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
	FCL017056	A. BUILDING B. WING	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABUNDANT LIVING # 2	3816 CHERRY GROVE ROAD ELON, NC 27244

(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
C000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 11, 2021	C000		
C231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) had an assessment and care plan completed withing 30 days following admission (#1) and updated annually (#2, #3). The findings are	C231		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Paul F Humphrey — 6-6-21

Reviewed, amended with the Administrator via telephone and accepted on July 2, 2021. Pamela Dailey 07/2/2021

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C231	Continued From page 1 1. Review of Resident #1's current FL-2 dated 03/02/21 revealed diagnoses included schizophrenia, cannabis use and unspecified cannabis induced drug overdose. Review of Resident #1's Resident Register revealed resident #1 was admitted to the facility 02/23/21. Review of Resident #1's care plan revealed it was not dated and had not been signed by Resident #1's primary care provider (PCP). Interview with Resident #1 on 05/11/21 at 8:46am he had been admitted to the facility about two months ago. Attempted interview with Resident #1's PCP on 05/11/21 at 1:20pm was unsuccessful. Attempted interview with the Administrator on 05/11/21 at 3:30pm was unsuccessful. Refer to the interview with the Assistant to the Administrator on 05/11/21 at 10:37am. 2. Review of Resident #2's current FL-2 dated 08/17/20 revealed diagnoses schizophrenia, constipation, hypertension, enuresis, and non-insulin-dependent diabetes. Review of Resident #2's record revealed the most recent care plan was dated 10/15/19. Interview with Resident #2 on 05/11/21 at 9:35am revealed: -He had lived at the facility for almost four years. he could not recall when he was admitted. -He could do everything for himself; he dressed,	C231	Effective May 11, 2021 SIC will ensure that all current and future residents will be examined by NPC for facility within 30 days of admission. This is our current policy and procedure. However, the client had been enrolled into peer support program and staff allowed resident to attend peer support program on the day that NPC was schedule to examine the resident. Effective May 15, 2021 Administrator, has posted a schedule for the days that the NPC will be coming to the facility and has instructed all staff that residents are to refrain from peer support on the day that the NPC is scheduled to examine residents. Administrator has spoken with the peer support agency and arranged that if any resident cannot attend peer support because of a medical appoint that resident will be able to reschedule for another day according to the peer support agencies schedule. Effective May 20, 2021 has also created a checklist that has been placed in front of all current and future residents that will be checked for all core documents upon admission and every 30 days after by STAFF/SIC Administrator will be informed immediately if there is any discrepancy found, and reviewed by the Administrator quarterly.	05/11/2021 05/15/2021

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C231	Continued From page 2 bathed and cut his own fingernails. -He could walk and get up without assistance. Attempted interview with Resident #2's PCP on 05/11/21 at 1:20pm was unsuccessful. Attempted interview with the Administrator on 05/11/21 at 3:30pm was unsuccessful. Refer to the interview with the Assistant to the Administrator on 05/11/21 at 10:37am. 3. Review of Resident #3's current FL-2 dated 07/15/20 revealed diagnoses included chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), schizophrenia, nonpsychotic mental disorder, overactive bladder, osteoarthritis, and poly substance abuse. Review of Resident #3's record revealed the most recent care plan was dated 03/16/20. Interview with Resident #3 on 05/11/21 at 10:20am revealed he had lived at the facility for two years and he did everything for himself. Attempted interview with Resident #3's PCP on 05/11/21 at 1:20pm was unsuccessful. Attempted interview with the Administrator on 05/11/21 at 3:30pm was unsuccessful. Refer to the interview with the Assistant to the Administrator on 05/11/21 at 10:37am. Interview with the Assistant to the Administrator on 05/11/21 at 10:37am revealed: -The Administrator had a folder with documents for the residents' records.	C231		

