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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on May 05, 2022 and May 06, 2022.	{D 000}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#5) who was prescribed a medication for acid reflux. The findings are: Review of Resident #5's current hospital discharge FL2 dated 11/01/21 revealed: -Diagnoses included chronic kidney disease, congestive heart failure, and aortic valve disease. -There was an order for omeprazole (used to treat acid reflux) 20mg 2 times a day before a meal.	D 344		

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Review of Resident #5's previous FL2 dated 08/25/21 revealed diagnoses included gastro-esophageal reflux disease (GERD).

Review of Resident #5's physician visit summary from an encounter dated 11/17/21 revealed:
-There was an order to stop omeprazole (20mg).
-There was an order to start Protonix (used to treat acid reflux/GERD) 40mg twice a day for 2 weeks, then one daily before a meal.

Review of Resident #5"s signed physician's orders dated 12/08/21 revealed:
-Protonix 40mg one tablet twice a day for 14 days was listed and scheduled for administration at 8:00am and 8:00pm.
-Protonix 40mg one tablet before a meal once daily was listed with no time of administration.

Review of Resident #5's physician's orders revealed:
-On 02/25/22, there was an order for omeprazole 20mg twice a day for 90 days.
-On 03/02/22, there was an order for Protonix 40mg (pantoprazole is generic) once daily for 90 days.
-There were no orders regarding discontinuing omeprazole 20 mg.

Review of Resident #5's March 2022 medication administration record (MAR) revealed:
-There was an entry for pantoprazole 40mg pre-printed on the MAR with instructions for one tablet every day before a meal and scheduled for administration at 6:00am.
-Pantoprazole was documented as administered daily from 03/01/22 to 03/31/22.
-Omeprazole 20mg was not listed on the MAR.

Review of Resident #5's April 2022 MAR

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revealed:
-There was an entry for pantoprazole 40mg pre-printed on the MAR with instructions for one tablet every day scheduled for administration at 8:00am daily.
-Pantoprazole 40mg was documented as administered daily from 04/01/22 to 04/30/22.
-There was an entry for omeprazole 20mg pre-printed on the MAR with instructions for one capsule twice a day scheduled for administration at 8:00am and 8:00pm.
-Omeprazole 20mg was documented as administered at 8:00am and 8:00pm from 04/01/22 to 04/30/22.

Review of Resident #5's May 2022 MAR revealed:
-There was an entry for pantoprazole 40mg pre-printed on the MAR with instructions for one tablet every day scheduled for administration at 8:00am daily.
-Pantoprazole 40mg was documented as administered daily from 04/01/22 to 04/30/22.
-There was an entry for omeprazole 20mg pre-printed on the MAR with instructions for one capsule twice a day scheduled for administration at 8:00am and 8:00pm.
-Omeprazole 20mg was documented as administered at 8:00am and 8:00pm from 05/01/22 at 8:00am to 05/05/22 at 8:00am.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/05/22 at 2:14pm revealed:
-On 02/25/22, Resident #5 was dispensed omeprazole 20mg labeled one capsule twice a day for a quantity of 60 capsules.
-The order for pantoprazole 40mg dated 11/17/21 was discontinued when the order for omeprazole was received on 02/25/22.

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-The MAR for March 2022 had already been sent to the facility prior to receiving the order for omeprazole 20mg twice a day dated 02/25/22.
-On 03/02/22, Resident #5 was dispensed pantoprazole 40mg labeled one capsule daily for a quantity of 30 capsules.
-The order for pantoprazole 40mg dated 03/02/22 was entered back into the pharmacy's computer and the order for omeprazole 20mg dated 02/25/22 was not clarified by the pharmacy regarding if Resident #5 should be on both medications.
-There was no documentation regarding staff at the facility's contracted pharmacy contacting Resident #5's primary care provider (PCP) regarding whether Resident #5 should be receiving both pantoprazole and omeprazole therapy.
-The was no documentation regarding the facility contacting the contracted pharmacy for clarification if Resident #5 should be receiving pantoprazole 40mg daily and omeprazole 20mg twice a day as a duplicate therapy.
-On 04/01/22, Resident #5 was dispensed pantoprazole 40mg labeled one capsule daily for a quantity of 30 capsules.
-On 04/13/22, Resident #5 was dispensed omeprazole 20mg labeled one capsule twice a day for a quantity of 60 capsules.

