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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Yadkin County Department of Social Services conducted an annual and follow-up survey from 06/08/22 through 06/10/22.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure hot water temperatures for 6 fixtures (sinks) used by residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are: Observation of the facility on 06/08/22 at 10:12am revealed there was a men's bathroom and a women's bathroom on the left hall and a men's bathroom, a men's shower room, and a women's bathroom on the right hall. Observation of the women's bathroom on the right hall on 06/08/22 at 10:13am revealed:	D 113		

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-There were double sinks and visible steam was coming from the faucet when the water was turned on.
-The water temperature was 122 degrees F at both sink faucets.

Observation of the men's shower room on the right hall on 06/08/22 at 10:15am revealed:
-There was visible steam coming from the sink faucet when the water was turned on.
-The water temperature was 126 degrees F at the sink faucets.

Observation of a second men's bathroom on the right hall on 06/08/22 at 10:37am revealed:
-There was visible steam coming from the sink faucet when the water was turned on.
-The water temperature was 124 degrees F at the sink faucets.

Observation of the men's bathroom on the left hall on 06/08/22 at 10:20am revealed there were double sinks and the water temperature was 70 degrees F at both sink faucets.

Observation of the women's bathroom on the left hall on 06/08/22 at 10:22am revealed the water temperature was 70 degrees F at the sink faucet.

Review of the facility's water temperature logs for March 2022, April 2022, May 2022, and June 2022 revealed:
-Water temperatures were checked on 03/15/22 and 03/25/22 in the dishwasher, 3 water heaters, 2 men's bathrooms (hallway not indicated) and 2 women's bathrooms (hallway not indicated); the water temperatures in the 4 bathrooms ranged from 103 degrees F to 114.7 degrees F.
-Water temperatures were checked on 04/01/22, 04/15/22, 04/22/22, and 04/27/22 in the

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dishwasher, 3 water heaters, 2 men's bathroom (hallway not indicated) and 2 women's bathrooms (hallway not indicated); the water temperatures in the 4 bathrooms ranged from 108.7 degrees F to 114.6 degrees F.
-There was no documentation of water temperature checks in May 2022.
-Water temperatures were checked on 06/06/22 in the dishwasher, 3 water heaters, 2 men's bathrooms (hallway not indicated) and 2 women's bathrooms (hallway not indicated); the water temperatures in the 4 bathrooms ranged from 108.7 degrees F to 114.6 degrees F.
-There was no documentation water temperatures were checked in all bathrooms on both halls.
-There was no documentation water temperatures were checked in residents rooms with private or shared bathrooms.

Interview with the Maintenance Staff on 06/08/22 at 10:17am revealed:
-He checked the water temperatures once a week and documented them in a log.
-He checked the water temperatures in the hallway bathrooms, the water heater, and in the kitchen dishwasher, but he did not check the water temperatures in rooms with private bathrooms.
-Water temperatures in the hallway bathrooms usually measured around 108 degrees F.

Second observation of the men's bathroom on the right hall on 06/08/22 at 10:18am revealed the Maintenance Staff measured the water temperature and his thermometer ranged from 121 to 125 degrees F.

Observation of the bathroom in Room #15 on 06/08/22 at 10:26am revealed:

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-There was visible steam coming from the sink faucet when the water was turned on.
-The water temperature was 128 degrees F at the sink.

Interview with the resident in Room #15 on 06/08/22 at 10:27am revealed:
-The water at the sink was hot.
-She adjusted the water by turning the cold water on with the hot water.
-She had never been burned by the hot water.

Interview with 3 residents who resided on the right hallway on 06/08/22 between 10:55am and 11:05am revealed:
-The residents used either the men's or women's bathrooms on the right hallway.
-One resident stated the water temperatures in the men's hallway bathrooms were hot, but he used the cold water to help cool it off.
-A second resident stated the water temperature in the men's hallway bathrooms got too hot sometimes, but he turned the hot water knob to the middle and turned on the cold water to regulate it.
-A third resident stated the water temperature in the women's hallway bathroom was very hot.

Interview with a housekeeper on 06/08/22 at 11:07am revealed she had not noticed the water temperatures in the men's, women's or private bathrooms being too hot because housekeeping used chemicals to clean opposed to water.

Observations of re-check of water temperatures on 06/09/22 revealed:
-There was a signs posted at each bathroom or shower door documenting high hot water temperatures.
-At 10:33am, the hot water temperature in the

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right hall men's bathroom was 102 degrees F at the sink faucet.
-At 10:36am, the hot water temperatures in the right hall women's bathroom was 112 degrees F at the double sink faucets.
-At 10:41am, the hot water temperature in the left hall women's bathroom was 74 degrees F at the sink faucet.
-At 10:43am, the hot water in the left hall men's bathroom was 74 degrees F at the double sink faucets.
-At 5:15pm, the hot water temperature in the right hall men's shower room was 108 degrees F at the sink faucet.
-At 5:17pm, the hot water temperature in a resident's room #15 was 116 degrees F at the sink faucet.

Observation of the facility at various times on 06/09/22 revealed there was a plumbing company at the facility checking the water heaters and water temperatures.

Interview with the Administrator on 06/08/22 at 1:07pm revealed:
-Maintenance staff was supposed to check water temperatures at all faucets once a week.
-A staff had complained in May 2022 that water temperatures were too cool, so she contacted a plumbing company for an estimate.
-The plumbing company sent her an estimate on 06/01/22 without coming out to the facility to assess water temperatures or plumbing issues.
-The facility had not followed up with the plumbing company.
-She had not heard any complaints from maintenance staff, other staff, or residents that the water temperatures were too hot.
-She would contact the plumbing company to come out to assess water temperatures and the

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D 113	Continued From page 5 hot water heaters. A second interview with the Administrator on 06/10/22 at 5:02pm revealed: -The plumbing company had checked for problems with the water temperatures and they found a thermostat needed to be replaced and a water heater needed to be replaced to address the low water temperatures on the left hall. -She expected for maintenance to check water temperatures in all bathrooms, shower rooms, and resident rooms twice a week. _____ The facility failed to ensure hot water temperatures for 6 fixtures used by residents were maintained between 100-116 degrees F. A hot water temperature of 128 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/08/22 for this violation. CORRECTION DATE FOR THE TYPE A VIOLATION SHALL NOT EXCEED JULY 25, 2022.	D 113		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:	D 164		

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D 164	Continued From page 6 (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled medication aides (Staff A & Staff C) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars and administering insulin. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -Staff A was hired on 03/24/22. -Certification of training for diabetic care was not completed until 05/10/22. Review of the April 2022 electronic medication	D 164		

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administration record (eMAR) for an insulin dependent resident revealed:
-From 04/01/22 through 04/30/22 Staff A documented 44 fingerstick blood sugar (FSBS) checks.
-From 04/01/22 through 04/30/22 Staff A documented administration of insulin 12 times.

Review of the May 2022 eMAR for an insulin dependent resident revealed:
-From 05/01/22 through 05/10/22, Staff A documented 16 FSBS checks.
-From 05/01/22 through 05/10/22, Staff A documented administration of insulin 8 times.

Interview with Staff A on 06/10/22 at 2:45pm revealed:
-She was hired on 03/24/22 and had been providing care to diabetic residents since her hire date.
-She had performed FSBS checks and administered insulin as needed to residents.
-She was not made aware by the Administrator or by the Resident Care Coordinator (RCC) that care could not be provide to diabetic residents prior to receiving diabetic training.

2. Review of Staff C's medication aide (MA) personal record revealed:
-Staff C was hired on 09/20/21.
-There was no documentation of training on the care of diabetic residents.

Review of the April 2022 electronic medication administration record (eMAR) for an insulin dependent resident revealed:
-From 04/01/22 through 04/30/22, Staff C documented 26 fingerstick blood sugar (FSBS) checks.
-From 04/01/22 through 04/30/22, Staff C

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documented administration of insulin 6 times.

Review of the May 2022 eMAR for an insulin dependent resident revealed:
-From 05/01/22 through 05/31/22, Staff C documented 19 FSBS checks.
-From 05/01/22 through 05/31/22, there was no documentation Staff C administered insulin.

Review of the June 2022 eMAR for an insulin dependent resident revealed:
-From 06/01/22 through 06/08/22, Staff C documented 4 FSBS checks.
-From 06/01/22 through 06/08/22, there was no documentation Staff C administered insulin.

Interview with Staff C on 06/10/22 at 4:50pm revealed:
-She was hired on 09/20/21.
-She received diabetic training around 09/24/21.
-She was not aware that a copy of the certificate for training was not in her personnel record.
-She did not have a copy of her diabetic training certificate.
-Her training was set up by the Administrator and completed by the facility's contracted pharmacy.
-She had completed FSBS checks and administered insulin as needed to residents since her training in September 2021.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 3:15pm revealed:
-The RCC received a spread sheet from Human Resources (HR) that listed all the training that staff had completed.
-HR was responsible for updating personnel records with training certificates or documentation that training had been completed.
-She was not aware that diabetic training certificates were not in personnel records for Staff

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D 164	Continued From page 9 A or Staff C. -She did not have access to personnel records due to confidential information. -She never had access to personnel records to ensure that staff training had been completed or that documentation of training was in the personnel records. -She and the Administrator were responsible for setting up training for newly hired staff and for retained staff. -She had been given access to staff certificates and completed trainings done by the facility's contracted pharmacy. Interview with the Administrator on 06/10/22 at 3:45pm revealed: -She began employment at the facility about three weeks prior. -She was not aware that the personnel records were missing documentation of diabetic training. -She did not know that Staff A and Staff C were missing the required training for care of diabetic residents and had been performing FSBS checks and administering insulin. -She was aware that the RCC received a spread sheet of staff that were trained and the type of training that staff needed to complete. -HR staff were responsible for updating personnel records with staff training certificates and documentation of staff training. -HR staff were responsible for making the RCC aware of which staff had completed training along with any training that needed to be completed. -The RCC did not have access to personnel records due confidential information.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up to meet the health care needs for 3 of 5 sampled residents (#4, #2 and #3) related to a resident who had a referral to a gastrointestinal (GI) specialist hospital, orders for continuous oxygen and did not have a portable oxygen tank, orders to see a podiatrist, and orders to contact the primary care provider (PCP) regarding increases in weights (#4); a resident who had orders to notify the PCP for a weight gain of 2 or more pounds in 24 hours, and who had been refusing an anti-diabetic medication (#2); and a resident who had a referral to see a urologist (#3).

