The facility was licensed for a capacity of 84 beds including 36 beds for the assisted living (AL) area and 48 beds for the memory care unit (MCU). -There was not any notation in the license that accounted for the separation of the MCU into 2 separate halls. Review of the facility's resident census reports dated 11/16/20-11/20/20 revealed there was a census of 28 residents on each of those days in the AL area, which required 16 staff hours on first and second shift and 8 staff hours on third shift. Review of the employee time cards dated 11/17/20 (Tuesday) revealed there was a total of 11.47 staff hours provided on first shift with a shortage of 4.53 hours. Review of the employee time cards dated 11/19/20 (Thursday) revealed there was a total of 11.27 staff hours provided on first shift with a shortage of 4.73 hours. Review of the facility's resident census reports for 12/12/20 revealed there was a census of 27 residents in the AL area, which required 16 staff	D 188	Staff were re-educated on the community expectations related to call bell response time on 2/18/21. The community's nurse call system has added additional notifications to nursing leadership via cell phone when resident calls have gone unanswered for 15 minutes, and to the ED when calls have gone unanswered for 20 minutes. 3.The ED/designee will review/initial the nursing Daily Assignment Sheets prior to posting to ensure adequate staff coverage through 5/19/21. The ED or designee will complete unannounced rounds on night shift to ensure compliance with minimum staffing level requirements on the Assisted Living Unit. Rounds will be completed twice weekly for 1 month, weekly for 1 month, and monthly for 1 month thru May 19, 2021. Results will be reviewed for staff compliance, trends and patterns and will be reviewed at QA for on-going recommendations. Nurse Call reports recording response times will be monitored by the ED or designee daily to ensure compliance with community expectations. The report will be reviewed daily for 3 months. Results will be reviewed for non-compliance, trends, and patterns and report to QA for on-going recommendations.	

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D 188	Continued From page 11 hours on first and second shift and 8 staff hours on third shift. Review of the employee time cards dated 12/12/20 (Saturday) revealed: -There was a total of 13.75 staff hours provided on first shift with a shortage of 2.25 hours. -There was a total of 10.75 staff hours provided on second shift with a shortage of 5.25 hours. -There was a total of 2.25 staff hours provided on third shift with a shortage of 5.75 hours. Review of the facility's resident census reports for 12/25/20 revealed there was a census of 24 residents in the AL area, which required 16 staff hours on second shift. Review of the employee time cards dated 12/25/20 (Friday) revealed there was a total of 14.70 staff hours provided on second shift with a shortage of 1.30 hours. Interview with a resident residing on the Assisted Living section on 12/30/20 at 10:15am revealed: -The resident had lived at the facility for 2 ½ years. -There were times the resident had to wait 30 minutes to one hour for staff to respond to her when she pressed the call light for staff assistance and thought this depended on if staff were busy or if there were more staff on duty. -The facility's first shift staffing was "good", second shift was "not quite as good", and third shift staffing "don't expect any body". -The resident occasionally would observe the hallways of the facility until she saw staff passing and she would get the staff's attention when there were long time periods of waiting for staff to respond to her activated call light.	D 188	4. All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	

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D 188	Continued From page 12 Interview with the Resident Care Director (RCD) on 01/20/21 at 10:11am revealed: -She was the one responsible for scheduling the staff. -She had the monthly schedule completed by the 15th of the month for the next month. -All staff who requested time off were to do so ahead of time. -When there was a change needed after the schedule was posted, such as if staff called-off, staff were to find coverage. -If staff could not find coverage, the Supervisor/medication aide (S/MA) was responsible to find coverage. -If the S/MA was not able to find coverage, then she helped find coverage. -She completed a daily log that let the staff see who was working. -The S/MA was responsible to complete the daily assignment sheet based on the daily log. -On first shift, she tried to schedule seven staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on the 4 halls. -On second shift, she tried to schedule 6 to 7 staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on the 4 halls. -On third shift, she tried to schedule staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. -There were two supervisors on first shift, the medication aides (MA) could work as a MA or personal care aid (PCA). -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. -Currently based on the census, she had tried to	D 188		

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D 188	Continued From page 13 schedule two staff on B Hall at all times. -She and the Memory Care Director (MCD) tried to pitch in when they were working. -When someone called out, it was hard to cover at times. -In November and December 2020, the facility was short some shifts. -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. -"We have had some short shifts for one reason of another." -Staff were to punch in and punch out for breaks. -Everyone got 15 minutes in the first part of their shift and another 15 in the latter part of their shift for a total of 30 minutes. -Some staff chose to take one 30-minute break. -The facility has had numerous meetings with staff to make sure that they clocked out for the 30-minute breaks. -For staff breaks, the staff did leave the floor. -They could go to the break room or wherever they chose to take their break. -They were supposed to report to the S/MA to let them know as well as the PCA that they were going on break. -The staff who were going on break was to have whoever was covering for them to take their pager to cover the floor. -The facility had 2 activities staff, the activities director and activities assistant, that did work as PCAs. -Staff were to clock in and clock out and help as needed. -The monthly schedule was posted at the nurses' stations, in the break room, and she would text it to the staffs' phone numbers to ensure they received it. -During the monthly meetings, the schedules were handed out to the staff.	D 188		

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D 188	Continued From page 14 Telephone interview with the Administrator on 01/06/21 at 11:07am revealed: -Staffing schedules were completed monthly ahead of time. -The facility tried to staff 6 staff on 1st and 2nd shift and 4 staff on 3rd shift. -He was not aware of the facility being staffed below "regulatory numbers" but was staffed below what he considered "optimal" and what the facility's goal would have been. -The facility had established a 3rd party staffing contract to ensure the facility stayed above regulations. -The first documentation noted with a 3rd party staff member on a daily assignment was on December 18, 2020. -PCAs for the AL side of the facility were only used to cover staffing and not used in the MCU. -Contracted staff did not utilize the facility's clock in and out time system. -He was not sure if contracted staff were added to the daily staffing log. -Contracted staff did not work at the facility from 12/11/20 - 12/13/20. -Contracted staff was only used on the AL side of the facility. -The facility had many staff to resign in December 2020.	D 188		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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D 270	Continued From page 15 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure staff on the memory care unit (MCU) were available to supervise and meet the needs of the residents to provide any supervision for 1 of 5 sampled residents (#5) resulting in one resident having a fall and being found on the floor in feces. The findings are: 1. Review of Resident #5's current FL-2 dated 11/05/20 revealed: -Diagnoses included dementia, congestive heart failure, major depressive disorder, anxiety, and diabetes. -The resident was ambulatory. -There was no documentation to her orientation status. -Resident #5 resided on the assisted living side of the facility. -The recommended level of care was documented as other memory care unit (MCU). Review of Resident #5's previous FL-2 dated 10/04/20 revealed: -Diagnoses included multiple fractures of ribs, subsequent encounter for fracture with routine healing, repeated falls, and non-traumatic acute subdural hemorrhage. -Resident #5 was previously resided in a skilled nursing rehabilitation center. -The resident was ambulatory. -There was no documentation regarding her orientation status. -The recommended level of care was documented as assisted living facility (ALF).	D 270	D 270 – Community POC Response 1. Resident #5 was assessed for injury and provided incontinence care. Resident #5 sustained no injury related to the fall and experienced not skin breakdown related to the incontinence of stool. Resident #5 was hospitalized on 2/15/21 for change in condition post to COVID vaccination. Psychiatric referrals have been requested from the resident's PCP and hospital Care Manager. A Significant Change assessment will be completed upon her return to the community. The staff on duty on the third shift at the time of the incident and the Activities Director were immediately re-educated on the requirements for maintaining minimum staffing levels at all times (including breaks and assigned duties that take staff of the unit), personal care and supervision for residents in accordance with their assessed needs and care plan; first shift staff were also provided immediate re-education. 1/6/21. Additional staff re-education was completed on 1/7/21. Staffing patterns were immediately increased on the third shift to ensure there are two (2) PCAs in Memory Care – one on the B unit, and one on the C unit, plus a readily available supervisor for the campus. Staff responsible for the care of resident #5 on night and day shift have been provided coaching/counseling.	2/19/2021

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D 270	Continued From page 16 Review of Resident #5's Resident Register signed 10/08/2020 revealed: -Resident #5 was admitted to the facility on 10/09/20 from a rehabilitation facility. -Resident #5 was forgetful and needed reminders. -Resident #5 required assistance from staff with ambulation with a walker, orientation to time and place, and scheduling appointments. Review of Resident #5's fall assessment revealed: -The fall assessment tool was completed without a date entered for the assessment or who completed it. -This tool was noted in other residents' records that were reviewed. -The scoring guidelines were based on history of falling, secondary diagnosis, ambulatory aid, tubing (such as foley or oxygen), gait, and mental status. -The total points given for Resident #5 was 45. -Risk Levels were as follows: -Level 1 = Score 0-24 Good basic resident care and coordination of health services. -Level 2 = Score 25-50 Implement standard fall prevention interventions. -Level 3 = Score >or= 51 Implement high risk fall prevention interventions. Review of Resident #5's Licensed Health Professional Support (LHPS) review dated 10/14/20 revealed: -Resident #5 was able to ambulate independently with the use of a rollator (wheeled walker). -Resident #5 was able to let her needs be known. -There were no LHPS tasks listed. Review of end of shift reports revealed:	D 270	2. Current resident care staff have been re-educated on personal care and supervision of residents in accordance with their assessed needs and care plan. Prompt response to resident's needs is the standard and expectation. Additional re-education will be provided by the Executive Director, Resident Services Coordinator or Designee on 1/28/21 and 2/18/21. A Shift Supervisor responsibility checklist has been created, and Supervisors will be trained on 2/18/21 and as needed for compliance. A PCA shift checklist has been created. The expectation for staff to complete rounds 8 times per shift on night shift for all Memory Care residents was communicated, which can be verified by staff pushing the Nurse Call rounding button. A report to validate staff observation will be run daily and reviewed by the ED or designee. Non-compliance will be investigation and responded to appropriately. PCA's will be formally trained on this process on 2/18/21, with implementation on 2/19/21. 3. The ED or designee will complete unannounced rounds on night shift to observe staffing and care delivery based on resident needs on the Memory Care Units. Rounds will be completed twice weekly for 1 month, weekly for 1 month, and monthly for 1 month thru May 19, 2021. Results will be reviewed for staff compliance, trends and patterns and will be reviewed at QA for on-going recommendations.	

