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D 000	Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted a complaint investigation and a COVID-19 Focused Infection Control survey with onsite visits on November 3, 2020 and November 10, 2020 and a desk review survey on November 4-6, 2020, November 9, 2020, November 12-13, 2020 and November 16-17, 2020. The Durham County Department of Social Services initiated the complaint on October 9, 2020.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure coordination of health care for 5 of 5 residents sampled (#2, #4, #8, #12, #13) related to failing to notify the primary care provider (PCP) for a resident with a broken hip (#2); to notify the PCP concerning a resident with discolored and long toenails who was not added to the facilty podiatrist visit list (#12); to notify the PCP and seek immediate medical evaluation for a resident with symptoms of COVID-19 who was later hospitalized, diagnosed with COVID-19 and passed away (#4); to notify the PCP of an attempted elopement by a resident with a history of eloping at other facilities (#8); and failing to notify the PCP of a fall for a resident with a history of falls with injuries including a fractured arm (#13).	D 273		

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D 273	Continued From page 1 The findings are: 1. Review of Resident #4's current FL-2 dated 03/20/20 revealed: -Diagnoses included vascular dementia, atrial fibrillation, lower back pain, anxiety, gastroesophageal reflux disease, constipation, hyperlipidemia, delirium, major depression, psychological condition, generalized weakness, and mild protein malnutrition. -The resident was intermittently disoriented. -The resident was ambulatory and required assistance with bathing and dressing. Review of Resident #4's current assessment and care plan dated 05/29/20 revealed: -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required supervision by staff for eating and transferring. -The resident required limited assistance by staff for toileting and ambulation. -The resident required extensive assistance by staff for bathing, dressing, and grooming. Review of Resident #4's incident/accident report dated 09/26/20 at 8:30pm revealed: -The resident was "very sick". -The resident was coughing, had chest pains, vomiting, and had a fever of 100.5 degrees Fahrenheit (F). -Emergency medical services (EMS) was called and the resident was taken to the hospital. Review of Resident #4's progress notes revealed no progress notes had been documented since 07/14/19. Review of Resident #4's lab results for	D 273		

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coronavirus (COVID-19) testing revealed:
-The resident was tested on 09/01/20, 09/08/20, and 09/14/20 and the results were negative each time.
-There were no other COVID-19 test results after 09/14/20.

Review of Resident #4's EMS report dated 09/26/20 revealed:
-EMS arrived on scene to the resident at 8:36pm.
-The resident was slightly pale and slightly warm to the touch and the resident reported she was not feeling well for a couple of days.
-The resident's temperature was noted to be 100.5 degrees F.
-The resident had a slightly increased respiratory rate and she reported chest pain while coughing.
-Facility staff reported the resident had been complaining of chest pain and had nausea, vomiting, and diarrhea for the "past several hours" as well as a cough for 2 days.
-EMS staff noted the resident was in atrial fibrillation (irregular, rapid heart rate).
-The resident was placed on oxygen due to increased respiratory rate and transported to the hospital.

Review of Resident #4's hospital emergency room (ER) notes and discharge summary dated 09/26/20 revealed:
-The resident was admitted to the ER on 09/26/20.
-The resident complained of cough, chest pain when coughing, nausea, vomiting, diarrhea, and was in atrial fibrillation at 130 - 150s heart rate on scene per EMS.
-The resident's oxygen saturation levels were in the low 90s and the resident was put on 2 liters of oxygen via nasal canula with levels improving.
-The resident reported over the last few days she

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had developed a cough and she had some chest pain and shortness of breath when she coughed.
-The resident also noted some diarrhea over the last few days.
-In the ER, the resident was found to be positive for coronavirus.
-The scans showed COVID-19 pneumonia in the lungs.
-The resident also had elevated white blood cells consistent with the resident's presumed leukemia.
-While on the COVID-19 unit, the resident had progressive worsening hypoxic respiratory failure and was transferred to the medical intensive care unit for further care.
-The resident passed away on 10/02/20.

Telephone interview with Resident #4's family member on 11/09/20 at 1:35pm revealed:
-Her family sometimes visited Resident #4 at the window of her room due to the COVID-19 pandemic.
-She last did a window visit with Resident #4 on 09/20/20 and the resident was not feeling well and would not get out of bed.
-The resident had been diagnosed with leukemia in August 2020 and sometimes the resident was sleepy and laid down.
-On the afternoon or evening of 09/26/20, (could not recall time) either the Resident Care Coordinator (RCC) or a medication aide (MA) called and reported Resident #4 was complaining of her chest hurting and when staff checked the resident "a little while later", the resident's balance was off and she had a low grade fever.
-She asked the staff if the resident had COVID-19 and staff said they did not know.
-The resident was sent to the hospital.
-She later received a phone call from a physician at the hospital who told her Resident #4 had tested positive for COVID-19 at the hospital.

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-The resident passed away at the hospital on 10/02/20.

Interview with a MA on 11/10/20 at 1:40pm revealed:
-Resident #4 had been diagnosed with cancer so the resident had good days and bad days meaning some days, the resident ached all over.
-The last couple of days before Resident #4 went to the hospital (09/26/20), the resident was weaker and needed more assistance from staff with getting out of bed.
-She thought she had called the primary care provider's (PCP) office and notified the medical assistant who answered the phone about the resident's weakness, but she probably did not document it.
-She did not work directly with the resident before she went to the hospital, so she was not sure about the resident's symptoms on 09/26/20.
-If a resident had symptoms of COVID-19, staff should report it to the RCC or the Administrator and then staff should call the PCP.

Telephone interview with a second MA on 11/13/20 at 4:39pm revealed:
-On 09/26/20, when she realized Resident #4 did not eat supper, she went to check on the resident and she had a temperature.
-Two personal care aides (PCAs) also reported to her the resident was having cough, chest pain, vomiting and diarrhea sometime in the latter part of second shift (could not recall when).
-On 09/26/20, Resident #4 was coughing, complaining of chest pain, and had diarrhea, so she called 911 and the Administrator.
-Resident #4 told her the day before, 09/25/20, that she had been coughing all day and her chest hurt and the resident said she told another MA about it yesterday.

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-The resident had also been vomiting on 09/25/20.
-When she asked the other MA about it, the MA said Resident #4 always complained.
-She told the other MA that the resident should have been sent to the hospital yesterday, 09/25/20.
-If a resident had a change in condition, the MA was supposed to send the resident to the hospital, especially if the resident had chest pains or fever.

Telephone interview with the RCC on 11/12/20 at 4:34pm revealed:
-She did not recall the last time she saw Resident #4 prior to the resident going to the hospital on 09/26/20.
-If the resident had a change in condition, the PCA should notify the MA and the MA should notify the PCP.
-Staff had not reported to her that Resident #4 was having any symptoms prior to going to the hospital on 09/26/20.
-The facility's PCP was at the facility almost every day and she expected staff to report symptoms to the PCP as well.

Telephone interview with the Administrator on 11/12/20 at 11:50am revealed:
-Resident #4 had leukemia so one day she would be up walking around but the next day she would not be doing well.
-She did not know how Resident #4 had symptoms at least 2 days before the resident was sent to the hospital on 09/26/20.
-If Resident #4 was having symptoms of COVID-19, staff should have discussed it with her or the RCC, notify the PCP, and they should have sent the resident to the hospital when she started experiencing those symptoms.

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-She was not working on 09/26/20 so staff should have called the RCC to report any symptoms or changes in the resident's condition as soon as the symptoms started.
-If the resident was having chest pains and nausea, the resident should have been sent out to the hospital immediately.

Telephone interview with the former Administrator on 11/12/20 at 2:15pm revealed:
-He remembered Resident #4 being sent to the hospital at the end of September 2020.
-He did not recall staff reporting that the resident was having symptoms prior to going to the hospital but staff would have reported that to the RCC or the facility's nurse (the current Administrator).
-If Resident #4 was having symptoms of COVID-19, the resident should have been sent out immediately when the symptoms started.

Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed:
-The facility's contracted PCP came to the facility 4 or 5 days per week.
-He expected staff to communicate with the PCP so the PCP could have seen Resident #4 as soon as her symptoms started.

Telephone interview with the certified medical assistant (CMA) at Resident #4's PCP office on 11/12/20 at 1:05pm revealed:
-She took calls for their office 24 hours a day and the facility could contact them anytime.
-She usually documented phone calls with the facility or the facility would send them an incident report.
-She forwarded all correspondence to the resident's PCP in their practice.
-They did not receive any phone calls or reports

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from the facility regarding any concerns with Resident #4's condition or symptoms prior to the resident being sent to the hospital on 09/26/20.
-They received an incident report dated 09/26/20 at 8:30pm indicating Resident #4 was sent to the hospital.
-They were not made aware the resident was experiencing any symptoms prior to the resident being sent to the hospital on 09/26/20.
-The PCP expected to be notified of any symptoms or change in a resident's condition.

Telephone interview with Resident #4's PCP on 11/09/20 at 4:30pm revealed:
-Resident #4 had been ill for a little while as she was seeing a hematologist because she had leukemia.
-When she saw Resident #4 at the facility, the resident would up walking in the hallway one day and in the bed sleeping the next day.
-The resident would say she did not feel well on the days she was in bed but her vital signs were always stable.

A second telephone interview with Resident #4's PCP on 11/13/20 at 1:07pm revealed:
-She was not aware Resident #4 was unable to get out of bed independently before going to the hospital on 09/26/20.
-It was not normal for the resident because the resident could usually get out of bed independently.
-She was not aware Resident #4 was having symptoms of COVID-19 a couple of days before being sent to the hospital.
-She would have expected the facility staff to notify her immediately or send the resident to the hospital for evaluation when she first presented with symptoms of chest pain, coughing, fever, nausea, vomiting, and diarrhea.

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D 273	Continued From page 8 2. Review of Resident #8's current FL-2 dated 07/02/20 revealed: -Diagnosis included dementia. -The resident was intermittently disoriented. -The resident was ambulatory. Review of Resident #8's Resident Register revealed the resident as admitted to the facility on 07/10/20. Review of Resident #8's current assessment and care plan dated 07/13/20 revealed: -The resident had wandering behavior and the resident did not think she needed to be at the facility. -The resident was receiving mental health services and was very easily redirected. -The resident was oriented and had adequate memory. -The resident was independent with toileting, ambulation, and transferring. -The resident required supervision by staff for eating and grooming. -The resident required limited assistance by staff for dressing. -The resident required extensive assistance by staff for bathing. Review of Resident #8's psychotherapy progress note dated 08/27/20 revealed: -The resident had a history of anxiety, delusions, depression, paranoia, and stress of being in a long term care facility. -The resident wanted to leave the facility to move closer to family. Review of Resident #8's psychotherapy progress note dated 09/02/20 revealed: -Symptoms noted included restlessness and	D 273		

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exit-seeking.
-The resident was frustrated and wanted to move closer to family.
-The resident reported anxiety over the coronavirus (COVID-19) outbreak at the facility.
-The resident spoke about her wish to disguise herself to sneak out of the building.

Review of Resident #8's psychotherapy progress note dated 09/09/20 revealed:
-Symptoms noted included restlessness, anxiety, and suspicious/paranoid.
-The resident continued to want leave the facility to live closer to family.
-The resident reported "feeling trapped" in long-term care.

Review of Resident #8's psychotherapy progress note dated 09/23/20 revealed:
-Symptoms noted included guilt/uselessness and worry.
-Staff reported the resident was threatening to leave the facility.
-The resident originally reported wanting to the leave the facility this morning but was feeling calmer and was willing to stay now.

Review of Resident #8's psychiatry progress note dated 10/08/20 revealed:
-The resident had Parkinson's disease, dementia, psychosis, mood disorder, and anxiety.
-Staff stated the resident had labile mood (mood swings) and recently tried to remove her window and escape (no date or time documented).
-The psychiatrist increased the resident's antipsychotic medication dosage.

Review of Resident #8's primary care provider (PCP) visit note dated 10/08/20 revealed:
-The resident was seen due to being COVID-19

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positive but was currently asymptomatic.
-Staff denied any acute concerns.
-The section to note psychiatric concerns had no documentation regarding the resident trying to remove her window and escaping.

Interview with a medication aide (MA) on 11/10/20 at 4:23pm revealed:
-Resident #8 was residing on 200 hall when she got out of the window (could not recall date).
-Someone told her Resident #8 had gotten out of the facility so she went outside to help.
-When she got outside, she saw Resident #8 and some staff standing outside by the resident's window.
-It occurred on second shift but she could not recall when or how long ago it had been.
-She was not working on 200 hall that day so she did not know if anyone reported the incident to the resident's PCP or if an incident report was completed.

Interview with a second MA on 11/10/20 at 5:20pm revealed:
-A couple of months ago (not sure of date), Resident #8 said she wanted to get off the hall because her roommate had tested positive for COVID-19 and Resident #8 was afraid she would get COVID-19.
-Staff took the resident outside and let her call her family because that usually helped when the resident was upset.
-The personal care aide (PCA) heard a lot of noise from Resident #8's room (could not recall time or date) and the PCA went in the room and saw Resident #8 with one leg out of the window.
-The PCA notified her since she was the MA on duty.
-The resident had one leg out of the window but the window was not broken.

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-She let the resident talk to the Administrator.
-She did not know if the PCP was notified of the incident.

Telephone interview with a third MA on 11/13/20 at 4:39pm revealed:
-She was working as a supervisor on the day when Resident #8 attempted to get out of the window.
-She thought it occurred in September 2020 but she could not recall the date.
-The MA working on the 400 hall saw Resident #8 coming out of the window on the 200 hall.
-The MA on the 400 hall came running to let her know about it.
-They ran down to the resident's room and the resident had one leg out of the window.
-She told the resident to come back inside the facility and the resident complied.
-The window was not broken but the screen had been kicked out.
-She reported it to the former Administrator and the current Administrator because she was the supervisor on duty.
-The MA on 200 hall would have been responsible for completing an incident report so she did not know if one was done.
-The resident was upset because her roommate had COVID-19 and the resident was negative for COVID-19.
-She did not contact the PCP or MHP because the Administrator would have handled that.

Attempted telephone interview on 11/13/20 at 11:59am with the PCA who heard the noise and saw Resident #8 with one leg out of the window was not successful.

Telephone interview with the Resident Care Coordinator (RCC) on 11/12/20 at 4:34pm

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revealed:
-She thought Resident #8 tried to bust out a window; she was not aware the resident tried to get out of the window.
-Staff on second shift had reported the incident to her.
-She knew it was reported to the mental health provider (MHP) and she was "pretty sure" it was reported to the residents' PCP but she could not locate the incident report.
-She expected staff to write an incident report and notify the PCP immediately, in addition to the MHP.

Telephone interview with the Administrator on 11/12/20 at 11:50am revealed:
-Resident #8 was trying to force the window open in her room but she never eloped.
-She could not recall when the incident happened and she could not locate an incident report.
-She thought it occurred on a Sunday and staff called and told her about it.
-The resident tried to get out because the resident "feels like she's in prison".
-The resident had a history of eloping at her previous facility.
-The mental health therapist and the psychiatrist usually came to the facility on Wednesdays and she kept in close contact with the psychiatrist and she notified him when he came on-site unless it was a critical need and she would notify him immediately.
-The MHPs would have been notified of Resident #4's attempt to elope when they came for their on-site visits.
-When asked if the the resident's attempt to elope was a critical need she replied that she could not answer that and would have to check on it.
-She did not remember the specific details of the incident and she did not know if the PCP was

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notified.
-All incidents were supposed to be reported to the PCP in addition to the MHP within 24 hours.
-She could not locate an incident report for Resident #4's attempted elopement.

Telephone interview with the former Administrator on 11/12/20 at 2:15pm revealed:
-He thought the incident involving Resident #8 trying to get out of a window was reported to him during a stand-up meeting.
-He did not have a date of the incident and he could not find the incident report.
-The resident was living on the 200 hall when it happened and he thought it occurred around the first of October 2020.
-The resident had mentioned wanting to go where her family was located but he was not aware of the resident trying to leave prior to this incident.
-The incident should have been reported to the resident's PCP in addition to the MHP but he did not know if that was done.

Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed:
-If a resident attempted to get out of the facility, staff should notify the PCP and MHP to see if anything could be done to alleviate the underlying factor.
-Primarily, the MA would be responsible for notifying the RCC and the RCC would follow-up.
-He was not sure if an incident report was done for Resident #8 or what the former RCC did regarding the incident.

Telephone interview with Resident #8's psychiatrist on 11/13/20 at 8:16am revealed:
-He usually went to the facility for on-site visits every Wednesday and most Thursdays.
-He was notified during his on-site visit to the

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facility on 10/08/20 that Resident #8 had tried to remove a window and escape.
-It sounded like the incident had occurred the week before his visit on 10/08/20.
-If the resident had further issues or had gotten aggressive, staff could have paged him when the incident occurred.
-The Administrator also had his cell phone number and could contact him if needed.
-He would let the Administrator know that it was okay for staff to page him.

Telephone interview with Resident #8's mental health therapist on 11/13/20 at 10:52am revealed:
-When she went to the facility for weekly visits, staff usually updated her about the residents.
-Staff reported to her on her 10/14/20 visit to the facility that Resident #8 got one leg out of the window (did not know the date).
-Staff reported they told the resident to come back in and the resident did.
-The resident told her that the resident had unscrewed the bolt on the window and the resident's plan was to hide in the woods and hitchhike home.
-The resident was unhappy being at the facility and two hours away from her family.
-She felt like if it was an acute issue like agitation and needing medications, the facility would have reached out to they psychiatrist at the time of the incident.

Telephone interview with the certified medical assistant (CMA) at Resident #8's PCP office on 11/12/20 at 1:05pm revealed:
-She took calls for their office 24 hours a day and the facility could contact them anytime.
-She usually documented phone calls with the facility or the facility would send them an incident report.

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-She forwarded all correspondences to the resident's PCP in their practice.
-They did not receive any phone calls or incident reports from the facility regarding Resident #8 attempting to elope from the facility.
-The PCP expected to be notified of any incidents regarding a resident, no matter the issue.

Telephone interview with Resident #8's PCP on 11/09/20 at 4:30pm revealed:
-The facility had not reported any exit-seeking behaviors for Resident #8 and she was at the facility multiple days each week.
-She was not aware Resident #8 had attempted to open a window and tried to escape from the facility.
-She expected the facility to notify her so she could coordinate care with the MHP if needed.

3. Review of the facility's fall risk policy and procedures revealed:
-There was no date documented on the policy.
-When a fall occurs, the medication aide on that hall will notify the responsible party and the primary care provider.
-An incident report will be completed and turned into the Resident Care Coordinator (RCC).

Review of the facility's 72-hour monitoring policy revealed:
-There was no date on the policy.
-In the case of a resident that needs additional short-term monitoring, they may be placed under a 72-hour monitoring period.
-During this time, the medication technician on each shift will monitor and document on a resident and their condition or behaviors.
-Residents may additionally be placed on 72-hour monitoring for an incident/accident at the discretion of the Administrator or RCC.

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-Upon completion of the last monitoring period, the form will be filed in a binder in the RCC's office.

Review of Resident #2's current FL-2 dated 01/16/20 revealed:
-Diagnoses included Alzheimer's dementia, glaucoma, irritable bowel syndrome, anxiety and depression.
-The resident was semi-ambulatory with a walker.

Review of Resident #2's assessment and care plan dated 10/29/19 revealed:
-The resident was ambulatory with a walker and required limited assistance for ambulation.
-The resident was always disoriented, had significant memory loss, and must be directed.

Review of an incident report dated 09/27/20 for Resident #2 revealed:
-The time of incident was 6:00pm.
-The resident was observed resident on the floor.
-There was no visible injury.
-The RCC was notified option was circled yes.
-The Primary Care Provider (PCP) was notified.

Interview with a second shift medication aide (MA) on 11/9/20 at 2:42pm revealed:
-The MA normally worked the hall Resident #2 resided.
-Resident #2 had a fall, around supper time on 09/27/20.
-The MA was walking beside Resident #2 to the dining area, when Resident #2's leg "lost mobility."
-The MA caught Resident #2, broke the fall before she hit the floor.
-The MA laid the resident down on the floor.
-Resident #2 said she got dizzy.
-The former Administrator came down the hall

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and helped her with Resident #2.
-The former Administrator picked Resident #2 up off the floor and placed her in a regular chair
-The MA had gotten her up from the regular chair, and walked Resident #2 to her room.
-The MA and former Administrator checked her for possible injuries and performed a full range of motion on Resident #2, but did not note any injuries.
-The MA did not recall reporting off to the oncoming shift MA.
-The MA did not recall notifying Resident #2's family.
-The MA did not recall notifying Resident #2's PCP.

Review of second incident report dated 09/28/20 for Resident #2 revealed:
-The time of incident was 7:00am.
-Resident #2 complained of pain and discomfort.
-Resident #2 was taken to the hospital.
-The RCC was notified option was circled yes.
-The PCP was notified option was circled yes.

Review of an emergency medical service (EMS) for Resident #2 report dated 09/28/20 at 7:36am revealed:
-EMS arrived at the facility, and observed Resident #2 lying in bed.
-The facility staff reported Resident #2 was in respiratory distress, but EMS did not observe Resident #2 to be respiratory distress.
-The facility staff were finishing dressing Resident #2.
-Resident #2's left leg was shortened and internally rotated.
-No staff knew of a recent fall for the resident.
-Staff reported that the resident was "weak" the previous day when she was up walking with staff.

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D 273	Continued From page 18 Telephone interview with EMS staff on 11/12/20 at 11:20am revealed: -She responded to a call to the facility on 09/28/20 for Resident #2. -Resident #2 was lying in bed with her left foot rotated out and lying flat on the bed. -Resident #2's left leg was noticeably shorter than the right leg. -Staff told them that they had tried to get Resident #2 out of bed on 09/28/20. -Staff told EMS staff Resident #2 may have fallen the night or day before, on 09/27/20. -Staff told her Resident #2 was "really weak" when they tried to walk with her the day before. -Staff reported the resident was in pain but was not clear on the location. -Resident #2 groaned loudly and reached for her hands when EMS attempted a physical assessment. Telephone interview with another emergency medical technician (EMT) on 11/12/20 at 1:02pm revealed: -She recalled being on the emergency call for Resident #2 on 09/28/20. -Facility staff expressed Resident #2 was in respiratory distressed. -She went into Resident #2's room. -She observed Resident #2 laid flat on her back and a facility staff attempted to put shoes on her feet. -Resident #2 moaned deeply and pushed the EMT's hands away when her left hip was touched. -She recalled Resident #2's her left leg was shortened and internally rotated. -She asked facility staff to return to Resident #2's room. -She showed the facility staff Resident #2's left leg.	D 273		

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-It was the worst internally rotated legs they had observed.

Review of Resident #2's progress notes revealed there was no documentation that the PCP had been notified of Resident #2's fall on 09/27/20 or being sent to the hospital on 9/28/20.