The findings are:

1. Review of Resident #4's current FL2 dated 05/24/22 revealed diagnoses included chronic obstructive pulmonary disorder, chronic renal failure, dementia, depression, and deep vein thrombosis.

a. Review of Resident #4's local hospital After Visit Summary dated 03/01/21 revealed Resident #4 was hospitalized from 02/24/21 through 03/01/21 due to a GI bleed.

Review of Resident #4's local hospital after visit summary dated 03/23/21 revealed Resident #4 was hospitalized form 03/17/21 through 03/23/21

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D 273	Continued From page 11 due to acute blood loss anemia. Review of Resident #4's unsigned and undated physician's order sheet revealed: -The physician's order sheet was faxed to Resident #4's primary care provider (PCP) on 03/04/22. -There was documentation Resident #4 had a referral to see a GI physician and she did not attend the appointment. -There was a request to get an updated referral for Resident #4 to see a GI physician. Review of Resident #4's local hospital medical records dated 03/21/22 revealed: -Resident #4 was admitted on 03/19/22 and discharged on 03/21/22 with diagnoses that included gastrointestinal hemorrhage. -Resident #4 presented to the hospital with a several day history of melena (black tarry stools) and rectal bleeding. -There was a consult with a physician from the gastroenterologist's office where Resident #4 had previously been seen. -Resident #4 had a longstanding history of intermittent GI bleeding thought to be secondary to a small bowel arteriovenous malformations (AVM) (defects in the vascular system consisting of tangles of abnormal blood vessels connecting veins and arteries). -Her endoscopy procedure revealed one small non-bleeding AVM in the mid small bowel. -Resident #4 was last hospitalized in March 2021 with melena; an appointment was scheduled for Resident #4 to see a physician at the GI specialist hospital for a double-balloon endoscopy procedure for small bowel AVM, however Resident #4 stated she did not go. -Small bowel AVM was likely the source of Resident #4's bleeding.	D 273		

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-The gastroenterologist's office left the facility a detailed message about the appointment and sent a reminder letter.
-Resident #4 stated the facility never took her to the GI specialist hospital for the appointment.
-The gastroenterologist made a referral (date not indicated) for Resident #4 to see a physician at the GI specialist hospital to assess for possible small bowel endoscopy procedure and AVM treatment, but Resident #4 did not make the appointment.
-The gastroenterologist documented he would reinitiate the referral process for Resident #4 to be seen at the GI specialist hospital.

Review of Resident #4's progress notes for March 2022 revealed:
-On 03/18/22 at 11:28pm, Resident #4 came from the restroom and reported to a medication aide (MA) that she had a lot of blood coming from her rectum.
-The MA checked Resident #4's rectum and found that her hemorrhoids were protruding and bleeding significantly.
-The MA contacted the Administrator and called emergency medical services (EMS).
-On 03/19/22 at 2:04am, the MA followed up with the local hospital and was informed Resident #4 would be admitted.
-On 03/20/22 at 12:45am, a nurse from the local hospital called to report Resident #4 was admitted to the hospital for observation.
-The emergency department (ED) physicians wanted to keep Resident #4 to consult a GI physician.
-The gastroenterologist wanted Resident #4 to have a follow-up at a GI specialist hospital to have a double balloon endoscopy to "really fix the resident's problem."
-The resident was admitted to the hospital

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roughly a year ago, so medical staff wanted to fix what was causing the issues.

Interview with Resident #4 on 06/10/22 at 9:06am revealed:
-She had been hospitalized after having bloody stools, but she did not remember when.
-She had pain in her left side most of the time that would not go away.
-She remembered she had an appointment scheduled with a GI doctor, but the facility did not take her.
-She did not remember when the appointment was scheduled for.

Interview with the Business Office Manager (BOM) on 06/09/22 at 2:36pm revealed:
-She was responsible for scheduling residents' appointments and transportation to the appointments.
-The Resident Care Coordinator (RCC) received the referrals and sent them to her via fax or email.
-After receiving the referrals, she checked the resident's insurance and contacted providers to see who would accept the resident's insurance.
-Resident #4 was seen by a gastroenterologist on 03/25/22 and was seen at a specialist hospital on 06/03/22.
-She had not received any other faxes or emails prior to 03/25/22 regarding a referral to a gastroenterologist or a GI specialist hospital.
-Resident #4 attended her appointments regularly most of the time, unless she was really tired.

Interview with the BOM on 06/10/22 at 3:10pm revealed the referral to the GI specialist hospital in 2021 was prior to her taking over scheduling appointments and she did not have access to view the GI specialist hospital appointment

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D 273	Continued From page 14 scheduled in 2021. Interview with the RCC on 06/09/22 at 3:42pm revealed she started working at the facility in March 2022 and did not know anything about any orders or referrals to see a gastroenterologist prior to her start date. Interview with a MA on 06/08/22 at 4:12pm revealed: -When new orders were received at the facility, the MA who received the order made a copy to go in the resident's record and then faxed the order to the BOM. -She did not know about any GI appointments for Resident #4. Interview with a nurse at Resident #4's gastroenterologist's office on 06/10/22 at 10:29am revealed: -Resident #4 was hospitalized from 03/17/21 to 03/23/21 and was seen by a gastroenterologist on 03/18/21 while she was in the hospital. -The gastroenterologist who saw Resident #4 on 03/18/21 referred her to the GI specialist hospital for a double balloon endoscopy due to diagnoses of chronic GI bleeding, AVM, and iron deficiency anemia. -On 03/18/21, the referral was sent from the gastroenterologist's office to the GI specialist hospital. -The gastroenterologist's office received a message from the GI specialist hospital with a scheduled appointment date of 06/09/21 for Resident #4. -On 06/21/21, the gastroenterologist's office received a message from the GI specialist hospital indicating Resident #4's appointment was cancelled on 06/09/21 and was not rescheduled. -Resident #4 was seen in the gastroenterologist's	D 273		

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office on 04/08/22 as a follow-up to a hospitalization in March 2022.
-There was another referral sent to the GI specialist hospital for a double balloon endoscopy due to the same diagnoses as the previous referral in 2021: GI bleeding, AVM, and iron deficiency anemia.

Interview with a medical specialist at Resident #4's GI specialist hospital on 06/10/22 at 10:43am revealed:
-Resident #4 was referred to the GI specialist hospital for a double balloon endoscopy.
-Resident #4's original appointment was scheduled for 05/13/21, but the appointment was rescheduled by the facility to 06/09/21.
-On 06/09/21, the facility called to cancel the appointment and it was not rescheduled.

Interview with the RCC on 06/10/22 at 2:30pm revealed:
-She was not working at the facility when Resident #4 had a scheduled appointment at the GI specialist hospital.
-She did not know anything about the referral, or the request dated 03/04/22 for a referral for Resident #4 to see a gastroenterologist.

Interview with the Administrator on 06/10/22 at 1:19pm revealed:
-She did not know about the referral to the GI specialty hospital in 2021 and she did not know why Resident #4 did not attend the appointment.
-For referrals that came into the facility, the RCC was responsible for sending the referrals to the BOM and the BOM scheduled the appointment.
-She had not reviewed Resident #4's record since coming to work at the facility in March 2022.
-Resident #4 was hospitalized in March 2022 due to vomiting and severe diarrhea.

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-After her March 2022 hospitalization, Resident #4's PCP wanted to try to refer her to a GI specialist located closer to the facility.
-Resident #4 was seen at her gastroenterologist's office on 04/08/22 and the gastroenterologist referred Resident #4 back to the GI specialist hospital for consultation.

Attempted interview with Resident #4's PCP on 06/10/22 at 5:23pm was unsuccessful.

b. Review of a physician's order dated 04/06/22 revealed there was an order for Resident #4 to see a podiatrist for toenail and foot care.

Review of Resident #4's progress note dated March 2022 revealed:
-On 03/04/22, Resident #4 complained of pain in both feet and toes.
-Resident #4 stated the pain was due to her ingrown toenails.
-The medication aide (MA) informed Resident #4 she would speak to the Business Office Manager (BOM) regarding a referral to a podiatrist.
-On 03/18/22, Resident #4 had been complaining of both her big toes hurting and being ingrown.
-The MA checked Resident #4's toes and let the Resident Care Coordinator (RCC) know.

Interview with Resident #4 on 06/10/22 at 9:06am revealed:
-There had not been a podiatrist in the facility for a few months, and she had not been sent outside the facility to see a podiatrist.
-She did not remember the last time she saw a podiatrist.
-She wanted to see a podiatrist because her toenails hurt.

Second interview with Resident #4 on 06/10/22 at

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D 273	Continued From page 17 2:56pm revealed: -Her toes hurt when she put her shoes on, so she wore her bedroom shoes all the time. -She would have gone to see an outside podiatrist if the facility would have taken her. Observation of Resident #4's feet on 06/10/22 at 9:11am revealed: -Resident #4 had thick and discolored toenails on her left and right big toes. -There was a lifted ridge near the bed of her toenail on her left big toe. Interview with the BOM on 06/09/22 at 2:36pm revealed: -She was responsible for scheduling residents' appointments -There used to be a provider who regularly visited residents at the facility, but the provider stopped providing podiatry services to the facility. -The facility started referring residents to outside podiatrists and she scheduled podiatry visits when she received them. -She had not received a referral or order for Resident #4 to see a podiatrist. Interview with a MA on 06/10/22 at 10:09am revealed: -Resident #4 complained to her about her toenails hurting. -She did not know if there was a referral for a podiatrist. -The RCC was responsible for sending referrals to the BOM so that appointments could be scheduled. -The facility had been working on getting a podiatrist to come to the facility to visit residents. -She did not know when a podiatrist was last in the facility.	D 273		

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Interview with a second MA on 06/10/22 at 12:50pm revealed:
-Resident #4 complained about her toenails and especially her big toe.
-She saw Resident #4 had thickened toenails.
-She told Resident #4's PCP about her toenails, but she did not remember when.
-She did not know Resident #4 had a referral to see a podiatrist.
-The RCC was responsible for ensuring the referral was sent to the BOM so an appointment could be made.
-There used to be a podiatrist who came into the facility, but the podiatrist had not been in a while (She did not know how long).