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D 270	Continued From page 17 -On 11/05/20, third shift staff documented Resident #5 had wandered during the night, was anxious and requested acetaminophen. -On 11/22/20, third shift staff documented Resident #5 had trouble sleeping, got up every 20 minutes, and was very loud waking her roommate. -On 11/23/20, third shift staff documented Resident #5 had gotten out of bed every 10 minutes to ask for assistance and would get back in bed, could not sleep and kept waking her roommate. Review of Resident #5's Licensed Health Professional Support (LHPS) review dated 10/14/20 revealed: -Resident #5 was able to ambulate independently with the use of a rollator (wheeled walker). -Resident #5 was able to let her needs be known. -There were no LHPS tasks listed. Attempted telephone interviews with Resident #5's power of attorney on 01/05/21 at 10:32am and on 01/06/21 at 11:44am were unsuccessful. Observations on 12/30/20 from 6:32am - 7:11am on B Hall of the memory care unit (MCU) revealed: -While standing at the entrance door to B hall looking through the window slat in the door, there were no staff visible in the hallways. -At 6:32am, the surveyor was let in to the locked MCU by the Activities Director (AD) when she entered a code into a keypad at the door. -There were no staff visible in the hallways upon entering. -The AD did not enter the MCU. -Upon entering the MCU, a resident was heard calling for help and saying, "I'm on the floor, help me." -The plea for help was coming from the last room	D 270	Shift Supervisor Shift Responsibilities Checklists will be reviewed by the department supervisor, ED, or designee weekly for 3 months through 5/19/21. Results will be reviewed for compliance, trends and patterns reported through QA for on-going recommendations. 4. All corrective measures will be implemented by 2/19/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	

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D 270	Continued From page 18 on the right end of the hallway. -Resident #5 kept saying she was on the floor and no staff were visible coming to assist her. -There were several residents rooms with the door closed. -Upon investigation, Resident #5 who was yelling, was in the room with the door locked. -At 6:44am, a female resident exited from room B 11 and was walking in the hallway without her mask heading towards the resident's room who was yelling. -When the female resident approached Resident #5's door, Resident #5 said, "who's there, I need help". -Another resident was "yelling" but was incoherent. -There were no staff observed in any open rooms or in any hallways of the B unit. -At 6:48am, Resident #5 continues yelling "help me". -The surveyor continued to search for any staff for the MCU. -At 6:53am, Resident #5 continued to yell for help and no staff were observed on any of the hallways or exiting any residents' rooms. -No change had been noted in the sound, tone or volume of Resident #5's voice when she continued to call for help. -The surveyor had been on the MCU for 21 minutes without observing any staff who may have been present providing care to other residents. -At 6:59am, two staff were visible at the doorway into B Hall but did not enter until 7:01am. -At 7:01am, the medication aide (MA) from third shift and first shift MA entered B Hall and proceeded with medication counts at the medication cart at the nurse's station while Resident #5 continued yelling for help. -At 7:03am, as the surveyor was standing at the	D 270		

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D 270	Continued From page 19 entry to B hall farthest away from Resident #5's room, the surveyor was able to hear her yelling, "I'm on the floor". -The MAs continued counting the narcotics on the medication cart. -At 7:05am, the third shift MA asked the surveyor if she needed to be let out of the hallway as Resident #5 continued to yell for help and the surveyor prompted staff to tend to Resident #5. -At 7:06am, the first shift MA had to get a key for Resident #5's door to unlock it. -Resident #5 was noted lying on the floor at the foot of her bed on her right side with bed linen covered in feces were to the side of the bed. -At 7:09am, a second staff member entered onto B Hall. -At 7:11am, the second staff member went to Resident #5's room but returned to the nurse's station to put on shoe covers and then returned to the room to assist MA in personal care for Resident #5. Review of the first shift daily assignment sheet dated 12/12/20 revealed in the announcements section, a handwritten note stating, "B & C hall employees must stay on hall until end of shift" and was signed by the Supervisor. Interview with the first shift MA on 12/30/20 at 7:35am revealed: -Resident #5 who had fallen, had been assessed and found to have no injuries. -Resident #5 "does that (sits down and says she fell) all the time". -She would play in her own stool. -She did not always fall; she would sit down and say she fell. -Other staff had seen Resident #5 "sit" on the floor and then call for help.	D 270		

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D 270	Continued From page 20 Interview with a personal care aide (PCA) on 12/30/20 at 10:53am revealed: -Resident #5 was declining. -Resident #5 recently started falling more, if she did not use her walker. -Resident #5 was incontinent of bowel frequently, 3 times yesterday. -Resident #5 was provided perineal care for those incontinent episodes. -Resident #5 did not intentionally lock her door; it may have happened by mistake where the door was locked, and she pushed it closed. -There were keys at the nurse's station for the residents' doors, the laundry room, and supply closet. -There were some residents on the MCU who wandered. -The residents' doors were not normally locked. -Resident #5's door was not normally locked. Second interview with the first shift MA on 12/30/20 at 11:01am revealed: -She assessed Resident #5 after she was found on the floor this morning. -Resident #5's vital signs were good. -Resident #5's Power of Attorney (POA) and Primary Care Provider (PCP) were notified. -Resident #5 did not "normally fall but would get down on the floor". -Resident #5 and her POA declined to have Resident #5 sent to the emergency room (ER) for further evaluation. Interview with a second PCA on 01/05/21 at 5:43pm revealed: -Resident #5 was originally admitted in the assisted living (AL) section on D Hall. -While on the AL side, she had episodes of yelling and going into the hallway nude. -She had disturbed other residents, so she was	D 270		

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D 270	Continued From page 21 moved into the MCU around November. -Resident #5 originally had a roommate but because of altercations was moved into a private room at the end of the hall on B hall in the MCU (could not remember the date). Confidential interview with staff on 12/31/20 at 12:00pm revealed: -She had previously had verbal and physical altercations with other residents, but no injuries resulted. -Resident #5 was moved into a private room. -The MA was notified and filled out any required paperwork when altercations occurred. -Resident #5 had bowel movements frequently. -"She would play in her feces and did it for attention." -This had been reported to the Memory Care Director (MCD) and the Administrator by MCU staff during stand up's but was not aware of any plans for changes in care for Resident #5. Confidential telephone interview with a second staff member revealed: -Residents on the MCU should not be left alone because it was a locked unit. -The residents' needed supervision always on the MCU. -Something could happen to residents if they were left unattended such as a resident walking and accidentally fall/trip loose balance. Telephone interview with the RCD on 01/05/21 at 1:08pm revealed: -The RCD was told by Resident #5's POA that Resident #5 was able to be on the AL unit. -The FL-2 dated 10/04/20 recommended level of care as assisted living facility (ALF). -The FL-2 dated 11/05/20 recommended level of care as other memory care unit (MCU).	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22 -The POA was looking for a facility that could accommodate Resident #5's needs. -Resident #5 used a rollator to help ambulate. -The POA had told the RCD Resident #5 wanted to move back home. -Resident #5 began to become combative with residents using violent language, verbally abusive to staff and residents and would tell staff, "I'm acting this way because you won't let me go home". -Resident #5's POA requested to have Resident #5 moved to the MCU due to Resident #5's bowel and urinary incontinence. -Resident #5 would get outraged and throw feces at staff. -Resident #5 was currently waiting for psychiatric evaluation. -The POA had not paid the fee for the facility's provider to see Resident #5 and the previous mental health provider was no longer following Resident #5. -The POA was looking for a facility that could accommodate Resident #5's needs. Interview with the Administrator on 12/30/20 at 11:50am revealed: -His expectations were always that someone stay on the MCU. -If there were only 3 staff, then one would be assigned to each hall (B & C) and one would float between the two assisted living halls (A and D halls). -Resident #5 had orders for a psychiatric evaluation for her behaviors (not sure of the date). -She had been admitted as a resident on the assisted living side (10/09/20) but an increase in her behaviors led them to transfer her to the MCU (11/05/20) for closer monitoring. -For several weeks now, Resident #5 had	D 270		

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D 270	Continued From page 23 "attention seeking behaviors through defecating on herself". -The facility was trying to find someone to do her psychiatric evaluation. -Not having a clinical staff member on the MCU could cause harm to residents. -It was the responsibility of the S/MA to ensure that the MCU had coverage at all times. Telephone interview with primary care provider for the facility on 01/06/21 at 8:05am revealed: -Staff should have been on the floor and always should have had staff coverage prior to leaving the MCU. -There should have been no times when staff were not present on the MCU because the residents in the MCU all had a diagnosis of dementia. -Resident #5 had not transitioned over to the PCP's care yet but they were trying to transition her to the provider group. -The PCP had been visiting other residents on the MCU and heard Resident #5 call or yell out and she had done that frequently. -Staff needed to check on the resident when she yelled out because of complications that could present if the resident had fallen and was behind a locked door. -There were concerns that no one checked on the resident after yelling out for help including the resident's safety, the risk for potential skin breakdown, concerns that feces on the skin in the perineal area and that placed the resident at high risk for feces backing up into the urinary tract that could have resulted in urinary tract infections. -The PCP had "great" concern if a resident was calling out for help and staff were observed not to respond. -The PCP had concerns for the supervision needs for all the residents on the MCU when staff	D 270		

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D 270	Continued From page 24 left the floor unattended with no supervision of the residents. -If staff were not present in the MCU, they would not know if there was an emergency involving a resident. -There should always be staff on the floor of the MCU. -Thirty minutes was a long time and incidents could have occurred that were not being addressed because of no staff being on the floor to monitor the residents with possible death of a resident being the highest risk. Interview on 01/06/21 at 10:58am with Resident #5's mental health provider revealed: -Resident #5 was seen at her previous facility location and was discharged from that facility on 10/09/20 and admitted to her current location. -Resident #5 had not been seen since 08/06/20 by her mental health provider. -He was unable to provide any current information on Resident #5 since she had not been seen in 4 months. -He did not provide services at her current facility. Attempted telephone interviews with Resident #5's power of attorney on 01/05/21 at 10:32am and on 01/06/21 at 11:44am were unsuccessful. The facility failed to provide supervision for all of the residents on the memory care unit (MCU) including Resident #5 had been yelling for help for at least 34 minutes and was found lying on the floor in her own feces with no staff present to assist her. The failure of the facility to provide supervision resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in	D 270		