Telephone interview with Resident #2's Responsible Person (RP) on 11/05/20 at 2:20pm revealed:
-She was called on 09/28/20 midmorning by a local hospital anesthesiologist who requested consent for surgery to repair Resident #2's severe left hip fracture.
-She was unaware that Resident #2 had fallen and been hospitalized.
-The hospital anesthesiologist apologized for RP's daughter not knowing of Resident #2's fall, hospitalization and need for surgery.
-She was called on 09/28/20 around 1:00pm by a facility staff informing her that Resident #2 had a fall and was sent out to the local hospital for further observation.
-The staff member proceeded to inform her he went into Resident #2's room and checked on her around 7:00am when he came on shift.
-The staff knew something was wrong, because the resident told the staff "help me, help me."
-The staff knew that was out of character for Resident #2; she was normally quiet, reserved and pleasant.
-The staff checked her vitals, called 911 and Resident #2 was taken to the local hospital.
-She called to the facility on 10/07/20 around 1:00pm to speak with the former Administrator.
-She asked the former Administrator about the events that led up to Resident #2's fall.
-He was aware of Resident #2's fall.
-He was the one who assisted Resident #2 and

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heard her when she fell.
-He came down the hall and saw Resident #2 on the floor.
-He picked Resident #2 up off the floor, placed her in a regular chair, and performed a full range of motion assessment on Resident #2.
-He left Resident #2 with another staff member at the facility.
-She asked the former Administrator was he qualified to complete a full range of motion assessment on Resident #2 after her fall.
-The former Administrator gave no response to the RP.
-She asked the former Administrator, why they did not get help for Resident #2 when, they knew she had fell.
-She was disappointed in the facility staff for not obtaining assistance for nearly 13 hours for Resident #2.
-No staff ever communicated to the RP that Resident #2 had a fall on 09/27/20, experienced any type of discomfort or pain, or was sent to the local hospital.
-She was informed by the orthopedic surgeon Resident #2's fracture was so severe that a metal rod was placed from her left hip to right above her knee.
-She was told by the hospital medical team that Resident #2's prognosis did not look promising.

Confidential interview with a staff member revealed:
-Staff went into Resident's #2 room a little after 7:00am, while doing rounds.
-Staff realized right away something was wrong with Resident #2.
-Resident #2 asked for help.
-Resident #2 was in severe pain and distress.
-Resident #2's vital signs were checked, and Resident #2 was lying flat on her back in the bed.

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D 273	Continued From page 21 -Staff informed the RCC and called 911. -The paramedics came to the facility, assessed Resident #2, and asked staff to return to Resident #2's room. -Resident #2's leg was turned inward, as if she was "pigeon toed." -Resident #2's left big toe was turned to a 3:00-4:00 O'clock position. -The third shift Supervisor did not report anything about Resident #2 having a fall during the shift. -On 09/28/20, the shift report from third shift to first shift did not occur. -There was no 72-hour acute monitoring report completed on Resident #2 after her fall on 09/27/20. -When a resident had an incident, they would notify the Nurse Practitioner (NP), RCC and the Administrator. -Staff would tell them verbally, when passing by them throughout the facility, or slide a note under their door if after hours, or the weekend. -He recalled he completed an incident/accident report for Resident #2. Confidential interview with a second staff revealed: -Resident #2 was quiet and slept throughout the night. -Staff remembered being assigned to Resident #2 on 09/27/20. -Staff went into Resident #2's room around 11:00pm to check on her. -Resident #2 slid from the bed to the floor and put Resident #2 back to bed. -The staff got Resident #2 up from the floor. - "Clearly she was hurt, because she could not stand up." -Resident #2's right leg looked like it was "out of the socket." -Staff felt like Resident #2 was in pain because of	D 273		

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the way Resident #2's leg looked.
-Staff told the 3rd shift MA at 12:00am.
-Staff did not recall if the 3rd shift MA went into Resident #2's room to check on her.
-Staff did not recall hearing from second shift staff that Resident #2 fell earlier that day.
-Staff recalled not having any urgency in what was observed and when the 3rd shift MA was told.
-Staff checked on Resident #2 at 1:00am, 3:00am, and 5:00am, and Resident #2 was asleep.
-Staff went into Resident #2's room around 5:30am and put her pants on for the day.
-Staff rotated Resident #2's hips in a left to right motion while she pulled her pants up.
-Resident #2 looked fine.

Interview with the 3rd shift MA on 11/17/20 at 9:22am revealed:
-Resident #2 slept throughout the night on third shift, and needed assistance with all activities of daily living.
-She did not recall Resident #2 having a fall, experiencing any pain or discomfort on 3rd shift.
-She did not recall any 2nd shift staff reporting any incident for Resident #2.
-She did not recall any 3rd shift staff reporting to her any incident or concerns for Resident #2.
-She could not remember completing documentation on the 72-hour acute monitoring report for Resident #2 on 09/27/20.
-The MA could not recall contacting or speaking with the PCP on 3rd shift.
-The former Administrator called her around the week of 11/3/20 questioning her about Resident #2 and if Resident #2 had a fall on third shift and she did not recall a fall.

Interview with the Primary Care Provider's

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Business Office Manager on 11/13/20 at 2:14pm revealed:
-She was the point of contact for the facility and normally had daily communication with the facility's Administrator, RCC and MAs.
-The facility normally communicated notifications of incidents, or other urgent matters through phone calls, voice messages left on the PCP's answering service, or via fax.
-There were no notifications to the PCP regarding Resident #2 on 09/27/20 or 9/28/20.
-The facility faxed over two incident reports for Resident #2 on 10/01/20.

Interview with Resident #2's PCP on 11/12/20 at 4:37pm revealed:
-Staff did not notify her of Resident #2's fall on 9/27/20 or 9/28/20.
-The PCP was told by a staff about Resident #2's falls while doing rounds at the facility 4 to 7 days after the 09/27/20 and 09/28/20 incidents with Resident #2.
-The protocol was for staff to call Primary Care Provider Business Office Manager or leave a message on her answering services.
-Her expectations were that the staff would call, notify her about residents falls and hospitalizations.

Interview with the RCC on 11/17/20 at 5:08pm revealed:
-She recalled Resident #2 but was not familiar with the fall that occurred.
-She expected the staff to follow the facility's fall risk and 72-hour monitoring policies when an incident occurred with a resident.
-She expected the MA's to notify the PCP and document in the resident record on progress notes.
-She was not aware that the PCP was not

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notified.

Interview with the facility's BOM on 11/17/20 at 12:07pm revealed:
-He was aware of Resident #2 had a fall around 09/27/20.
-He was informed by the 2nd shift MA, that Resident #2 had a fall, on 10/17/20.
-He was told by the former Administrator that he assisted the 2nd shift MA, by picking Resident #2 up off the floor.
-He was aware that the former Administrator performed a range of motion assessment on Resident #2.
-He was not aware the 2nd shift MA did not notify the PCP.
-He was not aware that the PCP was notified by a staff while doing rounds at the facility 4 to 7 days after the 09/27/20 fall and 09/28/20 hospitalization for Resident #2.

Attempted telephone interviews with the former RCC on 11/12/20 at 3:47pm and 11/13/20 at 2:00pm were unsuccessful.

Attempted telephone interviews with the former Administrator on 11/13/20 at 11:11 am and 4:47 pm were unsuccessful.

4. Review of Resident #12's current FL-2 dated 03/26/20 revealed diagnoses included dementia, fracture right femur, muscle weakness and dysphagia.

Review of Resident #12's assessment and care plan dated 10/21/20 revealed:
-The resident was ambulatory with a walker and required limited assistance for ambulation.
-The resident was always disoriented, had significant memory loss, and must be directed.

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D 273	Continued From page 25 Observation of Resident #12's feet on 11/10/20 at 3:40pm revealed: -All her toenails were yellow, thick, brittle and ragged nails. -There was a brownish, flaky build up of dead skin particles in between Resident #12's toes. -Her right big toenail was brown, blackish in color, thickened, and brittle. Telephone interview with Resident #12's responsible person (RP) on 11/08/20 at 3:24pm revealed: -She spoke with the Administrator around the week of 10/18/20 and expressed concern to make sure Resident #12 was getting her toenail care. -The Administrator promised her she would check and cut Resident #12's toenails personally. -She went to the facility on 11/03/20 to follow up with the Administrator. -She was told Resident #12's toenails were trimmed by the Administrator. -She was upset and expressed concern regarding Resident #12's toenail care was not completed as promised. -She showed the Administrator a picture of Resident #12's feet exhibiting the long yellowish thickened, and brittle toenails. -The Administrator acknowledged she promised the RP that she would personally check and cut Resident #12's toenails the week of 10/18/20. -The Administrator acknowledged she forgot to perform the task the week of 10/18/20. -The Administrator completed the task on 11/03/20. Interview with second shift medication aide (MA)on 11/10/20 at 4:02pm revealed: -The MA normally worked the hall Resident #12	D 273		

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resided.
-Resident #12 refused personal care frequently.

Confidential interview with a staff member revealed:
-Resident #12's toenails needed to be trimmed.
-Her toenails were long, thick and yellowish in color.

Interview with the Primary Care Provider's Business Office Manager (BOM) on 11/13/20 at 2:14pm revealed:
-She was the point of contact for the facility.
-She normally had daily communication with the facility Administrator, Resident Care Coordinator (RCC) and MAs on the halls.
-The facility normally communicated notifications of incidents or other urgent matters through phone calls, voice messages left on the Primary Care Provider's (PCP) answering service, or via fax.
-There were no notifications to the PCP regarding Resident #12 on 11/03/20 for podiatry referral.
-The PCP last saw Resident #12 on 11/09/20.

Interview with the facility's Podiatrist on 11/12/20 at 1:26pm revealed:
-They come out to the facility every 9-11 weeks.
-The last 3 visits to the facility were 07/13/20, 07/28/20 and 08/25/20 to the facility.
-Resident #12 was not seen by the Podiatrist.
-She did not see Resident #12 in their data base.
-No facility staff had contacted the Podiatrist to add Resident #12 for any scheduled clinics.

Interview with the PCP on 11/12/20 at 4:37pm revealed:
-No staff had notified the PCP of Resident #12's need for a podiatry consult.
-The PCP assessed Resident #12 on 11/09/20.

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-Her toenails were extremely long.
-The PCP saw onychomycosis (a nail fungus causing thickened, brittle, crumbly, or ragged nails) on all her toes and needed a podiatry referral.
-The protocol was for staff to call Primary Care Provider's BOM or leave a message on her answering services.
-Her expectations were that the staff would call, notify her and follow her orders.

Review of the PCP progress notes for Resident #12 dated 11/09/20 revealed:
-Resident #12 had some slight dry skin on her legs.
-Resident #12 had onychomycosis and needed a podiatry referral.

Review of Resident #12's progress notes revealed only two entries dated 04/04/19 and 05/26/19 revealed no documentation that the PCP had been notified of Resident #12's need for podiatry consult.

Interview with the RCC on 11/10/20 at 4:45pm revealed:
-She recalled Resident #12 and the RP came to the facility regarding toenail care concerns.
-She had not received any verbal notifications or notes slid under her door from staff regarding Resident #12 refusing toenail care.
-She was not aware that Resident #12's toenails had onychomycosis and needed a podiatry referral.
-She was not aware that 31 staff entries were documented on Resident #12's Activities Daily Living log from 10/1/20 through 11/10/20 that bathing: skin care (including face, hand and feet) were completed.
-She expected the MAs to notify the PCP and

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document the notification in the resident's record on the progress notes.

Interview with the Administrator on 11/13/20 at 4:46pm revealed:
-The Administrator spoke with the RP around the week of 10/18/20.
-The Administrator promised Resident #12's RP she would check and cut Resident #12's toenails .
-Resident #12's RP came to the facility on 11/03/20.
-Resident #12's RP was upset and expressed concern regarding Resident #12's toenail care.
-The Administrator acknowledged she promised the RP that she would personally check and cut Resident #12's toenails the week of 10/18/20.
-The Administrator forgot to perform the task the week of 10/18/20.
-The Administrator completed the task on 11/03/20.
-The Administrator apologized to Resident #12's RP for not cutting Resident #12's toenails as promised.
-The Administrator told the RCC on 11/03/20 to place Resident #12 on the facility podiatry list for the next scheduled visit for 11/19/20.
-The Administrator made a second request to the RCC on 11/13/20 to add Resident #12 to the facility podiatry list.
-The Administrator was not aware the RCC did not add Resident #12 to the facility podiatry list next scheduled clinic for 11/19/20.
-The Administrator was not aware that Resident 12's PCP assessed her on 11/09/20.
- Resident #12 needed a podiatry referral.

Interview with the facility's BOM on 11/17/20 at 12:33pm revealed:
-He was somewhat familiar with Resident #12

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and toenail care concerns.
-He was aware Resident #12's RP had a discussion with the Administrator regarding toenail care.
-He was not aware that Resident #12's PCP assessed her on 11/09/20.
-He was not aware Resident #12 had onychomycosis and needed a podiatry referral.
-He was not aware that staff did not notify the PCP or add Resident #12 to the facility podiatry list for the next scheduled visit for 11/19/20.

5. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, glaucoma, depression, arthritis, hypothyroidism, insomnia and restless leg syndrome.

Observation of the 100 Hall on 11/10/20 at 2:30pm revealed:
-Housekeeping staff alerted a personal care aide (PCA) that Resident #13 was on the floor.
-Resident #13 was observed on his knees beside his bed with his elbows and forearms resting on the bed wearing a shirt and an adult incontinent brief.
-Resident #13 had a cast on his left arm.
-Two PCAs assisted Resident #13 up and back into bed.
-A fall mat was placed on the floor beside the resident's bed.
-The medication aide (MA) assigned to 100 Hall was not on the 100 Hall at the time of the incident.
-There was no notification made to the MA assigned to the 100 Hall by the PCAs.
-The PCAs left the 100 Hall when their shift ended at 3:00pm and the MA had not returned to the 100 Hall at that time.

Interview with a PCA assigned to the 100 Hall on

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D 273	Continued From page 30 11/10/20 at 2:35pm revealed: -She had responded and assisted Resident #13 back to bed when alerted by housekeeping that the resident was on the floor. -She was not aware of any previous falls for Resident #13. -When asked if the resident was injured, the PCA stated the resident was "okay". Interview with the MA assigned to the 100 Hall on 11/10/20 at 3:05pm revealed: -All the PCAs assigned to the 100 Hall on first shift had left for the day. -She had not received a report regarding Resident #13 falling or being found on the floor by either PCA. -PCAs were supposed to report falls and other incidences to the MA immediately. Interview with the current Administrator on 11/10/20 at 3:20pm revealed: -She expected the PCAs to report incidents to the MA on duty when the incident occurred. -The MA on duty notified her of Resident #13 being found on the floor after the MA was notified by a surveyor. -Resident #13 has a history of frequent falls, most recently on 10/19/20, resulting in a fracture. _____ The facility failed to notify the PCP for Resident #2, who had a broken hip and was exhibiting symptoms of pain and a leg deformity and later required surgery to repair the hip and to notify Resident #4's PCP and to seek immediate medical attention when the resident exhibited symptoms of COVID-19, was later hospitalized, diagnosed with COVID-19 and passed away. The facility's failure resulted in serious physical harm, serious injury and serious neglect which constitutes a Type A1 Violation.	D 273		

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D 273	Continued From page 31 The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/10/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2020.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to cohort staff and residents, quarantine staff as indicated by the local health department (LHD) once they tested positive for COVID-19; and failed to provide residents on two hallways with over the bed tables for in-room meal service after stopping communal dining, as recommended by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), and directives from the LHD. The findings are: Review of the local health department (LHD) COVID-19 Death Reporting documentation for the facility revealed: -There was a resident who tested positive for	D 338		

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COVID-19 on 09/26/20, hospitalized on 09/26/20 and died at the hospital on 10/02/20 with cause of death of COVID-19.
-There was another resident who tested positive on 08/24/20, hospitalized on 10/07/20, and died on 10/20/20 at the hospital with cause of death of COVID-19.
-There were two residents who died on 10/23/20 at the facility with cause of death of COVID-19.
-There was a fifth resident who tested positive for COVID-19 on 10/05/20, hospitalized from 10/07/20 to 10/14/20, and died on 10/29/20 at a skilled nursing facility with cause of death of COVID-19.

Review of the facility's resident COVID-19 tracing spreadsheet revealed:
-In the month of September 2020, there was an average census of 120.
-In the month of September 2020, 22 residents tested positive for COVID-19 and 1 resident tested inconclusive for COVID-19.
-The final day of quarantine for residents who tested positive in September 2020 was 10/16/20.

Review of the LHD COVID-19 task force resident spreadsheet revealed:
-16 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the 100-hall.
-3 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the 200-hall.
-2 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the 300-hall.
-1 of the 22 residents who tested positive for COVID-19 in September 2020 resided on the 400-hall.

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D 338	Continued From page 33 Review of the facility's resident COVID-19 tracing spreadsheet revealed: -In the month of October 2020, there was an average census of 112. -During the month of October 2020, 91 residents tested positive for COVID-19 and 3 residents tested inconclusive for COVID-19. -The final day of quarantine for residents who tested positive for COVID-19 in October 2020 was 11/06/20. Review of the LHD COVID-19 task force resident spreadsheet revealed: -12 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 100-hall. -26 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 200-hall. -25 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 300-hall. -28 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 400-hall. 1. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the COVID-19 in long term care (LTC) facilities dated 04/30/20 revealed: -Facilities could continue admitting residents but needed to ensure new residents were quarantined away from other residents for 14 days depending on the prevalence of COVID-19 in the community. -The facility should consider testing new admissions at the end of the quarantine. -Facilities should cohort residents according to COVID-19 test results, and exposure to COVID-19.	D 338		

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-Facilities should assign specific staff to work with residents who tested positive for COVID-19 and residents who tested negative.
-Facilities should consider halting admissions until the extent of the transmission could be clarified and interventions implemented.

Review of NC DHHS guidance on visitation, communal dining, and indoor activities for larger residential settings dated 10/16/20 revealed one of the core principles of infection prevention was effective cohorting of residents.

Review of the NC DHHS guidance on What to Expect: Response to New COVID-19 Cases or Outbreaks in LTC settings dated 09/04/20 revealed the LHD would guide facilities on placement of residents within the facility, and cohorting of staff and residents.

Review of the facility list of admissions for September 2020 revealed there were three residents admitted during the month of September 2020.

Review of the facility list of admissions for October 2020 revealed there were three residents admitted during the month of October 2020.

Review of the timeline documentation from the LHD COVID-19 task force revealed:
-There was a COVID-19 outbreak within the facility on 08/25/20 with two residents who tested positive for COVID-19.
-Two LHD COVID-19 task force leads conducted an onsite visit on 09/29/20 at 10:00 am to offer guidance on residents cohorting based on the CDC guidelines to reduce the risk of transmission.
-The facility had 14 new positive COVID-19 cases

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among the residents on 09/30/20.
-There were 91 residents who tested positive for COVID-19 between 10/04/20 and 10/27/20.

a. Review of Resident #9's Resident Register revealed she was admitted on 09/11/20.

Review of Resident #9's Primary Care Provider (PCP) notes revealed:
-On 10/01/20 Resident #9 was exposed to COVID-19 and would be monitored for symptoms.
-On 10/08/20 Resident #9 was on quarantine for close exposure to a resident who tested positive for COVID-19.
-On 10/19/20 Resident #9 was tested weekly for COVID-19.

Review of the facility resident room roster revealed Resident #9 had a roommate who tested positive for COVID-19 on 10/05/20 and resided on the 200-hall.

Review of the documentation from the LHD COVID-19 task force revealed Resident #9 tested positive for COVID-19 on 10/19/20.

Telephone interview with Resident #9's family member on 11/12/20 at 1:21pm revealed:
-She was told by the former Administrator that Resident #9 was in a room alone since admission.
-She was not told the room number, but Resident #9 liked to keep to herself.
-She was told by the former Administrator that the facility had a few residents who tested positive for COVID-19.

Refer to telephone interview with one of the LHD COVID-19 task force leads on 11/04/20 at

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D 338	Continued From page 36 9:56am. Refer to telephone interviews with another LHD COVID-19 task force lead on 11/09/20 at 11:53am and 1:05pm. Refer to telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am. Refer to telephone interview with a personal care aide (PCA) on 11/06/20 at 3:02pm. Refer to telephone interview with a medication aide (MA) on 11/16/20 at 3:26pm. Refer to confidential interview with a staff. Refer to telephone interview with the PCP on 11/09/20 at 4:31pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/10/20 at 4:23pm. Refer to interview with the RCC on 11/10/20 at 5:00pm. Refer to telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to telephone interview with the BOM on 11/12/20 at 4:41pm. b. Review of Resident #10's Resident Register revealed he was admitted on 09/30/20.	D 338		

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D 338	Continued From page 37 Review of the COVID-19 laboratory reports from 10/22/20 to 11/03/20 revealed Resident #10 tested positive on 10/26/20. Review of the facility resident room roster revealed Resident #10 had a roommate who tested positive on 10/12/20 and resided on the 100-hall. Review of the documentation from the LHD COVID-19 task force revealed Resident #10 tested positive for COVID-19 on 10/26/20 and resided on the 100-hall. Attempted interview with Resident #10's family member on 11/12/20 at 1:05pm was unsuccessful. Refer to telephone interview with one of the LHD COVID-19 task force leads on 11/04/20 at 9:56am . Refer to telephone interviews with another LHD COVID-19 task force on 11/09/20 at 11:53am and 1:05pm. Refer to telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am. Refer to telephone interview with a PCA on 11/06/20 at 3:02pm. Refer to telephone interview with a MA on 11/16/20 at 3:26pm. Refer to confidential interview with a staff. Refer to telephone interview with the PCP on 11/09/20 at 4:31pm.	D 338		

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D 338	Continued From page 38 Refer to interview with the RCC on 11/10/20 at 4:23pm. Refer to interview with the RCC on 11/10/20 at 5:00pm. Refer to telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to telephone interview with the BOM on 11/12/20 at 4:41pm. c. Review of Resident #11's Resident Register revealed she was admitted on 10/09/20. Review of the COVID-19 laboratory reports from 10/22/20 to 11/03/20 revealed Resident #11 tested positive for COVID-19 on 10/26/20 and resided on the 100-hall. Review of the facility resident room roster revealed Resident #11 was in a room without a roommate and resided on the 100-hall. Review of the documentation from the LHD COVID-19 task force revealed Resident #11 tested positive for COVID-19 on 10/26/20. Attempted interview with Resident #11's family member on 11/12/20 at 1:10pm was unsuccessful. Refer to telephone interview with one of the LHD	D 338		

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D 338	Continued From page 39 COVID-19 task force leads on 11/04/20 at 9:56am . Refer to telephone interviews with a representative from the LHD COVID-19 task force on 11/09/20 at 11:53am and 1:05pm. Refer to telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am. Refer to telephone interview with a PCA on 11/06/20 at 3:02pm. Refer to telephone interview with a MA on 11/16/20 at 3:26pm. Refer to confidential interview with a staff. Refer to telephone interview with the PCP on 11/09/20 at 4:31pm. Refer to interview with the RCC on 11/10/20 at 4:23pm. Refer to interview with the RCC on 11/10/20 at 5:00pm. Refer to telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to telephone interview with the BOM on 11/12/20 at 4:41pm. _____ Telephone interview with one of the LHD	D 338		

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D 338	Continued From page 40 COVID-19 task force leads on 11/04/20 at 9:56am revealed: -She and another task force lead conducted an onsite visit on 09/29/20. -She recommended to the former Administrator and BOM on 09/29/20 to not take any new admissions due to the observation of continued communal dining, difficulty "cohorting" positive cases, exposed cases, and negative cases, and inconsistent use of personal protective equipment (PPE). -She did not provide any written recommendations concerning admissions to the facility, but the facility was supposed to follow the CDC recommendations and guidelines. Telephone interviews with another LHD COVID-19 task force leads on 11/09/20 at 11:53am and 1:05pm revealed: -Facility management was informed they needed to have a quarantine system in place for new admissions. -She spoke with the Administrator two weeks ago and was told the Administrator did not know anything about the quarantine system and would get back to her. -The Administrator did not get back to her about the quarantine system. -In late October 2020, around the 28th, the LHD advised facility management to refrain from accepting new admissions. Telephone interview with the same LHD COVID-19 task force lead on 11/17/20 at 8:31am revealed: -The former Administrator and the former RCC were told to attempt to "cohort" the residents in August 2020 and September 2020 when there were fewer residents who tested positive for COVID-19.	D 338		

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-Cohort meant to group residents who tested positive for COVID-19 with other residents who tested positive for COVID-19, group residents who tested negative for COVID-19 with other residents who tested negative for COVID-19, and residents who were exposed to COVID-19 with other residents who were exposed to COVID-19.
-The former Administrator was told to cohort residents but he expressed concerns because the residents were memory care residents and were affected by sudden changes in their environment.
-The former Administrator was sent guidance for memory care units.