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C231	Continued From page 3 -The Administrator was due to come to the facility that day (05/11/21). -She did not know what was in the folder, but she knew there were documents for the PCP to sign. -She did not know if there were care plans and assessments in the documents the Administrator had	C231		
C274	10A NCAC 13G .0904(d)(3)(B) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the daily menus served included 2 servings of fruit, with one being a citrus fruit or a single strength juice daily. The findings are: Observation of the facility's kitchen on 05/11/21 at 8:27am revealed: -There was no fresh fruit, and no frozen fruit in the facility. -There was one 11 ounce can of mandarin	C274	Effective May 11, 2021 SIC directed staff to the facility menu book which described and defined what a regular diet is. Administrator arranged in-house training for facility staff on June, 2021 on "Documentation". Training covered the following: • Menu • Food Preparation • Modified Diet(documentation) • Identifying different types of diets Administrator added the facility Menu Manual to Staff Orientation Checklist for all current and future staff upon hire. SIC will monitor daily and report to the Administrator immediately if this rule is not being met. Bulk food supplies are kept in a central storage building next to the facility. The Administrator will do a weekly inventory of food supplies to ensure fruit and fruit juices are available. Staff will write down a daily list of food supplies needed and submit it to the Assistant Administrator. The Assistant Administrator and the SIC will do a weekly inventory at the facility to ensure the food is in the facility and available for meal service to the resident.	05/11/2021

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C274	Continued From page 4 orange segments and twelve one-ounce boxes of raisins in the dry storage pantry. Interview with two residents on 05/11/21 at 8:46am and 12:29pm revealed: -One resident had not had orange juice or fresh fruit since he was admitted to the facility two months ago. -One resident had not had orange juice in over a month. -They would like to drink orange juice for breakfast. -They had not had fruit and could not remember the last time they had been served fruit. -They would like to eat fresh fruit or canned fruit if it was served. Interview with the medication aide (MA) on 05/11/21 at 12:20pm revealed: -The personal care aide (PCA) usually did the cooking but she had left for the day, so he was cooking. -He did not know the schedule for the food delivery's for the facility. -He could not find any fruit in the kitchen other than the mandarin oranges and raisins. Interview with the Assistant to the Administrator on 05/11/21 at 12:48pm revealed: -She purchased large amounts of food for the facility when she did the food shopping twice a month. -She was due to purchase food for the facility that day (05/11/21). -She did not keep the food receipts each time she purchased food for the facility. -She would purchase 48 cans of fruit at least once a month; including mixed fruit, fruit cocktail, peaches, apples and mandarin oranges. -She had purchased a large bunch of bananas	C274		

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C274	Continued From page 5 and a bag of apples for the facility two weeks ago. -She purchased 20 to 24 cans of frozen orange juice and fruit juice concentrate at least twice a month; the last time she purchased frozen orange juice was two weeks ago. -There was probably no fruit in the kitchen because she was due to bring in food supplies that day, 05/11/21. Attempted interview with the Administrator on 05/11/21 at 3:30pm was unsuccessful.	C274		
C288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop and implement an activity program that promoted active involvement for 5 of 5 sampled residents who resided in the facility. The findings are: Observation of the activity calendar posted in the main hallway on 05/11/21 at 9:30am revealed: -The calendar was written on a dry erase board and was dated March 2021. -There were daily activities listed but there were no start or end times listed for the activities. Observation of the common living room on 05/11/21 at 8:38am revealed there were no	C288	Effective 05/15/2021 I have a new Activity Director who has updated the activity calendar on the board. The Activity Director has also placed all board / card games in a common area where all residents who would like to take part in these activities will have access to them. The Activity Director will continue to work to provide activities for all the current and future residents while observing the current CDC COVID-19 recommendations. Activity Director will provide training for all current and future staff and the administrator will monitor monthly to ensure the this policy is being met.	05/15/2021