Telephone interview with the triage Nurse at Resident #5's PCP's office on 05/05/22 at 4:30pm revealed:
-The notes at the PCP's clinic contained documentation Resident #5 should be on pantoprazole 40mg daily.
-There was documentation the PCP's office sent an electronic order for omeprazole 20mg twice a day on 02/25/22 per a request for a refill by the pharmacy.

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D 344	Continued From page 4 -There was documentation the PCP's office sent an electronic order for pantoprazole 40mg once a day on 03/02/22 per a request from a pharmacy. -The pantoprazole 40mg once a day should have canceled the order requested for omeprazole 20mg. -There was no documentation the pharmacy or the facility contacted the PCP regarding the duplication of therapy for Resident #5's GERD/reflux using pantoprazole and omeprazole. -The facility could fax a clarification request or call the clinic for leaving message for the PCP for medication clarifications. Interview with the Resident Care Coordinator (RCC) on 05/05/22 at 5:30pm revealed: -She called Resident #5's PCP for the duplicate therapy of omeprazole 20mg and pantoprazole 40mg in early March 2022. -She did not document the PCP phone call for Resident #5 to be on pantoprazole 40mg daily. -She knew Resident #5's March 2022 MAR was correct for pantoprazole 40mg daily. -The April 2022 MAR had the order for omeprazole 20mg twice a day received by the pharmacy and pantoprazole 40mg daily received listed for Resident #5. -She was responsible for auditing the residents' MARs from month to month for accuracy. -She also used a lead supervisor/medication aide (MA) to assist with auditing the month to month MAR transitions. -Resident #5's PCP should have been contacted for a written order to discontinue omeprazole 20mg twice a day. -There was no documentation that the PCP was contacted by the facility for clarification of the pantoprazole and omeprazole for Resident #5. Interview with the Administrator on 05/06/22 at	D 344		

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D 344	Continued From page 5 12:45pm revealed: -He was not involved in the everyday activity for medication administration. -The RCC was responsible to ensure medications were administered as ordered and clarifying any medication orders if needed. -Any medication orders that were not clear or duplicated should be clarified with the PCP. Interview with the Wellness Secretary (WS) on 05/06/22 at 1:20pm revealed: -She was a medication aide(MA) and the WS. -She had been in her position for 3 months -She and any medication aide (MA) could and should contact a PCP for clarification of medication orders if the orders were not clear or duplicated. -She thought Resident #5 had one of his reflux medications discontinued a while back. -She had not worked the medication cart recently. -She did not assist with checking the month to month residents' MAR for April 2022 or May 2022 and had not seen omeprazole 20mg and pantoprazole 40mg listed on Resident #5's May 2022 MAR. Interview with Resident #5 on 05/06/22 at 1:30pm revealed: -He was not able to identify his medications. -He knew he took medication to help with his stomach but did not know the name of the medication. Interview with a day shift MA on 05/06/22 at 1:40pm revealed: -She overlooked that Resident #5 was ordered 2 medications for acid reflux. -She had not contacted Resident #5's PCP regarding the duplicate therapy of pantoprazole 40mg and omeprazole 20mg for clarification if he	D 344		

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should be on both medications.
-The RCC normally audited the MARs for medication orders including duplicate therapy.

{D 358} 10A NCAC 13F .1004(a) Medication Administration {D 358}

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:
FOLLOW-UP TO CONTINUING TYPE B VIOLATION

Based on these findings, the Previously Unabated Type B Violation was abated. Non-compliance continues.

Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents(#2) related to administering doses of a discontinued narcotic, administering a pain medication at the wrong frequency and administering the wrong dose of a long acting insulin for 26 days.

The findings are:

1. Review of Resident #2's current FL-2 dated 10/08/21 revealed diagnoses included history of falls, unsteadiness of feet, and muscle weakness.

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a. Review of Resident #2's current FL-2 dated 10/08/21 revealed there was an order for tramadol 50mg (used to relieve moderate to moderately severe pain) one tablet every 8 hours as needed for left heel pain.

Review of Resident #2's hospital discharge summary dated 11/28/21 revealed an order to stop tramadol 50mg.

Review of Resident #2's February 2022 medication administration record (MAR) revealed:
-There was a hand-written entry for tramadol 50mg one tablet every 8 hours as needed for heel pain.
-There was documentation that Resident #2 was administered tramadol 50mg on 02/25/22.
-There was no documentation that tramadol was discontinued.