Telephone interview with a PCA on 11/06/20 at 3:02pm revealed:
-When the outbreak began, the residents who tested positive for COVID-19 were moved to the 200-hall, and were quarantined for ten days.
-As the number of COVID-19 cases increased, there was no more room to quarantine the residents on the 200-hall.
-Not many of the halls had enough rooms to contain the residents who tested positive for COVID-19.
-Residents who tested positive for COVID-19 and who tested negative for COVID-19 were assigned to the same room.

Telephone interview with a MA on 11/16/20 at 3:26pm revealed:
-No instructions were given on providing care to residents who tested positive for COVID-19.
-Hearts were placed on the doorposts of residents who tested positive for COVID-19.
-The heart on the doorpost did not indicate which resident was COVID-19 positive if there were two residents in the room.
-Residents who tested positive were placed in the

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same room with residents who tested negative in October 2020.

Confidential interview with a staff revealed:
-The 200-hall was initially used to quarantine residents who tested positive for COVID-19.
-Residents would be quarantined from 10-14 days.
-A zippered plastic barrier was placed on the doorways of residents' who tested positive for COVID-19 when there was no room left to quarantine residents on the 200-hall.
-She did not know who was responsible for placing the plastic barrier on the residents' doors.
-Hearts were placed on the doorposts of the residents' rooms to indicate a resident was COVID-19 positive.
-The RCC or the facility owner was responsible for placing and removing the hearts from the residents' doorposts.
-When there were no other rooms available at the facility, residents who tested positive for COVID-19 were roomed with residents who had tested negative for COVID-19 in October 2020.

Telephone interview with the PCP on 11/09/20 at 4:31pm revealed:
-She wanted to contain COVID-19 when the first cases of COVID-19 occurred at the facility.
-She wanted the residents who tested positive for COVID-19 and the residents who had been exposed to COVID-19 to be placed on a designated hall.
-Doors to the residents' rooms were not closed to contain the virus.
-Residents would be exposed to COVID-19 if they went into the hallway.
-The doors to each hall were kept closed, but the outbreak worsened every week.
-Facility management did not implement any

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safeguards to stop the outbreak despite her instruction.
-Residents were not moved to another room or hall to contain the spread of COVID-19.
-Residents who tested positive for COVID-19 were roomed with residents who tested negative for COVID-19.
-She was informed by the Administrator, former Administrator, and RCC that the LHD advised it would be worse to move exposed residents or those who tested positive for COVID-19 to another room.

Interview with the RCC on 11/10/20 at 4:23pm revealed:
-Residents who tested positive for COVID-19 were previously quarantined on the 200-hall.
-She could not remember when there was no longer a designated hall for residents who tested positive for COVID-19.
-Newly admitted residents who tested negative for COVID-19 were not put in the same room as residents who tested positive for COVID-19.
-The LHD instructed facility management to place residents on quarantine for ten days after testing positive for COVID-19.
-The LHD advised the former Administrator and the former RCC (on an unknown date) not to move residents whose roommates had tested positive for COVID-19; the rationale being the residents were already exposed to the virus.

Interview with the RCC on 11/10/20 at 5:00pm revealed:
-She was not involved with the decision to admit new residents.
-She was told by the former Administrator when residents were arriving to the facility.
-The former Administrator assigned the rooms to new admissions.

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D 338	Continued From page 44 Telephone interview with the former Administrator on 11/04/20 at 11:00am revealed: -No resident admitted to the facility resided where there was an active case of COVID-19 in September 2020. -He did not know the exact rooms the new residents resided within the facility in September 2020 or October 2020. -Admissions were continued because they thought they could keep new residents safe. Interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm revealed: -She participated in conference calls with representatives from the LHD. -The LHD did not put guidance in writing. -"When they (the LHD) say to do it, we do it." -Residents who tested positive for COVID-19 were supposed to be quarantined for ten days, and longer if they continued to be symptomatic. -Residents who had been exposed to COVID-19 were supposed to be quarantined for 14 days. -Sometime around August or September 2020, the LHD advised not to remove residents who tested negative for COVID-19 out of the rooms of residents who tested positive for COVID-19. Telephone interview with the BOM on 11/04/20 at 11:00am revealed: -The LHD COVID-19 task force had not provided anything in writing about discontinuing admissions. -The facility continued admitting residents because they thought if they followed the recommendations of the LHD the residents would not become positive for COVID-19. -The facility discontinued admissions between 10/09/20 and 10/22/20 because the number of positive COVID-19 cases within the facility	D 338		

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increased.
-In September 2020, although there were some positive resident cases of COVID-19, the majority were contained on the 200-hall.
-In October 2020, the facility had more residents who tested positive for COVID-19 but were quarantined.
-He thought the new admissions were not assigned to rooms where they were at risk for exposure to COVID-19.
-The LHD COVID-19 task force told them not to put residents on one hall in a different area of the facility.
-The facility placed a plastic covering over the door of residents who tested positive for COVID-19 in mid to late September 2020.
-When the facility admitted residents in September 2020 and October 2020, he ensured there was a room available that did not expose the resident to active COVID-19.
-He did not know the location of the room for residents admitted in September 2020 and October 2020.
-He knew that residents who were admitted in September 2020 and October 2020 tested positive for COVID-19 after being admitted, but he thought the facility took every precaution to protect them.

Telephone interview with the BOM on 11/12/20 at 4:41pm revealed:
-Residents were previously quarantined on the 200-hall.
-A plastic barrier separated the residents who tested positive for COVID-19 from the residents who tested negative for COVID-19 on the 200-hall.
-Around late September 2020, the LHD informed management they did not have to relocate residents who had been exposed to a roommate

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who tested positive for COVID-19.
-Residents who tested positive for COVID-19 were quarantined for ten days unless they continued to be symptomatic.
-Residents who had been exposed to roommates who tested positive for COVID-19 were quarantined for 14 days.
-The former Administrator was responsible for room assignment for new admissions.

2. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities revealed personnel should be designated to care for residents who tested positive for COVID-19 and residents who tested negative for COVID-19.

Review of the facility daily staffing sheets from 09/26/20 to 09/28/20, 10/05/20, from 10/14/20 to 10/17/20, from 10/30/20 to 11/05/20, and 11/10/20 revealed:
-There were columns for assignments, first, second and third shifts.
-Under the column for assignments, there were spaces for a 100-hall medication aide (MA), a 200-hall MA, a 300-hall MA, a 400-hall MA, three 100-hall personal care aides (PCA), three 200-hall PCAs, three 300-hall PCAs, and three 400-hall PCAs.
-At the bottom of the daily staffing sheet were specific break times for staff based on hall number assignment.
-There were no instructions concerning assignment to specific rooms for residents based on COVID-19 testing results.

Review of an undated staff memo revealed:
-The memo's topic was COVID-19 100-hall.
-There were only six staff signatures at the bottom of the memo without dates.

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-There were 12 bullet statements on the memo to include: staff were to go to their designated hall assignment, one staff was to care for the resident who tested positive for COVID-19 and the other two staff were to care for all other residents and keep residents in their rooms.

Based on record reviews and interviews, no other documentation was provided for staff training or memos related to COVID-19 and the other three halls within the facility.

Review of emails from the local health department (LHD) COVID-19 task force revealed an email was sent to the former Administrator from the Deputy Public Health Director on 06/10/20 providing the link for guidance for memory care units from the CDC.

Review of CDC guidance for memory care units in LTC facilities dated 05/12/20 revealed:
-Due to the challenge of restricting memory care residents to their rooms, all personnel should wear a N-95 or face mask and universal eye protection.
-Personnel should follow the Infection Prevention and Control guidance for assisted living facilities.

Telephone interview with one of the LHD COVID-19 task force leads on 11/04/20 at 8:31am revealed
-She recommended that staff remain on the hall they were assigned to for the entire shift.
-She also recommended "cohorting" staff so that there were designated staff to care for residents who tested positive for COVID-19, residents who tested negative for COVID-19, and residents who were exposed to COVID-19.
-She thought this recommendation was not done because when she called the facility to gather

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information in October 2020, the staff who answered the phone told her to hold on so that she could walk over to another hall to ask another staff about residents who resided on another hall.

Telephone interview with a personal care aide (PCA) on 11/09/20 at 3:47pm revealed:
-She worked with all the residents on the hall and was not assigned to residents who tested positive or negative.
-No one had ever told her who tested positive for COVID-19 and who tested negative for COVID-19.

Confidential interview with a staff revealed:
-One staff was supposed to interact with the residents on the hall who tested positive for COVID-19.
-The Resident Care Coordinator (RCC) or the MA would let the PCAs know which residents tested positive for COVID-19.

Telephone interview with a MA on 11/09/20 at 2:52pm revealed:
-She worked on the hall she was assigned to by the RCC and worked with all residents on the hall.
-She was not assigned to work with either residents who tested positive for COVID-19 only or residents who tested negative for COVID-19 only on the hall.

Telephone interview with the primary care provider (PCP) on 11/09/20 at 4:31pm revealed:
-Staff needed more guidance from management to contain the spread of COVID-19 and which residents had tested positive or negative for COVID-19.
-There needed to be better training of staff to contain the spread of COVID-19 in the facility.
-During the third week of October 2020, she

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asked a MA if management provided guidance for staff she replied, "They [have not] even told us who was positive or negative."

Interview with the RCC on 11/10/20 at 4:23pm revealed:
-She did the staff assignment sheets.
-Staff were assigned based on the hall number only.
-There were four halls in the facility where residents resided and staff were assigned to each hall.

Telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am revealed:
-The facility had designated staff assigned to residents who tested positive for COVID-19.
-The RCC and the HR Office Manager did staff assignments and decided which staff took care of the residents.

Telephone interview with the BOM on 11/12/20 at 4:41pm revealed staff were encouraged to limit their interaction between residents who tested positive for COVID-19 and residents who tested negative for COVID-19.

3. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed:
-Personnel should stay at home if sick.
-Personnel with mild to moderate symptoms and who were not immunocompromised should stay home 10 days since the date of symptoms first appeared.
-Symptoms included coughing, shortness of breath, and loss of taste and smell.

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Review of a letter given to Staff B from the LHD revealed:
-The letter was regarding monitoring release and was dated 10/19/20.
-There was a release date of 10/19/20 from isolation and she may return to work.

Review of the local health department (LHD) COVID-19 task force documents revealed:
-Staff B, a personal care aide (PCA), tested positive on 09/30/20 and had symptoms on 09/28/20.
-Staff B was released from monitoring on 10/19/20.

Review of the facility list of staff who tested positive for COVID-19 revealed:
-Staff B tested positive on 09/27/20.
-Staff B was to return to work on 10/11/20.

Review of the facility timecards from 10/01/20 to 10/15/20 for Staff B revealed Staff B was paid for 7 hours on 10/12/20.

Review of the facility's daily staffing sheet for 10/12/20 revealed Staff B's name was hand written under the second shift column and assigned to the 400-hall.

Interview with the Administrator on 11/03/20 at 2:30 pm revealed:
-Staff were tested weekly for COVID-19 until staff tested positive for COVID-19.
-Once staff tested positive for COVID-19, staff quarantined for 10 days without signs or symptoms of COVID-19.
-The LHD contacted staff and made the guidelines for when staff returned to work.

Telephone interview with Staff B on 11/10/20 at

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12:43pm revealed:
-She had symptoms of migraine headaches, diarrhea, loss of taste and smell during her quarantine and she had a history of asthma.
-She tested positive on 09/30/20 but the Resident Care Coordinator (RCC) called her on 10/03/20 to tell her she had tested positive for COVID-19.
-She spoke with a person from the LHD daily.
-She received a letter via the United States Postal Service and a text message that indicated her release date to return to work.
-Her release date was 10/19/20, and she had not received any other letters from the LHD.
-The Human Resource (HR) Office Manager called her on 10/12/20 to tell her she had to come to work or she would lose her job.
-She reported to work late on 10/12/20 and she thought she worked on the 400-hall.

Telephone interview with the LHD COVID-19 task force lead on 11/12/20 at 1:58pm revealed:
-Staff B tested positive on 09/30/20 but Staff B reported symptoms of COVID-19 started on 09/28/20.
-Staff B was given an extended release date of 10/19/20 because she was still symptomatic.

Interview with the facility's HR Office Manager on 11/10/20 at 3:15pm revealed
-None of the staff had worked during their quarantine time.
-Staff quarantined due to a positive COVID-19 test for 10 days.
-The former RCC kept a spreadsheet with all staff who tested positive for COVID-19 and their release dates.
-The former RCC spoke with the LHD daily to gather the information about release dates for staff.

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D 338	Continued From page 52 Telephone interview with the RCC on 11/12/20 at 5:00pm revealed: -She called staff who were out on quarantine status daily. -She asked staff how they were doing and if they needed anything. -She checked on Staff B and Staff B never reported any symptoms to her. -She did not see the letter from the LHD for Staff B. -The former RCC kept up with the release to work dates of staff. -She did not know why Staff B returned to work on 10/12/20 and then did not work again until 10/19/20. Telephone interview with the facility's HR Office Manager on 11/16/20 at 2:58pm revealed: -The RCC told her that Staff B worked on 10/12/20 and did not work again until 10/19/20. -She and the former RCC called Staff B on 10/12/20. -The reason she and the former RCC called Staff B was because Staff B was scheduled to work on 10/12/20. -When Staff B answered the telephone, she did not report any symptoms and stated she was fine. -Staff B was told she was scheduled to work on 10/12/20 and was expected to report to work. -She thought Staff B called the LHD on 10/13/20 and reported symptoms of COVID-19 to extend her release date. -She thought Staff B knew staff were paid for quarantining and did not want to return to work. -She and the former RCC telephoned the LHD task force lead on 10/13/20 and inquired about Staff B's release date. -The LHD told them Staff B's release date was 10/19/20. -The former RCC had a release date of 10/11/20	D 338		

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for Staff B documented on the staff spreadsheet for quarantine release dates.

Telephone interview with the Administrator on 11/17/20 at 9:27am revealed:
-She was made aware on 11/16/20 of Staff B working on 10/12/20 by the RCC and the HR Office Manager.
-The LHD provided them with the release dates for staff to return to work.

Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 10:00am revealed:
-The HR Office Manager and/or the RCC told him Staff B worked on 10/12/20 and her release date to work was 10/19/20.
-He expected staff to return to work at the end of their quarantine.
-The RCC and HR Office Manager were responsible for ensuring staff returned to work once quarantine ended.

4. Review of emails from the local health department (LHD) COVID-19 task force revealed:
-One of the lead team members of the task force sent an email on 10/08/20 at 12:16pm to the local county Department of Social Services (DSS) staff to locate a local resource for over the bed tables.
-A response from the local county DSS staff was sent to the task force lead team member on 10/08/20 at 12:32pm indicating locations to purchase over the bed tables.
-Another response from the local county DSS staff was sent to the task force lead team member on 10/08/20 at 12:51pm indicating another local resource and prices for over the bed tables.
-These emails were sent to the former Administrator, Administrator and former Resident

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Care Coordinator (RCC) on 10/21/20 at 9:17am.

Review of the facility invoices and receipts for over the bed tables revealed:
-An order was placed on 11/06/20 from an online vendor for 30 over the bed tables.
-The over the bed tables were shipped on 11/07/20 to the address for the facility.

Review of the facility's resident roster revealed:
-There were 29 residents who resided on the 200-hall.
-There were 27 residents who resided on the 400-hall.

Observations of the 200-hall on 11/03/20 from 11:07am - 12:16pm revealed:
-There were 16 residents who ate lunch in the living room/dining area at the end of the hall.
-There were 10 residents who ate lunch in their rooms.
-At 11:53am, the food cart was delivered to the 200 hall.
-At 11:54am, a personal care aide (PCA) near the entrance to 200 hall started passing plates to some residents who were in their rooms.
-The PCA delivered food trays to residents in rooms 201, 207, 210, 211, 213, 215, 218, and 220.
-At 11:55am, the PCA went into room 211 and delivered lunch to the resident on a night stand as there was no over the bed table for the resident.
-At 11:58am, the PCA went in room 220 and delivered lunch to the resident by the window on her bed as there was no over the bed table for this resident.
-At 12:03pm, the PCA went into room 213 and delivered lunch to the resident on a night stand as there was no over the bed table for the resident.
-At 12:09pm, the PCA went into room 215 and

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delivered lunch to a resident on her night stand as there was no over the bed table for the resident.
-At 12:10pm, the PCA went into room 207 and delivered lunch to a resident on her night stand as there was no over the bed table for the resident.
-At 12:13pm, the PCA went into room 201 and delivered lunch to a resident on her night stand as there was no over the bed table for the resident.

Observation of residents on the 400-hall during lunch meal service on 11/03/20 from 12:14pm to 12:49pm revealed:
-There was a resident sitting on the side of the bed.
-The resident's body was leaning left towards the headboard.
-The resident slumped forward towards the back of the two-drawer nightstand.
-The resident did not have an over the bed table to use for meal service.
-The resident attempted to slide the plate of food across the top of the two-drawer nightstand towards her.
-The resident's left leg was bent behind the backside of the two-drawer nightstand, and there was no space to place her left foot beneath the nightstand.
-The resident's right leg and foot were extended out, on the right side of the two-drawer nightstand.
-Another resident was sitting in her wheelchair faced toward the foot of the bed.
-The resident's plate of food was on her bed, near the footboard.
-The resident attempted to move closer to the plate of food on the bed in her wheelchair.
-The resident backed away from the bed in her

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wheelchair.
-The resident did not have an over the bed table, nightstand, or bedside table.

Telephone interview with the LHD COVID-19 task force lead on 11/04/20 at 9:56 am revealed:
-The facility was encouraged to discontinue communal dining when the guidance was released by the Centers for Disease Control (CDC) in April 2020.
-There was discussion that there were not enough over the bed tables for all residents.
-She reached out to local county DSS to request assistance in locating the over the bed tables for a reasonable price and locally in October 2020.
-The county DSS responded with various resources for the facility to obtain the over the bed tables and the prices in October 2020.
-She sent the information to the former Resident Care Coordinator (RCC), the former Administrator, and Administrator via email in October 2020.
-The task force members spoke with the facility about discontinuing communal dining in April 2020, May 2020, June 2020, July 2020, August 2020.
-She thought communal dining had stopped in September 2020 but saw a note on a resident's hospital record that communal dining continued in September 2020.
-In October 2020, an email was sent to the facility and a long term care facility lead and communal dining was not recommended again for the facility, so she forwarded the email from DSS staff concerning resources for acquiring the over the bed tables to facilitate in room meals.

Telephone interview with a PCA on 11/06/20 at 3:30pm revealed:
-He had noticed the residents on the 400-hall did

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not have over the bed tables for all the residents.
-He thought about half of the residents on the 400-hall had over the bed tables and half of the residents had nightstands.
-He did not think there was a problem, because he placed the residents' plates on the nightstands.
-He had to move the nightstands from beside the resident's bed and place the nightstand in front of the resident for the resident to eat.
-Residents were not able to place their legs under the nightstand but residents leaned forward to eat their meals.
-He had not told anyone that residents on the 400-hall needed more over the bed tables.

Confidential interview with a staff revealed:
-Staff had noticed residents on 200 and 400-halls did not have enough over the bed tables for all the residents.
-The nightstands were moved from beside the resident bed and placed in front of the resident to allow them a place to eat their meal.
-The residents were not able to place their legs under the nightstands and some of the residents placed their plates on their beds to eat, in the drawers to eat or walked away.
-Staff did not know the specific residents who did not have over the bed tables unless they were on the hall.

Telephone interview with a medication aide (MA) on 11/10/20 at 2:35pm revealed:
-The residents needed more over the bed tables and the facility received the over the bed tables on 11/09/20.
-Before the new over the bed tables were delivered, she had to move some residents into high back chairs with their plates on the nightstands so the residents could eat.

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D 338	Continued From page 58 -Some residents had to turn to the side to eat their plates because of the position of the table. -She thought this was uncomfortable for residents because of the position residents were in while eating. Confidential interview with another staff revealed: -Several residents did not have over the bed tables. -Only residents in residents rooms 402, 405, and 409 had over the bed tables. -The other residents ate on their beds or nightstands. Confidential interview with a third staff revealed: -The former Administrator told staff to use the resident nightstands to serve plates for meal service. -Staff asked the former Administrator, "how were the residents supposed to eat their meals on the nightstands? " -Staff was concerned because the nightstands were low. Interview with a local medical supply store representative on 11/6/20 at 11:45am revealed: -The facility called about 1- 1.5 weeks ago. -The facility inquired about bedside tables and pricing. -The facility never placed an order to purchase bedside tables. -The facility was told it took 3-5 business days from the date of order to ship the over the bed tables to the facility. Interview with the RCC on 11/10/20 at 5:00pm revealed: -None of the staff told her residents needed over the bed tables. -She monitored the 100-hall most of the time and	D 338		

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the former RCC would monitor the 400-hall.
-She had not monitored the 200-hall recently.
-She did not purchase equipment for the facility.

Telephone interview with the Administrator on 11/13/20 at 11:49am revealed:
-She remembered receiving the email from the LHD COVID-19 task force lead.
-She remembered discussing the need for over the bed tables in a management meeting, but she did not think the Business Office Manager (BOM) was at the meeting.
-She did not tell the BOM the facility needed over the bed tables because she did not know it was an urgent issue.