Interview with the RCC on 06/10/22 at 3:49pm revealed:
-She was responsible for reviewing orders that came into the facility, and she sent orders to the BOM to schedule appointments with outside providers.
-She did not remember seeing the order dated 04/06/22 for podiatry services for toenail and foot care.
-The order was written by a provider at a quick care clinic when Resident #4 went to the clinic because she had been throwing up.
-The clinic wrote medication orders and listed the order for podiatry services in addition to the medication orders.
-She had not followed up with a podiatrist or Resident #4's PCP because she was not aware of the order dated 04/06/22.

Interview with the Administrator on 06/10/22 at 5:02pm revealed:
-She did not know there was an order for Resident #4 to see a podiatrist.
-The facility did not currently have a podiatrist

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coming in the facility since the previous provider stopped providing podiatrist services to the facility a few months ago.
-The facility could have sent residents to an outside podiatry provider, but a lot of the residents did not want to go outside the facility for podiatry services.
-The facility had now secured services with a podiatrist who would come into the facility to see residents and Resident #4 would be seen.
-She expected Resident #4 to be referred to podiatry services with an outside provider when the order dated 04/06/22 was received in the facility.

Attempted interview with Resident #4's PCP on 06/10/22 at 5:23pm was unsuccessful.

c. Review of Resident #4's current FL2 dated 05/24/22 revealed an order for daily weights.

Review of Resident #4's 6-month physician's orders dated 04/12/22 revealed an order to check weight daily; if Resident #4 gained 2-3 pounds in 1 day or 5 pounds in five days notify the physician.

Interview with a pharmacy technician at the facility's contracted pharmacy on 06/10/22 at 2:42pm revealed there was an active order for weights dated 06/26/20 to check weight daily and if she gains 2-3 pounds in 1 day or 5 pounds in 4 days, notify the physician.

Review of Resident #4's electronic Medication Administration Record (eMAR) for March 2022 revealed:
-There was an entry to check weight daily and if she gains 2-3 pounds in 1 day or 5 pounds in 4 days, notify the physician.

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D 273	Continued From page 20 -There was documentation Resident #4 had a weight gain of 2 pounds or more in 1 day on 5 occasions on 03/02/22, 03/07/22, 03/14/22, 03/24/22, and 03/31/22. -Resident #4's weights ranged from 174 pounds to 182 pounds. Review of Resident #4's eMAR for April 2022 revealed: -There was an entry to check weight daily and if she gains 2-3 pounds in 1 day or 5 pounds in 4 days, notify the physician. -There was documentation Resident #4 had a weight gain of 2 pounds or more in 1 day on 3 occasions on 04/02/22, 04/04/22, and 04/29/22. -Resident #4's weights ranged from 171 pounds to 183 pounds. Review of Resident #4's eMAR for May 2022 revealed: -There was an entry to check weight daily and if she gains 2-3 pounds in 1 day or 5 pounds in 4 days, notify the physician. -There was documentation Resident #4 had a weight gain of 2 pounds or more in 1 day on 4 occasions on 05/02/22, 05/17/22, 05/21/22 and 05/23/22. -Resident #4's weights ranged from 174.2 pounds to 181.8 pounds. Review of Resident #4's eMAR for June 2022 revealed: -There was an entry to check weight daily and if she gains 2-3 pounds in 1 day or 5 pounds in 4 days, notify the physician. -There was documentation Resident #4 had a weight gain of 2 pounds or more in 1 day on 1/03/22. -Resident #4's weights ranged from 172 pounds to 182 pounds.	D 273		

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D 273	Continued From page 21 Interview with Resident #4 on 06/10/22 at 9:06am revealed: -Staff weighed her daily. -She did not know if her weight fluctuated up or down. Interview with a medication aide (MA) on 06/08/22 at 4:12pm revealed: -The scales were located in the medication room. -Resident #4 had an order for daily weights. -Resident #4's weights usually fluctuated down when she checked them. -The MAs should have contacted Resident #4's primary care provider (PCP) if there was a weight gain, but she could not remember the order without looking at it. Interview with the Resident Care Coordinator (RCC) on 06/09/22 at 3:42pm revealed: -She did not know about weight gain of more than 2 pounds in a day for Resident #4. -There was a time when there were issues with residents having high weights and the scales were replaced. -There may have been fluctuations with Resident #4's weights prior to getting a new scale. -The MAs were responsible for contacting Resident #4's PCP with weight gains greater than 2 pounds in 1 day. Interview with a second MA on 06/10/22 at 10:09am revealed: -She documented an increase in weights on the eMAR once when the facility got a new scale. -She did not contact Resident #4's PCP to inform of an increase of more than 2 pounds when the new scale was used. -Other times when she documented an increase of more than 2 pounds in a day for Resident #4,	D 273		

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she told the RCC.
-She did not contact Resident #4's PCP regarding an increase in weight because she did not have the PCP's direct phone number.

Interview with a third MA on 06/10/22 at 12:50pm revealed:
-She knew Resident #4 had orders to check her weight daily.
-Resident #4's order for daily weight checks was on the eMAR, but she did not remember seeing the second part of the order to notify the physician if Resident #4 gained 2-3 pounds in one day or 5 pounds in five days.
-There were days when she documented at least a 2-pound weight gain in a day, but she did not contact Resident #4's PCP because she did not know she needed to.
-She had not talked to the RCC either regarding Resident #4's weight gains, but hopefully Resident #4's PCP saw it on her eMARs when she came to the facility.

Interview with Resident #4's PCP on 06/10/22 at 5:12pm revealed:
-The facility staff notified her about Resident #4's weights every few months.
-She did not know Resident #4 had weight gain multiple times in March 2022, April 2022, May 2022, and June 2022.
-She did not write the original order for weights, and the orders probably came as a result of a hospitalization.

Interview with the Administrator on 06/10/22 at 5:02pm revealed:
-She did not know about the order for Resident #4's weights and that there was no documentation the MAs contacted Resident #4's PCP when she had 2-3 pounds weight gain in a

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day.
-She expected the MAs to report weight gains requiring physician notification to the RCC and the RCC was to contact Resident #4's PCP.

d. Review of Resident #4's FL2 dated 05/24/22 revealed an order for continuous oxygen at 2 liters/minute.

Review of Resident #4's electronic Medication Administration Records (eMAR) and electronic Treatment Administration Records (eTAR) for May 2022 and June 2022 revealed there was not an entry for oxygen on the eMAR or eTAR for May 2022 or June 2022.

Observation of Resident #4's room on 06/10/22 at 9:03am revealed Resident #4 had an oxygen concentrator, but there were no portable oxygen tanks available in her room.

Interview with Resident #4 on 06/10/22 at 9:06am revealed:
-She had chronic obstructive pulmonary disease (COPD) and had trouble breathing.
-She wore oxygen 24/7 unless she left her room to go to the dining hall or the bathroom.
-She did not have a portable oxygen tank, but she needed one.
-She got short of breath when she walked to the dining hall and to the bathroom.
-Sometimes she felt like she was not going to make it.
-She told the Resident Care Coordinator (RCC) this morning, 06/10/22, she needed a portable oxygen tank, but she had not told anyone prior to today.

Interview with the RCC on 06/09/22 at 3:42pm revealed:

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-She was responsible for reviewing the eMARs and eTARs at least weekly.
-She did not know why Resident #4's oxygen was not on the eMAR or eTAR for documentation.
-She did not pay attention to Resident #4's previous oxygen orders which were 2L as needed.
-She completed Resident #4's FL2 dated 05/24/22 with documentation Resident #4 was on 2L of oxygen continuously because she saw Resident #2 with oxygen on all the time when she was in her room, but she did not wear oxygen when she went to the dining hall.

Second interview with the RCC on 06/10/22 at 3:49pm revealed:
-She did not think to order a portable oxygen tank for Resident #4.
-She was responsible for reviewing orders and would have been responsible for obtaining an order for a portable oxygen tank for Resident #4.
-Resident #4 walked with a rollator and sat on the rollator in the hallways and in the dining hall.
-She had not seen Resident #4 short of breath when ambulating in the hallway.

Interview with a medication aide (MA) on 06/09/22 at 4:12pm revealed:
-Resident #4 usually wore her oxygen when she was in her room laying down.
-She had not seen Resident #4 outside of her room with oxygen on and had not seen a portable oxygen tank for her.
-She did not know what Resident #4's oxygen orders were and had not seen oxygen on the eMAR or eTAR to document use.

Observation of Resident #4 on 06/10/22 at 12:50pm revealed:
-Resident #4 was walking down the hallway to her

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room from the dining hall.
-Resident #4 stopped at the nurse's desk to rest and was short of breath.

Interview with another MA on 06/10/22 at 12:50pm revealed:
-She did not know what Resident #4's current order for oxygen was.
-Resident #4 wore her oxygen only when she was in her room and she had never seen her wear oxygen outside of her room.
-She had not seen Resident #4 with a portable oxygen tank since she started working at the facility in August 2021.
-The RCC would have been responsible for obtaining an order for a portable oxygen tank.

Interview with the Administrator on 06/10/22 at 5:02pm revealed:
-She did not know about Resident #4's oxygen orders for continuous oxygen and she did not know she did not have a portable oxygen tank.
-Resident #4 should have had a portable oxygen tank since she had orders for continuous oxygen.
-The RCC was responsible for requesting orders for a portable oxygen tank for Resident #4.

Attempted interview with Resident #4's PCP on 06/10/22 at 5:23pm was unsuccessful.

2. Review of Resident #2's current FL2 dated 05/04/22 revealed diagnoses included type 2 diabetes with neurological manifestations, ischemic heart disease due to coronary artery obstruction, hypertension, and thoracic aortic aneurysm.

a. Review of Resident #2's current FL2 dated 05/04/22 revealed there was an order for daily weight checks.

