STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on November 2-4, 2021.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#2) with orders for brushing teeth three times daily, removal of a upper partial denture at night, and nightly use of a special oral rinse. The findings are: Review of Resident #2's current FL-2 dated 11/02/20 revealed: -Diagnoses included anxiety disorder psychosis, dementia with Lewy bodies, diabetes mellitus, spinal stenosis, constipation and peripheral neuropathy. -Resident #2 needed assistance with bathing and dressing. Review of Resident #2's periodontal office orders dated 09/21/21 revealed there was an order for Resident #2 to brush her teeth three times per day, remove her upper partial denture at night, and use an oral gel rinse nightly.	D 276		

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D 276	Continued From page 1 Review of Resident #2's September 2021, October 2021 and November 2021 electronic medication administration records (eMAR) revealed there were no entries for brushing teeth three times daily, removal of the upper partial denture nightly, or an oral gel rinse nightly. Observation of Resident #2's of Resident #2's bathroom on 11/03/21 at 10:00am revealed she had an unopened box of oral gel rinse in a basket near her sink. Interview with Resident #2 on 11/04/21 at 11:42am revealed: -She brushed her own teeth in the morning and night. -She took out her upper partial at night and cleaned it without staff prompting or assistance. -Her gums were sore, and she used the toothpaste in the tube in her bathroom. -Staff did not assist or ask her about brushing her teeth. Telephone interview with a representative at Resident #2's Prosthodontist office on 11/03/21 at 3:40pm revealed: -Resident #2 had an appointment on 10/06/21 -Resident #2 had a visit at the office because her upper partial denture was chipped at the edges causing the ends to be sharp. -The sharp edges of Resident #2's upper partial denture caused sores on her gums. Telephone interview with a dental hygienist at Resident #2's periodontal office on 11/03/21 at 4:00pm revealed: -Resident #2 visited the office for an appointment on 09/21/21. -Resident #2's oral exam indicated that she had	D 276		

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	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

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ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 276	Continued From page 2	D 276		

poor oral hygiene and her upper partial denture was not clean
-When she looked at Resident #2's upper partial denture, it appeared to not have received nightly cleaning.
-Resident #2 had general redness and sores along her gums.
-She was given a form to fill out for the facility by Resident #2's family member.
-She ordered for Resident #2 to brush her teeth three times per day because that was recommended for people at high risk for periodontal disease.
-She also ordered for the removal of Resident #2's upper partial denture nightly and use of an oral gel rinse each night.
-Any oral appliance or equipment should be removed and cleaned to prevent yeast infections, other systemic infections, and sore gums.
-Resident #2's upper partial denture needed to be cleaned each night before using it the next day.
-The oral gel rinse was an anti-microbial, anti-inflammatory, anti-bacterial rinse.
-The oral gel rinse was used to soothe gums and decrease inflammation.
-She gave the form that she wrote the orders on back to Resident #2's family member.
-She reviewed the orders with Resident #2 and the family member.
-She did not call the facility to discuss the orders for Resident #2.
-No one from the facility had called her about Resident #2's orders.

Telephone interview with Resident #2's family member on 11/04/21 at 2:06pm revealed:
-He took Resident #2 to her dental appointment on 09/21/21.
-A medication aide gave him the order form to take with them to the dental office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 276	Continued From page 3 -When they returned from the dental office, he gave the form to the receptionist. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/03/21 at 4:15pm revealed: -The facility faxed over orders to the pharmacy and the orders were placed on the eMARs. -The pharmacy placed treatment orders on the eMAR such as vital signs, dressing changes, and brushing teeth if ordered. -An order for brushing teeth three times a day, removal of an upper partial denture nightly and use an oral gel rinse nightly was not received for Resident #2. Telephone interview with a personal care aide (PCA) on 11/04/21 at 10:16am revealed: -She worked a 12 hour shift from 7:00pm to 7:00am. -Many residents were able to prepare for bed independently. -She did not help residents with brushing their teeth. -If there was a special order or order change for residents, the MAs told her. -She knew Resident #2 brushed her teeth because she came into Resident #2's bathroom one evening and saw her brushing her teeth. -She did not know which toothpaste Resident #2 used, and she did not know if Resident #2 removed her upper partial denture. Interview with a medication aide (MA) on 11/03/21 at 10:25am revealed: -Resident #2 had two types of toothpaste in her bathroom. -Resident #2 was supposed to brush her teeth twice a day. -She knew Resident #2 brushed her teeth	D 276		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 276	Continued From page 4	D 276		

because she saw her brushing her teeth in the past in the morning.
-She did not know which toothpaste Resident #2 utilized.