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D 270	Continued From page 25 accordance with G.S. 131D-34 on 01/07/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2021	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, observations and record reviews, the facility failed to ensure 1 of 6 sampled residents were treated with dignity, privacy, and respect Resident #6 (female) who was placed in a room with a male resident. The findings are: Review of Resident #6's current FL-2 dated 03/17/20 revealed: -Diagnoses included dementia, post-concussion syndrome and a history of falls. -The resident was constantly disoriented -The resident was non-ambulatory. -The recommended level of care was a memory care unit. Review of Resident #6's Care Plan dated 08/20/20 revealed: -The resident's orientation was severely impaired. -The resident required total staff assistance with toileting, dressing, transferring, grooming and	D 338	D 338 – Community POC Response 1. Resident #6 was moved to C7 on 12/2/21, which was considered the communities designated COVID isolation area after testing positive for COVID. The male resident tested positive for COVID on 12/7/21 and was also moved to the COVID designated area. The male resident was in the hospital from 12/12 to 2/13/21. Resident #6 expired 12/14/21. Upon being made aware the residents' cohabitation, resident care staff were re-educated on the Resident's Bill of Rights, to include the right to preservation of dignity and respect while under the care of the facility by the ED on 1/7/21. 2. The ED/designee will continue community staff re-training on Residents' Bill of Rights will continue, 1/28/21 and 2/18/21. The local Ombudsman has been contacted to provided staff training on Resident Rights and on the abuse guidelines on 2/25/21. A new system for internal resident transitions has been created, which requires ED/designee approval for placement and verification of room	3/6/2021

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D 338	Continued From page 26 extensive staff assistance with ambulation. Telephone interview with Resident #6's Power of Attorney (POA) on 01/04/21 at 10:48am revealed: -The resident had lived at the facility for almost 2 years. -The resident passed away 12/14/20 at the facility. -The resident was residing on the C hall of the memory care unit (MCU) but was moved to the B hall on the MCU due to COVID-19 just before she passed away. -On 12/14/20, the POA visited the facility after the resident had passed away. -The resident's body was in a resident room with a male resident. -The male resident was lying in a bed closer to the door making "grunting" sounds, the resident's body was in a bed positioned close to the window of the room and there was a named staff member in the room. -The POA had no idea who the male resident was but thought the named staff member told him who the male resident was during the visit. Confidential interview with staff revealed: -During the first part of December 2020, Resident #6 was moved from the B hallway to the C hallway after testing positive for COVID-19. -A male resident was placed in the same room with Resident #6. -The staff found out from another staff and Resident #6's POA shortly after and was not sure who made that decision to place Resident #6 in a resident room with a male resident. -The staff was not sure how long Resident #6 was in the same room with the male resident. -The male resident had been to the hospital and tested positive for COVID-19. -The staff never discussed why Resident #6 was	D 338	readiness. Community leadership will be trained on the new system and implementation will occur on 2/19/21. Shift Supervisors will be educated that no internal transitions may take place without the written/emailed authorization of the ED or designee on 2/18/21. Care staff and managers will be re-educated to respect residents' dignity by not pairing unauthorized cohabitation on 2/19/21. 3. The ED or designee will round twice weekly for four weeks to ensure resident occupancy matches census room assignment and to ensure that unauthorized cohabitation has not occurred. Rounding will continue weekly for 2 additional months. Results will be reviewed for staff compliance, trends and patterns and reported through QA. The QA Committee make on-going recommendations. 4.All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns	

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D 338	Continued From page 27 in the same room with a male resident who was not related to her because the Administrator decided which residents would be moved to the isolation area on C hall. -The staff had concerns of a female/male resident being in the same room because, it was "just common sense" not to place a male/female resident in the same room if the residents were not related. Confidential interview with a second staff member revealed: -The named male resident was in the same with room with his female roommate until he tested positive with COVID-19 then he was placed in the same room with Resident #6. -There was no barrier placed between the two residents for privacy; Resident #6's bed was by the window of the room and the male resident's bed was by the door. -The staff thought Resident #6 should not have been placed in the same room with a male resident or vice versa; that was just not supposed to happen. -Staff had concerns of privacy and dignity due to the male resident being placed in the same room with Resident #6; however, there was nothing staff could have done because the Administrator told staff to place the two residents together. -There were additional model rooms available at the facility that were not utilized at that time. (A model room was a room designated to show visitors the living quarters of the residents). -The male resident could not get out of bed without staff assistance at that time due to his condition when he was in the same room with Resident #6. Confidential telephone interview with a third staff revealed:	D 338		

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D 338	Continued From page 28 -Resident #6 was moved from the B hall and placed in a room on the C hall (around 12/09/20). -A named male resident was moved from his room that he shared with his family member on C hall into the same room with Resident #6 after the named male resident tested positive for COVID-19. -The named male resident was moved into the room with Resident #6 just before she passed away. Confidential interview with a fourth staff revealed: -The staff had observed Resident #6 in the same room with a male resident. -A male resident should not have been in a room with a female. Telephone interview with the named male resident's POA on 01/05/21 at 10:34am revealed: -Since COVID-19, it has been hard to assess how care was being provided. -She talked with the male resident to see how things were going. -She was told he was "not his normal self and shaking"; on 12/11/20 and he was sent to the emergency room (ER). -She was not aware that he had been placed in a room with another female who was not his wife upon returning from the hospital ER. Telephone interview with the Resident Care Director (RCD) on 01/05/21 at 1:06pm revealed Resident #6 was never placed in a room with a male resident when she was moved to the C hallway of the MCU, "that's not true". Telephone interview with the Administrator on 01/05/21 at 3:32pm revealed: -Male and female residents residing at the facility were not assigned to the same resident room	D 338		

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D 338	Continued From page 29 unless they were related. -Resident #6 was in a room by herself when she passed away. -There should not have been any roommate with her, male or female when she was moved to the MCU on C hall because she was in isolation. -He remembered delivering fluids for her on the hall to keep her hydrated and "peeped" in the room and she was the only resident in the room (unable to recall a specific date). Telephone interview with the Administrator on 01/06/21 at 10:54am revealed: -He was not sure why there would be reports that he gave a directive to staff to place Resident #6 in the same room with a male resident. -He had never given staff that directive. Telephone interview with Resident #6's primary care provider (PCP) on 01/06/21 at 8:05am revealed: -She last visited the resident on 12/10/20 at the facility and at that time there was no other resident in the room with Resident #6 when she visited. -She was not aware that a named male resident was placed in the same room with Resident #6. -She had concerns related to privacy and dignity for Resident #6 and the other male resident when they were in the room together. -Male and female residents should not be placed together unless they were married. -The PCP had concerns with privacy and dignity because the named male resident was married and lived with his wife at the facility on C Hall. Based on observations, interviews and record reviews, the named male resident was not interviewable.	D 338		

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D 338	Continued From page 30 Observation of the male resident on the C hallway on 01/04/20 at 12:36pm revealed the male resident was assigned and in the same room with his female family member. Attempted interview with the male resident's family member was unsuccessful on 01/04/21 at 12:36pm. The facility failed to ensure residents were free from neglect and treated with respect, consideration, dignity, and right to privacy as evidenced by Resident #6 (female) who was placed in a room with a male resident who was not related to nor married to one another. The facility's failure was detrimental to the residents' health, safety and welfare which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/07/21 with addendum for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 06, 2021	D 338		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 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	D 454	D 454 – Community POC Response 1.Resident #6's husband, who is alert and oriented and assigned as her Responsible Person on the Resident Register, was being routinely updated on her status via telephone conversation and text message by the ED. Resident #6 expired on 12/14/20. 2.Community Directors and Shift Supervisors will be re-educated on the	3/6/2021

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D 454	Continued From page 31 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 interviews and record reviews, the facility failed to ensure a family member (Power of Attorney (POA) for 1 of 6 residents sampled (#6) received leaving four messages on 12/12/20 for staff at the facility with no return calls/contact and delayed notification to the POA of a change in the resident's status by contacting the POA after midnight. The findings are: Review of Resident #6's current FL-2 dated 03/17/20 revealed: -Diagnoses included dementia, post-concussion syndrome and a history of falls. -The resident was constantly disoriented -The resident was non-ambulatory. -The recommended level of care was a memory care unit. Review of Resident #6's Care Plan dated	D 454	expectation to respond to residents' responsible person or contact person listed on the Resident Registry within 24 hours. Care staff will be re-educated on the expectation that responsible persons requesting resident status updates are responded to within 24 hours by the Shift Supervisor, department leader, or ED. The community has added "Care Merge" as a form of real-time, direct family communication to community leadership. It is a messaging application that can be downloaded by family members with free enrollment, and the community goal is for 100% family participation. Family members will be encouraged to use Care Merge as a form of communication with community leadership, and leadership staff are required to respond to family communication within 24 hours. An emailed communication with all listed Responsible Persons regarding the use of Care Merge as a source of communication to community leadership will be sent on 2/17/21. 3.The ED or designee will communicate with resident's Responsible Persons (RPs) via email and complete phone calls to 10% of the RP's based on community census to request feedback on the timeliness of community response to family inquiries (within 24 hours). The ED will complete feedback requests weekly for four weeks, and then monthly for two months. Feedback will be reviewed for staff compliance, trends and patterns and submitted to the QA Committee for on-going	

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D 454	Continued From page 32 08/20/20 revealed: -The resident's orientation was severely impaired. -The resident required total staff assistance with toileting, dressing, transferring, grooming and extensive staff assistance with ambulation. Telephone interview with Resident #6's Power of Attorney (POA) on 01/05/21 at 10:32am revealed: -The resident was residing on the B hallway; however, was moved to the C hallway on 12/09/20 or 12/10/20. -The resident had tested positive for COVID-19 around 12/03/20. -The resident was transferred from the facility to the emergency room (ER) on 12/09/20. -The resident was treated for dehydration in the ER and returned to the facility. -The POA was dependent on facility staff to provide updates by phone concerning the resident's status since no visitors were allowed to visit due to COVID-19. -The POA had called the facility 4 times on 12/12/20 to get a telephone update on the resident's condition. -She left messages with facility staff answering the phone who advised they would give the staff on the floor a message to return the call. -The POA was concerned about the resident's condition since she was treated in the ER for dehydration. -The POA never received a call back from staff at the facility until 12:17am on 12/13/20. -Receiving a call at that time of night "scared her to death". -The staff was getting ready to leave from the shift on 12/12/20 and told the POA the resident had stopped eating and drinking and had not taken her medications. -The POA felt frustrated because it was so hard to get an update on the resident's condition and	D 454	recommendations. 4. All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns	

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D 454	Continued From page 33 thought the change in the resident's status was known prior to 12:17am on 12/13/20. -The resident passed away on 12/14/20. Telephone interview with the Memory Care Director (MCD) on 01/06/21 at 12:49pm revealed she was not aware Resident #6's POA had left 4 messages for staff on 12/12/20. Telephone interview with the Administrator on 01/05/21 at 3:32pm revealed: -He was not aware Resident #6's POA had left 4 messages on 12/12/20 to get an update on Resident #6 status. -Staff were responsible to return family members' calls when messages were left and if the family had not received a return call, he expected the family to reach out to him.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the required staffing hours for the memory care units (MCU). The census for the MCU ranged from	D 465	D 465 – Community POC Response 1. The staff on duty on the third shift at the time of survey and the Activities Director were immediately re-educated on the need to always maintain minimum staffing levels (including breaks and assigned duties that take staff of the unit) on the Memory Care Units. First shift staff were also provided immediate re-education. 1/6/21. Additional staff re-education was completed on 1/7/21. Staffing patterns were immediately increased on the third shift to ensure there are two (2) PCAs in Memory Care – one on the B unit, and one on the C unit, plus a readily available supervisor for the campus.	3/6/2021