Review of Resident #2's March 2022 MAR revealed:
-There was a hand-written entry for tramadol 50mg one tablet every 8 hours as needed for heel pain.
-There was documentation that Resident #2 was administered tramadol 50mg on 03/01/22, 03/02/22, 03/12/22, and 03/27/22.
-There was no documentation that tramadol was discontinued.

Review of Resident #2's April 2022 MAR revealed:
-There was a hand-written entry for tramadol 50mg one tablet every 8 hours as needed for heel pain.
-There was no documentation that Resident #2 was administered tramadol 50mg.
-There was no documentation that tramadol was

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discontinued.

Observation of Resident #2's medications in the facility on 05/06/22 at 10:30am revealed there were three bubble packages containing a total of 72 tablets of trazodone 50mg that were dispensed on 11/03/21.

Telephone interview with a representative at Resident #2's facility contracted pharmacy on 05/06/22 at 9:07am revealed:
-There was a discontinue order for Resident #2 on hospital discharge dated 11/28/21.
-There were 90 tablets dispensed on 11/03/21.
-When tramadol was discontinued, the pharmacy expected the narcotic to not be given and returned for disposal.
-There was a secure process for returning narcotics to the pharmacy via the courier.

Interview with Resident #2 on 05/05/22 at 9:51am revealed:
-She had a wound on both heels when she was admitted to the facility.
-A nurse took care of her wounds and the wounds healed.
-She had heel pain and used pain medication for it.

Interview with a medication aide (MA) on 05/06/22 at 11:55am revealed:
-Hospital discharge summaries were reviewed by the MA on duty at the time the resident arrived at the facility.
-The MA faxed medication orders on the hospital discharge summary to the pharmacy and made changes on the MAR.
-Sometimes the emergency medical technician (EMT) told the MAs of any medication changes.
-She did not know Resident #2's tramadol was

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discontinued in November 2021.
-She thought it was the responsibility of the MA who accepted Resident #2 after the November 2021 hospital admission.
-She thought the MA who reviewed the new MAR each month wrote the tramadol because it was written on the previous months MARs.
-Resident #2's tramadol should have been removed from the cart and discontinued on the MARs.

Interview with the Resident Care Coordinator (RCC) on 05/06/22 at 12:40pm revealed:
-She did not know Resident #2 had a discontinue order for tramadol dated 11/2021.
-She did not know that Resident #2 had a discontinued narcotic administered after the discontinue order date.
-The order should have been reviewed by the MA who was on duty when Resident #2 came back from the hospital.
-She expected the MAs to document discontinued medications on the MAR and highlighted with a yellow highlighter.
-She expected discontinue orders for medications to be faxed to the pharmacy.
-She thought the former regional Registered Nurse checked the hospital discharge summary.
-She held herself responsible for ensuring discontinued medications were noted on the MARs.

Refer to interview with the Administrator on 05/06/22 at 1:16pm.

Attempted telephone interview with Resident #2's physician on 05/05/22 at 4:18pm was unsuccessful.

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

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10/08/21 revealed there was an order for Lantus 100 units/ml (a long acting insulin used to treat diabetes mellitus) 38 units daily at 10:00am.

Review of Resident #2's subsequent physician orders revealed:
-There was an order dated 12/14/21 to decrease Lantus 100 units/ml to 34 units every morning.
-There was an order dated 12/16/21 to decrease Lantus by 6 units.
-There was an order dated 04/20/22 for Lantus 25 units daily.

Review of Resident #2's February 2022 medication administration record (MAR) revealed:
-There was a typed entry for Lantus insulin inject 34 units every morning, scheduled for 8:00am.
-There was documentation of administration of Lantus insulin 34 units from 02/01//22 to 02/28/22 at 8:00am.
-There was no documentation of administration of Lantus insulin 28 units.

Review of Resident #2's March 2022 MAR revealed:
-There was a typed entry for Lantus insulin inject 34 units every morning, scheduled for 8:00am.
-This entry for Lantus 34 units was marked through with a single black line and "see new order" was written near the entry.
-There was another handwritten entry for Lantus insulin 28 units in the morning, scheduled for 8:00am.
-There was documentation of administration of Lantus insulin 28 units from 03/01//22 to 03/31/22 at 8:00am.

