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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 01/26/22-01/28/22, on 01/31/22 via desk review and onsite on 02/01/22.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 sampled residents (Residents #2, #3, #4) including antifungal and antibiotic medications (#2), an antianxiety medication (#3), and topical steroid cream (#4). The findings are: 1. Review of Resident #2's current FL2 dated 08/23/21 revealed diagnoses included diabetes mellitus type II, insulin dependent, and hypertension. a. Review of Resident #2's primary care provider's (PCP) order dated 12/08/21 revealed terbinafine (used to treat fungal infection) 250mg	D 358		

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1 tablet every day for 90 days.

Review of Resident #2's December 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for terbinafine 250mg 1 tablet daily for 90 days scheduled for 9:00am.
-The terbinafine was documented as administered daily from 12/11/21 to 12/31/21.

Review of Resident #2's January 2022 eMAR revealed:
-There was an entry for terbinafine 250mg 1 tablet daily for 90 days scheduled for 9:00am.
-The terbinafine was documented as administered daily from 01/01/22 to 01/26/22.

Observation of Resident #2's medications on hand on 01/27/22 at 11:22am revealed there was no terbinafine available.

Interview with a medication aide (MA) on 01/27/22 at 11:30am revealed:
-There was no terbinafine available for Resident #2.
-She would request a refill from the pharmacy.

Telephone interview with a representative from the contracted facility pharmacy on 01/27/22 at 12:00pm revealed:
-They received an electronic prescription for Resident #2 on 12/08/21 for terbinafine 250mg 1 tablet daily for 90 days.
-They dispensed 30 tablets (a 30-day supply) of the terbinafine on 12/08/21.
-The terbinafine was documented on the delivery sheet as received by facility staff on 12/08/21 at 5:10pm.
-They had never received another refill request for the terbinafine and had not sent another refill

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of the medication.

Interview with the Administrator on 02/01/22 at 1:39pm revealed the pharmacy had sent 30 tablets of terbinafine 250mg tablets on 01/27/22 for Resident #2.

Observation of Resident #2's medications on hand on 02/01/22 at 1:40pm revealed:
-There was one bubble pack of terbinafine 250mg tablets.
-There were 30 tablets dispensed on 01/27/22.
-There were 25 tablets remaining in the bubble pack.

Telephone interview with the Resident Care Coordinator (RCC) on 01/31/22 at 10:38am revealed:
-She had not worked in the facility for two weeks.
-She did not know Resident #2's terbinafine was not available.

Interview with the Administrator-In-Training (AIT) on 02/01/22 at 2:00pm revealed:
-The RCC was responsible for performing medication cart audits "once or twice a month."
-All residents' medications were checked during a medication cart audit.
-The RCC would look at all the residents' medications on one medication cart on one day and then audit the second medication cart the next day.
-The medication cart audit included ensuring all medications on the resident's eMAR were available for administration.
-She did not know when the medication carts were last checked for availability of medications.
-The medication aides (MAs) were also responsible for ensuring medications were available for administration when they were

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administering medications to residents.
-She did not know the terbinafine had not been available for administration.
-Staff had not informed her the terbinafine was unavailable for administration.

Interview with the Administrator on 02/01/22 at 3:36pm revealed:
-When the MAs realized a medication was unavailable for administration, they were supposed to notify the pharmacy and get a medication refill.
-The MAs were supposed to look at the medication supply as they were administering medications and should reorder medications 5 days prior to the medication running out.
-The facility also had a local backup pharmacy available.
-The facility's contracted pharmacy made daily deliveries, so the staff did not usually use the backup pharmacy.
-She did not know when the last medication cart audit had been done.
-She did not know if staff had been doing medication cart audits since the COVID-19 outbreak and with the RCC having been out of work for the last two weeks.

Telephone interview with Resident #2's primary care provider (PCP) on 02/01/22 at 10:54am revealed:
-She had ordered the terbinafine for Resident #2 on 12/08/21 for a "really bad" fungal infection of the toenails.
-The toenail fungal infection had caused the resident's toenails to thicken.
-The resident had complained the thickened toenails "made her feet hurt."

b. Review of Resident #2's physician's order

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dated 01/24/22 revealed cefdinir (used to treat bacterial infection) 1 capsule every 12 hours for 10 days.