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C288	Continued From page 6 boardgames, cards and no activity supplies available for the residents to play. Observation of the facility and residents on 05/11/21 between 7:45am and 4:45pm revealed: -Staff did not offer residents activities to do and interacted very little with the residents. -Residents wandered in and out of the building to go outside and smoke, walk around the yard or walk over to the facility's sister building. -Two residents were at the facility all day and three residents returned from a day program at 12:30pm. Interview with a resident on 05/11/12 at 8:46am revealed: -He did nothing all day and activities were not offered. -He felt like somedays he was "going bonkers" because the only thing to do was watch television. -He did not participate in a day program and was not allowed to go out anywhere and there was nowhere to walk to. -He would participate in activities if they were offered. -He would like to play board games and go on outings. Interview with a second resident on 05/11/21 at 9:35am revealed: -He spent his days sleeping, smoking and "hanging out". -He would "really like to do arts and crafts"; he wanted to make items to decorate his room with. -There was a staff that would play checkers with him, but the staff had not worked in 2 to 3 months. -He would also like to play other board games but, no one offered to play games with him.	C288		

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C288	Continued From page 7 -He used to go to the local store about once a month, but they were not allowed to go on outings since the pandemic started. -He did not participate in a day program and was not interested in going to a day program. Interview with a medication aide (MA) on 05/11/21 at 9:12am revealed: -He worked in the sister facility next door and only filled in when staff called off. -He was not familiar with the activities that were offered in the facility. -He had not worked in the facility in a few months. Interview with the Assistant to the Administrator on 05/11/21 at 1:11pm revealed: -The medication aides (MA) were supposed to follow the activity calendar and offer activities to the residents. -The MAs were responsible for writing the activity calendar on the board in the main hallway. -Some of the activities offered were bingo, porch talk and bible study. -She thought the activity calendar was supposed to have at least 10 hours of activities per week. -She did not know a minimum of 14 hours activities were required to be offered. -She had not looked at the activity calendar in the main hallway, so she had not noticed it was from March 2021. -There was a book in the MA office that had a years' worth of monthly activities calendars. -The MAs were supposed to follow the monthly calendar in the book. -She did not know if the residents would participate in activities if they were offered. -There was a cookout on 04/04/21 and the residents participated with dancing and games at the cookout.	C288		

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C288	Continued From page 8 Attempted interview with the Administrator on 05/11/21 at 4:30pm was unsuccessful.	C288		
C611	10A NCAC 13G .1701 (b) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in	C611	Effective May 11, 2021 SIC directed staff to the facility COVID-19 Manual which describes and defines our policy on preventing the spread of infectious diseases among the residents and staff. Administrator arranged in-house training for facility staff on May 15, 2021 on "COVID-19 Policy". Training covered the following: • Face Mask • Temperature • Complete Questionnaire • Document Administrator added the COVID-19 Manual to Staff Orientation Checklist for all current and future staff to review upon hire. SIC will monitor daily and report to the Administrator immediately if this rule is not being met.	05/11/2021

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C611	Continued From page 9 accordance with Rule .1702 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to	C611		

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C611	Continued From page 10 North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) were implemented when caring for 5 residents during the global Coronavirus (COVID_19) pandemic as related to screening of staff, visitors and residents and the wearing of proper personal protection equipment (PPE). The findings are: Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/29/21 revealed: -Personnel should wear a facemask while in the facility and for protection during resident care encounters. -Personnel who worked in areas with minimal to no community transmission of the coronavirus should use a well-fitting facemask for source control. Review of the CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 04/27/21 revealed recommendations for use of personal protective equipment (PPE) by personnel was unchanged. Review of the NC Department of Health and Human Services Guidance for Best Practices for	C611		

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C611	Continued From page 11 Infection Prevention in Long Term Care Facilities (LTCFs) dated 02/10/21 revealed LTCFs should follow the CDC guidance for appropriate selection and use of PPE. Review of the Centers for Disease Control and Prevention (CDC) Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 03/10/21 revealed: -This guidance applies to all healthcare personnel (HCP) while at work and all patients and residents while they are being cared for in a healthcare setting -Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 -Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19. -Screening for fever and symptoms should also be incorporated into daily assessments of all residents. Observation of the entrance to the facility on 05/11/21 at 8:27am revealed: -There a sign on the door restricting visitation; there was no other signage on the door. -There was no instruction for screening of visitors and there was no visitor log or temperature and screening materials at the entrance. -The surveyor was let into the facility by a resident. -The facility staff came down a long hallway towards the surveyor and then went back into the kitchen but did not provide any instructions about screening or signing a visitor log. -The staff was not wearing a facemask.	C611		