Review of Resident #2's April 2022 MAR revealed:
-There was a typed entry for Lantus insulin inject

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34 units every morning, scheduled for 8:00am.
-There was documentation of administration of Lantus insulin 34 units every morning from 04/01/22 to 04/26/22 at 8:00am.
-There was documentation of discontinued and a date of 04/26/22 written beside staff initials.
-There was another handwritten entry for Lantus insulin 25 units every morning, scheduled for 8:00am.
-There was documentation of administration of Lantus insulin 25 units from 04/27/22 to 04/30/22 at 8:00am.
-There was no entry for Lantus insulin 28 units every morning and no documentation of administration of Lantus insulin 28 units.

Observation of Resident #2's medications on hand in the facility on 05/06/22 at 10:40am revealed:
-There was an opened pen of Lantus insulin without a documented open date on the medication cart.
-There were two Lantus insulin pens dispensed on 12/13/21, one Lantus insulin pen dispensed 08/2021, and four Lantus insulin pens dispensed 01/12/22 in the medication refrigerator.

Interview with Resident #2 on 05/05/22 at 9:51am revealed:
-She received two insulin injections.
-She called one insulin the "big insulin" and the other insulin "the little insulin".
-The MAs administered the insulin and she did not know her ordered dose for either insulin.

Telephone interview with a representative at the facility contracted pharmacy on 05/06/22 at 9:07am revealed:
-There was an order dated 12/14/21 for Lantus 34 units subcutaneously daily.

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-There was no subsequent order for Lantus for Resident #2.
-There was no order for Lantus 28 units dated 12/16/21.
-One box of five flex pens of Lantus was dispensed on 01/05/22 for Resident#2.

Interview with a medication aide (MA) on 05/06/22 at 11:55am revealed:
-The facility contracted pharmacy provided MARs for the residents.
-MARs were checked by a MA.
-When she reviewed the new MARs, she compared them to the previous month's MARS.
-She did not know Resident #2 had an order for Lantus insulin 28 units every morning.
-She knew Resident #2 had a recent order change for Lantus insulin in April 2022 and Resident #2's Lantus insulin 34 units was discontinued on her April 2022 MAR.
-She and the Resident Care Coordinator (RCC) discovered Resident #2's recent Lantus insulin order change on the April 2022 hospital discharge summary.
-Resident #2 was administered 34 units of Lantus from 04/01/22 to 04/26/22 and she should have received 28 units.

Interview with the RCC on 05/06/22 at 12:40pm revealed:
-She was not aware that Resident #2 had received the wrong dose of Lantus insulin in February 2022 and for 26 days in April 2022.
-She thought the regional nurse reviewed the MAR and wrote the accurate order on the March 2022 MAR.
-Whomever reviewed the new April 2022 MARs, did not correct Resident #2's Lantus insulin dosage.
-Resident #2 received the wrong dose of insulin

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because the MA who completed the MAR review did not note the correct insulin dose.
-She was responsible for ensuring residents received medications as ordered.

Refer to interview with the Administrator on 05/06/22 at 1:16pm.

Attempted telephone interview with Resident #2's PCP on 05/05/22 at 4:18pm was unsuccessful.

c. Review of Resident #2's current FL-2 dated 10/08/21 revealed there was an order for Tylenol 500mg (used to relieve moderate to moderately severe pain) one tablet every 8 hours as needed for left heel pain.

Review of Resident #2's February 2022 medication administration record (MAR) revealed:
-There was an entry for Tylenol 500mg one tablet every six hours, scheduled for 6:00am, 2:00pm, and 8:00pm.
-There was documentation of administration of Tylenol 500mg from 02/01/22 to 02/28/22 at 6:00am, 2:00pm and 8:00pm
-There was no documentation of administration of a fourth dose of Tylenol 500mg daily in February 2022.

Review of Resident #2's March 2022 MAR revealed:
-There was an entry for Tylenol 500mg one tablet every six hours, scheduled from 6:00am, 2:00pm, and 8:00pm.
-There was documentation of administration of Tylenol 500mg from 03/01/22 to 03/31/22 at 6:00am. 2:00pm, and 8:00pm.
-There was no documentation of administration of a fourth dose of Tylenol 500mg daily in March 2022.