Interview with Resident #2 during the initial tour on 01/26/22 at 10:40am revealed:
-The resident's Primary Care Provider (PCP) had told the resident she was going to order antibiotics to treat a sinus infection.
-A medication aide (MA) had given her the antibiotic "yesterday morning" (01/25/22).
-The MA "last night" did not have the antibiotic in her evening medications.
-She had asked the evening MA why the antibiotic was not in with her other medications.
-The MA had stated the antibiotic was not showing up on the electronic Medication Administration Record (eMAR) to administer.
-"This morning" (01/26/22) the MA brought a blue capsule in her morning medications and told her the blue capsule was the antibiotic ordered for the sinus infection.
-It was all "very confusing" when the staff identified medications as one thing and then the next day the medication was a capsule instead of tablet and a different color.
-She was not sure she had received the correct medications.

Review of Resident #2's January 2022 eMAR revealed:
-There was an entry for cefdinir 300mg 1 capsule every 12 hours for 10 days scheduled for 9:00am and 9:00pm.
-The cefidinir was documented as administered on 01/26/22 at 9:00am.
-There were no other documented administrations.

Observation of Resident #2's medications on

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hand on 01/27/22 at 11:22am revealed:
-There were two bubble packs of cefdinir 300mg capsules.
-One bubble pack had 8 of 10 capsules remaining with a dispense date of 01/24/22.
-A second bubble pack had 9 of 10 capsules remaining with a dispense date of 01/24/22.

Telephone interview with a representative from the facility's contracted pharmacy on 01/27/22 at 12:00pm revealed:
-The pharmacy received an electronic prescription for cefdinir 300mg 1 capsule every 12 hours for 10 days from Resident #2's PCP on 01/24/22.
-Twenty capsules of cefdinir 300mg were dispensed to the facility on 01/25/22.
-The facility staff signed the delivery sheet which indicated the cefdinir arrived at the facility at 12:07am on 01/25/22.

Telephone interview with a MA on 01/31/22 at 11:57am revealed:
-The pharmacy was responsible for entering new medication orders into the eMAR and scheduling administration times.
-The medication would not "show up" to be administered in the eMAR until it had been "approved" by management in the eMAR.

Telephone interview with Resident #2's PCP on 02/01/22 at 10:54am revealed:
-Her expectation was the facility staff should administer antibiotics as soon as they received it from the pharmacy.
-The cefdinir was ordered to treat Resident #2's sinus infection.
-The sinus infection caused the resident "discomfort."
-Delayed treatment of the sinus infection

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prolonged the resident's discomfort and could have caused the infection to spread to the resident's lungs.

Interview with the Administrator-In-Training (AIT) on 02/01/22 at 2:00pm revealed:
-She did not know why staff had not started Resident #2's cefdinir on 01/25/22.
-The staff might have failed to put the cefdinir on the medication cart with the resident's other medications when it arrived on 01/25/22.
-If the cefdinir had been dispensed, the pharmacy would have entered it into the eMAR.
-If a medication was on the cart but not on the eMAR, staff "usually" would come ask if the medication order had been flagged in the eMAR.
-The Resident Care Coordinator (RCC), AIT, and the Business Office Manager (BOM) were all able to approve eMAR entries.
-The eMAR system was checked for new orders flagged for approval "every morning and evening" and the MAs "let us know" if there were entries that needed approval.

Interview with the Administrator on 02/01/22 at 3:36pm revealed:
-If the cefdinir was delivered on 01/25/22 at 12:07am, then it should have started on 01/25/22.
-The cefdinir order should have "flagged" and prompted the MA to ask management about the entry for approval in the eMAR.

2. Review of Resident #3's FL2 dated 02/09/21 revealed:
-Diagnoses included convulsions, breakthrough seizures, acute hypoxic respiratory failure, and developmental delay.
-There was an order for lorazepam (used to treat insomnia) 0.5mg 1 tablet daily at bedtime.