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C611	Continued From page 12 Observation of the Administrator in Training (AIT) on 05/11/21 at 8:30am revealed: -He entered the facility and did not have on a facemask and did not prescreen. -He was not screened, and he did not ask the surveyor if they had done a prescreening prior to entering the facility. Observation of the facility on 05/11/21 from 9:12am to 10:30am revealed the medication aide (MA), the Assistant to the Administrator, and the Supervisor-in-Charge (SIC) entered the facility and did not have on a facemask and did not prescreen. Review of three residents' the medication administration (MAR) for March 2021 to May 2021 revealed there were no temperatures documented on the MARs. Interview with the personal care aide (PCA) on 05/11/21 at 8:27am revealed: -She was filling in for another staff. -She did not wear a facemask when she worked because the residents had all been vaccinated. -She had not been vaccinated. -She did not prescreen or take her temperature when she came to work, no one had ever told her to prescreen or take her temperature. -There were no visitors allowed inside so there was no reason to take any temperatures. Interview with two residents on 05/11/21 at 8:46am and 9:35am revealed: -Staff did not wear facemask while working in the facility. -Staff had not worn facemask for a few months. -They did not have their temperatures taken; they had never had their temperatures taken. -They had not had visitors since the pandemic	C611		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABUNDANT LIVING # 2	3816 CHERRY GROVE ROAD ELON, NC 27244

(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
C611	Continued From page 13 began. Interview with the medication aide (MA) on 05/11/21 at 9:12am revealed: -He stopped wearing a facemask once all the residents had received their second COVID-19 vaccine. -He could not remember who told him it was okay to stop wearing a facemask. -He did not take temperatures or prescreen visitors because there were none. -He did not take his own temperature because he had never been instructed by anyone to do that. -He never taken residents temperatures daily unless they were sick. Interview with the SIC on 05/11/21 at 10:39am revealed: -She usually did not wear a facemask while in the facility because the residents had all received two COVID-19 vaccines. -She was around the same residents all the time and did think she needed to wear a facemask. -She was familiar with the recommendations from the CDC about Health Care Professionals wearing a facemask, but she chose not to anyway. Interview with the Assistant to the Administrator on 05/11/21 at 10:38am revealed: -She normally wore a facemask when at the facility, but she had stopped once she received her second COVID-19 vaccine. -She was familiar with the recommendations from the CDC dated March 2021, but she chose not to wear a facemask due to personal preference and the fact she had received her vaccine. -The facility staff were not completing prescreening or taking their temperatures; she could not say why.	C611		

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C611	Continued From page 14 -Residents temperatures were taken each day but not documented; "there was no reason why" the temperatures were not documented. -Visitors were prescreened with a questionnaire and temperatures were taken but nothing was documented; the PCA got nervous when the surveyor came into the facility and forgot to prescreen them. -Staff were prescreened and temperatures were taken but not consistently and nothing was documented. -She understood there was no proof of temperatures for the residents and prescreening of staff and visitor because there was nothing documented. -Documentation should have been completed for the residents. staff and the visitors. Interview with the AIT on 05/11/21 at 10:43am revealed: -He had been vaccinated for COVID-19, so he did not think he needed to wear a facemask or to be prescreened. -He had kept up with the recommendations from the CDC because the Administrator had shared the information with him almost daily. -All the staff wore their facemask until two weeks before when all the residents had finished getting their vaccines. -The Administrator expected all the staff to wear a facemask while working. -He knew residents and staff were supposed to have their temperatures' taken daily but he did not know it needed to be documented. -He knew visitors were supposed to have their temperatures checked and a prescreening was supposed to be completed and documented, but he did not know it was not being documented. Attempted interview with the Administrator on	C611		

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C611	Continued From page 15 05/11/21 at 3:30pm was unsuccessful.	C611		