Telephone interview with the BOM on 11/06/20 at 9:26 am revealed:
-Staff usually told him or the other staff who worked in the business office what equipment was needed.
-If it was a special request, there was a group decision made by the management team.
-Residents who resided on the 400-hall needed increased supervision, or had specific restrictions related to health care such as fluid restrictions.
-He thought all the residents had a bedside table or nightstand to use for meal service.
-He knew the plates were served on the bedside tables or nightstands.
-He did not know which rooms or residents needed an over the bed table.
-He had brought over the bed tables over from a sister facility to provide for the residents but needed to order more.
-He ordered over the bed tables in October 2020, he thought, but the communal dining changed according to the number of residents who tested positive for COVID-19 and the guidance from the LHD.

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D 338	Continued From page 60 -It took a week or two weeks for the over the bed tables to arrive to the facility. -The original order for over the bed tables was much earlier and another order was done for over the bed table when the LHD recommended not serving meals in groups. -The 200-hall was cleared from quarantine and he thought the LHD allowed for communal dining now, 11/06/20. Telephone interview with the BOM on 11/17/20 at 9:45am revealed: -No one from the management team told him the facility needed more over the bed tables. -The former Administrator and another office staff had access to purchase items needed by residents. -No one told him the LHD COVID-19 task force lead had shared a place to purchase the over the bed tables in October 2020. -He ordered the over the bed tables on 11/06/20 and the items were delivered between 11/07/20 and 11/09/20. Attempted telephone interview with the former Administrator on 11/13/20 at 12:59pm was unsuccessful. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the Local Health Department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which staff returned to work prior to the date recommended by the LHD and worked on a hall with residents; properly quarantine new admissions, and designate staff to care for residents who tested positive for COVID-19 and designate staff to care	D 338		

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D 338	Continued From page 61 for residents who tested negative for COVID-19. This failure placed the residents at increased risk for transmission and infection from COVID-19, resulting in substantial risk of serious physical harm, and serious neglect, and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/20 for this violation and an addendum to the plan of protection was provided on 11/17/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2020.	D 338		
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 observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 2 residents (#13, #14) sampled who both missed doses of their narcotic pain medications due to the medications being unavailable.	D 358		

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D 358	Continued From page 62 The findings are: 1. Review of Resident #14's current FL-2 dated 07/07/20 revealed: -Diagnoses included unspecified dementia, arthritis, and schizophrenia - paranoid type. -There was an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #14's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. Review of Resident #14's incident/accident report dated 10/20/20 at 12:00pm revealed: -Staff went to get back up supply of Hydrocodone/Acetaminophen 5/325mg for Resident #14. -When the Resident Care Coordinator (RCC) called the pharmacy, they told the RCC that the pharmacy delivered 90 tablets on 10/08/20. -There were 60 tablets of Hydrocodone/Acetaminophen 5/325mg missing. -There was "no injury" to the resident. -Staff noted it was reported to the police department and the Health Care Personnel Registry (HCPR). -The incident/accident report was electronically signed by Resident #14's PCP on 10/23/20 at 5:03pm. Review of Resident #14's CS continuance of therapy prescription dated 10/08/20 revealed an order for 90 Hydrocodone/Acetaminophen	D 358		

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D 358	Continued From page 63 5/325mg tablets take 1 tablet 3 times a day. Review of Resident #14's CS emergency dispense prescription dated 10/20/20 revealed an order for 60 Hydrocodone/Acetaminophen 5/325mg tablets take 1 tablet 3 times a day. Review of Resident #14's pharmacy dispensing records from September 2020 - November 2020 revealed: -There were 90 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/08/20. -There were 90 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 10/08/20. -There were 60 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 10/21/20. Review of Resident #14's September 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered 3 times daily from 09/01/20 - 09/30/20 except for 1 occasion. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 09/08/20 at 1:00pm due to "awaiting pharmacy delivery". -There were 89 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 09/01/20 - 09/30/20. Review of Resident #14's October 2020 e-MAR revealed:	D 358		

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D 358	Continued From page 64 -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered 3 times a day from 10/01/20 - 10/18/20 and 10/22/20 - 10/31/20 and once on 10/19/20 at 9:00pm. -Documentation for Hydrocodone/Acetaminophen 5/325mg was blank on 6 occasions with no reason for the omissions on 10/19/20 at 9:00am and 1:00pm; 10/20/20 at 9:00am, 1:00pm, and 9:00pm; and 10/21/20 at 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/21/20 at 9:00am and 1:00pm due to "awaiting pharmacy delivery". -There were 85 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 10/01/20 - 10/31/20. Review of Resident #14's CS record for the supply dispensed on 09/08/20 revealed: -The first page had a prescription label on the upper left side of the page for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 09/09/20 with a starting amount of 30 tablets. -The first dose of those 30 tablets was documented as administered on 09/09/20 at 9:00am and the last dose on 09/18/20 at 9:00pm. -The next row noted a second card with 30 tablets was "placed on cart" on 09/18/20. -The first dose of those 30 tablets was	D 358		

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documented as administered on 09/19/20 at 8:00am and the last dose on the second page was on 09/28/20 at 9:00pm.
-The second page had an entry for the third card with 30 tablets "placed on cart" on 09/28/20.
-The first dose of those 30 tablets was documented as administered on 09/29/20 at 9:00am and the last dose on 10/08/20 at 9:00pm, leaving a balance of zero.

Review of Resident #14's CS record for the supply dispensed on 10/08/20 revealed:
-The prescription label on the upper left side of the page was for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day.
-The section on the upper right side of the page had date received documented as 10/08/20, amount received as 90, but received by line was blank.
-Documentation on the first row noted "placed on cart" on 10/08/20 with a starting amount of 90 but the 90 had been written over and changed to 30 with no initials to indicate who made the change.
-The first dose was documented as administered on 10/09/20 at 9:00am with amount remaining documented as 89 but the 89 had been written over and changed to 29 with no initials to indicate who made the change.
-The second dose was documented as administered on 10/09/20 at 1:00pm with amount remaining documented as 88 but the 88 had been written over and changed to 28 with no initials to indicate who made the change.
-The third dose was documented as administered on 10/09/20 at 9:00pm with the amount remaining documented as 27.
-The rest of the doses were documented as declining from 26 to 0 and administered from 10/10/20 at 9:00am through 10/18/20 at 9:00pm.

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-There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered from 10/19/20 - 10/21/20 due to no medication being on hand for a total of 9 missed doses.

Review of Resident #14's CS record for the supply dispensed on 10/21/20 revealed:
-Documentation on the first row noted "placed on cart" on 10/22/20 with a starting amount of 30 tablets.
-The first dose of those 30 tablets was documented as administered on 10/22/20 at 9:00am and the last dose on 10/31/20 at 8:00am.
-The second page had an entry for the second card with 30 tablets "placed on cart" on 10/28/20 at 3:00pm.
-The first dose of those 30 tablets was documented as administered on 10/29/20 at 1:00pm and the last dose on 11/10/20 at 8:00am, leaving a balance of zero.

Observation of Resident #14's medications on hand on 11/10/20 revealed there was no Hydrocodone/Acetaminophen 5/325mg tablets on hand for the resident.

Interview with a medication aide (MA) on 11/10/20 at 2:43pm revealed:
-She administered Resident #14's last Hydrocodone/Acetaminophen 5/325mg tablet this morning, 11/10/20.
-The medication bubble card had been thrown away and was irretrievable.
-There was no Hydrocodone/Acetaminophen 5/325mg available for administration to Resident #14.
-Resident #14 missed his 1:00pm dose of Hydrocodone/Acetaminophen 5/325mg.
-The PCP wrote a new order for Resident #14's

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Hydrocodone/Acetaminophen 5/325mg.
-The MA requested and received a second order to administer one dose of Hydrocodone/Acetaminophen 5/325mg as soon as the medication arrived at the facility to make up for the dose that had not been available at 1:00pm.
-Transportation staff was going to the pharmacy to pick up Resident #14's Hydrocodone/Acetaminophen 5/325mg.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/06/20 at 1:22pm revealed:
-The pharmacy dispensed 90 Hydrocodone/Acetaminophen 5/325mg tablets on 10/08/20 for Resident #14 that were delivered to the facility and signed for by a MA on 10/08/20 at 11:46pm.
-The supply was dispensed in 3 bubble cards of 30 tablets each, for a total of 90 tablets.
-There was a supply of 60 Hydrocodone/Acetaminophen 5/325mg tablets dispensed on 10/21/20 that were delivered to the facility and signed for by a MA on 10/22/20 at 12:32am.

A second telephone interview with a pharmacist at the facility's contracted pharmacy on 11/09/20 at 5:30pm revealed:
-The pharmacy was contacted by the RCC and a CS template for a refill request was faxed to the facility on 10/20/20.
-On 10/21/20, the pharmacy received the CS template prescription for Resident #14 with the PCP's signature dated 10/20/20 for 60 tablets of Hydrocodone/Acetaminophen 5/325mg.

Telephone interview with Resident #14's PCP on 11/09/20 at 4:30pm revealed:

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-She wrote the prescription dated 10/08/20 for Resident #14's Hydrocodone/Acetaminophen 5/325mg tablets.
-When she got a request for a refill for controlled substances, she usually took out her calendar and counted to see what the resident was allotted and if it was time for a refill.
-The RCC made it sound like they ran out of medications for Resident #14 because they borrowed some for another resident.
-She was not aware Resident #14 was missing medications until the Adult Home Specialist discussed it with her on 11/03/20.

Telephone interview with a second MA on 11/16/20 at 1:38pm revealed:
-She was working the morning that Resident #14's card with 30 tablets of Hydrocodone/Acetaminophen ran out.
-Someone had changed the 90 on the CS record to 30.
-She went to the RCC and the RCC told her this was not right because 90 tablets had been delivered to the facility for Resident #14.
-The MAs were supposed to tell the RCC before medications ran out.
-She had never heard Resident #14 complain of pain even when he missed the doses of pain medication.

Telephone interview with a third MA on 11/13/20 at 3:14pm revealed:
-She remembered Resident #14 having 3 bubble cards of Hydrocodone/Acetaminophen 5/325mg in the medication cart (could not recall the date).
-The next day (could not recall date) when she came to work on second shift, 60 tablets (2 cards of 30) were gone and there was one card left with less than 30 tablets (did not know how many).
-The RCC asked her where the tablets were but

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she did not know what happened to them.
-She did not know what kind of pain the resident took the medication for but the resident missed some doses when the medications were missing.
-She did not remember if the resident complained of pain when he did not receive the pain medication.

Telephone interview with the RCC on 11/12/20 at 4:34pm revealed:
-A MA came to her and reported Resident #14 was out of his Hydrocodone/Acetaminophen 5/325mg tablets (could not recall date).
-She usually kept the supply of back up medications in her office in a locked filing cabinet.
-She checked the filing cabinet but Resident #14 did not have any in the cabinet.
-She called the pharmacy and was told 90 tablets had been sent to the facility previously and the resident should have 60 tablets left.
-It looked like someone had written over the numbers on the CS record and changed it.
-The MA who signed for delivery of the medication (could not recall date) reported all 90 tablets were put on the active medication cart when it was received.
-A second MA also reported the other MA put all 90 tablets on the medication cart.
-She reported the missing medication to the Administrator and they called the police.
-She reported it to the PCP the same day (did not know date) but the pharmacy could not send more medication because it had just been filled.
-The PCP called another prescription to the pharmacy and more tablets were sent she thought on the same night.
-She thought the resident missed one dose of the pain medication.
-She was not aware the resident missed 9 doses of the pain medication.

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-They received batch medications monthly from the pharmacy except they had to order some controlled substances.
-The MAs were supposed to call the pharmacy once the medication got down to the blue section on the bubble card to see if a new prescription was needed.
-If the medication was not received, the MAs should follow-up with a call to the pharmacy.

Telephone interview with the certified medical assistant (CMA) at Resident #14's PCP office on 11/12/20 at 1:05pm revealed:
-On 10/20/20 at 12:00pm, the RCC called and stated the facility was missing 60 Hydrocodone/Acetaminophen 5/325mg tablets (2 bubble cards of 30 tablets each) for Resident #14.
-She told the RCC to notify the police and the HCPR.
-There had been 90 tablets refilled on 10/08/20 and 60 tablets of that supply were missing.
-The pharmacy sent an emergency refill request form on 10/20/20 at 1:28pm and a new prescription for 60 tablets was provided to the pharmacy.
-The RCC did not report the resident had missed any doses of the pain medication.

Telephone interview with the Administrator on 11/17/20 at 8:08am revealed:
-They never found Resident #14's missing pain medication.
-She did not recall any reports of pain or withdrawal symptoms when the resident missed the doses of pain medication.

Telephone interview with the RCC on 11/13/20 at 2:59pm revealed:
-She thought she told the PCP's office about

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Resident #14 missing doses of his pain medication when she called them about the missing tablets.
-She did not remember if Resident #14 complained of pain or withdrawal symptoms when he missed the doses of medication.

Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed:
-It should not have taken 3 days for Resident #14's missing medications to be replaced.
-The resident should not have missed any doses.
-The MAs were responsible for letting the RCC know when medications were running low and a new prescription was needed.

Telephone interview with Resident #14's PCP on 11/13/20 at 1:07pm revealed:
-Resident #14 took Hydrocodone/Acetaminophen 5/325mg for long-standing, chronic back pain and osteoarthritis.
-She was not aware Resident #14 missed 9 doses of medication when his medications were missing in October 2020.
-She was concerned the resident would have breakthrough pain and withdrawal symptoms since he had been taking the medication routinely 3 times a day.

Based on interviews and record review, Resident #14 was not interviewable.

2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism, insomnia, and restless leg syndrome.

Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1

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tablet at bedtime. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.)

Review of Resident #13's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain.

Review of Resident #13's PCP visit note dated 09/09/20 revealed:
-The resident had chronic pain that was managed well except the resident ran out of Hydrocodone/Acetaminophen 5/325mg for "a couple of days".
-There were no complaints of pain noted.
-The PCP would write a new prescription for Hydrocodone/Acetaminophen 5/325mg 1 tablet as needed a bedtime.

Review of Resident #13's emergency room (ER) after visit summary dated 10/19/20 revealed:
-The resident was seen at the ER on 10/19/20 for a fall and was diagnosed with a closed fracture of the left forearm.
-The resident's medication list included to continue taking Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime.

Review of Resident #13's physician's order sheet dated 10/21/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime and an order for Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime as needed for pain.

Review of Resident #13's physician's order dated 11/05/20 revealed an order to discontinue all previous Hydrocodone/Acetaminophen 5/325mg

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orders and start Hydrocodone/Acetaminophen 5/325mg 1 tablet every day at bedtime.

Review of Resident #13's pharmacy dispensing records from August 2020 - November 2020 revealed:
-There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 08/03/20.
-There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/08/20.
-There were 15 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/09/20.
-There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 11/05/20.

Review of Resident #13's September 2020 electronic medication administration record (e-MAR) revealed:
-There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 9:00pm.
-Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 09/01/20 - 09/03/20, 09/06/20, 09/07/20, and 09/09/20 - 09/30/20.
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 09/04/20 - 09/05/20, and 09/08/20 due to "awaiting pharmacy delivery".

Review of Resident #13's October 2020 e-MAR revealed:
-There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration

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time of 9:00pm.
-Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 10/01/20 - 10/18/20 and 10/20/20 - 10/25/20.
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/19/20 and from 10/26/20 - 10/31/20 due to the resident being out of the facility.

Review of Resident #13's November 2020 e-MAR revealed:
-There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm.
-Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 11/05/20 - 11/09/20.
-There was a note documented on 11/06/20 at 1:37am, "awaiting med to come in, meds arrived at 1:30".
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered from 11/01/20 - 11/03/20 due to the resident being out of the facility.
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 11/04/20 due to "awaiting pharmacy delivery".

Review of Resident #13's CS record for the supply dispensed on 08/03/20 revealed:
-Documentation on the first row noted "placed on cart" on 08/03/20 with a starting amount of 30 tablets.
-The first dose was documented as administered on 08/04/20 at 9:00pm and the last dose on 09/02/20 at 9:00pm.

Review of Resident #13's CS record for the supply dispensed on 09/08/20 revealed:

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-Documentation on the first row noted "placed on cart" on 09/08/20 with a starting amount of 30 tablets.
-The first dose was documented as administered on 09/09/20 at 9:00pm and the last dose on 10/08/20 at 9:00pm.
-There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered from 09/03/20 - 09/08/20 for a total of 6 missed doses.

Review of Resident #13's CS record for the supply dispensed on 09/09/20 revealed:
-Documentation on the first row noted "placed on cart" on 09/09/20 with a starting amount of 15 tablets.
-The first dose was documented as administered on 10/09/20 at 9:00pm and the last dose on 10/24/20 at 9:00pm.
-There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered on 10/19/20 or 10/25/20 - 10/31/20.
-There were 15 tablets documented as administered from 10/09/20 - 10/24/20.
-There would have not been any tablets remaining in this supply to administer to the resident on 10/25/20.

Review of Resident #13's CS record for the supply dispensed on 11/05/20 revealed:
-Documentation on the first row noted "placed on cart" on 11/06/20 with a starting amount of 30 tablets.
-There were 5 tablets documented as administered from 11/06/20 - 11/09/20, leaving a balance of 25 tablets.

Observation of Resident #13's medications on hand on 11/10/20 at 4:23pm revealed:
-There was one supply of

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D 358	Continued From page 76 Hydrocodone/Acetaminophen 5/325mg tablets with 30 tablets dispensed on 11/05/20. -There were 25 of 30 tablets remaining in the bubble card. Telephone interview with the Resident Care Coordinator (RCC) on 11/17/20 at 2:16pm revealed she did not recall Resident #13 running out of Hydrocodone/Acetaminophen 5/325mg from 09/04/20 - 09/08/20. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -She was not aware Resident #13 missed any doses of his pain medication. -The MAs should reorder medications when they got down to the blue strip on the bubble card. -She did not know how often the RCC was auditing the med carts to make sure medications were available. -Resident #13 was in pain because of a wrist fracture. -She did not know if the resident was in pain when he missed doses of the pain medication. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/17/20 at 9:04am revealed: -The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 09/08/20 was delivered to the facility and signed for by a medication aide (MA) on 09/09/20 at 12:06am. -The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 09/09/20 was delivered to the facility and signed for by a MA on 09/10/20 (time not specified). -The supply of Hydrocodone/Acetaminophen dispensed for Resident #13 on 11/05/20 was delivered to the facility and signed for by a MA on 11/06/20 at 1:26am.	D 358		

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D 358	Continued From page 77 Telephone interview with the certified medical assistant (CMA) at Resident #13's PCP office on 11/17/20 at 9:24am revealed: -She took calls for their office 24 hours a day and the facility could contact them anytime. -She usually documented phone calls with the facility or the facility would send them an incident report. -She forwarded all correspondences to the resident's PCP in their practice. -The facility requested a refill for Resident #13's Hydrocodone/Acetaminophen 5/325mg tablets on Friday, 09/04/20. -A prescription was sent to the pharmacy on 09/08/20 at 7:55am. -There may have been a delay due to the weekend and a holiday on Monday, 09/07/20. -They were not notified the resident was completely out of the medication or that he had missed any doses. Telephone interview with Resident #13's PCP on 11/13/20 at 1:07pm revealed: -Resident #13 was taking Hydrocodone/Acetaminophen at bedtime for a fractured arm. -She was not aware he had missed doses of his pain medication. Based on observations, interviews, and record review, Resident #13 was not interviewable.	D 358		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be	D 372		

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administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly and documented for 2 of 2 residents sampled (#13, #14) related to staff borrowing a controlled substance for moderate to severe pain from Resident #14 and administering it to Resident #13.

The findings are:

1. Review of Resident #14's current FL-2 dated 07/07/20 revealed:
-Diagnoses included unspecified dementia, arthritis, and schizophrenia - paranoid type.
-There was an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day.
(Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.)

Telephone interview with a medication aide (MA) on 11/13/20 at 3:14pm revealed:
-On 10/25/20, she was working on second shift on Resident #14's hall when she was told via telephone by the facility's nurse (now the current Administrator) to give one of Resident #14's Hydrocodone/Acetaminophen tablets to another MA for a resident on another hall.

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D 372	Continued From page 79 -She told the Administrator she was not supposed to borrow medications but the Administrator said the other resident needed it. -She documented using 1 tablet on the CS record and she wrote a note beside that row on the CS record that the Resident Care Coordinator (RCC) would handle it the next day. -She and another MA initialed the note on the CS record. -She did not document that she had borrowed the medication for another resident. -She had not replaced or paid back the pain medication to Resident #14 and she did not know if anyone else had done that. Review of Resident #14's October 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered 3 times a day from 10/01/20 - 10/18/20 and 10/22/20 - 10/31/20 and once on 10/19/20 at 9:00pm. -Documentation for Hydrocodone/Acetaminophen 5/325mg was blank on 6 occasions with no reason for the omissions on 10/19/20 at 9:00am and 1:00pm; 10/20/20 at 9:00am, 1:00pm, and 9:00pm; and 10/21/20 at 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/21/20 at 9:00am and 1:00pm due to "awaiting pharmacy delivery". -There were 85 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 10/01/20 - 10/31/20. -There was no documentation any medication	D 372		

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was borrowed from Resident #14.
-There was no documentation any medication was replaced or paid back to Resident #14.

Review of Resident #14's CS record for the supply dispensed on 10/21/20 revealed:
-There was a row between doses administered on 10/25/20 at 9:00pm and 10/26/20 at 9:00am that had no staff signature, no date and no time documented but amount given was recorded as 1 and the amount remaining declined to 16 tablets.
-There was a handwritten note beside this row initialed by two MAs.
-The MAs documented the facility's nurse (now the current Administrator) called the RCC and the RCC said to leave it blank and the RCC would handle it when she got there in the morning.
-The note did not indicate that a dose had been borrowed from Resident #14 and administered to another resident.
-There was no documentation the dose that was borrowed from Resident #14 and administered to another resident on 10/25/20 was paid back to Resident #14.

Telephone interview with Resident #14's primary care provider (PCP) on 11/09/20 at 4:30pm revealed:
-On 11/02/20 when she came to the facility, the RCC asked if she could write another prescription for Resident #14's Hydrocodone/Acetaminophen 5/325mg tablets because they had to borrow a couple of pain tablets from Resident #14 and administer to another resident who ran out of the pain medication.
-She told the RCC she could not write another prescription at that time for Resident #14's pain medication because of possible legal repercussions.
-She told the RCC it was too soon to refill

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D 372	Continued From page 81	D 372		

Resident #14's pain medication and she did not write a new prescription at that time.

Telephone interview with the RCC on 11/13/20 at 2:59pm revealed:
-She did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record.
-She did not recall the note indicating that she would handle the documentation on the CS record for Resident #14.
-She did not know if anyone documented the borrowing of Resident #14's pain medication or if anyone replaced it or paid it back.