Interview with another MA on 11/04/21 at 8:41am revealed:
-Residents took a copy of their six-month physician orders, a copy of their insurance information (if needed), and a blank order form with them to appointments.
-The order form was a form that was utilized by medical providers which communicated to staff any orders and details of the appointment.
-When a resident had an appointment, the resident returned with the order form from the appointment.
-If she was working, she received the order form back from the resident upon their return to the facility.
-She faxed the order form to the pharmacy for all orders so that pharmacy could place the orders on the eMARs.
-On the eMAR, treatments were initialed which indicated the treatment was completed.
-A copy of the order was given to the nurse and a copy was placed in the resident's record.
-The nurse checked to ensure the order was placed on the eMAR.
-If there was an order that was not completely processed on her shift, the second shift checked the order to ensure it was completed.
-The MAs wrote a note on the resident's progress notes if there were changes to orders or new orders.
-The MAs used a 24-hour report to communicate what occurred at appointments and order changes.
-There was also a "hot box" which was a box used to place any flagged resident records with

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D 276	Continued From page 5	D 276		

new orders, hospital paperwork, or notes about a resident's condition.
-Resident #2 needed assistance with showers, shoes, dressing, and making her bed.
-She sent Resident #2 out for her appointment on 09/21/21 but she did not recall receiving her back into the facility.
-She did not recall the orders from the periodontist's office dated 09/21/21.
-She looked at the orders from the periodontist's office dated 09/21/21 and she could tell the orders were not sent to the pharmacy.
-When orders were sent to the pharmacy, there was a stamp placed at the bottom of the page to initial and date for faxing to the pharmacy, progress note update, date order verified, and date the nurse reviewed the order.
-There were no initials or dates for the items indicated on the stamped areas at the bottom Resident #2's periodontal orders.
-If she had received Resident #2's orders, she would have faxed Resident #2's orders to the pharmacy and initialed at the bottom of the orders.
-She knew that residents' orders were not always processed because she found orders in the past that had not been faxed when she came in for work.
-When she found the orders that were not faxed, she faxed them to the pharmacy.
-She did not know why Resident #2's orders were not faxed to the pharmacy.
-The nurse was supposed to check resident's orders to ensure the orders were processed.
-She recalled that Resident #2 had the oral gel rinse.
-Resident #2 brushed her teeth independently and she did not know if resident #2 removed her upper partial denture at night.
-She saw Resident #2 brushing her teeth a week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 276	Continued From page 6	D 276		

ago.
-She was taught to remove and soak resident's dentures when she first began working as a MA.
-This task was on the activities of daily living list, but now the facility used care logs for showers.
-The residents were not assisted with their dentures unless there was an order from their provider.
-She wished Resident #2's periodontal orders were not missed, but the orders were not processed.

Interview with the Director of Health and Wellness (DHW) on 11/04/21 at 10:37am revealed:
-The facility did not have a Resident Care Coordinator (RCC).
-The process for resident's orders were to fax it to the pharmacy, attach the fax verification, and leave the order in the order tray in the medication room until the order was verified on the eMAR system.
-She and the support nurse verified orders, but in the past the MAs verified orders.
-The MAs stopped verifying orders at the beginning of October 2021.
-She checked the box where orders were placed each day during her rounds.
-She expected the MAs to process orders by faxing them to the pharmacy as soon as they received the order in hand.
-She expected the MAs to place the stamp at the bottom of the order.
-She did not know about Resident #2's periodontal orders and she thought Resident #2's order was not faxed to the pharmacy.
-She thought whomever took Resident #2's periodontal orders, upon her return, placed the order form directly into her record.
-She held the MAs responsible for ensuring residents' orders were implemented.

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	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

(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 276	Continued From page 7 Interview with the Administrator on 11/04/21 at 12:02pm revealed: -She expected the person who received the resident's orders to initiate the process used by the facility to process orders. -The MAs or the nurses processed resident's orders. -She was not aware of Resident #2's periodontal orders. -The DHW was responsible for ensuring residents' orders were implemented.	D 276		
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: Based on record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina	D 612		

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	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 612	Continued From page 8	D 612		

Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to Assisted Living (AL) and Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to the screening of residents.

The findings are:

Review of the facility's COVID-19 policy revealed:
-The policy was dated with an effective date of 03/27/20.
-Residents were checked during daily rounds; including meal times.
-Using the resident screening log ask each resident if they were exhibiting any symptoms and if they had a fever.
-If a thermometer was available check the resident's temperature and document the temperature in the log.

Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed residents should be actively monitored daily for fever, and symptoms consistent with COVID-19.

Review of the North Carolina Department of Health and Human Services (NC DHHS) COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19.

Review of five residents' September 2021, October 2021, and November 2021 electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

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D 612	Continued From page 9	D 612		

medication administration records (eMARs) revealed there was no documentation of any temperatures.

Review of residents' temperature logs revealed:
-There were temperature logs for the months of January 2021, August 2021, and September 2021 stored in a binder and large envelopes.
-There were temperature logs for April 2020 to August 2020 stored in a storage closet.

Interview with a resident who resided in the Assisted Living (AL) unit on 11/02/21 at 9:36am revealed he did not have his temperature checked daily and no one asked him any questions about COVID-19 symptoms.

Interview with another resident who resided in the AL unit on 11/02/21 at 9:41am revealed:
-Staff had not obtained her temperature daily and no one had asked her questions concerning COVID-19 symptoms.
-Staff obtained her temperature daily in the past, but now her temperature was obtained occasionally.