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D 465	Continued From page 34 19-22 residents during the sampled times. There were 13 of 23 shifts were sampled from 11/16/20-11/20/20, 12/12/20-12/13/20, 12/18/20, 12/19/20, 12/20/20, 12/25/20 and 12/26/20 which staffing did not meet the required hours on the MCU. The findings are: Review of the facility's current license revealed: -The license was effective 12/01/19 - 12/31/20. -There had been a change of ownership on 12/01/19. -The facility was licensed for a capacity of 84 beds including 36 beds for the assisted living (AL) area and 48 beds for the memory care unit (MCU). -There was not any notation in the license that accounted for the separation of the MCU into 2 separate halls. Observation on 12/30/20 at 6:30am revealed: -There were 2 separate, locked MCU halls. -One was identified as B Hall and the other as C Hall. -No staff was observed on B Hall from 6:32am until 7:01am when the 3rd shift medication aide (MA) came in with the 1st shift MA to count the medication carts. Interview with the supervisor/medication aide (S/MA) on 12/30/20 at 5:38am revealed: -She was in charge. -There were 2 personal care aides (PCA) working with her. -There had been a 3rd PCA but the PCA had to leave at 4:45am. -She was covering the assisted living (AL) halls and the 2 remaining PCAs were on the MCU halls.	D 465	2. The ED or designee will be notified of staffing changes and planned coverage via text after the Assignment Sheet has been posted. Anytime coverage has not been obtained, the ED/designee will be notified by phone and a member of the leadership team will report to the facility to cover/ensure adequate minimal staffing is maintained until additional coverage can be found. Staff will be trained on this process on 2/18 and 2/19/21, and the process will be implemented on 2/19/21. 3. The Executive Director will review/ initial the clinical staff Assignment Sheet prior to post to ensure adequate staff coverage through 5/19/21. The ED or designee will complete unannounced rounds on night shift to ensure compliance with minimum staffing level requirements on the Memory Care Units. Rounds will be completed twice weekly for 1 month, weekly for 1 month, and monthly for 1 month thru May 19, 2021. Results will be reviewed for staff compliance, trends and patterns and will be reviewed at QA for on-going recommendations. 4.All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be	

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D 465	Continued From page 35 -The Activities Director (AD) was called to come in to cover for the 3rd PCA and was on her way. -The AD was observed to enter the facility at 6:28am. -The AD was not observed entering either of the MCU halls. Review of the facility's resident census reports from B Hall dated 11/16/20 - 11/20/20 revealed there was census of 22 residents on the MCU on the dates from 11/16/20-11/20/20 each of those dates, which required 22 staff hours on first and second shifts. Review of the employee time cards dated 11/16/20 revealed there was a total of 18.43 staff hours provided on first shift on the MCU with a shortage of 3.67 hours. Review of the employee time cards dated 11/17/20 revealed there was a total of 18.53 staff hours provided on first shift on the MCU with a shortage of 3.47 hours. Review of the facility's resident census reports for 12/13/20 revealed the census for the MCU was 21 residents which required 21 staff hours on second shift. Review of the employee time cards dated 12/13/20 revealed there was a total of 19.46 staff hours provided on second shift in the MCU with a shortage of 1.54 hours. Review of the facility's resident census reports dated 11/18/20 there was a census of 22 residents on the MCU, which required staff hours on first shift. Review of the employee time cards dated	D 465	recommended through QA based on compliance, trends, and patterns.	

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D 465	Continued From page 36 11/18/20 revealed there was a total of 20 staff hours provided on first shift on the MCU with a shortage of 1.97 hours. Review of the facility's resident census reports for 12/25/20 revealed the census for the MCU was 20 residents which required 20 staff hours on second shift. Review of the employee time cards dated 12/25/20 revealed there was a total of 13.42 staff hours provided on second shift in the MCU with a shortage of 6.58 hours. Review of the facility's resident census reports for December 2020 revealed there was census of 20 residents on the MCU on 12/26/20, which required 20 staff hours on second shift. Review of the employee time cards dated 12/26/20 revealed there was a total of 19.067 staff hours provided on second shift on the MCU with a shortage of 0.933 hours. Interview with a resident's Power of Attorney (POA) on 01/05/21 at 10:34am revealed: -She was quite concerned as the facility had been under-staffed, especially on the weekends. -She talked on the phone almost daily with her family member. -She would call the facility to check on her family member and had trouble getting anyone to answer on the weekends. Interview with a Personal Care Aide (PCA) on 01/04/21 at 1:15pm revealed: -She worked 7:00am-3:00pm shift about four days a week. -She was unsure who she was relieving from 3rd shift because there was no staff on the MCU when she reported to work on 01/04/21.	D 465		

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D 465	Continued From page 37 -She arrived to the MCU at approximately 6:55am and she was unable to locate a staff member on that hall. Confidential staff interview revealed: -The facility had been short staffed on all shifts for a couple of months. -There had been times when a staff member would have to float between both MCU's leaving one of the MCU's unattended for a period of time. -Being short staffed caused residents to have longer wait times before services could be provided. Confidential interview with a second staff member revealed: -Staffing at the facility was "not the best" because shifts had been short staffed. -The Resident Care Director (RCD) was responsible for the schedule. -Staffing was short on the weekends. -The facility had been short staffed for about 3-6 months mostly on 2nd and 3rd shifts. -There had been times when staff had to float between B hall and C hall meaning one MCU would be left unattended due to being short staffed. -The residents could be harmed if there was not enough staff to monitor them and tend to their needs. -The staff was not aware of any resident incidents or accidents that occurred when staff had left the hall unattended. -Residents on the MCU should not be left alone because it was a locked unit and they need supervision at all times. -Something could happen to residents if they were left unattended such as a resident walking and losing their balance and falling. -Staff were responsible for finding their	D 465		

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D 465	Continued From page 38 replacement for missed shifts but if they could not find coverage then they notified the RCD. -The Memory Care Director (MCD) and RCD tried to cover vacancies in the schedule due to call outs. -Activities' personnel were personal care aides as well and would occasionally help on the hall. Confidential telephone interview with a third staff member revealed: -The daily staffing schedules did not reflect the actual staff and number of staff that worked each shift. -Many staff had recently resigned leaving shifts short. -There were more residents residing on the B hall of the MCU which required two staff members at all times. -There were times when the staff had worked alone in the MCU B hall. -The staff was concerned when the shift coverage was short because it was hard to complete all of residents' care needs. Interview with the Memory Care Director (MCD) on 01/06/21 at 12:59pm revealed: -The MCD and the RCD worked some of the shifts when the facility was short staffed. -The Supervisor/Medication Aide (S/MA) was responsible for finding their own replacement if they were going to be out as well as finding coverage if a PCA called out. -If the S/MA was not able to find placement, then the they would notify the MCD or the RCD. -Staff were responsible to check on the residents in the MCU every 30 minutes to one hour and to never leave the floor unattended. -Staff leaving the floor at any time was unacceptable. -Staff were not supposed to leave the MCU until	D 465		

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D 465	Continued From page 39 staff had arrived to relieve them; however there had been a few times that third shift had left before first shift arrived; incidents were reported to the RCD. Interview with the Administrator on 12/30/20 at 11:46am revealed it was the responsibility of the S/MA to ensure that the MCU had coverage at all times. Interview with the RCD on 01/20/21 at 10:11am revealed: -She was the one responsible for scheduling the staff. -She had the monthly schedule completed by the 15th of the month for the next month. -All staff who requested time off were to do so ahead of time. -When there was a change needed after the schedule was posted, such as if staff called-off, staff were to find coverage. -If staff could not find coverage, the S/MA was responsible to find coverage. -If the S/MA was not able to find coverage, then she helped find coverage. -She completed a daily log notifying staff who was working. -The S/MA was responsible to complete the daily assignment sheet based on the daily log. -On first shift, she tried to schedule seven staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on the 4 halls. -On second shift, she tried to schedule 6 to 7 staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on the 4 halls. -On third shift, she tried to schedule staff to cover medication administration on the 4 halls as well as the personal care needs for the residents on	D 465		

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D 465	Continued From page 40 the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. -There were two supervisors on first shift, the MAs could work as a MA or PCA. -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. -Currently based on the census, we have to have two staff on B Hall at all times. -She and the MCD tried to pitch in when they were working. -When someone called out, it was hard to cover at times. -In November and December 2020, the facility was short some shifts. -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. -"We have had some short shifts for one reason of another." -Staff were to punch in and punch out for breaks. -Everyone got 15 minutes in the first part of their shift and another 15 in the latter part of their shift for a total of 30 minutes. -Some staff chose to take one 30-minute break. -There had been numerous meetings with staff to make sure that they clocked out for the 30-minute breaks. -For staff breaks, the staff left the floor. -Staff could go to the break room or wherever they chose to take their break. -They were supposed to report to the S/MA to let them know as well as the PCA that they were going on break. -The staff who were going on break was to have whoever was covering for them to take their pager to cover the floor. -The facility had 2 activities staff, the activities director and activities assistant, that did work as PCAs.	D 465		

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D 465	Continued From page 41 -Staff were to clock in and clock out and help as needed. -The monthly schedule was posted at the nurses' stations, in the break room, and she would text it to the staffs' phone numbers to ensure they received it. -During the monthly meetings, the schedules were handed out to the staff. -She was aware of incidences when staff had left a unit prior to the staff on next shift arriving and had recently re-educated staff regarding this issue. Telephone interview with the Administrator on 01/06/21 at 11:07am revealed: -Staffing schedules were done monthly ahead of time. -The facility tried to staff 6 staff on 1st and 2nd shift and 4 staff on 3rd shift. -He was not aware of the facility being staffed below "regulatory numbers" but was staffed below what he considered "optimal" and what the facility's goal would have been. -The facility had established a 3rd party staffing contract to ensure the facility stayed above regulations. -The 3rd party staffing PCAs were only used to cover staffing for the AL side of the facility and not used in the MCU. -Contracted staff did not utilize the facility's clock in and out time system. -He was not sure if contracted staff were added to the daily staffing log. -Contracted staff did not work at the facility from 12/11/20 - 12/13/20. -Contracted staff was only used on the AL side of the facility.	D 465		