Telephone interview with the Administrator on 11/12/20 at 11:50am revealed:
-Staff (could not recall who) contacted her when a resident on the 100 hall ran out of his pain medication.
-She did not want the resident to suffer or be in pain so they borrowed pain medication from Resident #14 to administer to the other resident.
-The facility only borrowed medications if it was a "dire need".
-She did not know if the borrowed medication had been replaced and paid back to Resident #14.
-The RCC would know the process for borrowing medications.

Based on interviews and record review, Resident #14 was not interviewable.

Refer to telephone interview with the former Administrator on 11/12/20 at 2:15pm.

Refer to a second telephone interview with the former Administrator on 11/12/20 at 6:20pm.

Refer to telephone interview with the Business

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D 372	Continued From page 82 Office Manager (BOM) on 11/17/20 at 9:48am. 2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism, insomnia, and restless leg syndrome. Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #13's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain. Review of Resident #13's emergency room (ER) after visit summary dated 10/19/20 revealed: -The resident was seen at the ER on 10/19/20 for a fall and was diagnosed with a closed fracture of the left forearm. -The resident's medication list included to continue taking Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime. Review of Resident #13's physician's order sheet dated 10/21/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime and an order for Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime as needed for pain. Interview with a medication aide (MA) on 11/10/20 at 5:20pm revealed: -About 2 weeks ago, Resident #13 ran out of his Hydrocodone/Acetaminophen 5/325mg tablets.	D 372		

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-She got permission from the Administrator to borrow one Hydrocodone/Acetaminophen 5/325mg tablet from another resident.
-She did not know if the medication borrowed for Resident #13 had been replaced and paid back to the other resident.
-She was not sure if she documented borrowing the medication for Resident #13.

Review of Resident #13's October 2020 electronic medication administration record (e-MAR) revealed:
-There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 9:00pm.
-Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 10/01/20 - 10/18/20 and 10/20/20 - 10/25/20.
-There was no documentation a dose of Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20.
-There was no documentation at dose was paid back to the other resident from Resident #13's supply.

Review of Resident #13's CS record for the supply dispensed on 09/09/20 revealed:
-There were 15 tablets documented as administered from 10/09/20 - 10/24/20.
-There would have not been any tablets remaining in this supply to administer to the resident on 10/25/20.
-There was no documentation on the CS record that Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20.

Telephone interview with the Administrator on

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D 372	Continued From page 84 11/12/20 at 11:50am revealed: -Staff (could not recall who) contacted her when Resident #13 ran out of his pain medication. -She did not want Resident #13 to suffer or be in pain so they borrowed pain medication from another resident to administer to Resident #13. -The facility only borrowed medications if it was a "dire need". -She was not sure if the facility had a policy for borrowing medication or what the process was for borrowing medications. -She did not know if the borrowed medication had been replaced and paid back to the other resident. -The Resident Care Coordinator (RCC) would know the process for borrowing medications. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -The facility's policy was they were not allowed to borrow medications. -She was not aware Resident #13 ran out of Hydrocodone/Acetaminophen. -She did not tell anyone to borrow medication. -She would have called the pharmacy and the PCP. Telephone interview with Resident #13's PCP on 11/13/20 at 1:07pm revealed: -On 11/02/20, the RCC asked for a refill for another resident's Hydrocodone/Acetaminophen 5/325mg tablets because they had borrowed that resident's medication for Resident #13. -Resident #13 was taking Hydrocodone/Acetaminophen at bedtime for a fractured arm. Based on observations, interviews, and record review, Resident #13 was not interviewable.	D 372		

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D 372	Continued From page 85 Refer to telephone interview with the former Administrator on 11/12/20 at 2:15pm. Refer to a second telephone interview with the former Administrator on 11/12/20 at 6:20pm. Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am. _____ Telephone interview with the former Administrator on 11/12/20 at 2:15pm revealed: -He was not aware any medications had been borrowed at the facility. -They could borrow medications if it was an emergency like on weekends and they could not get a CS medication refilled but they had to report it and document replacing it. A second telephone interview with the former Administrator on 11/12/20 at 6:20pm revealed: -The facility did not have a policy for borrowing medications because they were not allowed to borrow medications. -It was a verbal policy, not written. Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed: -He was not aware a resident ran out of pain medication and staff borrowed from another resident. -The facility did not have a policy for borrowing medications. -He would expect staff to follow proper procedure if medications were borrowed.	D 372		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily	D 392		

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retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 2 of 2 residents sampled (#13, #14) who both received medication for moderate to severe pain.

The findings are:

1. Review of Resident #14's current FL-2 dated 07/07/20 revealed:
-Diagnoses included unspecified dementia, arthritis, and schizophrenia - paranoid type.
-There was an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day.
(Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.)

Review of Resident #14's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day.

Review of Resident #14's incident/accident report dated 10/20/20 at 12:00pm revealed:
-Staff went to get back up supply of Hydrocodone/Acetaminophen 5/325mg for Resident #14.

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-When the Resident Care Coordinator (RCC) called the pharmacy, they told the RCC that the pharmacy delivered 90 tablets on 10/08/20.
-There were 60 tablets of Hydrocodone/Acetaminophen 5/325mg missing.
-There was "no injury" to the resident.
-Staff noted it was reported to the police department and the Health Care Personnel Registry (HCPR).
-The incident/accident report was electronically signed by Resident #14's PCP on 10/23/20 at 5:03pm.

Review of Resident #14's CS continuance of therapy prescription dated 10/08/20 revealed an order for 90 Hydrocodone/Acetaminophen 5/325mg tablets take 1 tablet 3 times a day.

Review of Resident #14's CS emergency dispense prescription dated 10/20/20 revealed an order for 60 Hydrocodone/Acetaminophen 5/325mg tablets take 1 tablet 3 times a day.

Review of Resident #14's pharmacy dispensing records from September 2020 - November 2020 revealed:
-There were 90 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/08/20.
-There were 90 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 10/08/20.
-There were 60 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 10/21/20.

Review of Resident #14's September 2020 electronic medication administration record (e-MAR) revealed:
-There was an entry for

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D 392	Continued From page 88 Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered 3 times daily from 09/01/20 - 09/30/20 except for 1 occasion. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 09/08/20 at 1:00pm due to "awaiting pharmacy delivery". -There were 89 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 09/01/20 - 09/30/20. Review of Resident #14's October 2020 e-MAR revealed: -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered 3 times a day from 10/01/20 - 10/18/20 and 10/22/20 - 10/31/20 and once on 10/19/20 at 9:00pm. -Documentation for Hydrocodone/Acetaminophen 5/325mg was blank on 6 occasions with no reason for the omissions on 10/19/20 at 9:00am and 1:00pm; 10/20/20 at 9:00am, 1:00pm, and 9:00pm; and 10/21/20 at 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/21/20 at 9:00am and 1:00pm due to "awaiting pharmacy delivery". -There were 85 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 10/01/20 - 10/31/20. Review of Resident #14's November 2020 e-MAR revealed:	D 392		

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(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 392	Continued From page 89 -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day with a scheduled administration times of 9:00am, 1:00pm, and 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered as ordered from 11/01/20 - 11/10/20. -There were 28 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 11/01/20 - 11/10/20 at 9:00am. Review of Resident #14's CS record for the supply dispensed on 09/08/20 revealed: -The first page had a prescription label on the upper left side of the page for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 09/09/20 with a starting amount of 30 tablets. -The first dose of those 30 tablets was documented as administered on 09/09/20 at 9:00am and the last dose on 09/18/20 at 9:00pm. -The next row noted a second card with 30 tablets was "placed on cart" on 09/18/20. -The first dose of those 30 tablets was documented as administered on 09/19/20 at 8:00am and the last dose on the second page was on 09/28/20 at 9:00pm. -The second page had an entry for the third card with 30 tablets "placed on cart" on 09/28/20. -The first dose of those 30 tablets was documented as administered on 09/29/20 at 9:00am and the last dose on 10/08/20 at 9:00pm, leaving a balance of zero.	D 392		

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D 392	Continued From page 90 -There were 66 tablets documented as administered from 09/09/20 - 09/30/20. -There were 24 tablets documented as administered from 10/01/20 - 10/08/20. Review of Resident #14's CS record for the supply dispensed on 10/08/20 revealed: -The prescription label on the upper left side of the page was for 90 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page had date received documented as 10/08/20, amount received as 90, but received by line was blank. -Documentation on the first row noted "placed on cart" on 10/08/20 with a starting amount of 90 but the 90 had been written over and changed to 30 with no initials to indicate who made the change. -The first dose was documented as administered on 10/09/20 at 9:00am with amount remaining documented as 89 but the 89 had been written over and changed to 29 with no initials to indicate who made the change. -The second dose was documented as administered on 10/09/20 at 1:00pm with amount remaining documented as 88 but the 88 had been written over and changed to 28 with no initials to indicate who made the change. -The third dose was documented as administered on 10/09/20 at 9:00pm with the amount remaining documented as 27. -The rest of the doses were documented as declining from 26 to 0 and administered from 10/10/20 at 9:00am through 10/18/20 at 9:00pm. -There was no documentation on the CS record to account for the other 60 of 90 tablets dispensed on 10/08/20. -There were no other CS records provided for the supply of 90 tablets dispensed on 10/08/20.	D 392		

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D 392	Continued From page 91 -There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered from 10/19/20 - 10/21/20 due to no medication being on hand for a total of 9 missed doses. Review of Resident #14's CS record for the supply dispensed on 10/21/20 revealed: -The first page had a prescription label on the upper left side of the page for 60 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet 3 times a day. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 10/22/20 with a starting amount of 30 tablets. -The first dose of those 30 tablets was documented as administered on 10/22/20 at 9:00am and the last dose on 10/31/20 at 8:00am. -There was documentation of 1 tablet being administered on 10/25/20 at 9:00am leaving a balance of 20 tablets and the next entry was for 10/25/20 at 1:00pm with 1 tablet administered but the balance remaining was documented at 18 instead of 19 tablets. -There was no documentation on the CS record to account for that one tablet. -There was a row between doses administered on 10/25/20 at 9:00pm and 10/26/20 at 9:00am that had no staff signature, no date and no time documented but amount given was recorded as 1 and the amount remaining declined to 16 tablets. -There was a handwritten note beside this row initialed by two medication aides (MAs). -The MAs documented beside this row that the facility's nurse (now the current Administrator) called the Resident Care Coordinator (RCC) and the RCC said to leave it blank and the RCC would	D 392		

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handle it when she got there in the morning.
-The note did not indicate that a dose had been borrowed from Resident #14 and administered to another resident.
-There was no documentation on the CS record to account for the tablet or to reconcile what happened to this tablet.
-The second page had an entry for the second card with 30 tablets "placed on cart" on 10/28/20 at 3:00pm.
-The first dose of those 30 tablets was documented as administered on 10/29/20 at 1:00pm and the last dose on 11/10/20 at 8:00am, leaving a balance of zero.
-A dose for 10/29/20 at 1:00pm was already documented by another MA on the first page but both entries declined the count.
-There was not documentation for a dose being administered at 1:00pm on 10/31/20 but it was documented as administered on the e-MAR at that time.
-There were 59 of 60 tablets documented as administered from 10/22/20 - 11/10/20 at 8:00am but there was a balance of zero documented as the amount remaining.

Observation of Resident #14's medications on hand on 11/10/20 revealed there was no Hydrocodone/Acetaminophen 5/325mg tablets on hand for the resident.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/06/20 at 1:22pm revealed:
-The pharmacy dispensed 90 Hydrocodone/Acetaminophen 5/325mg tablets on 10/08/20 for Resident #14 that were delivered to the facility and signed for by a MA on 10/08/20 at 11:46pm.
-The supply was dispensed in 3 bubble cards of

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30 tablets each, for a total of 90 tablets.
-There was a supply of 60 Hydrocodone/Acetaminophen 5/325mg tablets dispensed on 10/21/20 that were delivered to the facility and signed for by a MA on 10/22/20 at 12:32am.

A second telephone interview with a pharmacist at the facility's contracted pharmacy on 11/17/20 at 9:04am revealed the pharmacy sent a CS record sheet with each 30-count blister card to the facility when the medication was dispensed.

Telephone interview with a MA on 11/13/20 at 3:14pm revealed:
-She remembered Resident #14 having 3 bubble cards of Hydrocodone/Acetaminophen 5/325mg in the medication cart (could not recall the date).
-The next day (could not recall date) when she came to work on second shift, 60 tablets (2 cards of 30) were gone and there was one card left with less than 30 tablets (did not know how many).
-The RCC asked her where the tablets were but she did not know what happened to them.
-She did not know what kind of pain the resident took the medication for but the resident missed some doses when the medications were missing.
-She did not remember why she documented the dose on 10/19/20 at 9:00pm was administered on the e-MAR when there was no medication available to administer.
-The MAs did shift counts of the CS medications each time they changed shifts.
-The MAs documented on the CS record when a CS medication was administered.
-On 10/25/20, she was working on second shift on Resident #14's hall when she was told via telephone by the facility's nurse (now the current Administrator) to give one of Resident #14's Hydrocodone/Acetaminophen tablets to another

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D 392	Continued From page 94 MA for a resident on another hall. -She documented using 1 tablet on the CS record and she wrote a note beside that row on the CS record that the RCC would handle it the next day. -She and another MA initialed the note on the CS record. -The CS record count usually started with the amount of medication received. -When they first got Resident #14's Hydrocodone/Acetaminophen (dispensed and received on 10/08/20), she and the other MA counted off and there were 90 tablets in the medication cart. -The CS record initially had 90 tablets as the starting count but someone marked over it and changed it to 30. -She did not know who changed it or why the documentation was not accurate. Telephone interview with a second MA on 11/16/20 at 1:38pm revealed: -She was working the morning that Resident #14's card with 30 tablets of Hydrocodone/Acetaminophen ran out. -Someone had changed the 90 on the CS record to 30. -She went to the RCC and the RCC told her this was not right because 90 tablets had been delivered to the facility for Resident #14. -The MAs were supposed to document administration of CS medications on the CS record. -She thought they usually started the balance on the CS record with the amount received, like 90 tablets for example. -The MAs did shift counts for the CS medications each shift and when she checked the count that morning, the CS record showed zero for the balance for Resident #14 and there was none on hand.	D 392		

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D 392	Continued From page 95 -A few months ago, there was a problem with the shift count not matching but it was because someone forgot to sign the CS record. Telephone interview with a third MA on 11/16/20 at 2:10pm revealed: -When she documented 10/29/20 on Resident #14's CS record for Hydrocodone/Acetaminophen, it was probably a documentation error. -She would have administered the dosage when she initialed on the e-MAR. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -A MA came to her and reported Resident #14 was out of his Hydrocodone/Acetaminophen 5/325mg tablets (could not recall date). -She usually kept the supply of back up medications in her office in a locked filing cabinet. -She checked the filing cabinet but Resident #14 did not have any in the cabinet. -She called the pharmacy and was told 90 tablets had been sent to the facility previously and the resident should have 60 tablets left. -It looked like someone had written over the numbers on the CS record and changed it. -The MA who signed for delivery of the medication (could not recall date) reported all 90 tablets were put on the active medication cart when it was received. -A second MA also reported the other MA put all 90 tablets on the medication cart. -She reported the missing medication to the Administrator and they called the police. -She reported it to the PCP the same day (did not know date) but the pharmacy could not send more medication because it had just been filled. -The PCP called another prescription to the pharmacy and more tablets were sent she	D 392		

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thought on the same night.
-The MAs were required to do shift counts for the CS medications each time they changed shifts.
-The MAs had not reported any discrepancies with the shift counts or any issues with documentation on the CS records.

A second telephone interview with the RCC on 11/13/20 at 2:59pm revealed:
-If the pharmacy only sent 1 CS record sheet for a supply of medication, they would start the count with the amount received, such as 90.
-If the pharmacy sent a CS record sheet for each bubble card, they would start store one bubble card and 1 CS record sheet in the medication cart.
-The other 2 bubble cards and CS record sheets should be stored in the back up supply cabinet.
-If staff documented "place on cart" on the CS record, it meant there was only 1 CS record sheet for the supply received.
-The MAs were supposed to document who received the medication, date received, and amount received in the upper right corner of the CS record sheet.
-She did not know why there was a blank line with 1 tablet deducted on 10/25/20 for Resident #14's CS record.
-She did not recall the note indicating that she would handle the documentation on the CS record for Resident #14.

Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am

2. Review of Resident #13's current FL-2 dated 03/18/20 revealed diagnoses included dementia, arthritis, depression, glaucoma, hypothyroidism, insomnia, and restless leg syndrome.

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D 392	Continued From page 97 Review of Resident #13's physician's order dated 03/31/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime. (Hydrocodone/Acetaminophen 5/325mg is a controlled substance (CS) used to treat moderate to severe pain.) Review of Resident #13's physician's orders revealed the primary care provider (PCP) wrote a prescription on 09/09/20 for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain. Review of Resident #13's emergency room (ER) after visit summary dated 10/19/20 revealed: -The resident was seen at the ER on 10/19/20 for a fall and was diagnosed with a closed fracture of the left forearm. -The resident's medication list included to continue taking Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime. Review of Resident #13's physician's order sheet dated 10/21/20 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime and an order for Hydrocodone/Acetaminophen 5/325mg 1 tablet at bedtime as needed for pain. Review of Resident #13's physician's order dated 11/05/20 revealed an order to discontinue all previous Hydrocodone/Acetaminophen 5/325mg orders and start Hydrocodone/Acetaminophen 5/325mg 1 tablet every day at bedtime. Review of Resident #13's pharmacy dispensing records from August 2020 - November 2020 revealed: -There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg	D 392		

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dispensed on 08/03/20.
-There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/08/20.
-There were 15 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 09/09/20.
-There were 30 tablets of Hydrocodone/Acetaminophen 5/325mg dispensed on 11/05/20.

Review of Resident #13's September 2020 electronic medication administration record (e-MAR) revealed:
-There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 9:00pm.
-Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 09/01/20 - 09/03/20, 09/06/20, 09/07/20, and 09/09/20 - 09/30/20.
-Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 09/04/20 - 09/05/20, and 09/08/20 due to "awaiting pharmacy delivery".
-There was a second entry for Hydrocodone/Acetaminophen 5/325mg 1 table at bedtime as needed (prn) for pain, not to exceed 4 grams of Acetaminophen from all sources in 24 hours.
-One prn dose of Hydrocodone/Acetaminophen was documented as administered on 09/18/20.
-There were 27 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 09/01/20 - 09/30/20.

Review of Resident #13's October 2020 e-MAR revealed:

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D 392	Continued From page 99 -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 9:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 10/01/20 - 10/18/20 and 10/20/20 - 10/25/20. -Hydrocodone/Acetaminophen 5/325mg was not documented as administered on 10/19/20 and from 10/26/20 - 10/31/20 due to the resident being out of the facility. -There was a second entry for Hydrocodone/Acetaminophen 5/325mg 1 table at bedtime as needed (prn) for pain, not to exceed 4 grams of Acetaminophen from all sources in 24 hours. -No prn doses of Hydrocodone/Acetaminophen were documented as administered. -There were 24 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 10/01/20 - 10/31/20. Review of Resident #13's November 2020 e-MAR revealed: -There was an entry for Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime with a scheduled administration time of 8:00pm. -Hydrocodone/Acetaminophen 5/325mg was documented as administered daily from 11/05/20 - 11/09/20. -There was a note documented on 11/06/20 at 1:37am, "awaiting med to come in, meds arrived at 1:30". -Hydrocodone/Acetaminophen 5/325mg was not documented as administered from 11/01/20 - 11/03/20 due to the resident being out of the facility. -Hydrocodone/Acetaminophen 5/325mg was not	D 392		

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documented as administered on 11/04/20 due to "awaiting pharmacy delivery".
-There was a second entry for Hydrocodone/Acetaminophen 5/325mg 1 table at bedtime as needed (prn) for pain, not to exceed 4 grams of Acetaminophen from all sources in 24 hours.
-No prn doses of Hydrocodone/Acetaminophen were documented as administered.
-There were 5 tablets of Hydrocodone/Acetaminophen 5/325mg documented as administered from 11/01/20 - 11/09/20.

Review of Resident #13's CS record for the supply dispensed on 08/03/20 revealed:
-The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime.
-The section on the upper right side of the page to document the date received, amount received, and received by was blank.
-Documentation on the first row noted "placed on cart" on 08/03/20 with a starting amount of 30 tablets.
-The first dose was documented as administered on 08/04/20 at 9:00pm and the last dose on 09/02/20 at 9:00pm.
-There were 28 tablets documented as administered from 08/04/20 - 08/31/20.
-There were 2 tablets documented as administered from 09/01/20 - 09/02/20.

Review of Resident #13's CS record for the supply dispensed on 09/08/20 revealed:
-The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime.

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D 392	Continued From page 101 -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 09/08/20 with a starting amount of 30 tablets. -The first dose was documented as administered on 09/09/20 at 9:00pm and the last dose on 10/08/20 at 9:00pm. -There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered from 09/03/20 - 09/08/20 for a total of 6 missed doses. -There were 22 tablets documented as administered from 09/09/20 - 09/30/20. -There were 8 tablets documented as administered from 10/01/20 - 10/08/20. Review of Resident #13's CS record for the supply dispensed on 09/09/20 revealed: -The prescription label on the upper left side of the page was for 15 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime as needed for pain. -The section on the upper right side of the page to document the date received, amount received, and received by was blank. -Documentation on the first row noted "placed on cart" on 09/09/20 with a starting amount of 15 tablets. -The first dose was documented as administered on 10/09/20 at 9:00pm and the last dose on 10/24/20 at 9:00pm. -There were no doses of Hydrocodone/Acetaminophen 5/325mg tablets administered on 10/19/20 or 10/25/20 - 10/31/20. -There were 15 tablets documented as administered from 10/09/20 - 10/24/20. -There would have not been any tablets remaining in this supply to administer to the	D 392		

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resident on 10/25/20.
-There was no documentation on the CS record that Hydrocodone/Acetaminophen 5/325mg was borrowed from another resident and administered to Resident #13 on 10/25/20.

Review of Resident #13's CS record for the supply dispensed on 11/05/20 revealed:
-The prescription label on the upper left side of the page was for 30 tablets of Hydrocodone/Acetaminophen 5/325mg take 1 tablet at bedtime.
-The section on the upper right side of the page to document the date received, amount received, and received by was blank.
-Documentation on the first row noted "placed on cart" on 11/06/20 with a starting amount of 30 tablets.
-The first dose was documented as administered on 11/06/20 at 1:37am and the last entry was documented on 11/09/20 at 9:00pm.
-There were two entries with one dose each of Hydrocodone/Acetaminophen 5/325mg being administered on 11/07/20 at 9:00pm by two different medication aides (MAs).
-There was no documentation of a dose of Hydrocodone/Acetaminophen being administered on 11/08/20 as indicated on the e-MAR.
-There were 5 tablets documented as administered from 11/06/20 - 11/09/20, leaving a balance of 25 tablets.

Observation of Resident #13's medications on hand on 11/10/20 at 4:23pm revealed:
-There was one supply of Hydrocodone/Acetaminophen 5/325mg tablets with 30 tablets dispensed on 11/05/20.
-There were 25 of 30 tablets remaining in the bubble card.