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Review of Resident #3's physician's order dated 06/04/21 revealed lorazepam 0.5mg 1 tablet daily at bedtime.

Review of Resident #3's January 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg 1 tablet at bedtime scheduled for 8:00pm.
-The lorazepam 0.5mg was documented administered daily at 8:00pm from 01/01/22 to 01/23/22.
-The lorazepam 0.5mg was documented as not administered from 01/24/22 to 01/30/22 due to "physically unable to take."

Review of Resident #3's Controlled Substance Sheet for lorazepam 0.5mg tablets revealed:
-There were 30 tablets of lorazepam 0.5mg received on 12/24/21.
-The lorazepam 0.5mg tablets were documented as administered daily from 12/24/21 to 01/23/22.
-The last lorazepam 0.5mg tablet was signed out on 01/23/22 at 7:28pm with an ending balance of 0 lorazepam 0.5mg tablets remaining.

Observation of Resident #3's medications on hand on 02/01/22 at 10:08am revealed there was no lorazepam 0.5mg tablets available.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 02/01/22 at 10:54am revealed:
-The resident was ordered lorazepam 0.5mg daily at bedtime for insomnia.
-The last refill for the resident's lorazepam 0.5mg tablets occurred on 12/23/21.
-A new prescription was needed to refill the medication.
-The original lorazepam 0.5mg prescription was

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written for a six month supply.
-The facility should have notified the pharmacy to request a refill.
-The pharmacy would then notify the PCP they needed a new prescription to refill the lorazepam.
-She had not received notification from the pharmacy or the facility requesting a new prescription for lorazepam 0.5mg for Resident #3.

Interview with the Administrator-In-Training (AIT) on 02/01/22 at 11:20am revealed:
-There was no lorazepam 0.5mg tablets available for Resident #3.
-The lorazepam 0.5mg tablets "must need to be reordered."

Interview with the Administrator on 02/01/22 at 11:30am revealed:
-The facility pharmacy sent a request to Resident #3's PCP for a lorazepam 0.5mg refill on 01/25/22, 01/26/22, and 01/27/22.
-The pharmacy was going to place a call to the PCP "today" (02/01/22) to request a new prescription.

Second interview with the Administrator on 02/01/22 at 3:36pm revealed:
-The pharmacy had sent several requests to Resident #3's PCP to refill the lorazepam 0.5mg.
-The pharmacy had been unsuccessful in getting the lorazepam 0.5mg prescription.
-Facility staff failed to follow-up with the PCP to get a new prescription for the lorazepam 0.5mg tablets.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

3. Review of Resident #4's current FL-2 dated

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09/27/21 revealed diagnoses included cerebral infarction, osteoarthritis, and epilepsy.

Interview with Resident #4 on 01/26/22 at 10:25am revealed:
-She needed to see a doctor.
-Her "bottom" was hurting.

Review of Resident #4's physician's order dated 11/22/21 revealed an order for Anusol-HC (used to treat pain from hemorrhoids) 2.5% topical cream with perineal applicator and apply a thin layer to the affected area(s) by topical route two to four times daily.

Review of Resident #4's November 2021 electronic Medication Administration Record (eMAR) revealed:
-There was no entry for the Hydrocortisone 2.5% topical cream to be applied 2 to 4 times daily on the eMAR.
-There was an order for Hydrocortisone 1% cream to be applied as needed to topical "itch or rash."
-The Hydrocortisone 1% cream was not documented as applied during November 2021.

Review of Resident #4's December 2021 eMAR revealed:
-There was no entry for the Hydrocortisone 2.5% topical cream to be applied 2 to 4 times daily on the eMAR.
-There was an order for Hydrocortisone 1% cream to be applied as needed to topical "itch or rash."
-The Hydrocortisone 1% cream was not documented as applied during November 2021.

Review of Resident #4's January 2022 eMAR revealed:

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-There was no entry for the Hydrocortisone 2.5% topical cream to be applied 2 to 4 times daily on the eMAR.
-There was an order for Hydrocortisone 1% cream to be applied as needed to topical "itch or rash."
-The Hydrocortisone 1% cream was not documented as applied during November 2021.