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D 612	Continued From page 42	D 612		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance from the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to screening of staff and residents for signs and symptoms consistent with COVID-19; staff working while displaying symptoms consistent with COVID-19; and staff being aware of each resident's COVID-19 diagnosis; staff wearing personal protective equipment (PPE); and redirection of residents to maintain social distancing and use of face masks when out of	D 612	D 612 – Community POC Response 1.It has been the community's practice to require COVID positive staff self-quarantine for 14-days and to send staff home if they exhibited an elevated temperature and/or signs or symptoms that may be related to COVID-19. Staff have been required to complete a screening prior to entry into the community including review of symptoms and temperature check on paper or electronically. The Concierge, BOD or designee has been assigned to monitor entry screenings to ensure compliance. All cloth masks were replaced with 3-ply surgical or KN95 masks. Current care staff were coached on the community's COVID-19 infection prevention policy and re-educated on which residents were COVID positive. The 3rd shift supervisor was re-educated on the proper check-in/screening procedures. Identifiers for residents who were no longer on COVID isolation were removed. 2. Resident temperatures continued to be monitored 3 times daily; monitoring of symptoms will be initiated on 2/19/21. Staff will be re-educated on the use of the resident screening form 2/18/21 and will be implemented on 2/19/21.	3/6/2021

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D 612	Continued From page 43 their rooms. The findings are: Review of the Centers for Disease Control (CDC) recommendations for long term care facilities dated 11/20/20 revealed: -The health department should be notified if COVID-19 is suspected or confirmed among residents or facility personnel. -The health department should be notified if a resident developed a severe respiratory infection resulting in hospitalization, or if three or more residents/facility personnel develop new-onset respiratory symptoms within 72 hours of each other. -All visitors and personnel should be screened for the presence of fever and symptoms consistent with COVID-19 before the start of each shift/when they enter the facility. -Anyone who has a fever (temperature of 100.0 degrees Fahrenheit or greater) or symptoms that are consistent with COVID-19 should be sent home. -Residents should be encouraged to wear face coverings (if tolerated) whenever they are around others, including when they leave their rooms and when they leave the facility. -Residents should be reminded to maintain social distancing of at least 6 feet apart from others when they are outside of their room. -All residents should be screened for fever and symptoms consistent with COVID-19 at least daily. -Recommended PPE for close contact with residents included: eye protection (goggles or face shield) and an N95 mask or higher-level respirator (or a face mask if respirators are not available) and gown and gloves should be used in addition to PPE listed above for direct contact.	D 612	All residents who test positive for COVID will be reported to care staff using the Med Tech to Med Tech Communication Binder, and the End of Shift Report Binder. The information will be communicated to all departments during morning Stand Up to share with their staff. All guests who enter the building are directed by the Concierge (including staff) to complete screening with temperature check via Accushield. Anyone with signs or symptoms of COVID or elevated temperature are requested to leave. A printed name tag is generated that confirms screening verification which will be worn by community guests to confirm completion of the screening process. A new "STARS" initiative was implemented on 1/28/21. The Shift Supervisor is responsible for ensuring that all staff have appropriate PPE for the shift and that there is enough PPE to provide care for isolated residents. This will be a line item on the Shift Supervisor's Responsibilities Checklist. Inventory of PPE, including M, L, XL, XXL gowns is being completed weekly by the ED or designee, and orders are placed for PPE as needed. The inventory is also sent the corporate office as a system of double checks to ensure adequate PPE for Cadence communities.If residents who reside on the Memory Care Unit become COVID positive, the resident will be confined to the COVID isolation area, and a team member will be assigned to the area to prevent the resident(s) from wandering outside of the isolation area. The team member may be community staff or outside agency. Staff will be re-educated that if a COVID positive resident is observed outside of a COVID isolation area, to escort the resident back to the isolation area.	

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D 612	Continued From page 44 -Cloth face coverings not considered PPE and should not be used when a respirator or facemask was indicated. -Staff using PPE should have received training on PPE selection, use of PPE and demonstrated the use and removal of PPE to prevent self-contamination. Review of North Carolina Department of Health and Human Service Regulation (NC DHHS) revealed: -All health care personnel should be screened for fever and respiratory symptoms before starting each shift and should be sent home if they are ill. -Residents should be screened at least daily for fever and respiratory symptoms and should be immediately isolated if symptomatic. -The local health department (LHD) should be notified if there were any cases of confirmed or suspected COVID-19 or severe respiratory disease or if there was a cluster (three or more residents and/or HCP) of any respiratory infections. -Social distancing amongst residents should be reinforced. -Facemasks should be worn throughout the facility by all residents, staff and visitors. -If COVID-19 was identified in the facility, staff should wear recommended PPE of facemask or N95 mask (if available), gown, gloves and face shields to care for residents in isolation or quarantine. -COVID-19 positive residents should cohort with dedicated staff in one area and COVID-19 negative residents should cohort with dedicated staff in a separate area. Review of the Facility's Infection Control Policy dated 12/12/20 revealed: -All team members were required to complete the	D 612	3.The night shift Supervisor will monitor the daily temperature logs to ensure all residents received 3 temperature checks and interviews or observations for COVID signs and symptoms. Omissions will be reported to the RSC or designee for on-going staff coaching. Results will be monitored for staff compliance, trends and patterns and reported through QA for on-going recommendations. Med Tech to Med Tech Communication Binder and the End of Shift Report Binders will be monitored by the RSC or designee daily to ensure residents who tested positive for COVID remain listed as positive until their isolation period is complete. Monitoring will be completed daily through 5/19/21. The ED or designee will compare the Accushield screening log to the staff timecards daily during business days, and on the next business day for weekends and holidays. The ED or designee will round daily (business day) to ensure that all community guests are wearing their verification badges. Comparisons and rounding will be completed each business day through 5/19/21. The Shift Supervisor Responsibilities Checklist will be reviewed by the department supervisor, RSC, and/or ED weekly for 3 months through 5/19/21 to ensure PPE supplies have been checked by Shift Supervisors. Results will be reviewed for compliance, trends and patterns reported through QA for recommendations. The ED or designee will complete unannounced rounds on night shift to observe staffing and care delivery based on resident needs on the Memory Care Units. Rounding will be completed twice weekly for 1 month, weekly for 1 month and monthly for 1 month thru May 19, 2021. Results will be reviewed for staff compliance, trends and patterns and will be reviewed at QA for on-going recommendations.	

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D 612	Continued From page 45 COVID-19 screening check list to include recorded temperature check, two times per shift (start and end of shift). -Team members should notify their supervisor immediately if they were exhibiting: cough or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, nausea, vomiting, new loss of taste or smell. -Team members that test positive with mild to moderate illness may return to work when at least ten days have passed since symptoms first appeared and; at least 24 hours passed since last fever without fever reducing medications and; symptoms are resolved and retesting with negative results are required. -Confirmed positive team members with severe to critical illness may return to work when: At least 20 days have passed since symptoms first appeared and; at least 24 hours have passed since last fever without the use of fever reducing medications and; symptoms have improved and retesting with negative results are required. -If a team member developed symptoms consistent with COVID-19 they should immediately stop work, isolate at home, and seek medical care. Staff will then need to remain off work for at least 14 days from the first symptom and return with a negative COVID-19 test result. -All staff assignments were to be documented daily/weekly to ensure appropriate contact tracing can be identified. -Any isolated or quarantined resident or outbreak identified within the community will require use of full PPE to include: N95 Mask, gown, bouffant cap, booties, gloves and face shield. All PPE to be put on prior to entry but removed prior to exiting the apartment in a biohazard trash bag at the door. The team member will immediately proceed to the nearest hand washing station before conducting any additional care.	D 612	The ED or designee will complete unannounced rounds on the memory care units on each shift. Observations will be made to ensure adequate PPE supplies are available and ensure that a team member is assigned to the COVID isolation area to prevent isolated residents from exiting the area (when residents are COVID positive and isolated in the area). Unannounced visits to the memory care units will start 2/19/21 with twice weekly visits for 1 month, weekly for 1 month, and every other week through May 19, 2021. Results will be reviewed for staff compliance, trends and patterns and will be reviewed at QA for on-going recommendations. 4. All corrective measures will be implemented by 2/19/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	

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D 612	Continued From page 46 1. Review of the resident roster with COVID-19 testing results document provided by the Administrator on 12/30/20 revealed: -The week of 11/30/20-12/04/20, there were 47 residents tested, of which 3 were positive. -The week of 12/07/20-12/11/20, there were 43 residents tested, of which 3 were positive. -The week of 12/14/20-12/18/20, there were 39 residents tested, of which 12 were positive. -Further testing was done during the weeks of 12/28/20 and 01/04/21 but no results were available. -All the COVID-19 positive residents resided on the MCU halls B & C. Telephone interview with the Local Health Department (LHD) Registered Nurse on 01/05/21 at 11:49am revealed: -Staff should not work if they were experiencing signs or symptoms of COVID-19 and should notify the Administrator or a management staff member immediately. -Staff should be quarantined for 14 days after testing positive for COVID-19. Telephone interview with the Administrator on 01/06/21 at 10:02am revealed: -He was not aware of any staff not feeling well and required to work their shift. -It was hard to comment on staff reporting they were not feeling well and needing to leave their shift because each situation was different and "staff's track record" had to be taken into account. -He thought it would have been important to establish if the staff had a temperature and were feeling ill and unable to work. -He would have expected the staff reporting they were sick and unable to work their shift to have reported that to him.	D 612		

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D 612	Continued From page 47 Telephone interview with a resident's primary care provider (PCP) on 01/06/21 at 8:05am revealed: -If a staff member complained of feeling fatigue, temperature or headache during the pandemic they should have not been exposed themselves or cared for the residents. -It was important for staff not to be sick when providing care to the residents due to risk of potentially passing illnesses on to the residents and other staff. Telephone interview with the Memory Care Director (MCD) on 01/06/20 at 12:59pm revealed: -She did not know of any staff member working while having symptoms of temperature or fatigue. -Staff should not work when they were sick to because they could pass germs and infections to residents and other staff. -If she had been aware that a staff member was sick, she would have either worked the shift or found someone else to work so that staff member could leave. Confidential staff interview revealed: -She reported to work on specified date (date and shift withheld to maintain confidentiality) and had a headache and fatigue. -The staff member reported symptoms to the Resident Care Director (RCD) and was advised that the facility was short staff and the staff was not able to go home. -Normal procedure was for staff to find their own coverage if they were calling out for their scheduled shift. -The staff was not able to find a replacement and stayed and worked the shift. -Worked multiple dates in December 2020 while having headache, fatigue and chills. -The staff did not report any symptoms beyond	D 612		