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D 392	Continued From page 103 Refer to telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am. _____ Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:48am revealed: -Nothing should be altered or changed on the CS records. -The CS records should be accurate. -The RCC was responsible for checking the CS records for accuracy.	D 392		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.	D 454		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to contact the responsible party of 5 of 10 residents sampled (#2, #3, #5, #6, and #9) concerning the facility's response to the coronavirus (COVID-19) outbreak, positive test results for COVID-19 (#3), and after incidents that required hospitalization (#2 and #5).

The findings are:

1. Review of Resident #2's Resident Register dated 04/05/16 revealed:
-She was admitted to the facility on 04/05/16.
-She had a responsible person.

Telephone interview with Resident #2's responsible person (RP) on 11/05/20 at 2:20pm revealed:
-She was called on 09/28/20 midmorning by a local hospital anesthesiologist who requested consent for surgery to repair Resident #2's severe left hip fracture.
-She was unaware that Resident #2 had fallen and been hospitalized.
-She was called on 09/28/20 around 1:00pm by a facility staff informing her that Resident #2 had a fall and was sent out to the hospital for further observation.
-She asked the staff member what happened to Resident #2 and why she was not notified.
-The staff apologized for not notifying her immediately after the incident.
-She called to the facility on 10/07/20 around 1:00pm to speak with the former administrator.
-She RP asked the former Administrator about the events that led up to Resident #2's fall.
-She asked the former Administrator why she was

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not notified of Resident #2's fall, and hospitalization.
-No staff member of the facility ever communicated to her that Resident #2 had a fall on 09/27/20, had been sent, or experienced any type of discomfort or pain.

Interview with Business Office Manager (BOM) on 11/17/20 at 12:07pm revealed:
-He was aware of Resident #2 had a fall around 9/27/20.
-The 2nd shift MA did not notify the RP for Resident #2's fall on 09/27/20.

2. Review of Resident #3's Resident Register revealed an admission date of 04/05/18.

Review of the local county health department COVID-19 revealed Resident #3 tested positive for COVID-19 on 10/19/20.

A telephone interview with a family member for Resident #3 on 11/05/20 at 10:00am revealed:
-She had been to the facility for a bedside visit with Resident #3 on 10/22/20.
-The Resident Care Coordinator (RCC) had told her that Resident #3 was negative for COVID-19 when she asked upon entering the facility on 10/22/20.
-The RCC returned to let her know Resident #3 had in fact tested positive upon her entering his room.
-There was no red heart on the door of Resident #3 to indicate that he had tested positive for COVID-19.
-She was told by staff on the 100 hall that they had "run out" of red hearts so not all residents that had tested positive had one on their door.

A telephone interview with a second family

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member and Power of Attorney (POA) for Resident #3 on 11/05/20 at 11:50am revealed:
-The facility did not notify him of positive results for COVID-19 for Resident #3.
-He learned of Resident #3 testing positive on 10/20/20 from another family member.
-He received an undated letter from the facility on 10/13/20 informing him of COVID-19 in the facility.

Interview with the current Administrator on 11/10/20 at 3:20pm revealed:
-Resident #3 tested positive for COVID-19 on 10/19/20.
-She thought the former Administrator had sent a letter out to families to inform them of the COVID outbreak sometime in September 2020.
-There was no time frame outlined for notifying families when a resident tested positive for COVID-19 but would "call when I can between other things".

Attempted telephone interview with the former Administrator on 11/13/20 at 12:59pm was unsuccessful.
3. Review of Resident #5's Resident Register revealed:
-There was a phone number and address listed for Resident #5's responsible person (RP).
-Resident #5's family member was a listed as the RP and signed the Resident Register.

Review of Resident #5's electronic medication administration record (eMAR) revealed there was a different phone number documented for Resident #5's RP.

Review of Resident #5's October 2020 electronic medication administration record (eMAR) revealed there was documentation that Resident

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D 454	Continued From page 107 #5 was out of the facility from 10/09/20 to 10/14/20. Review of Resident #5's incident and accident reports revealed: -There was an incident/accident report dated 10/09/20. -Resident #5 was sent to the hospital due to a fever of 104 degrees Fahrenheit. -Resident #5's RP was notified using the phone number on the eMAR profile. -There was documentation of "no answer" beside the line for the RP notification. Telephone interview with a medication aide (MA) on 11/09/20 at 3:10pm revealed: -MAs were responsible for contacting family members or RPs as soon as possible. -She notified RPs by using the phone number on the eMAR system. -Most of the time she reached the RP by telephone and had left messages. -She thought the Resident Care Coordinator (RCC) entered the information into the eMAR system. Interview with another MA on 11/10/20 at 2:30pm revealed: -RPs were contacted when a resident was injured, hospitalized, or if anything happened with the resident big or small. -She used the profile on the eMAR system but sometimes the profile did not have a phone number listed. -If the eMAR profile did not have a phone number for the RP, she used the contact information listed on the face sheet or resident register. -If the RP did not answer the phone, she left a message or continued to call until she reached the RP.	D 454		

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-She had remained over her shift to try to contact a resident's RP or she told the RCC.
-She had not contacted Resident #5's RP.

Confidential interview with staff revealed:
-RPs were contacted for any incident that occurred with a resident.
-The eMAR profile was the preferable way to find a phone number to contact a responsible person.
-A voicemail was left for the responsible person if there was no answer.
-Staff did not know who placed the information into the eMAR system for the resident profile.
-Staff did not speak with Resident #5's RP.

Interview with RCC on 11/10/20 at 5:00pm revealed:
-She expected the MAs to contact the RP when a resident went to the hospital or anytime an incident report was completed.
-She had spoken with Resident #5's RP because she came to the facility to speak with her and the former Administrator.
-She did not know the date Resident #5's RP visited the facility.
-She did not know Resident #5's RP was not notified concerning his hospitalization.
-If someone, the MA, had told her Resident #5's RP was not contacted she would have reached out to Resident #5's RP.
-She or the former Administrator were responsible for entering the information into the eMAR profile.
-She did not know the phone number for Resident #5's eMAR profile was incorrect.
-She expected staff to check the face sheet or resident register to ensure the correct phone number was used to contact the RP.

Telephone interview with the Administrator on

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11/13/20 at 11:49am revealed:
-She expected the MAs to contact family members or RPs as soon as possible.
-If a MA was not able to contact the RP, the MA needed to tell her or the RCC.
-She did not know Resident #5's RP was not notified about his hospitalizations due to using an incorrect phone number documented on the eMAR profile.
-She, and the MA were responsible for ensuring the RP was notified concerning hospitalizations.

Telephone interview with the Business Office Manager (BOM) on 11/17/20 at 10:00am revealed:
-He had not had success in contacting Resident #5's RP concerning financial issues.
-Correspondence was sent to Resident #5's RP who was also the payee in the past and the correspondence was returned to the facility.
-Resident #5's RP did not provide an updated address after moving.
-He did not know Resident #5's RP was not notified concerning Resident #5's 10/09/20 hospitalization.
-The former Administrator was responsible for ensuring resident's RP was notified of hospitalizations.

Attempted telephone interview with Resident #5's RP on 11/04/20 at 4:26pm was unsuccessful.

Attempted telephone interview with the former Administrator on 11/13/20 at 12:59pm was unsuccessful.

4. Review of the facility letter regarding COVID-19 outbreak within the facility revealed:
-There was no date on the letter.
-The letter stated there were some residents who

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had tested positive for COVID-19 and those families were notified, a list of specific vitamins, steroid, and an antibiotic were listed as treatments given to residents to fight the coronavirus, encouraged the family members to add elderberry to their daily regimen, encouraged window visits with residents, and the facility would notify them when indoor or outdoor visitation resumed.
-The letter was signed by the former Administrator and there were no other signatures.

a. Review of Resident #9's Resident Register revealed:
-There was a family member listed for Resident #9's responsible person.
-There was a phone number and address documented for Resident #9's responsible person (RP).

Telephone interview with Resident #9's RP on 11/12/20 at 1:26pm revealed:
-She was told by the Psychiatrist who cared for Resident #9 in the hospital about the facility as a place to transfer Resident #9.
-The former Administrator spoke with her prior to Resident #9's admission and told her the facility had a few COVID-19 resident cases.
-Resident #9 was admitted after Labor Day in September 2020, but she did not remember the exact day.
-She did not receive a letter from the facility concerning COVID-19 and measures taken to address the pandemic.
-She had received bills from the facility contracted pharmacy, but she had received no correspondence from the facility.

Attempted telephone interview with the former Administrator on 11/13/20 at 12:59pm was

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unsuccessful.

Refer to the interview with the former Administrator on 11/03/20 at 3:09pm.

Refer to the interview with the Staff Developer on 11/03/20 at 3:21pm.

Refer to the telephone interview with the Administrator on 11/13/20 at 11:49am.

Refer to the telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:50am.

b. Review of Resident #6's Resident Register revealed:
-Resident #6's admission date was 09/06/17.
-Resident #6 had a legal guardian assigned.

Review of Resident #6's record revealed:
-Resident #6 was transferred to the local hospital on 10/07/20.
-Resident #6 tested positive for the coronavirus on 10/04/20.

Interview with the Resident Care Coordinator (RCC) on 11/03/20 at 11:15am revealed:
-Resident #6 was transferred to the local hospital.
-Resident #6 did not return to the facility and was admitted to a skilled nursing facility in another town within the state.
-She was not involved with the letters sent to residents' responsible persons; the former Administrator sent the letters.

Telephone interview with Resident #6's guardian on 11/04/20 at 11:13am revealed:
-She was told Resident #6 was transferred to the hospital.

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D 454	Continued From page 112 -She did not receive the letter concerning the COVID-19 outbreak within the facility. Attempted telephone interview with the former Administrator on 11/13/20 at 12:59pm was unsuccessful. Refer to the interview with the former Administrator on 11/03/20 at 3:09pm. Refer to the interview with the Staff Developer on 11/03/20 at 3:21pm. Refer to the telephone interview with the Administrator on 11/13/20 at 11:49am. Refer to the telephone interview with the Business Office Manager (BOM) on 11/17/20 at 9:50am. _____ Interview with the former Administrator on 11/03/20 at 3:09pm revealed: -He wrote a letter to be sent out to the residents' families. -The letter discussed that some facility residents contracted the COVID-19 virus, medication regiment and facility visitation. -Those families were notified individually. -He forgot to date the letter and the letters were mailed around the second week of October 2020. -He had the staff developer to mail the letters out to the families. Interview with the Staff Developer on 11/03/20 at 3:21pm revealed: -The former Administrator wrote a letter to the residents' families and RPs regarding the COVID-19 pandemic and its effects on the facility. -The former Administrator asked her to mail the	D 454		

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D 454	Continued From page 113 letters out to the families. -She placed a copy of the letter in the residents' business file. -She mailed the letters out around 10/08/20. Telephone interview with the Administrator on 11/13/20 at 11:49am revealed: -The management team mentioned sending a letter to RPs concerning the status of COVID-19 within the facility. -She had not been involved with sending letters to residents' responsible persons notifying them of the COVID-19 outbreak within the facility. -She did not know the process used to distribute the letters. Telephone interview with the BOM on 11/17/20 at 9:50am revealed: -He was informed that a letter would be sent to resident's responsible person concerning COVID-19 within the facility. -He did not know when the letters were mailed, the process used to mail the letters nor the content of the letters. -The former Administrator was responsible for ensuring the letter was sent to responsible persons.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to	D 465		

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10 residents on third shift and .8 hours of staff time for each additional resident.

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

Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the Special Care Unit (SCU) with a census of 106 to 118 were met for 25 of 57 shifts sampled on 10/05/20, from 10/11/20 to 10/25/20, and from 11/06/20 to 11/08/20 after assistance with staffing was offered to the facility by the local county health department task force and another local county government agency.

The findings are:

Review of the facility's current license effective January 1, 2020 revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of 142 beds.

Review of the facility's Resident Bed List Report dated 10/05/20 revealed there was a SCU census of 118 residents, which required 118 staff hours on first and second shift and 94.4 staff hours on third shift.

Review of the individual employee time cards dated 10/05/20 revealed there was a total of 85.25 staff hours provided on third shift with a shortage of 9 hours.

Review of the facility's resident COVID-19 test tracing spreadsheet revealed 26 of 118 residents tested positive for COVID-19 on 10/04/20 and 19 of 118 remained on quarantine due to testing

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

(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 465	Continued From page 115 positive for COVID-19 on 09/27/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 8 staff and the Administrator that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/05/20. -There were 6 staff who tested positive for COVID-19 on 10/04/20. -There were 15 staff not available to work 10/05/20 due to testing positive for COVID-19. Review of the facility's Resident Bed List Report dated 10/11/20 and 10/13/20 revealed there was a SCU census of 112 residents, which required 112 staff hours on first and second shift, and 89.6 staff hours on third shift. Review of the individual employee time cards dated 10/11/20 and 10/13/20 revealed: -On 10/11/20, there was a total of 106.50 staff hours provided on first shift with a shortage of 5.50 hours. -On 10/13/20, there was a total of 63.25 staff hours provided on third shift with a shortage of 25.35 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 35 of 112 residents tested positive for COVID-19 on 10/11/20 and 26 of 112 remained on quarantine due to testing positive for COVID-19 on 10/04/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were six staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/04/20. -There were eight staff who tested positive for COVID-19 on 10/11/20.	D 465		

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D 465	Continued From page 116 -There were 14 staff not available to work on 10/11/20 and 10/13/20. Review of the facility's Resident Bed List Report dated 10/12/20 revealed there was a SCU census of 111 residents, which required 111 staff hours on first and second shift, and 88.8 staff hours on third shift. Review of the individual employee time cards dated 10/12/20 revealed there was a total of 71.75 staff hours provided on third shift with a shortage of 17 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 35 of 111 residents tested positive for COVID-19 on 10/11/20 and 26 of 111 remained on quarantine due to testing positive for COVID-19 on 10/04/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 6 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/04/20. -There were 8 staff who tested positive for COVID-19 on 10/11/20. -There were 14 staff not available to work on 10/12/20. Review of the Resident Bed List Report dated 10/15/20 and 10/17/20 revealed there was a SCU census of 114 residents, which required 114 staff hours on first and second shift, and 91.2 hours on third shift. Review of the individual employee time cards dated 10/15/20 and 10/17/20 revealed: -On 10/15/20, there were 81 staff hours provided on third shift with a shortage of 11 staff hours.	D 465		

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D 465	Continued From page 117 -On 10/17/20, there were 72 staff hours provided on third shift with a shortage of 19 staff hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 35 of 114 remained on quarantine due to testing positive for COVID-19 on 10/11/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 8 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/11/20. -There were 8 staff not available to work on 10/15/20 and 10/17/20. Review of the Resident Bed List Report dated 10/16/20 revealed there was a SCU census of 116 residents, which required 116 staff hours on first and second shift, and 92.8 hours on third shift. Review of the individual employee time cards dated 10/16/20 revealed: -There were 99.25 staff hours provided on second shift with a shortage of 16.75 staff hours. -There were 80.50 staff hours provided on third shift with a shortage of 12 staff hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 26 of 116 residents tested positive for COVID-19 on 10/18/20 and 35 of 116 remained on quarantine due to testing positive for COVID-19 on 10/11/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 8 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/11/20.	D 465		

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D 465	Continued From page 118 -There were 8 staff not available to work on 10/16/20. Review of the facility's Resident Bed List Report dated 10/18/20 revealed there was a SCU census of 114 residents, which required 114 staff hours on first and second shift and 91.2 staff hours on third shift. Review of the individual employee time cards dated 10/18/20 revealed: -There was a total of 91.08 staff hours provided on second shift with a shortage of 22.92 hours. -There was a total of 81.12 staff hours provided on third shift with a shortage of 10.08 hours. Review of the facility's resident COVID-19 test tracing spreadsheet revealed 26 of 116 residents tested positive for COVID-19 on 10/18/20. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 8 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/11/20. -There were 7 staff that tested positive for COVID-19 on 10/18/20. -There were 15 staff not available to work on 10/18/20. Review of the facility's Resident Bed List Reports dated 10/19/20, 10/21/20, and 10/22/20 revealed there was a SCU census of 113 residents, which required 113 staff hours on first and second shift and 90.4 staff hours on third shift. Review of the individual employee time cards dated 10/19/20, 10/21/20, and 10/22/20 revealed: -On 10/19/20, there was a total of 94 staff hours provided on first shift with a shortage of 19 hours.	D 465		

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-On 10/19/20, there was a total of 72.05 staff hours provided on third shift with a shortage of 18.35 hours.
-On 10/21/20, there was a total of 74.65 staff hours provided on third shift with a shortage of 15.75 hours.
-On 10/22/20, there was a total of 81.52 staff hours provided on third shift with a shortage of 8.88 hours.

Review of the facility's staff COVID-19 test tracing spreadsheet revealed:
-There were 8 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/11/20.
-There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20
-There were 8 staff not available to work on 10/19/20.
-There were 7 staff not available to work on 10/21/20 and 10/22/20.

Review of the facility's Resident Bed List Report dated 10/20/20 revealed there was a SCU census of 112 residents, which required 112 staff hours on first and second shift and 89.6 staff hours on third shift.

Review of the individual employee time cards dated 10/20/20 revealed:
-There was a total of 104.92 staff hours provided on first shift with a shortage of 7.08 hours.
-There was a total of 81.63 staff hours provided on third shift with a shortage of 7.97 hours.

Review of the facility's staff COVID-19 test tracing spreadsheet revealed:
-There were 8 staff that were within the 10 days of quarantine due to testing positive for

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COVID-19 on 10/11/20.
-There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20
-There were 15 staff not available to work on 10/20/20.

Review of the facility's Resident Bed List Reports dated 10/23/20 and 10/25/20 revealed there was a SCU census of 110 residents, which required 110 staff hours on first and second shift and 88 staff hours on third shift.

Review of the individual employee time cards dated 10/23/20 and 10/25/20 revealed:
-On 10/23/20, there was a total of 80.75 staff hours provided on third shift with a shortage of 7.25 hours.
-On 10/25/20, there was a total of 64 staff hours provided on third shift with a shortage of 24 hours.

Review of the facility's resident COVID-19 test tracing spreadsheet revealed 4 of 110 residents tested positive for COVID-19 on 10/25/20.

Review of the facility's staff COVID-19 test tracing spreadsheet revealed:
-There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20.
-There were 3 staff that tested positive for COVID-19 on 10/25/20.
-There were 7 staff not available to work on 10/23/20 due to COVID-19.
-There were 10 staff not available to work on 10/25/20 due to COVID-19.

Review of the facility's Resident Bed List Report dated 10/24/20 revealed there was a SCU census

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D 465	Continued From page 121 of 109 residents, which required 109 staff hours on first and second shift and 87.2 staff hours on third shift. Review of the individual employee time cards dated 10/24/20 revealed: -There was a total of 104.4 staff hours provided on first shift with a shortage of 4.6 hours. -There was a total of 72.12 staff hours provided on third shift with a shortage of 15.08 hours. Review of the facility's staff COVID-19 test tracing spreadsheet revealed: -There were 7 staff that were within the 10 days of quarantine due to testing positive for COVID-19 on 10/18/20. -There were 7 staff not available to work on 10/24/20 due to COVID-19. Review of the facility's Resident Bed List Report dated 11/06/20 revealed there was a SCU census of 110 residents, which required 110 staff hours on first and second shift and 88 staff hours on third shift. Review of the individual employee time cards dated 11/06/20 revealed there was a total of 72.5 staff hours provided on third shift with a shortage of 15.5 hours. Review of the facility's staff COVID-19 test tracing spreadsheet revealed there were two staff on quarantine due to testing positive for COVID-19 on 10/27/20. Review of the facility's Resident Bed List Report dated 11/07/20 revealed there was a SCU census of 108 residents, which required 108 staff hours on first and second shift and 86.4 staff hours on third shift.	D 465		

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D 465	Continued From page 122 Review of the individual employee time cards dated 11/07/20 revealed: -There was a total of 102 staff hours provided on second shift with a shortage of 6 hours. -There was a total of 72.25 staff hours provided on third shift with a shortage of 14.15 hours. Review of the facility's staff COVID-19 test tracing spreadsheet revealed there were two staff on quarantine due to testing positive for COVID-19 on 10/27/20. Review of the facility's Resident Bed List Report dated 11/08/20 revealed there was a SCU census of 106 residents, which required 106 staff hours on first and second shift and 84.8 staff hours on third shift. Review of the individual employee time cards dated 11/08/20 revealed: -There was a total of 96.25 staff hours provided on second shift with a shortage of 9.75 hours. -There was a total of 72.25 staff hours provided on third shift with a shortage of 12.55 hours. Review of the emails from the local county health department (LHD) COVID-19 task force revealed: -An email dated 10/19/20 at 10:26am was sent to the local county Division Chief of Emergency Management from the task force lead inquiring about the process to obtain staffing assistance for the facility. -A reply was sent from the local county Division Chief of Emergency Management on 10/19/20 at 11:16am with the seven items needed to assist with staffing at the facility. -The task force lead sent the email from the Division Chief of Emergency Management to the former Resident Care Coordinator (RCC), the	D 465		

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former Administrator, and the Administrator on 10/19/20 at 11:23am.
-The 10/19/20 at 11:23am email explained that the information was needed in order to provide the staffing assistance.

Telephone interview with the LHD COVID-19 task force lead on 11/13/20 at 8:26am revealed:
-Staffing assistance was offered to the facility multiple times verbally and via email.
-The local county Division Chief of Emergency Management was organizing staffing for facilities who needed assistance due to the pandemic.

Telephone interview with the local county Division Chief of Emergency Management on 11/13/20 at 1:51pm revealed:
-During the past summer of 2020, staffing assistance was made available to aggregate living facilities in response to the pandemic.
-She needed specific information from the facility and she could get staffing assistants to the facility within two hours.
-Staffing assistance was available for administrative jobs and certified nurse assistance for any shift.
-She understood that when the staffing assistance was first offered the facility reported they did not need any assistance.
-Then later the facility reported they needed help, help was offered, and the facility reported again that they did not need the help.
-She was notified again on 10/19/20 by the COVID-19 task force lead and reported the facility had 95% positive COVID-19 cases among the residents.
-On 10/19/20, she told the task force lead what information was needed to give staffing assistance to the facility but she never received a response from the facility.

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D 465	Continued From page 124 -She provided her mobile phone number so that the facility could call but she did not hear from anyone at the facility. -She checked back with the LHD task force lead on 10/21/20 and 10/22/20 but received no response from the facility. Interview with the Human Resource (HR) office manager on 11/10/20 at 3:15pm revealed: -She assumed the job of scheduling in June 2020. -She and the RCC made the schedule for staff. -To determine the number of staff needed for first and second shift, she took the total number of residents and divided that number by 8. -She knew the number of staff needed for third shift was different than the number of staff needed on first and second shift. -For example, if the census was 111 or 112, she needed to schedule 13 to 14 staff, but she tried to schedule 15 people on first and second shift. -If the census increased above 112 residents, she scheduled 18 to 19 staff on first and second shift. -She and the Administrator did interviews to hire new staff. -She had sometimes 14 interviews scheduled and only 2 people "show up". -She thought the pandemic was affecting the hiring of new staff because people were afraid. -When staff called out, she called other staff to determine if they could cover the shift or come in early. -She did not know the number of staffing hours missing on the third shift were as high as 25.35. -She thought maybe staff did not clock in correctly. -She had tried constantly to hire for third shift. -Staff were asked to do overtime, but she tried to ensure no staff worked too many overtime shifts in a row.	D 465		

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-The RCC was constantly trying to get staff to provide coverage for all shifts.
-The RCC came to work early in the morning during third shift and she was sure the RCC helped staff with what she could.
-She thought maybe the LHD offered staffing assistance, but she was not sure.