Observation of Resident #4's medications on hand on 01/27/22 at 10:21am revealed an unopened tube of Hydrocortisone 2.5% cream (equivalent to Anusol) was available for administration with a pharmacy label indicating it was filled on 11/23/21.

Telephone interview with the a representative from the facility's pharmacy on 01/27/22 at 9:52am revealed:
-An order for Anusol-HC 2.5% topical cream to the affected area 2 to 4 times daily had been received on 11/23/21.
-Hydrocortisone 2.5% cream was the equivalent to Anusol-HC 2.5% and had been substituted for the Anusol.
-One tube of Hydrocortisone 2.5% cream was delivered to the facility on 11/26/21.
-The order also indicated there were 11 refills.
-The pharmacy had not received a discontinue order for the Hydrocortisone 2.5% cream.
-If it was being administered as ordered, the supply would have lasted around 14 days and should have been reordered by now.
-No additional Hydrocortisone 2.5% cream had been requested or delivered to the facility since 11/26/21.

Interview with the Medication Aide (MA) on 01/27/22 at 10:21am revealed:
-Resident #4 did not have hemorrhoids to her

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knowledge.
-Resident #4 had not complained of her "bottom" hurting.
-Resident #4 had not asked for anything for "pain" for her bottom.
-She had never applied Hydrocortisone 2.5% topical cream to Resident #4.

Interview with Resident #4 with the MA present on 01/27/22 at 10:32am revealed:
-Her "bottom" had been hurting for a while.
-She showed the MA a bed liner with blood on it.
-She stated the blood was from her "bottom."
-The MA asked if she could look at her bottom but Resident #4 refused to let her.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 01/27/22 at 11:14am revealed:
-She had seen Resident #4 on 11/22/21.
-Resident #4 was diagnosed with hemorrhoids and ordered Anusol 2.5% cream to be administered 2 to 4 times daily.
-She had not been made aware the facility did not start the Anusol for Resident #4.
-It should have been applied 2 to 4 times daily as the order directed.
-If Resident #4 was having discomfort or pain, this would negatively affect her "quality" of life.

Interview with the Administrator on 01/27/22 at 11:30am revealed:
-The Resident Care Coordinator (RCC) or the Administrator were responsible for verifying orders.
-The way the order was written indicated it was supposed to be as needed.
-The RCC should have gotten clarification about the order.

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D 358	Continued From page 12 The facility failed to ensure medications were adminstered as ordered for Resident #2 for an antibiotic to treat a sinus infection, delaying treatment and putting Resident #2 at risk for the sinus infection moving to her lungs, an antifungal medication for Resident #2 to treat toenail fungus causing her toenails to thicken; an antianxiety medication for Resident #3 to treat insomnia and a topical steroid cream for Resident #4 to treat hemorrhoids, which caused the resident discomfort and could have decreased her qualfity of life and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/01/22 for this Type B Violation. COORECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 17, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	D 367		

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D 367	Continued From page 13 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 6 sampled residents (Resident #2) related to documentation of a medication to treat fungal infection. The findings are: Review of Resident #2's current FL2 dated 08/23/21 revealed diagnoses included diabetes mellitus type II, insulin dependent, and hypertension. Review of Resident #2's physician's order dated 12/08/21 revealed terbinafine (used to treat fungal infection) 250mg 1 tablet every day for 90 days. Review of Resident #2's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for terbinafine 250mg 1 tablet daily for 90 days scheduled for 9:00am. -The terbinafine was documented as administered daily from 12/11/21 to 12/31/21. Review of Resident #2's January 2022 eMAR revealed: -There was an entry for terbinafine 250mg 1	D 367		

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D 367	Continued From page 14	D 367		

tablet daily for 90 days scheduled for 9:00am.
-The terbinafine was documented as administered daily from 01/01/22 to 01/26/22.

Observation of Resident #2's medications on hand on 01/27/22 at 11:22am revealed there was no terbinafine available.