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D 612	Continued From page 48 the initial report to the RCD because the staff felt the management would not listen to concerns. -The staff went to the emergency room for these ongoing health concerns and was diagnosed with COVID-19. 2 a. Review of the facility's weekly time card report for facility staff compared with the facility's Screening of Infection or Communicable Disease Staff/Visitor Screening Forms for 12/16/20, 12/23/20 and 12/30/20 revealed: -On 12/16/20, there were 6 out of 11 staff clocked in for duty with no screening form. -On 12/23/20, there were 14 out of 32 staff clocked in for duty with no screening form. -On 11/05/20, there were 12 out of 24 staff clocked in for duty with no screening form. Observations of the main front entrance of the facility on 12/30/20 intermittently between 5:25am -5:38am revealed: -The supervisor/medication aide (S/MA) opened the entrance door and invited the survey team to enter the facility. -The S/MA was prompted by the surveyor at 5:36am and again at 5:38am, if there was anything that needed to be completed prior to entering the facility. -The S/MA advised that COVID-19 screening and temperature check needed to be completed by using the electronic computer pad after being prompted. -The three surveyors completed the facility's COVID-19 screening and a temperature check through the electronic computer pad stored on the table located to the right of the main walkway of the front entrance room at 5:40am, 5:45am and 5:47am. Telephone interview with a confidential staff	D 612		

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D 612	Continued From page 49 member revealed: -Management was not monitoring the facility's COVID-19 screening process when staff reported to work because staff could walk in, clock in and walk to the floor and start the shift. -There were times the staff would forget to complete the COVID-19 screening process before beginning a shift. Telephone interview with the Local Health Department (LHD) Registered Nurse on 01/05/21 at 11:49am revealed that all staff were expected to complete a COVID-19 screening prior to their scheduled shift and there should be a process in place to monitor for completion of screening. Telephone interview with a resident's primary care provider (PCP) on 01/06/21 at 8:05am revealed it was important for staff and anyone entering the facility to complete a COVID-19 screening to prevent bringing COVID-19 into the facility. Telephone interview with the Administrator on 12/31/20 at 3:01pm revealed: -Staff were responsible for completing a COVID-19 screening including a temperature check and questionnaire prior to the start of each shift. -The facility was using a COVID-19 screening questionnaire form and temperature checks prior to the current electronic screening system with temperature check that started in December 2020. -The concierge were responsible to check the staff's COVID-19 screening forms and place completed forms into a binder. -A report was generated weekly from the electronic screening system with temperature checks to ensure staff were completing the required screening process for COVID-19.	D 612		

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D 612	Continued From page 50 -The electronic screening system with temperature checks was new, so the staff were learning how to print the reports out and compare to time punch records. -Each staff member was assigned their own special code they used each time to log in and log out of the electronic screening machine. -There were instances when staff attempted to complete their screening and their code would not work. -The staff would have been responsible for completing the paper screening questionnaire. -The facility was in the middle of a transition period with handwritten forms and the electronic screening system. -Staff screening reports were compared with the staffs' clock in and out time. -Some staff had completed the handwritten screening forms after 12/16/20. -He would provide a copy of all handwritten screening forms after 12/16/20. Telephone interview with the Administrator on 01/06/21 at 10:02am revealed: -The facility had a handwritten screening tool prior to initiating an electronic screening system in December 2020. -The electronic screening system had "holes" in staffs' screenings. -The Administrator was going to take a look at the staffs' screenings to determine if staff was completing screenings or if there were any technical issues that did not allow staff to screen in. -There was no monitoring process in place to ensure all staff were screening in prior to the start of their shift. -He had given staff verbal reminders to ensure they were screening in prior to the start of their shift.	D 612		

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D 612	Continued From page 51 -Because the facility was trying to put out "COVID-19 fires", the screenings for staff was something he could not monitor because he did not have time. No additional staff COVID-19 screening forms were provided prior to survey exit. b. Review of the residents' temperature recording log revealed: -The forms were printed with the resident's room number, name and temperature. -There was no section for screening for other symptoms of COVID-19 for the residents. -There were multiple screening log forms without dates. Review of the screening logs for 6 sampled residents for October 2020 revealed: -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #1 with exceptions of documentation of a temperature recording on 10/02/20, 10/04/20, two readings on 10/21/20, one on 10/22/20, 10/23/20, two on 10/24/20, one on 10/25/20 and two on 10/30/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #5 with exceptions of documentation of a temperature recording on 10/19/20, 10/22/20, two on 10/25/20, and two on 10/30/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #2 with exceptions of documentation of a temperature recording on 10/22/20 and 10/23/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #4 with exceptions of	D 612		

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D 612	Continued From page 52 documentation of a temperature recording on 10/03/20, two on 10/21/20, one on 10/22/20, 10/24/20 and 10/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #3 with exceptions of documentation of a temperature recording on two on 10/21/20, one on 10/22/20, 10/24/20, and 10/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #6 with exceptions of documentation of a temperature recording on 10/22/20 and 10/23/20. Review of the screening logs for 6 sampled residents for November 2020 revealed: -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #1 with exceptions of documentation of a temperature recording with three readings on 11/01/20 and one on 11/02/20, 11/27/20 and 11/30/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #4 with exceptions of documentation of a temperature recording with one reading on 11/01/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #3 with exceptions of documentation of a temperature recording with one reading on 11/01/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #6 with exceptions of documentation of a temperature recording with one reading on 11/01/20. -There was no documentation of temperature checks or screening for other symptoms of	D 612		

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D 612	Continued From page 53 COVID-19 for Resident #2 with exceptions of documentation of a temperature recording with one reading on 11/01/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #5 for the month of November 2020. Review of the screening logs for 6 sampled residents for December 2020 revealed: -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #4 with exceptions of documentation of a temperature recording on 12/02/20, 12/03/20, two on 12/05/20, one on 12/19/20, 12/21/20, 12/30/20 and 12/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #1 with exceptions of documentation of a temperature recording on 12/03/20, 12/04/20, 12/05/20, 12/15/20, 12/16/20, 12/17/20, two on 12/18/20, one on 12/19/20, 12/20/20 and 12/22/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #2 with exceptions of documentation of a temperature recording on two on 12/04/20, two on 12/17/20, one on 12/19/20, two on 12/20/20, one on 12/21/20 12/23/20, 12/29/20 and three on 12/30/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #6 with exceptions of documentation of a temperature recording on 12/04/20 (The resident passed away on 12/14/20). -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for Resident #5 with exceptions of documentation of a temperature recording on	D 612		

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D 612	Continued From page 54 12/04/20, two on 12/17/20, one on 12/19/20, two on 12/20/20, one on 12/21/20, 12/23/20, 12/29/20, three on 12/30/20 and one on 12/31/20.. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for a Resident #3 with exceptions of documentation of a temperature recording on 12/02/20, 12/03/20, two on 12/05/20, one on 12/19/20, 12/21/20, 12/30/20 and 12/31/20. Interview with a personal care aide (PCA) working on the assisted living section of the facility on 12/30/20 at 6:00am revealed: -The residents' temperatures were taken twice per shift, at the beginning and end of shift. -No screening questions were asked however if a resident had a cough, it was documented on the report sheet. -The report sheet was given to the Supervisor/Medication Aide (S/MA) -If a resident had a temperature of 99 degrees Fahrenheit (F) to 100 F, then the PCA would report it to the (S/MA). Telephone interview with the Administrator on 01/06/21 at 10:54am revealed he would review and provide the six sampled residents' temperature logs that were missing from October-December 2020. Interview with a resident residing in room# A8 on the Assisted Living (AL) section on 12/30/20 at 7:57am revealed: -Staff obtained her temperature at least daily for COVID-19 screening. -Staff did not ask her any questions about symptoms of COVID-19 daily when her temperatures were obtained.	D 612		

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D 612	Continued From page 55 Interview with a second resident residing in room# D13 on the AL section on 12/30/20 at 8:15am revealed: -Staff obtained his temperature readings several times per day for COVID-19. -Staff did not ask him any symptom screening questions for COVID-19. Telephone interview with the Local Health Department (LHD) Registered Nurse on 01/05/21 at 11:49am revealed: -Residents should be screened daily by checking temperatures and asking questions about the presence of COVID-19 symptoms. -He discussed with the Administrator during the on-site visit on 12/17/20 about the importance of screening residents, staff and visitors for COVID-19 symptoms. Telephone interview with the Administrator on 12/31/20 at 4:00pm revealed: -The LHD provided the facility with verbal and written recommended guidance for COVID-19. -Resident COVID-19 screening questions were only documented if the resident had symptoms such as a cough or temperature. -When the LHD RN made an onsite visit this month, he was more concerned with temperature checks of the residents. -Staff were responsible for documenting if residents had symptoms that were not normal for that resident. Telephone interview with the Memory Care Director (MCD) on 01/06/21 at 12:59pm revealed: -Staff were responsible for screening residents for COVID-19 daily by obtaining temperatures. -There were no COVID-19 screening questions for residents residing on the MCU; however, staff monitored how much the residents ate.	D 612		

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D 612	Continued From page 56 -The Administrator provided staff updates, guidance and informed staff of processes and procedures for COVID-19. No additional resident COVID-19 temperature screening forms were provided by the Administrator prior to survey exit. 3. Review of Resident #4's FL-2 dated 07/28/20 revealed: -Diagnoses included neuro cognitive disorder (severe dementia), major depressive disorder, hypertension and arthritis. -Resident #4 was intermittently disoriented. -The resident's recommended level of care was memory care. Observation of MCU on 12/30/20 at 6:35am revealed there was no precautions sign posted on Resident #4's room door related to isolation. Interview with the Administrator on 12/30/20 at 7:14am revealed: -Resident #4 tested positive for COVID-19 on 12/18/20 and was still within the 14-day window and should still be on contact isolation precautions. -Resident #4 had a dry cough which was close to his baseline. -COVID-19 positive residents should have an isolation sign on their room doors. Telephone interview with the Memory Care Director (MCD) on 01/06/21 at 12:59pm revealed: -Precaution signs related to isolation were placed on the room doors of residents who tested positive for COVID-19. -PPE required to enter COVID-19 positive rooms included: face shields, face masks, gowns, gloves and shoe covers.	D 612		

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CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D 612	Continued From page 57 -She placed isolation signage on the B hall and she assigned a named staff member to post isolation signage on the C hall. -Resident #4 had a history of pulling things down from the wall. -She was not sure if staff ever placed an isolation sign on Resident #4's door or if Resident #4 tore the sign down. Based on observations, interviews and record reviews, Resident #4 was not interviewable. Interview with the supervisor/medication aide (S/MA) on 12/30/20 at 5:24am revealed: -The residents with a COVID-19 diagnosis were cohorted on the B hall and C hall which were also memory care units (MCUs). -She was not sure of the facility's current census and was not sure of the total number of COVID-19 positive residents in the facility at that time but "heard" there were four. -She administered medications to both residents who tested positive for COVID-19 and residents who tested negative for COVID-19. Interview with a personal care aide (PCA) on 12/30/20 at 6:31am revealed: -She could identify COVID-19 positive residents by the isolation signs posted at the residents' doors. -She was unsure of the current COVID-19 status of some of the residents residing on the C hall. -She believed there was a total of six current residents that were COVID-19 positive. Observation on the C hall of the MCU on 12/30/20 at 6:57am. -There were Isolation signs posted on the door of six residents' rooms labeled as "Isolation Protocol" with instructions for full PPE required,	D 612		