Interview with a resident who resided in the Special Care Unit (SCU) on 11/04/21 at 8:19am revealed his temperature was never taken and no one had taken his temperature that day.

Interview with a medication aide (MA) who worked in the SCU on 11/04/21 at 8:23am revealed:
-She only took the residents' temperatures when the eMAR prompted her to and that was usually once a month or while a resident was on an anti-biotic.
-She took the residents' temperatures and monitored them for symptoms related to

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	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

(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 612	Continued From page 10	D 612		

COVID-19 during the beginning of the pandemic and when there were positive cases in the facility but that had all stopped about two months ago.
-She could not remember who had told her to stop monitoring the residents for COVID-19 symptoms and to stop taking daily temperatures.

Interview with a second MA who worked in the SCU on 11/04/21 at 8:30am revealed she did not screen the residents for symptoms of COVID-19 or take their temperatures daily; she thought second shift monitored the residents and documented it in a log.

Interview with a third MA who worked in the SCU on 11/04/21 at 10:06am revealed:
-She worked third shift in the SCU.
-She took the residents' temperatures during the last COVID-19 outbreak and documented them on a log sheet that was given to the HWD, but she did not know what happened to the documents after she turned them in.
-She had not taken temperatures or documented them since the facility did not have any more positive residents; that had been over a month ago.
-Another MA had told her during a shift change that they did not have to take the residents' temperatures anymore.
Telephone interview with a personal care aide (PCA) on 11/04/21 at 10:31am revealed:
-The residents were screened for COVID-19 in 2020.
-The residents were no longer screened for COVID-19 because there were no active cases of COVID-19 within the facility.

Interview with a MA who worked in the AL unit on 11/03/21 at 10:25am revealed:
-The facility had an outbreak in August 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 612	Continued From page 11	D 612		

-Residents temperatures were checked three times a day during the COVID-19 outbreak.
-The first and second shifts checked residents' temperatures.
-There was a temperature log used to document the residents' temperatures and the MAs placed the temperature logs into a binder.
-She did not know where the documented temperatures were now.
-Resident's temperatures were no longer checked frequently and the MAs stopped checking residents' temperatures a month ago.

Interview with another MA who worked in the AL unit on 11/04/21 at 8:41am revealed:
-She received training concerning COVID-19 in March 2020 from the Administrator.
-Any updates or reminders about COVID-19 were sent via a group message to all staff from the Administrator.
-She took the residents' temperatures daily throughout the year of 2020.
-Now she did not take residents' temperatures daily, and she was told by a co-worker that they could stop taking residents' temperatures daily.
-She took residents' temperatures if they complained of not feeling well, or if they left the facility and returned.
-There was a thermometer for use on each medication cart.
-Previously, she obtained resident temperatures daily and documented the resident's temperatures on a temperature log.
-The residents' temperature logs were placed in a box in the medication room for the nurse.
-There was a COVID-19 outbreak in August 2021 and the residents' temperatures were checked every shift.
-Once the facility was COVID-19 free, the daily temperature checks stopped about a month ago.

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D 612	Continued From page 12 -A rapid COVID-19 test was also done if a resident had complaints of not feeling well. -The facility had a policy for COVID-19. Interview with the Director of Health and Wellness (DHW) on 11/04/21 at 10:37am revealed: -She was a Licensed Practical Nurse (LPN) and she had held the position for 36 days. -The facility had a COVID-19 policy that was developed before she was hired. -She came to the job with COVID-19 training which she received at her previous job. -The residents' temperatures were taken daily during the COVID-19 outbreaks at the facility. -There was a COVID-19 outbreaks at the facility in August 2021 and it ended in September 2021. -She did not know the CDC guidance related to screening for residents. -Residents' temperatures were obtained frequently during COVID-19 outbreaks within the facility. -Her understanding was that the residents should be screened with daily temperatures during the COVID-19 outbreak. -Staff stopped monitoring residents' temperatures daily in September 2021. -The residents' temperatures were documented on a temperature log. -The MAs were responsible for checking the residents' temperatures and placed the temperatures into a system called "care tracker". -The Administrator was responsible for ensuring the CDC guidelines concerning daily resident COVID-19 screenings were followed. Interview with the Administrator on 11/04/21 at 12:02pm revealed: -Visitors and staff were screened and their temperatures were checked. -The facility had two COVID-19 outbreaks, one	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

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D 612	Continued From page 13 prior to the COVID-19 vaccine and another in 2021. -Residents temperatures were checked every shift during the COVID-19 outbreak. -New admissions were monitored daily with daily temperature checks. -She misunderstood the CDC guidance related to resident screening for COVID-19 on the most recent CDC COVID-19 guidelines dated 09/10/21. -She thought it was in reference to new admissions. -There were no daily temperature monitoring for residents in October 2021. -She was responsible for ensuring staff followed the CDC guidelines related to resident screening for COVID-19.	D 612		