Telephone interview with a representative from the facility's contracted pharmacy on 01/27/22 at 12:00pm revealed:
-They received an electronic prescription for Resident #2 on 12/08/21 for terbinafine 250mg 1 tablet daily for 90 days.
-They dispensed 30 tablets (a 30-day supply) of the terbinafine on 12/08/21.
-The terbinafine was documented on the delivery sheet as received by facility staff on 12/08/21 at 5:10pm.
-They had never received another refill request for the terbinafine and had not sent another refill of the medication.

Review of Resident #2's record revealed the 30-day supply of terbinafine received on 12/08/21 administered daily starting 12/11/21 would have run out on 01/09/22.

Telephone interview with a medication aide (MA) on 01/31/22 at 11:57am revealed:
-She did not know why staff had continued to document administering Resident #2's terbinafine daily in the eMAR even though the medication supply had run out on 01/09/22.
-In the eMAR, there was an exception drop down list of choices for reasons to choose from when a medication was not being administered as ordered.
-"Sometimes" the exception comment would not "go in" to the eMAR because the computer would

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D 367	Continued From page 15 lose WiFi signal. Interview with the Administrator on 02/01/22 at 3:36pm revealed: -Staff should not document on the eMAR administering a medication if they did not administer the medication. -The staff should document an exception in the eMAR when a medication was unavailable for administration.	D 367		
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 and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of	D 612		

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Health and Human Services (NCDHHS) and the facility's COVID-19 policy were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the proper use of personal protective equipment (PPE) by staff to reduce the risk of transmission and infection of COVID-19, appropriate hand hygiene after care was given to residents and placing PPE outside of the isolated resident's door with adherence to donning/doffing PPE with each isolated residents' care interaction.

The findings are:

Review of the CDC guidelines for the prevention and spread of COVID-19 in long-term care (LTC) facilities updated 09/10/21 revealed:
-Healthcare personnel caring for residents with suspected or confirmed COVID-19 should use full PPE (gowns, gloves, eye protection, and a NIOSH approved N-95 or equivalent or higher-level respirator).
-Healthcare personnel should wear facemasks to prevent spread of respiratory secretions.
-Healthcare personnel should wear facemasks when they are in areas of the healthcare facility where they could encounter residents.
-The CDC recommends use of facemasks recommended by the Occupational Safety and Health Administration (OSHA).
-OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared."

Review of the NCDHHS guidelines for prevention and spread of COVID-19 in LTC facilities updated 11/19/21 revealed facilities should adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential

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D 612	Continued From page 17 exposure. Review of the facility's COVID-19 Infection Control Policy revealed: -Normal hand hygiene practices should be followed for staff to wash or sanitize their hands with each care occurrence as appropriate. -If a resident is placed in isolation, personal protective equipment (PPE) should be placed outside their door, and staff should enforce strict adherence to donning/removing PPE with each care interaction. -Staff should don the following PPE before entering the resident care area before each encounter until resident is deemed recovered for COVID-19: Mask (N-95 preferred, but regular mask if not available), eye protection (safety glasses or face shield), gown, and gloves. -Staff should remove PPE at doorway and dispose of the used PPE and hand hygiene should immediately be performed. Observation of the facility entrance on 01/26/22 at 8:56am revealed: -There were signs posted on the entrance doors to inform visitors face masks were required to be worn upon entry to the facility. -There was a table inside a foyer upon entry to the facility. -The table held several items including ink pens, an infrared thermometer, hand sanitizer, a box of gloves, a COVID-19 screening log, and a small plastic cabinet which contained surgical face masks, gowns, and face shields. Observation in the facility dining room on 01/26/22 at 9:15am revealed: -There were two staff in the dining room. -One of the staff was a personal care aide (PCA) and was wearing a surgical face mask, but was	D 612		

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not wearing eye protection.
-The second staff was the Administrator-In-Training (AIT),
-The AIT was wearing eyeglasses without eye protection over the glasses and was not wearing a face mask.

Observation of the AIT on 01/26/22 at 9:23am revealed she had put on a surgical face mask but still only wore eyeglasses.

Interview with the AIT on 01/26/22 a 9:23am revealed:
-The facility's census was 32.
-The facility was in COVID-19 outbreak status and there were 21 residents who had tested positive for COVID-19.