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D 612	Continued From page 58 change before and after care. Telephone interview with the Administrator on 12/31/20 at 3:01pm revealed: -There were multiple residents that tested positive for COVID-19 within the same time frame and were currently outside of their 14-day quarantine window. -There were isolation precaution signs on some resident's doors who were outside of their 14-day quarantine window and no longer required to be on isolation precautions because staff did not remove the signs. -The isolation precaution signs for all residents on B hall and C hall were updated on 12/30/20. Interview with a PCA on 01/04/21 at 3:24pm revealed: -She floated on A, B, C and D Hall. -She was aware that there were COVID-19 positive residents, but unsure which residents were positive for COVID-19. -She knew of some residents' COVID-19 status because of "hearsay" from other staff members. -No one from management communicated with her the COVID-19 status of any residents. Confidential staff interview revealed: -Staff were not updated by management when a resident tested positive for COVID-19. -The staff did not know Resident #4 was positive for COVID-19 until 4 days ago after caring for the resident (01/01/21). Telephone interview with the Local Health Department (LHD) Registered Nurse on 01/05/21 at 11:49am revealed staff providing direct patient care should be aware of residents' COVID-19 status so that correct PPE can be utilized.	D 612		

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D 612	Continued From page 59 4. Observation of a Supervisor/Medication Aide (S/MA) on 12/30/20 at 5:48am revealed: -The S/MA was observed from the Assisted Living (AL) section hallway standing at the door on the B Hall of the Memory Care Unit (MCU) through the paned windows. -The S/MA was not wearing a personal protective equipment (PPE) gown. -The S/MA was moving a handheld disinfectant device across her clothing. Interview with S/MA on 12/30/20 at 6:19am revealed: -She provided care for residents who were positive for COVID-19 and provided care for residents who were negative for COVID-19. -She did not wear the PPE isolation gowns because they were too tight. -This concern was reported to the Resident Care Director (RCD). -She used the facility's handheld disinfecting device on her clothing whenever she exited COVID-19 areas. Confidential interview with staff revealed: -One named staff could not wear the facility's PPE isolation gowns. -The RCD was notified the named staff was unable to wear the PPE gowns and the RCD informed the Administrator and more PPE gowns would be ordered. Confidential interview with second staff revealed: -The staff had worked with a named staff that could not wear the facility's PPE gowns and the Memory Care Director (MCD) was aware of this. -There were times the staff had to care for residents who tested positive for COVID-19 without a PPE gown.	D 612		

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D 612	Continued From page 60 Confidential interview with a third staff revealed: -The staff was not able to wear the PPE isolation gowns provided by the facility because they were too small. -The concern was reported to the MCD approximately 1-2 months ago. -The staff provided care for residents who tested positive for COVID-19 and residents who tested negative for COVID-19. -Other staff helped, when able, by providing care for residents who tested positive for COVID-19 since the staff could not wear the PPE isolation gowns. -When other staff were not available, the staff provided care for residents with COVID-19 and did not use the PPE isolation gowns. Telephone interview with a resident's primary care provider (PCP) on 01/06/21 at 8:05am revealed: -The PCP expressed concern that if PPE was not worn appropriately it could increase the spread of COVID-19 amongst residents and staff. -Wearing face masks, face shields, gowns, gloves and shoe coverings offered better protection against COVID-19 than using a handheld disinfecting device. -The handheld disinfecting device would not be able to disinfect your whole body and clothes. Telephone interview with the Local Health Department (LHD) Registered Nurse (RN) on 01/05/21 at 11:49: -Staff providing care for residents diagnosed with COVID-19 should wear the recommended PPE: surgical mask or N95 mask, face shield, gown, gloves and shoe coverings. -If PPE was not worn appropriately it could further spread COVID-19 to other residents and staff. -If staff could not wear all recommended PPE appropriately then they should not be assigned to	D 612		

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D 612	Continued From page 61 work with residents diagnosed with COVID-19. -If the facility had contacted the LHD, guidance on PPE gowns could have been provided. Telephone interview with the Administrator on 01/05/21 at 3:34pm revealed: -He was not aware that some staff were not able to wear PPE isolation gowns. -The facility had different sizes available of PPE isolation gowns and he has personally seen the different sizes. -He was only aware of one staff member who used the handheld disinfecting device on their personal clothing. -The use of the handheld disinfecting device on personal clothing was not a "common practice" and it was not a "substitution for PPE." Telephone interview with the Administrator on 01/06/21 at 10:02am revealed: -He had spoken with all department managers regarding any staff not being able to wear PPE gowns. -There was one particular staff who would return to work this weekend and ensured there was a PPE gown that would fit the staff. 5. Review of the Centers for Disease Control (CDC) Infection Prevention and Control (IPC) Guidance for Memory Care Units (Last updated on 05/12/20) revealed: -Staff should provide assistance with frequent hand hygiene, social distancing and use of face coverings. -Limit the number of residents or space residents at least six feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory, and within close proximity to other residents or staff. -The facility should dedicate staff to care for	D 612		

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D 612	Continued From page 62 residents who were COVID-19 positive on the MCU. Observations on 12/30/20 on B Hall (MCU) revealed: -At 6:44am, a female resident exited from room# B11 and was walking in the hallway without her mask heading towards another residents' room with no staff available to redirect her or assist with donning a mask. -At 6:48am, a male resident exited room# B3 wearing only one shoe and no mask and proceeded to ambulate in the hallway with no staff available to redirect or assist with getting his other shoe or donning a mask. Observation of Resident #4 on 12/30/20 intermittently between 9:57am - 10:17am revealed: -At 9:57am, the resident entered the hallway from his room without a face mask and walked down the hall, past the Resident Care Director (RCD) who was sitting in an office with the door in an opened position. -The resident was in view of the RCD as he passed the office door. -The RCD did not provide any redirection back to his room or assistance to the resident to apply a face mask or redirection. -The resident continued walking down the hallway to the MCU's dining room, removed a cup from the cabinet and poured water into the cup and began drinking the water. -At 10:03am, a personal care aide (PCA) was in the hallway and had passed the MCU's dining room where the resident was walking out of the dining room. -The resident was in view of the PCA in the hallway MCU, however, the PCA did not provide any redirection for the resident to apply a face	D 612		

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D 612	Continued From page 63 mask. -The PCA continued to walk to the back area of the MCU and through the double doors carrying a resident's laundry to the laundry room. -At 10:05am, the resident was walking down the hall of the MCU without a face mask. -At 10:14am, the resident was walking down the hall with no face mask and passed the RCD sitting in the office. -The RCD was not observed providing any redirection to the resident to return to his room and or apply a face mask. -At 10:15am, the Administrator entered the MCU hallway. -The resident was walking back up the hallway without a face mask, passing the Administrator who was talking with the RCD in the office. -The resident was not provided any redirection or assistance from the Administrator or the RCD to return to his room or apply a face mask. -At 10:17am, the resident was observed walking in the hallway without a face mask passing the RCD in the office with office door in an opened position. -The RCD was not observed providing any redirection to the resident to return to his room and or apply a face mask. Observations of the MCU on 01/04/21 intermittently from 12:34pm-12:59pm revealed: -A personal care aide (PCA) assisted two residents from the dining room to their rooms, via wheelchair. -Neither resident wore a mask, and neither were prompted to put a mask on by the PCA. -The PCA was wearing a face mask. Observations of the MCU on 01/04/21 at 3:16pm revealed: -There were four residents sitting in the TV room	D 612		

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D 612	Continued From page 64 socializing and three of the four residents were not sitting at least six feet apart from each other. -Three residents were not wearing a mask and one resident had the mask placed on top of her forehead, not covering her nose or mouth. -One of the four residents sitting in the TV room had a negative COVID-19 diagnosis, was not sitting at least six feet apart from other residents known to have positive COIVD-19 diagnosis and was not wearing a mask. -A PCA was at the nurses' station, across from the TV room; residents were visible to the PCA from the nurses' station. -Residents were not encouraged by the PCA to maintain social distancing, not redirected to their rooms and were not encouraged to wear masks. Telephone interview with one of the facility's primary care providers (PCPs) on 01/06/21 at 8:05am revealed the residents in the MCU needed guidance and redirection from staff to wear a face masks and to maintain social distancing to minimize the spread of infections when out of their rooms. Telephone interview with the Local Health Department (LHD) Registered Nurse (RN) on 01/05/21 at 11:49am revealed staff should redirect residents to stay in their room, encourage social distancing and remind residents to wear masks when in common areas. Telephone interview with the Administrator on 01/05/21 at 3:34pm revealed: -Chairs were spaced out in common areas of the MCU to encourage social distancing amongst residents. -Staff were expected to encourage social distancing, remind residents to wear masks and redirect residents to stay in their rooms as often	D 612		

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D 612	Continued From page 65 as they saw them getting close or not following COVID-19 precautions. Telephone interview with the Memory Care Director (MCD) on 01/06/21 at 12:59pm revealed: -Staff were responsible for monitoring and redirecting residents to wear masks and maintain social distancing when residents were out of their rooms. -She reminded staff on the MCU "all the time" to ensure residents were redirected to social distance and wear a face mask when out in common areas such as the halls and living rooms. -Staff were responsible for redirecting residents back to their room when quarantined due to testing positive for COVID-19. -If staff were unable to redirect a resident on quarantine back to their room, the staff would have been responsible for redirecting the resident to wear a mask. -There were some staff that did not follow the directives given and required reminders and re-education for directing residents as needed. The facility failed to maintain the recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) for the screening of staff and residents, staff working while displaying symptoms consistent with COVID-19, staff wearing personal protective equipment inappropriately and staff not encouraging residents to maintain social distancing or wear face masks. The facility's failure to follow the guidance related to infection prevention for COVID-19 placed the residents at risk for increased transmission for the virus to spread. This failure resulted in substantial risk of	D 612		

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D 612	Continued From page 66 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 12/30/20 for this violation with addendum on 01/07/21. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2021	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings and resident rights. The findings are: 1. Based on interviews, observations and record reviews, the facility failed to ensure 1 of 6 sampled residents were treated with dignity, privacy, and respect Resident #6 (female) who was placed in a room with Resident #3 (male). [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D912	D 912 – Community POC Response Resident #6 was moved to C7 on 12/2/21, which was considered the communities designated COVID isolation area after testing positive for COVID. The male resident tested positive for COVID on 12/7/21 and was also moved to the COVID designated area. The male resident was in the hospital from 12/12 to 2/13/21. Resident #6 expired 12/14/21. Upon being made aware the residents' cohabitation, all resident care staff were re-educated on the Resident's Bill of Rights, to include the right to preservation of dignity and respect while under the care of the facility by the ED on 1/7/21. The soiled furniture was immediately removed from the hallway on 1/4/21. The laundry room door was pulled closed and locked automatically. Personal items and medications were immediately removed from room C7. Housekeeping staff and personal care staff were re-educated on the importance of prompt removal of soiled items, that laundry room and janitorial closets must remain locked at all times in the secured units, and that all personal care items must be secured and out of residents' reach.	3/6/2021

2. The ED/designee will continue community staff re-training on Residents' Bill of Rights will continue, 1/28/21 and 2/18/21. The local Ombudsman has been contacted to provided staff training on Resident Rights, date to be determined.