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Review of Resident #2's April 2022 MAR revealed:
-There was an entry for Tylenol 500mg one tablet every six hours, scheduled from 6:00am, 2:00pm, and 8:00pm.
-There was documentation of administration of Tylenol 500mg from 04/01/22 to 04/30/22 at 6:00am. 2:00pm, and 8:00pm.
-There was no documentation of administration of a fourth dose of Tylenol 500mg daily in April 2022.

Review of Resident #2's May 2022 MAR revealed:
-There was an entry for Tylenol 500mg one tablet every six hours, scheduled from 6:00am, 2:00pm, and 8:00pm.
-There was documentation of administration of Tylenol 500mg from 05/01/22 to 05/04/22 at 6:00am. 2:00pm, and 8:00pm.
-There was documentation of administration of Tylenol 500mg on 05/05/22 at 6:00am and 2:00pm.
-There was no documentation of administration of a fourth dose of Tylenol 500mg daily in May 2022.

Observation of Resident #2's medications on hand in the facility on 05/06/22 at 10:40am revealed:
-There was a bubble package dispensed on 03/06/22 with 14 of 30 tablets remaining.
-There was an opened bottle of over the counter Tylenol.
-There was no opened date on the box containing the bottle of Tylenol or on the bottle of Tylenol.
-There were 50 Tylenol gel capsules in an unopened bottle.

Interview with Resident #2 on 05/05/22 at 9:51am revealed she took Tylenol for heel pain.

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Telephone interview with a representative at the facility contracted pharmacy on 05/06/22 at 9:07am revealed:
-There was an order dated 10/22/21 for Tylenol 500mg one tablet every 6 hours.
-this was a scheduled does that was on Resident #2's FL-2.
-The Tylenol should be scheduled for 2:00am, 8:00am, 2:00pm, and 8:00pm or 12:00am, 6:00am, 12:00pm, and 6:00pm.
-The scheduled times depended upon the facility's policy and the residents preference for being awakened for the dose of Tylenol.
-He did not know why Resident #2's Tylenol dose was scheduled for 3 times per day versus 4 times per day on the MAR.
-Resident #2's Tylenol should be administered 4 times per day because that was the ordered frequency.
-One-hundred twenty tablets of Tylenol were last dispensed on 03/06/22.

Interview with a medication aide (MA) on 05/06/22 at 11:55am revealed:
-She administered Tylenol to Resident #2 at 2:00pm.
-She read the order for Resident #2's Tylenol but she did not know it was for every six hours and the scheduled times did not correlate.
-The scheduled times should have been 6:00am, 12:00pm, 6:00pm and 12:00am.
-The MAs should have noticed it during the MAR review each month.

Interview with the Resident Care Coordinator (RCC) on 05/06/22 at 12:40pm revealed:
-She expected the MAs to read the order entry on the MAR.
-She was not aware that Resident #2's Tylenol

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{D 358}	Continued From page 16 order was every 6 hours. -She expected the MAs to know what time to administer a medication ordered for every 6 hours. -The MAs reviewed the MARs for accuracy when the MARs were delivered from the pharmacy. -She held herself responsible for ensuring medications were administered as ordered by the physician. Refer to interview with the Administrator on 05/06/22 at 1:16pm. Attempted telephone interview with Resident #2's PCP on 05/05/22 at 4:18pm was unsuccessful. _______________ Interview with the Administrator on 05/06/22 at 1:16pm revealed: -He expected the MAs to administer medications to residents as ordered. -He held the RSD responsible for ensuring medications were administered as ordered	{D 358}		
{D 611}	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 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	{D 611}		

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{D 611}	Continued From page 17 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 accordance with Rule .1802 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	{D 611}		

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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 North Carolina or a public health emergency declared by the State of North Carolina.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

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 Department of Health and Human Services (NCDHHS) 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 proper use of facemask (source control) by staff.

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The findings are:

Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) in Nursing Homes and Long-Term Care Facilities and Your Guide to Masks updated 01/21/22 revealed:
-Source control measures were to be implemented for Healthcare Personnel (HCP).
-Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose to prevent the spread of respiratory secretions when the person was breathing, talking, sneezing, or coughing and wearing a mask over your nose and mouth was required.
-Fully vaccinated Health Care Provider (HCP) should wear source control when they are in areas of the healthcare facility where they could encounter patients.

Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) in Nursing Homes and Long-Term Care Facilities updated 01/21/22 revealed a Health Care Provider (HCP) should wear a face mask when they are in areas of the healthcare facility where they could encounter patients.