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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 273	Continued From page 26 Review of Resident #2's Physician Order dated 03/14/22 revealed there was an order to weigh Resident #2 daily first thing in the morning after toileting and with only pajamas on, and to report a 2-plus weight gain in a 24-hour period. Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry to check weight first thing in the morning after toileting with only pajamas on and to call the primary care provider (PCP) if weight gain was greater than 2 pounds in a 24 hour period. -There was documentation that there was a 2-plus weight gain in a 24-hour period five times from 04/01/22 through 04/30/22. -There was no documentation that the PCP had been notified of the 2-plus pound weight gain for four out of the five occurrences. -Resident #2's weight ranged from 211.0 pounds to 218.8 pounds from 04/01/22 through 04/30/22. Review of Resident #2's April 2022 Progress Notes revealed there was no documentation the PCP had been notified of Resident #2's 2-plus pound weight gain on 04/02/22 (weight increase of 3.6 pounds), 04/08/22 (weight increase of 3.0 pounds), 04/23/22 (weight increase of 2.9 pounds), or 04/27/22 (weight increase of 3.7 pounds). Review of Resident #2's May 2022 eMAR revealed: -There was an entry to check weight first thing in the morning after toileting with only pajamas on and to call the PCP if weight gain was greater than 2 pounds in a 24-hour period. -There was documentation that there was a	D 273		

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2-plus weight gain in a 24-hour period five times from 05/01/22 through 05/31/22.
-There was no documentation that the PCP had been notified of the 2-plus pound weight gain for any of the five occurrences.
-Resident #2's weight ranged from 208.3 pounds to 219.0 pounds from 05/01/22 through 05/31/22.

Review of Resident #2's May 2022 Progress Notes revealed there was no documentation the PCP had been notified of Resident #2's 2-plus pound weight gain on 05/06/22 (weight increase of 4.7 pounds), 05/10/22 (weight increase of 2.2 pounds), 05/15/22 (weight increase of 6.0 pounds), 05/18/22 (weight increase of 2.2 pounds), or 05/25/22 (weight increase of 3.4 pounds).

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry to check weight first thing in the morning after toileting with only pajamas on and to call the PCP if weight gain was greater than 2 pounds in a 24-hour period.
-There was documentation that there was a 2-plus weight gain in a 24-hour period one time from 06/01/22 through 06/08/22.
-There was no documentation that the PCP had been notified of the 2-plus pound weight gain.
-Resident #2's weight ranged from 210.0 pounds to 217.8 pounds from 06/01/22 through 06/08/22.

Review of Resident #2's June 2022 Progress Notes revealed there was no documentation the PCP had been notified of Resident #2's 2-plus pound weight gain on 06/02/22 (weight increase of 3.2 pounds).

Interview with a medication aide (MA) on 06/09/22 at 10:33am revealed:

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-The night shift MA was responsible for checking Resident #2's weight as soon as she woke up in the morning and had toileted.
-The night shift MA would let the day shift MA know what the weight was so that it could be documented and followed up on.
-She had documented Resident #2's weight on 04/27/22, 05/18/22 and 05/25/22 when the weight gain was over 2 pounds.
-She thought she had notified the PCP of Resident #2's weight on 05/18/22 but did not think she remembered to document the notification.
-The MAs mostly communicated through electronic mail (e-mail) shift notes, where they would let the oncoming shift know any new orders, resident concerns, or issues that needed follow-up or monitoring.
-She did not know why staff did most of their documentation in the shift notes rather than in the resident's progress notes.

Interview with Resident #2 on 06/09/22 at 4:00pm revealed:
-She had her weight checked on the scale in her room every morning.
-She sometimes kept track of her weight but unless she felt like she had more fluid in her body she did not concern herself with it every day.

Interview with a representative from Resident #2's PCP office on 06/10/22 at 8:50am revealed:
-The last notification they had received from Resident #2's facility regarding her weight increasing 2 or more pounds was on 05/10/22, and prior to that it was 03/14/22.
-The PCP expected to be notified every time Resident #2's weight was up two or more pounds so that she could advise the MAs whether to just administer an extra furosemide (a medication used to treat fluid retention) or if she wanted

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Resident #2 to come in to the clinic for an evaluation.

Telephone interview with a MA on 06/10/22 at 9:30am revealed:
-She worked primarily on the night shift which was 7:00pm to 7:00am.
-The night shift MA was responsible for weighing Resident #2 in the morning when she woke up after she had used the bathroom.
-If Resident #2's weight had increased two or more pounds from the day prior they were supposed to call the PCP office for further instruction.
-She had documented Resident #2's weight on 04/23/22, 05/06/22, and 05/15/22 when it had increased more than two pounds.
-She usually documented what Resident #2's weight was and told the day shift MA if there was a two or more-pound weight gain so that the day shift MA could call the PCP office.
-She had notified the PCP of Resident #2's weight gain one time but she could not remember when it was or if she had documented the notification.
-Usually when Resident #2's weight was up two pounds, the PCP's office asked them to administer an extra dose of furosemide to help get rid of the extra fluid from Resident #2.

Telephone interview with a second MA on 06/10/22 at 9:50am revealed:
-She had documented Resident #2's weight gain on 04/08/22.
-The night shift MA checked Resident #2's weight and if it was over a 2-pound gain from the previous day, that same night shift MA was responsible for contacting the PCP's office because they had a 24-hour nurse available.
-She could not remember if she had contacted

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the PCP's office on 04/08/22 or not, but thought that if she had, she would have documented it in the progress notes.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 10:30am revealed:
-The night shift MA was responsible for weighing Resident #2 after she woke up and had toileted.
-Whoever checked Resident #2's weight when it was up two or more pounds was responsible for contacting the PCP's office on their 24-hour telephone line.
-She had sent out an e-mail in the last month or two to all of the MAs advising them that whoever checked Resident #2's weight was the person responsible for also completing the notification to the PCP's office.

Interview with a third MA on 06/10/22 at 12:20pm revealed:
-She had documented Resident #2's weight on 04/02/22 when it had increased 3.6 pounds from the previous day.
-The night shift MA weighed Resident #2 and if the weight was over two pounds higher than it was the day before, the day shift MA was supposed to call the PCP's office to notify them.
-She thought that she had called to notify the PCP about Resident #2's weight on 04/02/22 but did not know why it was not documented.
-The MAs wrote in their staff e-mail group to each other what Resident #2's weight was and who would be the staff to notify the PCP's office.
-She was aware that the e-mail shift note was not part of the resident record.

Interview with the Administrator on 06/10/22 at 12:50pm revealed:
-She expected the MAs to follow Resident #2's weight check order as it was written on the eMAR

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which included an update to the PCP office any time the weight had increased two or more pounds.
-If the MAs did not document the PCP notification on the eMAR she expected them to document it in the progress notes which were part of the resident record.
-It was not acceptable to only complete certain documentation such as notifying the PCP in the e-mail shift note.

b. Review of Resident #2's current FL2 dated 05/04/22 revealed there was an order for metformin (an anti-diabetic medication used to help control blood sugar) 500mg twice daily.

Review of Resident #2's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 500mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation that Resident #2 refused her metformin every night at 8:00pm from 05/22/22 through 05/30/22, except for one time on 05/29/22.
-There were no notes documented on the eMAR that the primary care provider (PCP) was aware of the refusals.
-Resident #2's fingerstick blood sugar (FSBS) values ranged from 47 to 375 from 05/01/22 through 05/31/22.

Review of Resident #2's June 2022 eMAR revealed:
-There was an entry for metformin 500mg twice daily scheduled at 8:00am and 8:00pm.
-There was documentation that Resident #2 refused metformin at 8:00pm four times from 06/01/22 through 06/07/22.
-There were no notes documented on the eMAR

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that the PCP was aware of the refusals.
-Resident #2's FSBS values ranged from 50 to 226 from 06/01/22 through 06/08/22.

Review of Resident #2's progress notes revealed:
-There was a note dated 05/28/22 that Resident #2 had been refusing metformin in the evenings due to a concern about it causing her to have low blood sugar in the mornings, and that Resident #2 had blood sugars in the 40s or 50s some mornings after taking the 8:00pm metformin.
-There was no documentation that the PCP had been made aware of the metformin refusals.

Review of the facility's Medication Administration policy dated 10/27/11 revealed there was no specific information on medication refusals and when to notify the PCP.

Interview with Resident #2 on 06/09/22 at 4:00pm revealed:
-She refused to take metformin in the evening a lot because she felt it caused her to have a low blood sugar in the morning.
-She did not know if her PCP knew about her refusing the metformin prior to her appointment earlier that day when she told the PCP about her concerns.
-Her PCP wanted her to continue taking her metformin twice daily but adjusted the dosage of another one of her diabetic medications.

Telephone interview with a representative from Resident #2's PCP office on 06/10/22 at 8:50am revealed:
-They had not received any notification from the facility regarding Resident #2 refusing metformin prior to her appointment the day prior (06/09/22).
-The PCP expected to be notified of medication refusals once the medication had been refused

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three or four times in the same week.

Telephone interview with a medication aide (MA) on 06/10/22 at 9:30am revealed:
-Resident #2 had refused metformin on 05/25/22, 05/26/22, and 06/07/22.
-She was not sure if anyone had updated the PCP regarding the metformin refusals.
-She had not updated the PCP because she did not work during the day shift hours when the PCP's office was open.
-Day shift MAs were supposed to either notify the PCP about medication refusals or let the Resident Care Coordinator (RCC) know so that she could notify the PCP.
-She documented Resident #2 refusing her metformin on the eMAR and the staff electronic mail (e-mail) shift notes, so she thought the day shift staff would have seen it and notified the PCP.

Telephone interview with a second MA on 06/10/22 at 9:50am revealed:
-Resident #2 had been refusing her metformin a lot lately because it caused her blood sugar to drop too low at night.
-She documented Resident #2's metformin as refused on 05/22/22 but did not notify the PCP because when Resident #2 had appointments with the PCP they sent the eMAR with her to the appointment and she figured the PCP would see the refusals on the eMAR.
-She did not know the facility policy on when to notify the RCC or PCP about medication refusals.