Interview with the RCC on 11/10/20 at 5:00pm revealed:
-She came in early "like 3:00am" to help with resident care.
-She tried to get staff to come in early or scheduled extra staff to cover call outs.
-She scheduled 14 staff on first and second shift and 12 staff on third shift based on a census of 118 residents.
-She sometimes asked the former Administrator how many residents were within the building to determine how many staff to schedule.

Interview with the Business Office Manager (BOM) 11/10/20 at 5:31pm revealed:
-The HR office manager had shared the time card staffing hours with him.
-He thought staff who no longer worked at the facility were filed under archives in the time card system.
-He planned to look at the time cards for staff who no longer worked at the facility to determine if there were additional staffing hours for the time period from 10/11/20 to 10/25/20.
-He would provide the time cards if there were additional staffing hours.
-He found it hard to believe that there were 25.35 staffing hours not provided on 10/13/20 third shift.

Telephone interview with a medication aide (MA) on 11/16/20 at 3:26pm revealed:
-There were supposed to be three personal care

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aides (PCAs) and one MA assigned to each hall.
-Sometimes there would be one or two PCAs and one MA on each hall.
-Sufficient staff was not always provided; staff would "just need to work the shift."
-The Administrator, RCC, and former RCC did not help with providing care to the residents.
-The Administrator would check in with the PCAs, but never provided care on the halls.

Confidential staff interview revealed:
-Around 10/19/20, when the facility had so many residents who tested positive for COVID-19, the facility was "so shorthanded".
-They usually had 3 PCAs and 1 MA on each hall but during that time, they only had 2 PCAs and 1 MA on each hall.
-Sometimes they only had 1 PCA and 1 MA on a hall and they would have to call someone to come in.
-Sometimes staff had to wait 2 to 2 and ½ hours before another PCA was available to help with resident care.

Telephone interview with a PCA on 11/06/20 at 3:10pm revealed:
-There was usually 1 MA and 2 PCAs on each hall and sometimes possibly 3 PCAs.
-There was an assignment sheet at the front desk so staff would know their hall assignments when they arrived to work.
-The facility was sometimes short staffed on second shift and they tried to cover the shift by calling in staff or by asking other staff from the previous shift to work a double shift.
-He did not know how many staff usually worked on third shift because as soon as one staff person showed up to work on their hall, second shift staff left.

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D 465	Continued From page 127 Interview with a second PCA on 11/10/20 at 4:25pm revealed: -She was currently working with 1 other PCA and 1 MA to care for 28 residents on the 200 hall on evening shift. -It was common to work with 2 PCAs and 1 MA during the evening shift. -There had been times when there was 1 PCA and 1 MA working on the 200 hall but could not recall the date. -She has requested to work overtime on shifts that were short staffed but her requests had been denied. -The former RCC and the RCC did not work on the hall to assist with resident care when staffing was short. Telephone interview with a third PCA on 11/09/20 at 5:50pm revealed: -She was assigned to the 200- hall for the past two months. -When she worked overtime, she was assigned to another hall. -Staffing for the 200-hall was supposed to be one MA and three PCAs, but she worked with only one other person sometimes. -She had trained several people in the past few months, but sometimes staff did not come back to work again. -When there was only one other PCA on the hall with her, it made meal time more difficult because it was had to monitor the television room and watch the hall and the other residents in their rooms. -She had not observed anyone from the management team working on the halls. -A member of the management team might come to the double doors and yell down the hall to ask a question, but that was all she saw.	D 465		

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Interview with a second MA on 11/10/20 at 4:44pm revealed:
-She thought there should be 4 PCAs and 1 MA working each hall.
-Most days there were only 2 PCAs and 1 MA.

Telephone interview with the BOM on 11/06/20 at 12:44pm revealed:
-The HR office manager and the RCC were responsible for doing the staffing schedule and they knew the ratios and how many staff were required to be at the facility each shift based on the census.
-No concerns had been expressed to him about the facility being short staffed.
-It was a large facility and they were constantly hiring staff each week.
-Some staff had been out due to COVID-19 and it had been harder to staff but he was not aware of any certain shift being a problem with staffing.
-They could call someone in to cover a shift if they were short staffed.
-One of the Department Heads (the RCC, the former RCC, the Administrator, or the Activities Director, who is a PCA) would cover shifts if they were short staffed.

Telephone interview with the RCC on 11/12/20 at 4:34pm revealed:
-She and the HR office manager made the staff schedule and assignment sheets.
-She was responsible for going over the schedule and if someone called out, she got coverage.
-On Fridays, Saturdays, and Sundays, a manager was on call to cover for call outs.
-She was always successful in finding a replacement when she was the manager on duty.
-Staff was supposed to let them know 2 hours before their shift if they could not come into work but sometimes that did not happen and staff

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would call 5 minutes before their shift.
-Staff were supposed to report to a supervisor if they could not make their shift but sometimes staff would just tell another staff person instead of the supervisor and that staff would forget to report the call out.
-They sometimes had call outs on third shift and sometimes third shift staff would come in late.
-Third shift staff would say they missed the bus or had to catch another bus.
-Sometimes second shift staff would stay over and help if third shift was short staffed.
-Sometimes third shift staff would text her about a call out and she may not see the text until she woke up in the morning, then she would go in early to help them.
-They made the staff schedule based on the census and she scheduled one extra staff in case someone called out.
-The facility had not been offered any staffing assistance by outside agencies to her knowledge.
-The former RCC never mentioned the LHD offered staffing assistance.

Telephone interview with the Administrator on 11/17/20 at 8:08am revealed:
-The facility's census had gone down so she thought the short-staffing had gotten better.
-They always had call outs but if someone called out, they should get someone to cover the shift.
-She or the RCC could cover shifts if needed.

Telephone interview with the Administrator on 11/16/20 at 2:31 pm revealed:
-She did not know there was a staffing shortage on third shift.
-She was in the process of learning the Administrator's job duties, because she assumed the job responsibilities on 11/13/20.
-She remembered the email from the LHD

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concerning staffing assistance.
-She called the LHD task force lead to inquire about the details of the offer for her own education.
-She had never experienced an offer for staffing assistance from a local government agency and she wanted to know how the process worked.
-She recalled the former Administrator stating that the facility was not in a staffing crisis and the assistance was not needed.
-She did not share the information with anyone else on the management team.

Attempted interview with the former Administrator on 11/13/20 at 12:59pm was unsuccessful.

At the time of exit, there was no additional staffing hours provided by the facility for 10/11/20 to 10/25/20.

Refer to Tag D0273 10A NCAC 13F. 0902(b) Health Care (Type A1 Violation)

Refer to Tag D0338 10A NCAC 13F. 0909 Resident Rights (Type A2 Violation)

Refer to Tag D0601 10A NCAC 13F. 1801(a)(b) Infection Prevention and Control Program (Type A2 Violation)

_____

The facility's failure to provide adequate staffing for a census of 106-118 residents for 25 of 57 shifts resulted in difficulty monitoring residents during meal service, two PCAs scheduled per hall to care for 27 to 36 memory care residents on first, second and third shifts; MAs not notifying the primary care provider (PCP) concerning a resident's falls and another resident's signs and symptoms of COVID-19, resulting in delay in care for residents; staff utilizing PPE inappropriately

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D 465	Continued From page 131 between residents when providing care; new admissions testing positive for COVID-19; and not accepting special staffing assistance offered by the local county Division of Emergency Management to work any needed shift during an outbreak of COVID-19 when there were 2 to 15 staff unable to work due to testing positive for COVID-19, resulting in order staffing shortages during the outbreak. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 1, 2021.	D 465		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human	D 601		

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D 601	Continued From page 132 Services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff being unaware of which residents tested positive for COVID-19 thereby failing to use personal protective equipment (PPE) as directed by CDC guidelines; gloves not changed appropriately by staff to reduce the risk of transmission and infection; a resident admitted on 10/23/20 and placed in the room of a resident who tested positive for COVID-19; and communal dining without social distancing 6 feet on one hallway of the facility. The findings are: Review of the local health department (LHD) COVID-19 Death Reporting documentation for the facility revealed: -There were two residents who died on 10/23/20 at the facility with cause of death of COVID-19. -There was a fifth resident who tested positive for COVID-19 on 10/05/20, hospitalized from 10/07/20 to 10/14/20, and she died on 10/29/20 at a skilled nursing facility (SNF) with cause of death	D 601		

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D 601	Continued From page 133 of COVID-19. Review of the facility's resident COVID-19 tracing spreadsheet revealed: -In the month of October 2020, there was an average census of 112. -During the month of October 2020, 91 residents tested positive for COVID-19 and 3 residents tested inconclusive for COVID-19. Review of the LHD COVID-19 task force resident spreadsheet revealed: -12 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 100-hall. -26 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 200-hall. -25 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 300-hall. -28 of the 91 residents who tested positive for COVID-19 in October 2020 resided on the 400-hall. 1. Review of the Centers for Disease Control and Prevention (CDC) guidelines for the prevention and spread of COVID-19 disease in long term care (LTC) facilities revealed: -All incoming residents should be quarantined away from the general resident population for 14 days. -Incoming residents should be quarantined separately from other residents who were quarantined due to contact with COVID-19. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in LTC facilities dated 09/28/20	D 601		

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revealed a core principle of infection prevention was the effective cohorting of residents (separate areas dedicated for COVID-19 care).

Review of Resident #1's current FL-2 dated 11/03/20 revealed diagnoses included dementia, schizophrenia, intellectual development disorder, and high blood pressure.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 10/23/20.

Review of an undated document indicating COVID-19 test results and estimated quarantine release dates revealed:
-There was a "P" (positive) in the column dated 10/18 (no year) for Resident #1's roommate.
-The test date for Resident #1's roommate was 10/19 (no year).
-Resident #1's roommate's estimated quarantine release date was 10/30/20.

Review of Resident #1's roommate's hospital discharge summary dated 10/27/20 revealed:
-Resident #1's roommate was admitted to the hospital on 10/21/20.
-Diagnoses included COVID-19.
-Resident #1's roommate was supposed to remain under COVID-19 droplet/isolation precautions until 10/31/20 based on CDC recommendations.

Interview with a medication aide (MA) on 11/03/20 at 11:30am revealed:
-New admissions would ideally be placed in a private room if one was available.
-Residents were quarantined for 10-14 days when returning to the facility after being in the hospital.
-The returning resident's roommate would be

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kept in the same room if he or she had already been exposed to COVID-19.
-Resident #1 was in a private room for the first couple of days after his admission on 10/23/20.
-She thought Resident #1's roommate was COVID-19 negative when Resident #1 was admitted to the facility. (Resident #1's roommate was hospitalized and had tested positive for COVID-19 when Resident #1 was admitted to the facility.)

Telephone interview with one of the LHD COVID-19 task force leads on 11/04/20 at 9:56am revealed she did not provide any written recommendations concerning admissions to the facility, but the facility was supposed to follow the CDC recommendations and guidelines.

Telephone interview with a personal care aide (PCA) on 11/06/20 at 3:02pm revealed:
-Resident #1's roommate was assigned the room before Resident #1 was admitted to the facility and placed in the same room.
-Resident #1's roommate was in the hospital when Resident #1 was admitted to the facility.
-He did not know the facility's policy related to COVID-19 and new admissions.
-The MA received the hospital discharge paperwork when a resident returned from the hospital.

Telephone interview with a representative from the LHD on 11/09/20 at 11:53am revealed:
-Facility management was informed they needed to have a quarantine system in place for new admissions.
-She spoke with the Administrator two weeks ago and was told the Administrator did not know anything about the quarantine system and would get back to her.

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D 601	Continued From page 136 -The Administrator did not get back to her about the quarantine system. -No one at the LHD would have recommended placing a newly admitted resident who tested negative for COVID-19 in the same room with a resident who tested positive for COVID-19 and had been recently discharged from the hospital. Telephone interview with a second MA on 11/09/20 at 2:58pm revealed: -She did not read the hospital discharge paperwork when Resident #1's roommate returned to the facility from the hospital on 10/27/20. -She gave the discharge paperwork to the Resident Care Coordinator (RCC). -The RCC and the Administrator were responsible for reading the hospital discharge summary. -Resident #1's roommate was returned to the same room he was in before he went to the hospital. -The new admission, Resident #1, was in the room also. -The facility's procedure was to return hospitalized residents to their previous room. -She did not know if Resident #1's roommate was COVID-19 positive or negative when he returned from the hospital. -She did not know if Resident #1's roommate needed to be quarantined when he returned to the facility from the hospital. Telephone interview with Resident #1's primary care provider (PCP) on 11/09/20 at 4:31pm revealed: -Resident #1 was never COVID-19 positive. -She did not know why Resident #1 was placed on a hall with COVID-19 positive residents. -She was not aware Resident #1's roommate was COVID-19 positive.	D 601		

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D 601	Continued From page 137 Second interview with a MA on 11/10/20 at 1:42pm revealed she was not aware of any resident who was positive for COVID-19 sharing a room with a resident who was negative for COVID-19. Interview with a third MA on 11/10/20 at 3:20pm revealed: -Resident #1's roommate may have been hospitalized when Resident #1 was admitted. -Resident #1's roommate was returned to the same room after he was discharged from the hospital. -The RCC was responsible for reviewing the hospital discharge summary. -New admissions to the facility were not placed on quarantine. -She did not know if residents returning to the facility after hospitalization were supposed to be placed on quarantine. -The Administrator was responsible for resident room assignments. Interview with the RCC on 11/10/20 at 4:23pm revealed: -She thought newly admitted residents who were COVID-19 negative were not put in the same room as residents who were positive for COVID-19. -She, the Administrator, and the former Administrator were responsible for resident room assignments. -She could not remember if there was a heart on the doorpost (signifying the resident was COVID-19 positive) of Resident #1's roommate's room before Resident #1 was admitted and assigned to the same room. -There were too many occurrences of COVID-19 in the facility for her to be able to remember the	D 601		

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specifics of any one case.
-The hospital discharge summary was supposed to be placed in the mailbox outside her office door if she was not onsite when a resident returned to the facility after hospitalization.
-She did not know who read Resident #1's roommate's hospital discharge summary.
-She did not remember any specific instructions on the hospital discharge summary regarding Resident #1's roommate remaining on COVID-19 contact/isolation precautions until 10/31/20 pursuant to CDC guidelines.

Interview with the Administrator on 11/10/20 at 4:50pm revealed:
-She was not involved in the admission process for Resident #1.
-The admission paperwork was completed by the former Administrator.
-The former Administrator was responsible for room assignments.
-Potential new admissions were pre-tested for COVID-19.
-Newly admitted residents who were COVID-19 negative would be quarantined for 14 days if they had been previously exposed to COVID-19.
-A newly admitted resident who tested negative for COVID-19 would not be placed in a room with a resident who tested positive for COVID-19.
-The RCC was responsible for reading hospital discharge summaries.
-It "was not a good idea" to have Resident #1, who was negative for COVID-19, share a room with a resident who tested positive for COVID-19.

Telephone interview with the Business Office Manager (BOM) on 11/12/20 at 4:41pm revealed:
-Newly admitted residents who were COVID-19 negative were put into a room with a resident who was also COVID-19 negative or had already

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completed quarantine.
-When a resident who tested positive for COVID-19 returned from the hospital, he or she would be quarantined from anyone who was negative.
-The duration of quarantine would be ten days after a positive test as long as the resident was asymptomatic or 24 hours after last showing symptoms.
-Room assignments were made by the former Administrator and the RCC.
-The former Administrator typically read hospital discharge summaries and provided the information to the RCC and the current Administrator.
-Residents who tested negative for COVID-19 were never intentionally placed with residents who tested positive for COVID-19.
-Resident #1 should not have been placed in the same room as his roommate, who tested positive for COVID-19.
-Less than a week ago, Resident #1 was moved into a room with a resident who tested negative for COVID-19; Resident #1's most recent COVID-19 test result (no date provided) was negative.

Telephone interview with the former Administrator on 11/13/20 at 11:01am revealed:
-He typically assigned resident rooms, but staff sometimes moved the residents to other rooms.
-Newly admitted residents who had a previous negative COVID-19 test were not typically quarantined.
-Residents who returned to the facility after hospitalization were typically returned to their previous room.
-A resident who tested positive for COVID-19 and was returning from the hospital would not be placed in the same room as a resident who

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tested negative for COVID-19.
-He could not remember the details of Resident #1's admission.
-He did not read Resident #1's roommate's hospital discharge summary.
-The current Administrator, the current RCC, or the former RCC were responsible for reading hospital discharge summaries.
-He was not aware Resident #1's roommate was COVID-19 positive when he returned from the hospital.
-All of Resident #1's COVID-19 tests at the facility were negative.
-Resident #1's roommate tested positive for COVID-19 on 10/18/20 and should have come off quarantine on 10/28/20.

Telephone interview with a MA on 11/16/20 at 3:32pm revealed there were residents who tested positive for COVID-19 sharing a room with residents who tested negative for COVID-19.

Based on interviews and observations, it was determined Resident #1 was not interviewable.

2. Review of the Centers for Disease Control and Prevention (CDC) guidelines for the prevention and spread of the coronavirus (COVID-19) disease in long term care (LTC) facilities revealed:
-Personnel should always wear a face mask while in the facility.
-Personnel should remove and discard personal protective equipment (PPE), other than respirators, upon completing a task before leaving a [resident's] room or care area.
-Personnel should wear gloves, gowns, facemasks, and eye protection when caring for new admissions due to unknown COVID-19 status.

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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D 601	Continued From page 141 Review of the NC DHHS guidance on What to Expect: Response to New COVID-19 Cases or Outbreaks in LTC settings dated 09/04/20 revealed: -Facility staff should wear appropriate PPE when caring for residents with undiagnosed respiratory infections or confirmed positive for COVID-19. -As required by NC Executive Order 131, facilities should implement the universal use of face masks for all staff while they were in the facility. -Facilities should consider the use of gloves for all resident interactions and the use eye protection was recommended in areas with moderate to substantial community transmission. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in LTC facilities dated 09/28/20 revealed a core principle of infection prevention was the appropriate use of PPE by staff. Telephone interview with a representative from the Local Health Department (LHD) on 11/09/20 at 1:05pm revealed the facility management was advised to refer to the CDC guidelines for PPE use. Review of two facility sign in logs for review of documents about wearing and removing PPE within the quarantine area revealed: -Nineteen staff signed the log 08/31/20. -There were no other sign-in logs provided by the facility. Observations of the facility's storage room on 11/03/20 at 10:57 am revealed: -There were 18 boxes of isolation gowns. -There were two boxes of N-95 masks.	D 601		

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-There was one box of shoe covers.
-There were 23 gallons of hand sanitizer.
-There were 7 boxes of face shields.
-There was a large storage container of face shields.

a. Review of an undated document indicating COVID-19 test results and quarantine release dates for each resident revealed:
-There were two residents on the 100-hall who tested positive for COVID-19.
-There was a "P" (positive) in the column dated 10/25 (no year) for both residents.
-The test date for both residents was 10/26/20.
-Both residents' estimated quarantine release date was 11/06/20.

Review of an undated staff memo revealed:
-The memo's topic was COVID-19 100-hall.
-There were six staff signatures at the bottom of the memo without dates.
-There were 12 bullet statements on the memo to include: staff were to put on personal protective equipment (PPE).

Observation of the 100-Hall on 11/10/20 at 1:35pm revealed:
-A personal care aide (PCA) was pulling trash from the bin containing discarded PPE with one glove on one hand.
-Two staff walked through the hall returning from break wearing only a face mask.
-Housekeeping staff was wearing a face mask and face shield that was flipped up so it did not protect her face and eyes.

Observation of the 100-Hall on 11/10/20 at 2:50pm revealed:
-A PCA wearing a mask and face shield walked with a resident down the hall to a room, hand in

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hand.
-The PCA was not wearing gloves during this observation.
-The PCA left the resident in the room and walked down the hall into another resident room.
-The PCA did not use hand sanitizer between interactions with the residents.

Interview with a PCA on the 100-hall on 11/03/20 at 10:57am revealed that the red hearts on the door of residents' rooms were to indicate that a resident was COVID-19 positive.

Interview with a second PCA on the 100 hall on 11/03/20 at 11:25am revealed:
-The red heart on the resident room doors were used to indicate that a resident in the room had tested positive for COVID-19 at some time during their stay.
-The red hearts were to be taken down once the resident had recovered.
-She did not know which residents had tested positive when there were 2 residents in the room.

Interview with the second PCA on 11/10/20 at 2:19pm revealed that PCAs must ask the medication aide (MA) on duty which residents had tested positive.

Telephone interview with a hospice nurse on 11/13/20 at 8:50am revealed:
-Staff on the 100-hall did not appropriately use PPE when there were residents who tested positive for COVID-19.
-She observed staff wearing face masks under their chin.
-She observed staff going in and out of rooms without changing gloves or other PPE.
-She observed many staff not wearing gloves.