A new system for internal resident transitions has been created, which requires ED/designee approval for placement and verification of room readiness. Community leadership will be trained on the new system and implementation will occur on 2/19/21.

Community leadership will be trained on the new system and implementation will occur on 2/19/21.

Shift Supervisors will be educated that no internal transitions may take place without the written/emailed authorization of the ED on 2/18/21.

All care staff and managers will be re-educated to respect residents' dignity by not pairing unauthorized cohabitation on 2/18/21.

A new procedure has been developed to ensure that all soiled furniture or furniture awaiting donation/disposal will be stored in a secured/locked area inaccessible to residents. Maintenance, housekeeping and care staff will be educated on this procedure by 2/19/21.

A new system for resident transitions has been created for verification of room readiness. The system will track room vacancies, when personal items have been removed by the family, when repairs have been completed and when the room has been terminally cleaned. Room assignment must be signed off by the ED once room readiness has been verified. Rooms must remain locked during the readiness process. Community leadership will be trained on the new system and implementation will occur

			on 2/19/21. Housekeeping and care staff re-education and training will continue regarding maintaining the adult home in an uncluttered, clean, and orderly manner, free of all obstructions and hazards. Training was provided on 1/28/21 and will be provided again on 2/18/21. A Shift Supervisor and PCA responsibility checklist has been created to including rounding in all areas of the unit each shift to ensuring all empty rooms, laundry areas, janitorial closets, and any area that would be considered hazardous to residents are locked. Supervisors and PCAs will be trained for implementation on 2/18/21 and as needed for compliance. Department leadership will be re-educated on the community expectation that leadership round on all areas of their units at least daily when on duty to ensure that any potential resident hazards are immediately addressed. Room sweeps on the memory care units will be assigned to care staff weekly to ensure personal care items, medications, cleaners and other hazardous materials are not stored accessible to residents in their rooms. Hazardous items found will be either secured or returned to the resident's family. Staff will be training on the room round process on 2/18/21, with 2/19/21 implementation. The community has added auto closing arms to both memory care laundry room doors to ensure doors remain secure. An electronic keypad for the doors will be purchased and installed on the laundry room doors on the secured memory care unit to ensure that laundry room doors are secured at all times while allowing staff easy access to the area when completing laundry. Keypad and auto closing features will be installed upon delivery and staff will be immediately trained on keypad use.	

			3. The ED or designee will round twice weekly for four weeks to ensure resident occupancy matches census room assignment. Rounding will continue weekly for 2 additional months. Results will be reviewed for staff compliance, trends, and patterns and reported through QA. The QA Committee make on-going recommendations. --- The ED or designee will round twice weekly for four weeks to ensure all empty rooms and areas containing hazards are secured, preventing resident access. 25% of occupied resident rooms will be spot checked to ensure compliance with weekly room rounds. Rounding will continue weekly for 2 additional months. Results will be reviewed for staff compliance, trends, and patterns and reported through QA. The QA Committee make on-going recommendations. Shift Supervisor and PCA Shift Checklists will be reviewed by the department supervisor, RSC, ED or designee weekly for 3 months through 5/19/21. 4. All corrective measures will be implemented by 3/6/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	

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D912	Continued From page 67 2. Based on observations, record reviews and interviews, the facility failed to ensure the facility was free of hazards as evidenced by storage of soiled furniture in a section of the hallway, toiletry items and a topical pain medication left unsecured in an unlocked and unoccupied resident room and bathroom and a unlocked laundry room accessible to all residents in a Memory Care Unit (MCU) including residents known to have dementia and/or wandering behaviors.[Refer to Tag 0079, 10A NCAC 13F .0306 (a) (5) Housekeeping and Furnishings (Type B Violation)].	D912	D 914 - Community POC Response Resident #5 was assessed for injury and provided incontinence care. Resident #5 sustained no injury related to the fall and experienced not skin breakdown related to the incontinence of stool. Resident #5 was hospitalized on 2/15/21 for change in condition post to COVID vaccination. Psychiatric referrals have been requested from the resident's PCP and hospital Care Manager. A Significant Change assessment will be completed upon her return to the community.	3/6/2021
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 from mental and physical abuse, neglect, and exploitation as related to resident supervision, and infection prevention and control program. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure staff on the memory care unit (MCU) were available to supervise and meet the needs of the residents to provide any supervision for 1 of 5 sampled residents (#5) resulting in one resident having a	D914	The staff on duty on the third shift at the time of the incident and the Activities Director were immediately re-educated on the requirements for maintaining minimum staffing levels at all times (including breaks and assigned duties that take staff of the unit), personal care and supervision for residents in accordance with their assessed needs and care plan; first shift staff were also provided immediate re-education. 1/6/21. Additional staff re-education was completed on 1/7/21. Staffing patterns were immediately increased on the third shift to ensure there are two (2) PCAs in Memory Care – one on the B unit, and one on the C unit, plus a readily available supervisor for the campus. The night shift Supervisor responsible for the care of resident #5 has been counseled, and the day shift Supervisor is no longer with the company.	

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	HAL092215	A. BUILDING: _____ B. WING _____	C 01/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE GARNER	200 MINGLEWOOD DRIVE GARNER, NC 27529

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D914	Continued From page 68 fall and being found on the floor in feces. [Refer to Tag 0270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance from the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to screening of staff and residents for signs and symptoms consistent with COVID-19; staff working while displaying symptoms consistent with COVID-19; and staff being aware of each resident's COVID-19 diagnosis; staff wearing personal protective equipment (PPE); and redirection of residents to maintain social distancing and use of face masks when out of their rooms. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)].	D914	D 980 – Community POC Response 1.The Executive Director was re-educated on the statutes related to supervision, infection control and prevention, residents' rights, and housekeeping and furnishings on 2/16 to 2/19/19. 2.An external Nurse Consultant has been contracted to support the community with nursing system implementation, staff training, and system monitoring. 3.A Cadence Living Corporate Regional Vice President of Operations will be present at the community consistently to monitor the Administrator's effectiveness in ensuring overall management, operations, policies and procedures, and total operations of the facility are implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules	2/19/2021
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record	D980		

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D980	Continued From page 69 reviews, the Administrator failed to ensure the overall management, operations, and policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to supervision, infection control and prevention, residents rights, and housekeeping and furnishings, all of which are the responsibility of the Administrator. The findings are: Telephone interview with the Administrator on 01/07/21 at 9:02am revealed: -He was responsible for the administration of the community. -His job responsibilities included finances, budgetary guidelines and for the overall regulatory needs of the facility including the facility's policies and procedures. -He was responsible for all staff and departments within the facility. -His work hours varied ranging from 9:00am - 5:00pm and approximately every 6th weekend covering manager on duty responsibilities. -The facility was actively hiring for a Resident Service Director nurse position that had been vacant since approximately 3 months. Non-compliance was identified in the following rule areas at violation level: 1. Based on observations, interviews, and record reviews, the facility failed to ensure staff on the memory care unit (MCU) were available to supervise and meet the needs of the residents to provide any supervision for 1 of 5 sampled residents (#5) resulting in one resident having a fall and being found on the floor in feces. [Refer to Tag 0270, 10A NCAC 13F .0901 (b) Personal	D980	related to supervision, infection control and prevention, resident rights, and housekeeping and furnishings 4.All corrective measures will be implemented by 2/19/21, with monitoring compliance through at least 5/19/21. On-going initiatives and monitoring will be recommended through QA based on compliance, trends, and patterns.	

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D980	Continued From page 70 Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance from the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to screening of staff and residents for signs and symptoms consistent with COVID-19; staff working while displaying symptoms consistent with COVID-19; and staff being aware of each resident's COVID-19 diagnosis; staff wearing personal protective equipment (PPE); and redirection of residents to maintain social distancing and use of face masks when out of their rooms. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)]. 3. Based on interviews, observations and record reviews, the facility failed to ensure 1 of 6 sampled residents were treated with dignity, privacy, and respect Resident #6 (female) who was placed in a room with Resident #3 (male). [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 4. Based on observations, record reviews and interviews, the facility failed to ensure the facility was free of hazards as evidenced by storage of soiled furniture in a section of the hallway, toiletry items and a topical pain medication left unsecured in an unlocked and unoccupied resident room and bathroom and a unlocked laundry room accessible to all residents in a Memory Care Unit (MCU) including residents	D980		

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D980	Continued From page 71 known to have dementia and/or wandering behaviors.[Refer to Tag 0079, 10A NCAC 13F .0306 (a) (5) Housekeeping and Furnishings (Type B Violation)]. The Administrator, who was responsible for the overall management, administration, supervision, and operation of the facility, failed to ensure staff were adhering to guidelines and recommendations established by the Center for Disease Control (CDC), local health department, and the North Carolina Department of Health and Human Services to protect the residents from infection and transmission during the global coronavirus (COVID-19) pandemic infection control guidelines by screening upon entry to the facility, monitoring for signs and symptoms for residents, failing to follow social distancing guidelines, and proper use of PPE to reduce the transmission and infection of the serious illness among the residents on the Memory Care Unit (MCU), failed to ensure enough staff were present on the MCU where multiple residents were left without any staff on the unit to provide supervision and meet their care needs, and failed to ensure the facility was free of hazards on the MCU where toiletry items and topical pain medication, chemicals and storage of soiled furniture were accessible to residents, and housing a non-related male and female resident in the same room. The Administrator's failure resulted in a lack of personal care assistance with incontinence care, bathing and dressing, supervision of residents at risk for falls and follow up for changes in condition The Administrator's failure resulted in detrimental harm and serious neglect which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/07/21.	D980		

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D980	Continued From page 72 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2021.	D980		

3-9-21