Interview with the RCC on 06/10/22 at 10:30am revealed:
-She was responsible for completing audits of the eMAR but had not had the time to do any audits since she started her position as RCC in March

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D 273	Continued From page 34 2022. -She thought Resident #2's PCP was aware of her refusing her 8:00pm doses of metformin prior to the appointment she had on 06/09/22. -If the MAs did not document that they notified the PCP of Resident #2's metformin refusals, that indicated that it was not done. -The facility's policy on medication refusals was to notify the RCC via e-mail if a resident had three consecutive days of refusing the same medication. -The RCC was responsible for notifying the PCP about any medication refusals the MAs told her about. -She did not know if the facility had a written policy on medication refusals and notifying the PCP, but it was a verbal policy all MA staff were trained on upon hire to the facility. Interview with the Administrator on 06/10/22 at 12:50pm revealed: -She was not aware of Resident #2 refusing her 8:00pm doses of metformin. -The MA was responsible for notifying the RCC once a resident refused the same medication three days in a row. -The RCC was responsible for notifying the PCP about medication refusals. -She expected MAs to look back on the eMAR if a resident refused a medication to see if that medication had been refused other times that week or not so that proper follow up could be done with the resident and with the PCP. 3. Review of Resident #3's current FL2 dated 05/31/22 revealed diagnoses included cystitis (an infection in any part of the urinary system), and recurrent urinary tract infections (UTI). Review of Resident #3's physician order from	D 273		

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urgent care clinic dated 04/13/22 revealed:
-There was an order for an antibiotic medication to treat a UTI.
-There was an order to schedule a follow-up appointment with Resident #3's urologist as soon as possible due to her having multiple UTIs.

Review of Resident #3's physician order dated 04/29/22 revealed there was an order for an antibiotic due to diagnosis of UTI.

Review of Resident #3's physician order dated 05/12/22 revealed there was an order for an antibiotic due to diagnosis of UTI.

Review of Resident #3's physician order dated 06/02/22 revealed there was an order for an antibiotic due to diagnosis of UTI.

Interview with the Resident Care Coordinator (RCC) on 06/09/22 at 12:50pm revealed:
-When a resident returned from an appointment with new orders for a referral or an appointment to schedule, the RCC was responsible for faxing the order to the business office manager (BOM) to schedule.
-Resident #3's order to follow up with urology was written by an urgent care provider so she would have needed to get a urology referral order from her PCP before scheduling.
-She had faxed the order from the urgent care provider to Resident #3's PCP on 04/13/22 but had never received a response back with an order for a referral to urology.
-It would have been her responsibility to follow up with the PCP office and obtain the order, but she thought she overlooked it.

Review of Resident #3's progress notes from 04/01/22 through 06/08/22 revealed there was no

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documented attempted calls to Resident #3's primary care provider (PCP) or urologist to schedule an appointment regarding frequent UTIs.

Interview with the BOM on 06/09/22 at 2:45pm revealed:
-When a resident came back from an appointment or the hospital, the paperwork went to the RCC first.
-If there were new orders to schedule a follow-up appointment or make a referral, the RCC would either e-mail or fax her the order so that she could arrange the appointment.
-If Resident #3's order was written to follow up with a urology and not specifically stating she should be referred to one, then the RCC would have been responsible for getting a referral order from Resident #3's PCP.
-She did not receive any appointment requests for Resident #3 to see urology or she would have scheduled it.

Interview with Resident #3 on 06/10/22 at 9:15am revealed:
-She had always gotten frequent UTIs due to her diagnosis of cerebral palsy.
-She had a urologist she had seen in the past, but it had been a while (at least more than three months) since she had an appointment there.
-She could tell when she had a UTI because her main symptom was always a burning sensation with urination.
-She denied having any current symptoms as she was taking antibiotics for a UTI and she felt like they were working.
-She wanted to have an appointment to see the urologist.

Telephone interview with a representative from

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D 273	Continued From page 37 Resident #3's PCP office on 06/10/22 at 11:40am revealed: -Resident #3 last had an appointment with urology on 10/14/21. -They had not received any requests from the facility for Resident #3 to see urology due to frequent UTIs. -Resident #3 last saw her PCP on 04/07/22 and there was no notation in the office visit note that UTIs were discussed at that visit. Interview with the Administrator on 06/10/22 at 12:50pm revealed: -She was not aware that Resident #3 never saw a urologist as ordered by a provider on 04/13/22. -Referral orders or requests were supposed to be sent (via fax or e-mail) to the BOM, who was then responsible for scheduling the appointment. -The RCC was responsible for clarifying any orders or reaching out to the PCP's office for a referral if it was requested by an outside provider such as urgent care. -She expected all orders to be followed up on and implemented as requested by any provider who saw Resident #3. _____ The facility failed to ensure referrals and appointments were scheduled for a resident, who had a scheduled appointment to see a gastrointestinal (GI) specialist after hospitalizations for a GI bleed and acute blood loss anemia, missed the appointment and it was not rescheduled and was re-hospitalized with a GI bleed; and who was referred to a podiatrist for complaints of pain in her feet, toes, and toenails (#4); and a resident who experienced frequent urinary tract infections (UTI), had an order to see a urologist, and did not see a urologist putting her at risk for continued UTIs (#3); and failed to have a portable oxygen tank for a resident who had an	D 273		

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D 273	Continued From page 38 order for continuous oxygen and experienced shortness of breath when ambulating outside her room placing her at risk of exacerbation of chronic obstructive pulmonary disease (COPD) (#4); and did not contact the PCP for a resident, who had an order for daily weights when there was a weight gain of 2 or more pounds in a day so that medication adjustments could be made and who refused an anti-diabetic medication putting the resident at risk for hyperglycemia (#2). The facility's failure resulted in substantial risk for neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 10, 2022.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the food storage areas in a clean and orderly manner, and free from contamination in the walk-in refrigerator and walk-in freezer.	D 282		

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D 282	Continued From page 39 The findings are: Review of the daily kitchen cleaning schedules revealed the last daily cleaning schedule was completed on 06/06/22 and did not include cleaning of the floors and walls in the walk-in refrigerator or walk-in freezer. Review of the weekly kitchen cleaning schedules revealed the last weekly cleaning schedule was completed on 05/24/22 and did not include cleaning of the floors and walls in the walk-in refrigerator or walk-in freezer. Review of the monthly kitchen cleaning schedules revealed the last monthly cleaning schedule was completed for May 2022 and did not include cleaning of the floors and walls in the walk-in refrigerator or walk-in freezer. Observation of the walk-in refrigerator/freezer on 06/09/22 at 8:30am revealed: -The handle and area surrounding the handle on the door to access the walk-in refrigerator/freezer had a layer of brownish substance on it. -The lining of the frame of the door to access the walk-in refrigerator/freezer was covered with a brownish blackish substance throughout. -There was a brownish substance that ran from the top of the left side of the door frame to halfway down the door frame. -There was a black substance from the bottom left side of the door frame that extended a foot and a half upward. -There was a thick layer of grime along the perimeter of the refrigerator floor. -There were dark splatters on the wall to the left and behind a metal food rack. -There were large areas of dirt buildup throughout	D 282		

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D 282	Continued From page 40	D 282		

the walk-in refrigerator.
-The walk-in freezer was adjacent and accessed through the walk-in refrigerator.
-There was a layer of ice on the middle and side of the floor along the bottom of the door on the outside of the walk-in freezer.
-There were layers of ice at various places on the floor in the walk-in freezer.
-There were areas of a brown buildup throughout the floor in the walk-in freezer.
-The left corner of one of the large metal floor tiles had lifted from the floor under one of the food racks.

Interview with the Dietary Manager (DM) on 06/09/22 at 8:31am revealed:
-The refrigerator and freezer were last cleaned, and the floors mopped 5 days ago.
-The dietary staff mopped once a week, so it was due to be mopped again.
-Dietary staff spot cleaned as necessary.
-He thought the splatters on the wall and buildup on the door and door handle could be removed with scrubbing.
-He did not know why the wall, door frame, door and door handle had not been cleaned.
-Dietary staff could mop one day and the floor would get back dirty due to staff tracking dirt in from their shoes.
-He had been waiting a long time for new flooring to be approved by management for the refrigerator.
-The metal flooring had been ordered and he was waiting for it to come in.

Interview with the Administrator on 06/09/22 at 9:56am revealed:
-The floors in the walk-in refrigerator and walk-in freezer should have been swept and mopped daily.

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D 282	Continued From page 41 -The refrigerator/freezer door handles needed to be cleaned daily. -The walls in the refrigerator/freezer should have been cleaned at least twice a month or as needed. -The flooring for the walk-in refrigerator had been ordered and would be replaced when it arrived at the facility. Review of a receipt dated 06/10/22 from a local welding and metal fabrication shop revealed aluminum sheets for flooring had been ordered and paid for.	D 282		
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: Based on observation, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#2) who had orders to receive glucose gel for fingerstick blood sugar (FSBS) less than 60 and to receive a diuretic for a weight gain of two or more pounds in a 24-hour period. The findings are: Review of Resident #2's current FL2 dated	D 358		

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D 358	Continued From page 42 05/04/22 revealed diagnoses included type 2 diabetes, ischemic heart disease due to coronary artery obstruction, hypertension, and thoracic aortic aneurysm. a. Review of Resident #2's Physician Orders dated 08/12/21 revealed there was an order for Glutose 15 40% oral gel (a gel that contains 15 grams of glucose to treat episodes of low blood sugar) give for FSBS 60 of below, recheck FSBS in 15 minutes, if FSBS was still below 60 repeat until above 60. Review of Resident #2's Standing Orders dates 04/22/22 revealed there was an order to administer one tube of Glutose 15 40% gel if FSBS was less than 60, recheck FSBS in 15 minutes and repeat steps until FSBS was over 60. Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks four times daily scheduled at 7:30am, 11:30am, 5:00pm, and 8:00pm. -There was an entry for FSBS checks as needed. -There was an entry for Glutose 15 40% gel, give if FSBS was 60 or below, recheck in 15 minutes, if FSBS was still below 60 repeat until above 60. -There was documentation that FSBS was 60 or lower 6 times from 04/01/22 through 04/30/22, ranging from 49 to 60. -There were no documented administrations of Glutose gel on 04/03/22 when FSBS was 59, on 04/08/22 when FSBS was 58, on 04/20/22 when FSBS was 55, on 04/22/22 when FSBS was 51, on 04/23/22 when FSBS was 60, or 04/25/22 when FSBS was 49 and no documented FSBS re-checks.	D 358		