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 exposure.

Observation of the Special Care Unit (SCU) on 05/05/22 from 10:21am to 11:50m revealed:
-The housekeeper was cleaning a resident's bedroom; the resident was not in the room.

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-The housekeeper had on a KN95 facemask; the facemask was below his nose.
-The housekeeper would leave the resident bedroom and retrieve items from the housekeeping cart in the hallway.
-There were residents walking and sitting in the hallway.
-There was a personal care aide (PCA) in the activity area; she had a surgical facemask on below her nose.
-There were six residents in the activity area.
-There two PCAs conducting an activity with seven residents; one PCA was wearing a KN95 facemask below her nose and the second was wearing a surgical facemask below her nose.
-The medication aide (MA) was assisting residents in the dining room; she had her surgical facemask under her nose.
-There were 11 residents in the dining room.
-A PCA was assisting a resident with putting on a sweater; the PCA had a surgical facemask under her chin.
-A PCA was hugging a resident; his surgical facemask was below his nose.

Observation of the SCU on 05/06/22 at 11:58am revealed a PCA came out of a resident's bedroom with a KN95 facemask under her nose; there was a resident in the room.

Interview with the housekeeper on 05/05/22 at 10:21am revealed:
-The facility provided the KN95 facemask at the front desk.
-He knew how to properly wear a facemask because he was trained when he was hired in January 2022.
-There was also a sign posted at the timeclock with the instructions on how to properly wear facemask.

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-He knew he was supposed to wear his facemask above and over his nose.
-He only pulled his facemask down below his nose when he was cleaning a resident's bedroom and only when the resident was not in the bedroom.
-He was not told by anyone that it was okay to wear his facemask below his nose.
-He knew not to wear his facemask below his nose, but he needed to breath.

Interview with a PCA on 05/05/22 at 10:35am revealed:
-Her facemask was below her nose because it pulled down when she spoke.
-She kept pulling it back over her nose, but it continued to move under her nose.
-She knew her facemask was supposed to cover her nose at all times.
-The facility provided surgical facemask for her to wear but she purchased her own and they did not fit well.
-No one had said anything to her about the facemask being worn under her nose.

Interview with a PCA on 05/06/22 at 12:05pm revealed:
-She knew to wear her facemask over her nose.
-She "just" could not breath with her facemask over her nose.
-She saw plenty of other staff with their facemask below their noses, so she did it too.
-She was told how to properly wear her facemask during training in November 2021.
-Other staff saw her wearing her facemask under her nose and never said anything to her.

Interview with a MA on 05/06/22 at 12:17pm revealed:
-Staff were trained to wear their facemask at all

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times when in the building and to wear their facemask over their nose.
-Staff were allowed to remove their facemask in the employee breakroom when eating.
-She was trained on proper facemask use when COVID-19 pandemic began in 2020, but she had not had any additional training.

Interview with the Memory Care Director (MCD) on 05/06/22 at 12:26pm revealed:
-The facility provided surgical facemask and KN95 facemask.
-Staff had to wear their facemask while in the building; the only exception was when they were in a designated break area eating a meal.
-Staff had to wear their facemask in the hallways and in resident rooms; even when there was no one around or in the room.
-Staff were trained when they were hired on the proper use and wearing of facemask.
-Staff were to wear their facemask over their nose and mouth; there were no exceptions.
-If she saw staff with their facemask below their nose or their mouth, she would instruct them to put their facemask on correctly.
-She has had to tell staff to place their facemask over their nose.
-She has caught staff taking a "breather" and she reminded them to put their facemask back on correctly.
-Reminding and instructing staff to properly wear their facemask was a "constant thing".

Interview with the Administrator on 05/06/22 at 1:17pm revealed:
-She expected all staff to wear their facemask while in the building.
-She expected staff to wear their facemask over their nose and mouth.
-The facility provided facemask for the staff to

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{D 611}	Continued From page 23 wear. -Staff were trained on the proper use and wearing of facemask upon hire and as the policy changes for COVID-19 precautions. -There was a training for facemask usage and proper wearing about two or three weeks ago. -There was signage with images at the time clock instructing the staff on the proper wearing of facemask. -She did rounds in the building at least once a day and if she found staff not wearing their mask correctly, she told them to pull it above their nose.	{D 611}		