Review of the resident room list on 01/26/22 revealed:
-There were 9 resident rooms on the 200 Hall.
-There were COVID-19 positive residents in 7 of the 9 resident rooms on 200 Hall.
-There were 9 resident rooms on the 100 Hall.
-There were COVID-19 positive residents in 5 of the 9 resident rooms on 100 Hall.

Observation of the 200 Hall during the initial tour on 01/26/22 at 9:35am revealed:
-There was one box of gloves on the hand railing in the hallway outside room 201.
-There was one box of gloves on the hand railing in the hallway outside room 205.
-There were no personal protective equipment (PPE) stations outside resident rooms identified with signs as residents on contact isolation precautions.
-There were no receptacles for disposal of PPE outside the resident rooms identified with signs as residents on contact isolation precautions.

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D 612	Continued From page 19 Interview with one resident on 01/26/22 at 10:05am revealed: -He was able to take care of his Activities of Daily Living (ADL's) himself. -Staff came in to administer his medication and deliver his meals since he was COVID positive. -Staff had been wearing face masks when they came in his room to administer his medication but was wearing no other PPE. -Staff had been wearing face masks when they came in his room to deliver his meal trays but was wearing no other PPE. Interview with a second resident who resided in a room identified as on contact isolation precaution room on 01/26/22 at 10:07am revealed: -She saw staff wearing face masks and gloves in the hallways. -Staff wore face masks, gowns, and gloves when they were inside her room providing care. -She was not sure when staff wore eye protection. Interview with a third resident on 01/26/22 at 10:13am revealed: -He tested positive for COVID-19 the previous week and had been staying in his room since that time. -Staff came into his room to administer his medication and deliver his meals trays. -Sometimes staff would be wearing a gown and gloves, but not always. -Staff always wore a face mask. Interview with a fourth resident who resided in a room that was not identified as a contact isolation precaution room on 01/26/22 at 10:16am revealed: -She was independent with activities of daily living	D 612		

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(ADLs).
-Her roommate required frequent incontinent care provided by staff.
-Staff who provided incontinent care to her roommate wore face masks and gloves to provide incontinent care to the resident.

Observation of a personal care aide (PCA) on 200 Hall on 01/26/22 at 10:30am revealed the PCA was wearing a cloth mask.

Interview with the PCA on 01/26/22 at 10:31am revealed:
-She "chose" to wear her own "personal mask."
-The facility provided surgical face masks for all employees.
-Staff were required to wear surgical face masks while working.
-She had forgotten to remove the cloth mask and put on a surgical face mask when she had entered the facility.

Observation of the 100 Hall during the initial tour on 01/26/22 at 10:40am revealed:
-There were no personal protective equipment (PPE) stations outside resident rooms identified with signs as on contact isolation precautions.
-There were no receptacles for disposal of PPE outside the resident rooms identified with signs as on contact isolation precautions.

Observation in resident room 105 on 01/26/22 at 10:50am revealed:
-The room was not identified as a contact isolation precaution room.
-The resident put on the call light to alert staff she needed assistance.
-A medication aide (MA) responded and entered the resident's room
-The MA was wearing a surgical face mask, but

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D 612	Continued From page 21 was not wearing eye protection and a gown. Observation of the same MA during the 12-noon medication pass on 01/26/22 at 11:52am revealed: -Resident room 205 had a contact isolation precaution sign on the door to the room. -The MA entered resident room 205 wearing a surgical face mask to administer oral medications to a resident for the 12-noon medication pass. -The MA did not wear eye protection, a gown, or gloves to administer the oral medications. -The MA did not use hand sanitizer upon exiting the room. Interview with the same MA on 01/26/22 at 11:53am revealed: -The contact isolation precaution sign on the door to resident room 209 meant the residents inside the room had tested positive for COVID-19. -Contact isolation precautions meant staff needed to take precautions and "wear your mask and gown." -She had forgotten to put on eye protection, gown, and gloves before entering the contact isolation precaution room. -The facility provided face shields, eye goggles, gowns, surgical masks, and gloves for employees to use in isolation precaution rooms. -The PPE supplies were available in a plastic storage bin located near the medication carts. Observation of the PPE station on 01/26/22 at 12:03pm revealed there was a PPE station located on the right side of one medication carts located on the wall in front of the nurse's station. Observation of the delivery of a meal tray to a COVID-19 positive resident room on 01/26/22 at 12:38pm revealed:	D 612		