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D 358	Continued From page 43 Review of Resident #2's May 2022 eMAR revealed: -There was an entry for FSBS checks four times daily scheduled at 7:30am, 11:30am, 5:00pm, and 8:00pm. -There was an entry for FSBS checks as needed. -There was an entry for Glutose 15 40% gel, give if FSBS was 60 or below, recheck in 15 minutes, if FSBS was still below 60 repeat until above 60. -There was documentation that FSBS was 60 or lower 1 time on 05/09/22 and a note that Resident #2 was drinking orange juice. -There were no documented administrations of Glutose gel on 05/09/22. Review of Resident #2's June 2022 eMAR revealed: -There was an entry for FSBS checks four times daily scheduled at 7:30am, 11:30am, 5:00pm, and 8:00pm. -There was an entry for FSBS checks as needed. -There was an entry for Glutose 15 40% gel, give if FSBS was 60 or below, recheck in 15 minutes, if FSBS was still below 60 repeat until above 60. -There was documentation that FSBS was 60 or lower 2 times from 06/01/22 through 06/08/22, ranging from 50 to 58. -There were no documented administrations of Glutose gel on 06/01/22 when FSBS was 58, or on 06/04/22 when FSBS was 50 and no documented FSBS re-checks Observation of medication on hand for Resident #2 on 06/09/22 at 4:00pm revealed there were two stock-supply unopened tubes of Glutose 15 40% gel in a drawer containing Resident #2's diabetic supplies in the medication room. Review of Resident #2's Progress Notes revealed	D 358		

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there was no documentation that Glutose gel was administered, or offered and declined, on the days where her FSBS were 60 or below.

Interview with a medication aide (MA) on 06/09/22 at 10:33am revealed:
-She checked Resident #2's FSBS 04/03/22 when it was 59, and on 04/20/22 when it was 55, and on 04/25/22 when it was 49, and on 05/09/22 when it was 47.
-She did not administer Glutose 15 40% gel to Resident #2 because the resident preferred to drink her supply of orange juice rather than use the Glutose gel.
-She did not recheck Resident #2's FSBS because Resident #2 was aware of how she felt when her FSBS was low and always said she felt better after she drank orange juice.

Interview with Resident #2 on 06/09/22 at 4:00pm revealed:
-MAs checked her FSBS four times daily, and sometimes more often than that if she requested it.
-When her FSBS was low she could tell because she would become sweaty and weak.
-When her FSBS was 60 or less she did not take the Glutose gel because the MAs did not offer it to her, they would just pour her a cup of the orange juice she kept in the fridge in her bedroom.
-The MAs did not recheck her FSBS after she drank the orange juice because she did not ask them to, but she would be willing to let them recheck it if they asked.
-She would try the Glutose gel if an MA offered it to her.

Telephone interview with a representative from Resident #2's primary care provider (PCP) office

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D 358	Continued From page 45 on 06/10/22 at 8:50am revealed: -The PCP reviewed FSBS values with Resident #2 at her appointments, her last appointment was the day prior on 06/09/22. -They expected that if Resident #2's FSBS was 60 or lower the MAs would administer the Glutose gel or if she refused, to give Resident #2 the orange juice but it should be documented and the FSBS should then be rechecked to ensure it was coming back up. -Possible adverse reactions for not administering Glutose when FSBS was 60 or lower included confusion, fainting, sweating, blurred vision, nausea, vomiting or heart palpitations. Telephone interview with a MA on 06/10/22 at 9:30am revealed: -She checked Resident #2's FSBS on 04/22/22 when it was 51, and on 04/23/22 when it was 60. -Resident #2 preferred to drink juice or have candy when her FSBS was low rather than take the Glutose gel. -She worked night shift and she checked Resident #2's FSBS around 5:00am per her request and if it was low she would document it in the progress notes. -When Resident #2's FSBS was low she never rechecked it because day shift was coming in and had to check it before breakfast anyway, so she would just let the oncoming MA know if her FSBS had been low at 5:00am. -When Resident #2's FSBS was 60 or lower she would keep an eye on her, but Resident #2 was familiar with the symptoms she had when her FSBS was low and was good about letting staff know if she needed to be rechecked or if she needed orange juice. Telephone interview with a second MA on 06/10/22 at 9:50am revealed:	D 358		

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-She checked Resident #2's FSBS on 04/08/22 when it was 58, and 06/01/22 when it was 58.
-When Resident #2's FSBS was less than 60 she gave her a cup of orange juice then would recheck her FSBS two hours later.
-She rechecked the FSBS two hours later because that was when Resident #2 was due for an insulin injection and needed her FSBS rechecked anyway.
-All residents who had insulin orders also had the order for Glutose 15 40% gel as a diabetic standing order.
-She did not document when she gave Resident #2 orange juice for a low blood sugar because she would just verbally tell the next shift if Resident #2 needed it due to low FSBS.
-Resident #2 did not report symptoms of low blood sugar to her and she did not know if Resident #2 was able to tell when her FSBS was low or not.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 10:30am revealed:
-Resident #2 had Glutose gel as a standing order that all diabetic residents had.
-The MAs did not document if they offered Glutose gel to Resident #2 and she refused because the eMAR did not give them an option to document a refusal on an "as needed" order.
-The MAs should be documenting Glutose refusals and what they offered Resident #2 as an intervention instead of documenting in the Progress Notes.

Interview with a MA on 06/10/22 at 12:20pm revealed:
-She checked Resident #2's FSBS on 06/04/22 when it was 50.
-She did not offer Glutose gel because Resident #2 was about to eat lunch so she figured it would

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come back up after she ate.
-She did not document FSBS re-checks unless the FSBS did not increase with food or orange juice.
-She was not aware that Resident #2 had an order to check FSBS as needed and that she could document FSBS values there.
-She documented if Resident #2 had a low FSBS in the shift notes which were in a group e-mail thread with the other MA staff, she was aware that e-mail was not part of Resident #2's record.
-She did not think that she needed to document FSBS rechecks or interventions such as administering orange juice in the Progress Notes.

Interview with the Administrator on 06/10/22 at 12:50pm revealed:
-She expected the MAs to check Resident #2's FSBS as ordered, and if the FSBS value was 60 or lower to administer Glutose 15 40% gel to her.
-If Resident #2 refused the Glutose gel, she expected the MAs to offer orange juice or a snack and to document what the FSBS value was, and what they gave to Resident #2 in the Progress Notes.
-She expected the MAs to recheck Resident #2's FSBS after 15 minutes as the order stated, so that if it was still below 60 they could try another intervention to increase her blood sugar.

b. Review of Resident #2's physician order dated 01/24/22 revealed:
-There was an order to begin weighing daily and report a 2 plus weight gain in a 24-hour period.
-There was an order for furosemide (a diuretic used to treat fluid retention) 40mg daily.

Review of Resident #2's physician order dated 04/11/22 revealed there was an order to take furosemide 40mg daily and an extra 40mg as

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needed (PRN) for a 2 pound or more weight gain in a 24-hour period.

Review of Resident #2's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to weigh daily first thing in the morning after toileting with only pajamas on, and to call the primary care provider (PCP) if weight was greater than 2 pounds in a 24-hour period.
-There was an entry for furosemide 40mg take 1 tablet PRN for 2 pound or more weight gain in a 24-hour period.
-There was a documented weight gain of 2 or more pounds 3 times from 04/11/22 through 04/30/22.
-There was no documentation the PRN furosemide was administered 2 of those 3 opportunities on 04/23/22 when there was a weight increase of 2.9 pounds, or on 04/27/22 when there was a weight increase of 3.7 pounds.

Review of Resident #2's May 2022 eMAR revealed:
-There was an entry to weigh daily first thing in the morning after toileting with only pajamas on, and to call the PCP if weight was greater than 2 pounds in a 24-hour period.
-There was an entry for furosemide 40mg take 1 tablet PRN for 2 pound or more weight gain in a 24-hour period.
-There was a documented weight gain of 2 or more pounds 5 times from 05/01/22 through 05/31/22.
-There was no documentation the PRN furosemide was administered 4 of those 5 opportunities on 05/06/22 when there was a weight increase of 4.7 pounds, on 05/15/22 when there was a weight increase of 6.0 pounds, on

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D 358	Continued From page 49 05/18/22 when there was a weight increase of 2.2 pounds, or on 05/25/22 when there was a weight increase of 3.4 pounds. Review of Resident #2's June 2022 eMAR revealed: -There was an entry to weigh daily first thing in the morning after toileting with only pajamas on, and to call the PCP if weight was greater than 2 pounds in a 24-hour period. -There was an entry for furosemide 40mg take 1 tablet PRN for 2 pound or more weight gain in a 24-hour period. -There was a documented weight gain of 2 or more pounds 1 time on 06/02/22 when there was a weight increase of 3.2 pounds and no documentation the PRN furosemide was administered. Observation of medication on hand for Resident #2 on 06/09/22 at 4:00pm revealed there was one medication card for furosemide 40mg PRN for weight gain of 2 or more pounds in a 24-hour period, with a dispensed date of 04/28/22 and had 28 tablets out of 30 remaining. Review of Resident #2's Progress Notes revealed there was no documentation that the PRN furosemide 40mg tablet was administered on the days when Resident #2 had a 2-plus pound weight gain. Interview with a medication aide (MA) on 06/09/22 at 10:33am revealed: -She had documented Resident #2's weight on 04/27/22, 05/18/22 and 05/25/22 when the weight gain was over 2 pounds. -She did not administer the additional 40mg of PRN furosemide because she did not know that Resident #2 had that order.	D 358		

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-The PRN medications did not show up on the same screen as the weight check because the weight check was scheduled daily, and the PRN medications were under a separate tab on the eMAR.
-Resident #2 did sometimes complain about feeling short of breath, but usually it was only in the morning when she first woke up.

Interview with Resident #2 on 06/09/22 at 4:00pm revealed:
-Staff checked her weight every morning on the scale she had in her room.
-If her weight was up, she thought she received an extra dose of furosemide, but she did not always remember what her weight had been the day prior.
-She thought she had last received an extra dose of furosemide about four days prior.
-When her weight was up and she had more fluid retention, she could tell because her heart rate increased and her head would feel "fuzzy."

Telephone interview with a representative from Resident #2's PCP office on 06/10/22 at 8:50am revealed:
-They were not aware Resident #2's weight had increased by two or more pounds seven times without receiving the PRN furosemide 40mg as ordered.
-They expected the PRN furosemide to be administered as ordered because without taking it, Resident #2 could have worsening congestive heart failure (CHF) which would cause difficulty breathing, increased swelling and strain on her heart.

Telephone interview with a MA on 06/10/22 at 9:30am revealed:
-She worked primarily on the night shift which

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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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was 7:00pm to 7:00am.
-The night shift MA was responsible for weighing Resident #2 in the morning when she woke up after she had used the bathroom.
-If Resident #2's weight had increased two or more pounds from the day prior they were supposed to call the PCP office for further instruction.
-She had documented Resident #2's weight on 04/23/22, 05/06/22, and 05/15/22 when it had increased more than two pounds.
-She usually documented what Resident #2's weight was then told the day shift MA if there was a two or more-pound weight gain so that day shift could call the PCP office and verify that the extra dose of furosemide should be administered.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 10:30am revealed:
-She was not aware that Resident #2 was not receiving her PRN dose of furosemide 40mg on the days where she had a weight increase of 2 or more pounds in a 24-hour period.
-She was responsible for completing audits of the eMAR but had not had the time to do an audit since she started in her position of RCC in March 2022.
-She had called and requested the order for PRN furosemide so that when the PCP office advised them to give Resident #2 an extra furosemide due to weight gain, the MAs would not need to take the furosemide from her medication card for daily scheduled furosemide 40mg.
-The night shift MA was responsible for getting Resident #2's daily weight and documenting it.
-If the night shift MA did not administer the PRN furosemide to Resident #2 on the days where her weight had increased two or more pounds, they were responsible for documenting in the Progress Notes that the day shift MA was notified and

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D 358	Continued From page 52 agreeable to administering it. Interview with the Administrator on 06/10/22 at 12:50pm revealed: -She was not aware that Resident #2 was not receiving her PRN dose of furosemide 40mg on the days where she had a weight increase of 2 or more pounds in a 24-hour period. -She expected the MAs follow medication orders as they were written on the eMAR. -Whichever MA weighed Resident #2 and documented a weight gain of 2-plus pounds should be administering the PRN furosemide, or documenting that they did not administer it so that the day shift MA would be aware and take responsibility for administering it.	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; (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	D 367		

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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 observation, record reviews and interviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 2 of 5 sampled residents (#2 and #4) who had orders for continuous oxygen (#2 and #4).

The findings are:

1. Review of Resident #2's current FL2 dated 05/04/22 revealed:
-Diagnoses included ischemic heart disease due to coronary artery occlusion, hypertension, thoracic aortic aneurysm, type 2 diabetes and obesity.
-There was an order for 2 liters (L) of continuous oxygen.

Review of Resident #2's May and June 2022 electronic medication administration record (eMAR) revealed there was no entry for documentation of oxygen 2L.

Review of Resident #2's Progress Notes revealed there was no documentation of Resident #2 wearing oxygen.

Observation of Resident #2 on 06/08/22 at 10:00am revealed she was sitting in her wheelchair in her room wearing oxygen 2L via nasal cannula.

Observation of Resident #2 on 06/09/22 at 8:25am and 3:55pm revealed she was in her room wearing oxygen 2L via nasal cannula.

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D 367	Continued From page 54 Interview with a medication aide (MA) on 06/09/22 at 10:33am revealed: -She did not document Resident #2's oxygen because there was not a place on the eMAR to document it. -She did not document Resident #2's oxygen in the Progress Notes because she did not think that she was supposed to, or what she was expected to document. -Resident #2 sometimes complained about having shortness of breath, but it was usually only in the morning when she first woke up if her nasal cannula had not been sitting in her nose correctly. -Resident #2 had her own pulse oximeter so she did not check Resident #2's oxygen saturation unless she asked her to. Interview with Resident #2 on 06/09/22 at 4:00pm revealed: -She wore her oxygen continuously and it was always at 2L. -She had her own pulse oximeter because she liked to be able to check her oxygen saturation when she wanted to. -She did not need help from staff with her oxygen except when she needed a new portable oxygen tank. Telephone interview with a MA on 06/10/22 at 9:30am revealed: -She did not document Resident #2's oxygen because there was nowhere to document it. -She only checked Resident #2's oxygen saturation if Resident #2 complained she did not feel well or was short of breath. -She did not know if she was expected to document Resident #2's oxygen under Progress Notes because it had not come up before.	D 367		

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Telephone interview with a second MA on 06/10/22 at 9:50am revealed:
-Resident #2 wore her oxygen continuously at 2L and always asked staff for help turning her portable oxygen tank off and on whenever she used it for leaving her room.
-She did not document Resident #2's oxygen because there was no place to document it.
-She only checked Resident #2's oxygen saturation as needed because Resident #2 had her own pulse oximeter that she used.

Interview with the Resident Care Coordinator (RCC) on 06/10/22 at 10:30am revealed:
-She was not aware that Resident #2's oxygen was not on the eMAR.
-Resident #2 always had her oxygen on.
-She was responsible for completing audits of the eMAR but since starting her position as RCC in March 2022 she had not had the time to complete one yet.

Interview with the Administrator on 06/10/22 at 12:50pm revealed:
-An entry for oxygen should be on the eMAR for the MAs to document on.
-She did not know that there was no documentation of Resident #2's oxygen.

2. Review of Resident #2's current FL2 dated 05/24/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease, chronic renal failure, and deep vein thrombosis.
-There was an order for 2 liters (L) of continuous oxygen.

Review of Resident #4's electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for May

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D 367	Continued From page 56 2022 and June 2022 revealed there no entry for documentation of use of continuous oxygen 2L. Review of Resident #4's progress notes revealed there was no documentation of Resident #4 wearing oxygen. Observation of Resident #4 on 06/10/22 at 9:06am and 3:02pm revealed she was lying in bed in her room wearing oxygen 2L via nasal cannula. Interview with Resident #4 on 06/10/22 at 9:06am revealed: -She wore her oxygen at 2L all the time when she was in her room and was supposed to wear it 24/7. -She did not wear her oxygen while outside of her room because she did not have a portable oxygen tank. Interview with the RCC on 06/09/22 at 3:42pm revealed: -She was responsible for reviewing the eMARs at least weekly. -She did not know oxygen why Resident #4's oxygen was not on the eMAR for documentation. -Resident #4 wore her oxygen continuously while she was in her room. Interview with a MA on 06/09/22 at 4:12pm revealed: -Resident #4 usually wore her oxygen when she was in her room laying down. -She did not know what Resident #4's oxygen orders were and had not seen oxygen on the eMAR to document use. -The RCC was responsible for reviewing the eMARs for accuracy every month and when new residents were admitted to the facility.	D 367		

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D 367	Continued From page 57 Interview with a MA on 06/10/22 at 12:50pm revealed: -Resident #4 wore her oxygen only when she was in her room and she had never seen her wear oxygen outside of her room. -She had never seen oxygen on the eMAR. -All residents' oxygen should be on the eMAR to document when the resident used it. -The RCC was responsible for reviewing the eMARs, but she did not know how often. Interview with the Administrator on 06/10/22 at 5:23pm revealed: -She did not know oxygen was not on the eMAR to document Resident #4's oxygen use. -There should have been an entry on the eMAR for oxygen so MAs could document use. -The RCC was responsible for reviewing the eMARs for accuracy.	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	D 612		

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D 612	Continued From page 58 shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, 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 (NC DHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status, who has a positive test for COVID-19, symptoms of COVID-19, or close contact/higher risk exposure to COVID-19. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22: -NCDHHS recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. -Facilities shall continue to screen all who enter for signs and symptoms of COVID-19. Review of the facility's infection control policy dated 10/23/20 revealed:	D 612		

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D 612	Continued From page 59 -All staff were to be screened for fever greater than 100 degrees F and respiratory symptoms at the start of each shift. -A checklist was to be used to capture staff screenings temperatures, the absence of shortness of breath, new or change in cough, and sore throat. -The facility's infection prevention and control program referenced adult care home rules: 10A NCAC 13F .1801. Review of the facility's sign-in and screening logs located in the medication room revealed: -There were blank sign-in forms and blank screening forms in a notebook. -There were no completed sign-in forms or screening forms for staff. Review of the facility's staff temperature logs from the main office for the week of 05/23/22 through 05/29/22 revealed: -There were 3 facility staff who screened for temperatures on 05/23/22. -There were 3 facility staff who screened for temperatures on 05/24/22. -There were 3 facility staff who screened for temperatures on 05/25/22. -There were 2 facility staff who screened for temperatures on 05/26/22. -There were 3 facility staff who screened for temperatures on 05/27/22. -There were 2 facility staff who screened for temperatures on 05/28/22. -There was 1 facility staff who screened for temperatures on 05/29/22. Review of the facility's staff temperature logs from the main office for the week of 05/30/22 through 06/05/22 revealed: -There were 3 facility staff who screened for	D 612		

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temperatures on 05/30/22.
-There were 2 facility staff who screened for temperatures on 05/31/22.
-There were 3 facility staff who screened for temperatures on 06/01/22.
-There were 3 facility staff who screened for temperatures on 06/02/22.
-There were 3 facility staff who screened for temperatures on 06/03/22.
-There were 3 facility staff who screened for temperatures on 06/04/22.
-There was no documentation of facility staff temperatures on 06/05/22.

Observation upon entrance to the facility on 06/09/22 at 7:25am revealed:
-The main office was closed and there were no staff to complete temperature checks and COVID-19 screening.
-There was no sign on the door instructing visitors or staff where to go or how to complete the screening.

Interview with a medication aide (MA) on 06/09/22 at 8:15am revealed:
-The staff in the main office arrived daily between 8:30am and 9:00am.
-Staff were supposed to check-in and complete COVID-19 screening process in the facility.
-There were supposed to be staff check-in forms in a binder in the medication room, but she had not seen any of the forms since she came back to work on 06/07/22.
-If a resident's visitor arrived at the facility prior to the main office opening, staff were supposed to complete their screening.