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D 612	Continued From page 22 -Two PCA's were working to deliver meal trays to residents on the 100 hall. -One PCA was designated to deliver meal trays to COVID-19 positive resident rooms and the other PCA was designated to deliver meal trays to COVID-19 negative resident rooms. -The PCA designated to deliver meal trays to COVID-19 negative residents was wearing a face mask, gown and gloves. -The PCA designated to deliver meal trays to COVID-19 negative residents was observed delivering a meal tray in a COVID positive resident room. -When the PCA exited the COVID-19 positive room she was observed continuing her meal tray delivery to a COVID negative room until surveyor intervened. Interview with the PCA on 01/26/22 at 12:55pm revealed: -She was designated to deliver meal trays to COVID-19 negative residents for the lunch meal on 01/26/22. -She had a list of residents who were COVID-19 positive and COVID-19 negative. -The resident in the room she went into was not noted as being positive on her list. -There was not a sign posted on the door for droplet precautions. -She would have continued delivering meal trays after being in a positive room because she was not aware that resident was positive. Interview with an Infectious Disease Nurse at the local health department on 01/27/22 at 9:26am revealed: -When they were contacted by the facility regarding their COVID-19 outbreak an e-mail was sent to the facility with the CDC guidelines. -When staff were caring for COVID-19 positive	D 612		

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D 612	Continued From page 23 residents they should be wearing gowns, gloves and face masks. -Signs should be on the doors for COVID-19 positive residents indicating they were on droplet precautions. -There should be a PPE station set up at each COVID-19 positive room. Interview with the Administrator on 02/01/22 at 3:36pm revealed: -All staff had been trained on proper infection control procedures. -All staff had been trained on COVID-19 protocols. -The most recent infection control training that including COVID-19 information and donning and doffing PPE was 08/26/21. -She was not sure why staff were not wearing appropriate PPE on 01/26/22. -Staff should have been wearing masks throughout the facility. -Staff should have been wearing full PPE when caring for COVID-19 positive residents. -PPE stations should have been set up outside the rooms of COVID-19 positive residents. -Staff had been told they could not wear cloth masks. -She sent infection control (IC) droplet precaution signs to the facility via e-mail on 01/19/22 to be placed on each door of the COVID-19 positive residents. -She did not know why the IC droplet precaution sign was put on the front door and not on COVID-19 positive resident doors throughout the facility. -There was a list of residents that were positive posted at the nurse's station that every staff member had access to. -She was not aware IC protocols were not being followed but they should have been.	D 612		

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D 612	Continued From page 24 The facility failed to follow the recommendations and guidelines from the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and the Local Health Department (LHD) for COVID-19 during the global pandemic for staff not wearing personal protective equipment, not wearing appropriate personal protective equipment, appropriate hand hygiene did not occur after care was given to residents, assisting and placing PPE outside the isolated resident's door with adherence to donning/doffing PPE with each resident care interaction, which placed the residents at increased risk for transmission for the virus to spread. This failure resulted in substantial risk of physical harm and neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131 D-34 on 01/26/22. _____ CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 03, 2022.	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, interviews, and record	D912		

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D912	Continued From page 25 reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to infection control and medication administration. The findings are: Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) and the facility's COVID-19 policy were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the proper use of personal protective equipment (PPE) by staff to reduce the risk of transmission and infection of COVID-19, appropriate hand hygiene after care was given to residents and placing PPE outside of the isolated resident's door with adherence to donning/doffing PPE with each isolated residents' care interaction.[Refer to Tag D 612 , 10A NCAC 13F .1008(c) Infection Control (Type A2 Violation)]. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 sampled residents (Residents #2, #3, #4) including antifungal and antibiotic medications (#2), an antianxiety medication (#3), and topical steroid cream (#4). [Refer to Tag D 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912		