Interview with the Business Office Manager (BOM) on 06/09/22 at 8:21am revealed:
-She usually arrived to work at the main office

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around 8:00am and left between 4:00pm and 4:30pm.
-If visitors arrived prior to her arrival or after she left for the day, staff screened visitors at the facility.
-Third shift staff were to screen at the facility and use the same screening form that was used at the main office.
-The sign-in log, screening form, and the thermometer were kept in the medication room.

Interview with the Resident Care Coordinator (RCC) on 06/09/22 at 8:20am revealed:
-She had been working as the RCC since March 2022 and she was not sure what the after-hours staff had been doing to complete their COVID-19 screening while the main office was closed.
-She thought the staff were supposed to complete their COVID-19 screening in the facility if the main office was closed.
-Staff were supposed to screen all visitors in the facility during the hours the main office was closed.

Second interview with the RCC on 06/09/22 at 9:00am revealed:
-First and second shift staff were supposed to go to the main office (located up the street from the facility) to sign in and screen for COVID-19.
-She did not know if or where third shift staff screened when the main office was closed because she had not seen any completed COVID-19 screening forms at the facility.
-She did not know if all first and second shift staffed screened in at the main office prior to their shifts.
-She knew all staff needed to be screened in prior to entering the facility.

Interview with a MA on 06/10/22 at 12:50pm

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revealed:
-Staff were supposed to screen with temperatures and a screening questionnaire prior to starting their shifts, but staff did not always screen.
-Staff should have screened at the main office Monday through Friday during first and second shifts and at the facility during third shift.

Interview with the Administrator on 06/09/22 at 9:56am revealed:
-She did not know there were no completed screening forms at the facility for staff.
-"Staff must just be coming into the facility without screening."
-She screened at the main office because she spent time at the main office daily before coming down to the facility.
-Staff should have been screening at the facility prior to their shift rather than at the main office.
-She did not know if any staff entered the facility from a side door, but she just informed the RCC all staff were to enter through the front door.
-She expected staff to screen for COVID-19 at the facility during first, second, and third shifts prior to entering.

2. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status, who has a positive test for COVID-19, symptoms of COVID-19, or close contact/higher risk exposure to COVID-19.

Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for

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Long-Term Care Facilities dated 02/10/22:
-NCDHHS recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.
-Facilities shall continue to screen all who enter for signs and symptoms of COVID-19.

Review of the facility's infection control policy dated 10/23/20 revealed:
-All visitors were to enter through the main door (No other door was indicated.).
-All visitors were to be screened for the presence of fever and symptoms consistent with COVID-19.
-The facility's infection prevention and control program referenced adult care home rules: 10A NCAC 13F .1801.

Observation upon entrance to the facility on 06/08/223 at 9:15am revealed:
-A staff was standing outside the facility and opened the locked, keypad door to let surveyors in the facility.
-There was a table in the foyer area with hand sanitizer on it.
-There was no visitor sign-in log, screening questions, or thermometer.
-The survey team was greeted by a medication aide (MA) and prompted the team to follow her into the facility.
-The MA did not ask the survey team if they had been screened for COVID-19.

Interview with a medication aide (MA) on 06/08/22 at 9:17am revealed visitors were to sign in and screen at the main office before coming to the facility.

Observation of the front door from the outside of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 64 the facility entrance on 06/08/22 at 9:18am revealed: -There was a sign that read "All visitors must sign in at the main office before entering the facility. -There were instructions for visitors regarding what they should do after hours, on the weekend, or if no one was in the main office. Review of the facility's sign-in and screening logs located in the medication room revealed: -There were blank sign-in forms and blank screening forms in a notebook. -There were no completed sign-in forms or screening forms for visitors. Interview with the Business Office Manager (BOM) on 06/09/22 at 8:21am revealed: -She usually arrived to work at the main office around 8:00am and left between 4:00pm and 4:30pm. -If visitors arrived prior to her arrival or after she left for the day, staff screened visitors at the facility. -The sign-in log, screening form, and the thermometer were kept in the medication room. Interview with the Resident Care Coordinator (RCC) on 06/09/22 at 9:00am revealed she knew all visitors needed to be screened in prior to entering the facility, but she did not think any visitors were screened after hours during the week or on the weekend because she could not find any screening sheets. Interview with a home health provider on 06/09/22 at 9:07am revealed: -She signed in and completed COVID-19 screening at the main office. -There was no one in the main office on the weekends or after 5:00pm.	D 612		

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D 612	Continued From page 65 -Most of the time, she was screened in by staff at the facility. with screening questions and temperature if she had to visit after 5:00pm or on the weekends. Interview with a second MA on 06/10/22 at 12:50pm revealed -Visitors should have screened at the main office Monday through Friday during first and second shifts and at the facility during third shift. -She had not screened any visitors during her shifts at the facility. Interview with the Administrator on 06/09/22 at 9:56am revealed: -She had only worked at the facility for a couple of weeks and was not aware facility staff were not screening visitors for COVID-19 when they came to the facility. -She did not agree with visitors being made to screen at the main office opposed to screening at the facility upon entering. -She did not know there were no completed screening forms at the facility for visitors. -She expected visitors to screen for COVID-19 at the facility during first, second, and third shifts prior to entering.	D 612		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D911		

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D911	Continued From page 66 failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her right to privacy related to residents seated in the dining hall having to wait longer than 30 minutes for their meals to be served. Observation of the lunch meal service on 06/08/22 between 12:00pm and 12:35pm revealed: -Residents were lined up in the hallway outside the dining hall waiting for staff to open the doors to the dining hall. -Residents were allowed into the dining hall at 12:02pm; all residents who wanted to eat the lunch meal came into the dining hall and sat down. -At 12:05pm, a personal care aides (PCAs) began serving beverages to residents. -At 12:07pm, the first plate was served by a different PCA. -At 12:29pm, a resident yelled out, "We want food." -At 12:31pm, another resident yelled out, "When are we going to get our tray. -The last resident was served at 12:33pm. -Some of the residents who had been served had eaten their meals and left the dining hall by the time the last try was served. Observation of the lunch meal service on 06/09/22 between 12:00pm and 12:40pm revealed: -Residents were lined up in the hallway outside the dining hall waiting for staff to open the doors to the dining hall. -There were 29 residents initially seated in the dining hall at 12:05pm. -The first resident received a lunch meal at 12:07pm.	D911		

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D911	Continued From page 67 -One resident received his meal at 12:34pm and another resident at his table had been served, finished his meal and left the dining hall prior to 12:34pm. -The last lunch meal was served at 12:36pm. Observation of the lunch meal service on 06/09/22 between 12:05pm and 12:50pm revealed: -Residents were lined up in the hallway outside the dining hall waiting for staff to open the doors to the dining hall. -There were 25 residents present in the dining room when the lunch meal started. -The first plate was served at 12:08pm. -At 12:26pm a resident asked for seconds and was told by a PCA "we have to finish feeding everybody else first. -At 12:26pm, there were 13 residents who had not yet been served. -At 12:48pm, the last resident who was initially seated was served. Interview with a resident on 06/10/22 at 9:06am revealed: -She had to wait a long time in the dining hall before being served her meal. -"It don't make no sense." -Sometimes other residents ate and left the dining hall before she was served her meal. Interview with 7 residents on 06/10/22 between 4:26pm and 4:56pm revealed: -One resident stated he had to sit in the dining room for 30 to 40 minutes at each meal because his table was always the last table served; there was nothing he could do about it. -Another resident stated she had to wait in line for a long time for the dining hall door to open and then she had to wait a long time to be served her	D911		

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D911	Continued From page 68	D911		

meals.
-A third resident stated she had to wait a long time to be served her meals and it made her feel anxious.
-A fourth resident stated she had to wait a long time to be served her meals and it made her mad that she had to sit that long while other residents were eating.
-A fifth resident stated the lunch meal started at 12:00pm, but she usually went to the dining hall around 12:30pm because she knew it was going to take a long time to be served; sometimes there was only one staff serving meals and beverages in the dining hall.
-A sixth resident stated she had to wait 40 minutes to be served her meals after having to wait in the hallway for the dining hall door to be opened.
-A seventh resident stated, it took a long time for staff to serve all residents in the dining hall; there had been times when she had eaten her meal and there were other residents present who had not been served.

Interview with the dietary manager on 06/09/22 at 3:21pm revealed:
-He was aware it took a long time for meals to be served to all residents.
-He was responsible for preparing and plating the meals.
-He served all residents with therapeutic diets first and chopped meats immediately prior to serving so the meats would not loose temperature.
-Both staff who assisted in the dining room on 06/09/22 were hired within the last two weeks.
-He would like to have at least one more staff to assist in the dining hall during meals.

Interview with a personal care aide (PCA) on 06/10/22 at 1:45pm revealed:

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D911	Continued From page 69 -The lunch meal service started at 12:00pm. -It usually did not take that long to serve meals to all residents. -All residents, including the residents who arrived in the dining room late, were served by 12:45pm. Interview with the Administrator on 06/10/22 at 1:19pm revealed: -She did not know residents were having to wait a long time in the dining room before receiving their meals. -She had only been at the facility a few weeks and had not observed a full meal yet. -During meals, she expected there to be 1 staff serving the meals, 1 staff preparing beverages before the residents are seated, and 1 staff observing in the dining hall for needed assistance. -She had not implemented her expectations yet.	D911		
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 reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to elevated hot water temperatures. The findings are:	D912		

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D912	Continued From page 70 Based on observations, interviews, and record reviews the facility failed to ensure hot water temperatures for 6 fixtures (sinks) used by residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. [Refer to Tag D0113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from neglect related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up to meet the health care needs for 3 of 5 sampled residents (#4, #2 and #3) related to a resident who had a referral to a gastrointestinal (GI) specialist hospital, orders for continuous oxygen and did not have a portable oxygen tank, orders to see a podiatrist, and orders to contact the primary care provider (PCP) regarding increases in weights (#4); a resident who had orders to notify the PCP for a weight gain of 2 or more pounds in 24 hours, and who had been refusing an anti-diabetic medication	D914		

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D914	Continued From page 71 (#2); and a resident who had a referral to see a urologist (#3). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	D914		