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D 601	Continued From page 144 Refer to the telephone interview with a family member on 11/06/20 at 10:31am. Refer to the telephone interview with a PCA on 11/06/20 at 3:02pm. Refer to telephone interview with another PCA on 11/09/20 at 3:47pm. Refer to the confidential interview with staff. Refer to the telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to the interview with the former Administrator on 11/10/20 at 1:07pm. Refer to the telephone interview with a primary care provider (PCP) on 11/09/20 at 4:31pm. Refer to another telephone interview with a primary care provider (PCP) on 11/16/20 at 8:02am. Refer to the telephone interview with a MA on 11/16/20 at 3:32pm. Refer to the second interview with a MA on 11/10/20 at 1:42pm. Refer to the telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am. Refer to the telephone interview with a second EMS staff on 11/12/20 at 1:20pm. Refer to the telephone interview with a third EMS staff on 11/17/20 at 8:00am.	D 601		

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D 601	Continued From page 145 Refer to the telephone interview with the Resident Care Coordinator (RCC) on 11/12/20 at 4:34pm. Refer to the interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to the telephone interview with the Administrator on 11/17/20 at 8:08am. Refer to the telephone interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am. Refer to the telephone interview with the BOM on 11/12/20 at 4:41pm. Refer to the telephone interview with the BOM on 11/17/20 at 9:48am. b. Review of the facility's COVID-19 tracking log for residents revealed: -The 25 of 26 residents currently residing on the 200-hall who previously tested positive for COVID-19 were beyond their established quarantine time. -The last established release date for quarantine time for the 25 residents who previously tested postive for COVID-19 was 10/30/20. -The 1 of 26 residents currently residing on the 200-hall who tested negative for COVID-19 on 11/01/20. Observations of the 200-hall on 11/03/20 revealed: -At 11:39am, a PCA walked out of the dining room and across the hall to Room 220 with her mask pulled down below her nose. -The PCA handed some food condiments to the resident near the window and then helped the other resident adjust the oxygen tubing on the	D 601		

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resident's face.
-When the PCA turned around, she had pulled the mask back up on her face.
-At 11:55am, the PCA who was passing plates to residents in their rooms, had her mask below her nose all the way to her bottom lip.
-The PCA delivered food trays to residents in room 210, 211, 213, 215, 218, and 220 with her mask pulled down below her nose all the way to her bottom lip.
-At 11:58am while in room 220, the PCA assisted another staff pull up a resident in bed then the PCA went back to the dining room and changed gloves but her mask was still below her nose.
-At 12:00pm, the PCA started passing plates to 16 residents in the small dining room with the mask under her nose.
-At 12:03pm, the PCA pushed the food cart back down the hall to the entrance doors and her mask was still under her nose as she went into room 213.
-At 12:07pm, the PCA went into room 220 and opened a condiment package, picked up one of the resident's French fries, dipped it in the condiment, then handed it to the resident and the resident ate it.
-At 12:08pm, the PCA went into room 218 to serve banana pudding without changing gloves or washing her hands.
-At 12:09pm, the PCA went into room 215 and pulled her mask up over her nose before she came out of the room.
-At 12:10pm, the PCA took off her gloves while in room 207, assisted the resident with a transfer from bed to wheel chair.
-The PCA pulled the resident's night stand near her wheel chair because the resident's food tray was on the night stand.
-The PCA handed the resident a napkin, a spoon, and opened condiment packages without wearing

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gloves.
-The PCA then washed her hands at the sink in the resident's room, then she touched the front of her gown with clean hands to pull the gown back to get to her pockets for a new pair of gloves.
-At 12:13pm, the PCA went in room 201 and assisted a resident with a transfer to a chair near the resident's food plate that was on a night stand.

Interview with the PCA assigned to the 200-hall on 11/03/20 at 2:43pm revealed:
-Staff were required to wear gowns, masks, and gloves; face shields were optional.
-Masks should cover the mouth and nose.
-Her mask sometimes slid off because she perspired.
-Staff was supposed to change gloves after incontinence care or anytime they came in contact with a resident.
-Staff should always have gloves on when serving meals.
-If staff left the hall, they had to change gowns and gloves but they could use the same masks and face shields.

Interview with a second PCA assigned to the 200-hall on 11/03/20 at 11:46am revealed:
-When on the resident halls, staff was supposed to wear masks, gowns, gloves, face shields, and booties.
-They usually had enough PPE and they did not run out.
-Once staff got to their assigned hall, they were supposed to stay on the hall unless they had to go to the bathroom.
-When they left the hall, they had to take off their gowns and gloves and put them in the trash can near the entrance doors to the hall.
-When they came back to the hall, they had to put

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on new gowns and gloves.
-Staff were tested for COVID-19 once a week.
-All residents on the 200-hall were COVID-19 positive to her knowledge so if staff went from room to room, they did not have to change PPE.

Observation on the 200-hall on 11/03/20 at 12:18pm revealed:
-The MA was standing at the medication cart with her face mask pulled under her nose.
-The MA was preparing medications to administer to a resident with the mask pulled under her nose.

Interview with the MA assigned to the 200-hall on 11/03/20 at 12:25pm revealed:
-The facility had plenty of PPE but she had observed staff on second shift only wearing masks and gloves, not gowns or face shields.
-Those staff would say that was what they were told to do by the Resident Care Coordinator (RCC) and the former Administrator.
-If staff left the hall, they were supposed to change gowns and gloves and use the trash can near the entrance doors of 200-hall to dispose of them.
-Staff had no formal in-service on how to put on and take off PPE.
-She pulled her mask down sometimes to "get a breath".
-Staff were supposed to keep masks over their noses and mouths at all times.

Observation on the 200-hall on 11/03/20 revealed:
-At 11:26am, the housekeeper came out of room 215 and went across the hall to room 216 without changing gloves or any other PPE.
-At 11:33am, the housekeeper came out of room 216 and went back to room 215 without changing

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D 601	Continued From page 149 gloves or any other PPE. Interview with the housekeeper on 11/03/20 at 3:20pm revealed: -Staff was required to wear gowns, masks, and gloves. -When staff came off of a hall, they were supposed to change gowns and gloves. -He used the same PPE while on a hall whether there were residents who tested positive or negative for COVID-19. Refer to the telephone interview with a family member on 11/06/20 at 10:31am. Refer to the telephone interview with a PCA on 11/06/20 at 3:02pm. Refer to telephone interview with another PCA on 11/09/20 at 3:47pm. Refer to the confidential interview with staff. Refer to the telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to the interview with the former Administrator on 11/10/20 at 1:07pm. Refer to the telephone interview with a primary care provider (PCP) on 11/09/20 at 4:31pm. Refer to another telephone interview with a PCP on 11/16/20 at 8:02am. Refer to the telephone interview with a MA on 11/16/20 at 3:32pm. Refer to the second interview with a MA on 11/10/20 at 1:42pm.	D 601		

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D 601	Continued From page 150 Refer to the telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am. Refer to the telephone interview with a second EMS staff on 11/12/20 at 1:20pm. Refer to the telephone interview with a third EMS staff on 11/17/20 at 8:00am. Refer to the telephone interview with the RCC on 11/12/20 at 4:34pm. Refer to the interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to the telephone interview with the Administrator on 11/17/20 at 8:08am. Refer to the telephone interview with the BOM on 11/04/20 at 11:00am. Refer to the telephone interview with the BOM on 11/12/20 at 4:41pm. Refer to the telephone interview with the BOM on 11/17/20 at 9:48am. c. Review of an undated document indicating COVID-19 test results and quarantine release dates for each resident revealed: -There were two residents on the 300-hall who tested positive for COVID-19. -There was a "P" (positive) in the column dated 10/25 (no year) for both residents. -The test date for both residents was 10/26/20. -Both residents' estimated quarantine release date was 11/06/20.	D 601		

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D 601	Continued From page 151 Observations on the 300-hall on 11/03/20 from 10:50am-12:21pm revealed: -There was an overflowing trash can for PPE disposal next to the hall doors. -There was a paper heart attached to the doorpost of a resident's room. (Neither of the two residents who were listed as COVID-19 positive on the document was assigned to the room.) -A MA came out of a resident's room wearing a surgical mask that was not covering her nose. -The MA repositioned the mask to cover her nose. -The MA left the hall without removing and discarding her gown and gloves. -The MA returned to the hall and continued to work in the same gown. -Kitchen staff and hall staff entered every resident room to distribute dining utensils and lunch trays; PPE was not changed after staff entered the rooms of the residents who were COVID-19 positive. Interview with a PCA on the 300-hall on 11/03/20 at 11:05am revealed there were no residents who were positive for COVID-19 on the 300-hall. Interview with a second PCA on the 300-hall on 11/03/20 at 11:05am revealed: -He did not know if any residents on the 300-hall were COVID-19 positive. -There was a heart on the doorpost of one of the rooms to signify the resident was COVID-19 positive, but the heart was "from a long time ago." Interview with the Activity Director on 11/03/20 at 11:10am revealed: -She did not know if any residents on the 300-hall were COVID-19 positive. -She treated all the residents as if they were COVID-19 positive.	D 601		

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D 601	Continued From page 152 Interview with kitchen staff on the 300-hall on 11/03/20 at 11:11am revealed: -Residents who tested positive for COVID-19 had a heart on the doorpost of their rooms. -He was never told to change his PPE when entering the hall or going between resident rooms. Interviews with a MA on the 300-hall on 11/03/20 at 11:19am and 2:48pm revealed: -There were no residents on the 300-hall who were COVID-19 positive. -Residents on the hall who were previously COVID-19 positive had come off quarantine on 10/23/20 and 10/30/20. -An administrative staff member was responsible for placing and removing the hearts from the residents' doorposts. -The MAs were given a list every Monday to let them know which residents were COVID-19 positive. -The most recent list was dated 10/25/20. -Residents were encouraged to stay in their rooms. -She did not discard her gown and gloves when she left the hall earlier because she went to administer medication to a resident whose room was not on the 300-hall but was assigned to the 300-hall staff. (There were two residents on the 300-hall who tested positive for COVID-19.) -There were two resident rooms in another area of the facility that were assigned to the 300-hall staff. -Staff were supposed to change PPE whenever they left the hall. Telephone interview with a hospice nurse on 11/05/20 at 9:15am revealed: -She visited the facility on 10/23/20 to attend to	D 601		

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the passing of a resident on the 300-hall.
-There was no red heart on the bedroom door at the time of her visit.

Telephone interview with a resident's family member on 11/05/20 at 10:00am revealed:
-She had been to the facility for a bedside visit with the resident on 10/22/20.
-She observed staff going in and out of different resident rooms without changing gloves or other PPE.

A second telephone interview with a resident's family member on 11/06/20 at 9:26am revealed:
-She had taken the resident a charger for his computer on 10/09/20.
-The staff that brought the resident outside to collect the charger was wearing his face mask below his chin and she asked him to raise it as he approached her.
-She observed residents' room doors opened on the 300-Hall when she visited the resident on 10/20/20.

Telephone interview with a second MA who worked on the 300-hall on 11/09/20 at 2:58pm revealed:
-A heart was placed on the resident's doorpost if the resident was COVID-19 positive and was on quarantine.
-The hearts on the doorposts of the residents' rooms were placed by the RCC or the Administrator.
-Staff were normally told which residents were COVID-19 positive when they reported to their shift.
-She was not told today about who was COVID-19 positive on the 300-hall; "maybe no one has it."
-Kitchen staff asked the MA or PCA which

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DURHAM RIDGE ASSISTED LIVING	3420 WAKE FOREST HWY DURHAM, NC 27703

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residents were COVID-19 positive.
-Kitchen staff passed out the meal trays on the hall.
-She was instructed on PPE use when she was hired.
-Staff were supposed to remove PPE before leaving the hall.
-Trash cans for PPE disposal were next to the hall doors.
-Staff were supposed to change gowns, gloves, face shield, masks, and booties when going between COVID-19 positive and negative resident rooms.

Interview with a third MA on the 300-hall on 11/10/20 at 3:20pm revealed:
-She was not informed if there were any residents who were positive for COVID-19 on the 300-hall today.
-She did not know how often the document indicating which residents were COVID-19 positive was updated.
-The most recent document was dated 11/04/20.
-Residents who were positive for COVID-19 were moved to rooms with other residents who were positive or were placed in a private room.
-She was "pretty sure" there were four residents on the hall who had not contracted COVID-19.
-She could not exactly remember when the PPE stations had been put into place but they had been in place for months.
-Staff were supposed to wear a gown, mask, face shield, and gloves when going into a resident's room.
-Staff was not provided specific COVID-19 training.
-There was some sort of training today, but she missed it.
-She did not know if a resident who tested positive could share a room with a resident who

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tested negative.
-Management instructed her to "act like everyone has COVID[-19]."

Telephone interview with the BOM on 11/12/20 at 4:41pm revealed:
-The kitchen staff did not directly interact with the residents.
-Kitchen staff did not enter the halls; they left the meal trays on a cart outside the hall doors.
-Staff assigned to the hall were responsible for delivering the trays to the residents' rooms.
-Before coming out of the room of a resident who tested positive for COVID-19, staff were supposed to remove and discard the PPE.
-Staff should not have been entering the rooms of residents who tested positive for COVID-19 and then entering the room of a resident who tested negative for COVID-19 without changing PPE.
-Staff knew there was a room roster on every medication cart indicating which residents had tested positive for COVID-19 and which residents had negative test results.
-He thought all the residents who tested positive for COVID-19 on the 300-hall had come off quarantine on 11/03/20. (The document provided by the facility indicated two residents who tested positive for COVID-19 on the 300-hall would be released from quarantine on 11/06/20.)

Refer to the telephone interview with a family member on 11/06/20 at 10:31am.

Refer to the telephone interview with a PCA on 11/06/20 at 3:02pm.

Refer to telephone interview with another PCA on 11/09/20 at 3:47pm.

Refer to the confidential interview with staff.

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D 601	Continued From page 156 Refer to the telephone interview with the former Administrator on 11/04/20 at 11:00am. Refer to the interview with the former Administrator on 11/10/20 at 1:07pm. Refer to the telephone interview with a PCP on 11/09/20 at 4:31pm. Refer to another telephone interview with a PCP on 11/16/20 at 8:02am. Refer to the telephone interview with a MA on 11/16/20 at 3:32pm. Refer to the second interview with a MA on 11/10/20 at 1:42pm. Refer to the telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am. Refer to the telephone interview with a second EMS staff on 11/12/20 at 1:20pm. Refer to the telephone interview with a third EMS staff on 11/17/20 at 8:00am. Refer to the telephone interview with the RCC on 11/12/20 at 4:34pm. Refer to the interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm. Refer to the telephone interview with the Administrator on 11/17/20 at 8:08am. Refer to the telephone interview with the BOM on 11/04/20 at 11:00am.	D 601		

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D 601	Continued From page 157 Refer to the telephone interview with the BOM on 11/12/20 at 4:41pm. Refer to the telephone interview with the BOM on 11/17/20 at 9:48am. _____ Telephone interview with a family member on 11/06/20 at 10:31am revealed: -He had gone to the facility to pick up the resident's wallet after he passed away on 10/23/20. -The residents were not socially distanced; they were seated two feet or less from each other. -A staff delivered the wallet to his car with a cloth mask worn below the nose. Telephone interview with a PCA on 11/06/20 at 3:02pm revealed: -A heart on the doorpost of a resident's room meant the resident was on quarantine. -He did not know who was responsible for placing and removing the hearts from the residents' doorposts. -The hearts on the doorposts of the residents' room were not current. -There was a sheet on the medication cart indicating which residents were on quarantine. -He checked the sheet at the beginning of his shift. -He would also get word of mouth information from the staff who worked the previous shift. -Staff treated all residents as if they were COVID-19 positive. Telephone interview with another PCA on 11/09/20 at 3:47pm revealed: -She had observed staff remove their face masks to speak with each other because they could not hear each other through the face mask.	D 601		

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-Staff tried to keep their masks in place over their nose and mouth.
-The PPE was hot to wear sometimes.
-She did not think it was her job to correct staff it they wore PPE incorrectly.
-The supervisor was the person who should tell other staff when PPE was not worn correctly.

Confidential interview with a staff revealed:
-COVID-19 spread throughout the facility because of staff.
-Some staff were not wearing masks while working and some staff would pull their masks below their noses.
-Some staff would pull down their masks when they talked to other staff and residents

Telephone interview with the former Administrator on 11/04/20 at 11:00am revealed he and management were constantly reminding staff to pull up and readjust their masks if they saw staff coming down the hall and their masks were hanging off or under their noses.

Interview with the former Administrator on 11/10/20 at 1:07pm revealed:
-There were no residents with COVID-19 in the facility at that time.
-The LHD informed him on 11/06/20 that staff were supposed to wear masks, face shields, and gloves while on the halls; gowns were optional since there were no residents with COVID-19 at that time.
-Staff were to continue to change gloves after providing care to residents.

Telephone interview with the primary care provider (PCP) on 11/09/20 at 4:31pm revealed:
-She was "taken aback" by the lack of PPE use by facility staff.

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D 601	Continued From page 159 -She noticed in mid-October 2020 there was signage in the facility about mask usage, but there was no signage about any other PPE. -She expected staff to wear a gown, mask, face shield, and gloves when they entered the room of a resident who tested positive for COVID-19. -She expected staff to remove PPE before exiting the room of a resident who tested positive for COVID-19. -PPE was not being used by all staff. -She had to remind staff to wear a mask. -Some staff wore gloves; some did not. -Staff did not wear face shields, masks, and gowns when providing care to residents who had tested positive for COVID-19. -When COVID-19 cases rose at the facility, she knew staff were not following prevention guidelines. -She asked staff if they had enough PPE and if anyone had taught them how to use it. -A MA informed her there was not enough PPE and staff was not instructed on how to use it. -PPE stations were placed throughout the facility around the third week of October 2020. -Seventy-five percent of the residents were already COVID-19 positive before the PPE stations were in place. Another telephone interview with the primary care provider (PCP) on 11/16/20 at 8:02am revealed: -She began seeing residents at the facility in June 2020. -She observed residents coughing and on quarantine for COVID-19 with their room door opened. -She had expressed concerns about the room doors being opened for residents on quarantine with the current Administrator and with the BOM but doors continued to be left opened. -She observed staff not wearing PPE	D 601		

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appropriately in all areas of the facility.
-She observed staff not wearing gowns and face shields on the resident halls.
-She observed staff not changing PPE between resident rooms.

Telephone interview with a MA on 11/16/20 at 3:32pm revealed:
-She was not given instructions on admitting new residents to the facility.
-She was aware of times when there was a red heart placed on a residents' door when only one of the roommates tested positive.
-Staff wore the same gown, face shield and mask from room to room but would change gloves and the process had "always been that way".
-There were some weeks they wore face shields and others they did not.

Second interview with a MA on 11/10/20 at 1:42pm revealed:
-Red paper hearts on the door were part of an old system and had not been taken down.
-When one roommate tested positive then both roommates would quarantine together for 14 days and if the second resident did not test positive after the 14-day quarantine, he/she would be moved to a room to themselves.

Telephone interview with emergency medical services (EMS) staff on 11/12/20 at 11:20am revealed:
-She responded to a call to the facility on 09/28/20.
-She observed staff were not changing PPE when going to different resident rooms.

Telephone interview with a second EMS staff on 11/12/20 at 1:20pm revealed:
-She responded to a call to the facility on

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D 601	Continued From page 161 09/20/20 for a resident experiencing shortness of breath. -She observed a MA administering medications to two residents while wearing gloves but did not change the gloves between the residents. -She had observed PCAs go in and out of different resident rooms without changing PPE Telephone interview with a third EMS staff on 11/17/20 at 8:00am revealed: -He responded to a call on 10/07/20 for another resident. -When he responded to the call, the resident's roommate was wearing a mask in the room because she said she had tested negative for COVID-19 but that the resident he transported tested positive. -He last responded to the facility on 11/16/20 and observed a staff on a resident hall wearing a face shield and no gloves or mask. -Staff informed him the resident he was transporting on the night of 11/16/20 had tested positive for COVID-19 but had recovered. -EMS staff found out during transport to the local medical facility that the resident had been transported 2-3 days prior and had tested COVID-19 positive at the time. -The facility frequently had residents that were COVID-19 positive and negative sharing a room. -He observed staff going in and out of resident rooms without changing gloves or other PPE when he responded to other calls to the facility. -There were times when he was called to the facility "3-4 times a night". Interview with the RCC on 11/10/20 at 4:23pm revealed: -Staff referred to the hearts on the doorposts of the residents' rooms as an indication of COVID-19 status.	D 601		

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D 601	Continued From page 162 -The previous RCC placed and removed the hearts from the residents' doorposts. -Staff also verbally informed each other which residents were COVID-19 positive. Telephone interview with the RCC on 11/12/20 at 4:34pm revealed: -She tried to make rounds on the hallways to make sure staff were wearing their PPE. -If staff was not wearing PPE as instructed, she would talk with them and tell them it was important, then she would write warnings or implement suspensions if needed to keep the residents and staff safe. -She had talked to a couple of staff whose masks might have been halfway down and she told them to pull them back up. -She usually told them one time and they would do it. Interviews with the Administrator on 11/10/20 at 4:50pm and 5:58pm revealed: -Staff knew who was COVID-19 positive by the hearts on the doorposts. -The previous RCC was responsible for placing and removing the hearts from the residents' doorposts. -The MAs were supposed to let staff know if any residents on the hall were COVID-19 positive. -The shift supervisor was provided with a copy of a report indicating which residents were COVID-19 positive. -The shift supervisor should have told staff which residents were currently COVID-19 positive. -Staff should not have been going between residents who were positive for COVID-19 and residents who were negative for COVID-19 without changing PPE. -Staff needed more training on appropriately using PPE.	D 601		

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D 601	Continued From page 163 -Infection control training was provided 11/09/20 and 11/10/20. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -Staff should wear masks over their mouths and noses at all times and they should wear a face shields. -The LHD representative said staff could stop wearing gowns unless a resident tested positive for COVID-19. Telephone interview with the BOM on 11/04/20 at 11:00am revealed: -Staff were currently required to wear masks, gowns, and gloves on all resident halls even if there were no residents who tested positive for COVID-19 on the hall. -Face shields were optional if no residents who tested positive for COVID-19 were on the hall. -If there were residents who tested positive for COVID-19, staff should be wearing full PPE including face shields. -Staff should change gloves between each resident and each task. -Staff should not be providing care or touching food without gloves. -Staff should wear face masks at all times and the mask should cover the nose and mouth. -The face mask sometimes moved when working but staff should make sure their noses and mouths are covered especially when performing tasks. Telephone interview with the BOM on 11/12/20 at 4:41pm revealed: -Staff should not have been entering the rooms of residents who tested positive for COVID-19 and then entering the room of a resident who tested negative for COVID-19 without changing PPE.	D 601		

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D 601	Continued From page 164 -Staff members knew there was a room roster on every medication cart indicating which residents had tested positive for COVID-19 and which residents had negative test results. -He did not remember when the lists were first provided as a resource for staff. -He did not know who was responsible for placing or removing the hearts from the residents' doorposts. Telephone interview with the BOM on 11/17/20 at 9:48am revealed: -The Administrator was ultimately responsible for staff using PPE. -He expected staff to change their PPE when they left an area where someone was quarantined before going to an area of non-quarantine. -From the beginning of the pandemic, all managers were instructed to watch staff and to remind staff to wear PPE. -They were supposed to re-educate, redirect, and remind staff to wear PPE. 3. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus (COVID-19) disease in long term care (LTC) facilities revealed: -Facilities should enforce social distancing (6 feet apart) with residents and staff. -Facilities should cancel all communal dining. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities dated 10/16/20 (replaced version dated 09/28/20) revealed: -While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur.	D 601		

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-These activities may be facilitated for residents who are not in isolation or quaratine for COVID-19.
-Mealtimes should be staggered.
-There should be six feet of space between each individual and each table.

Interview with the former Administrator on 11/03/20 at 3:10pm revealed:
-There were 25 of 26 residents currently residing on the 200-hall who had previously tested positive for COVID-19.
-There was 1 of 26 residents currently residing on the 200-hall who tested negative for COVID-19.
-All 25 of the residents currently residing on the 200-hall who had tested positive for COVID-19 were past their quarantine time.

Review of the facility's COVID-19 tracking log for residents revealed:
-The 25 of 26 residents currently residing on the 200-hall who previously tested positive for COVID-19 were beyond their established quarantine time.
-The last established release date for quarantine time for the 25 residents who previously tested postive for COVID-19 was 10/30/20.
-The 1 of 26 residents currently residing on the 200-hall who was negative last tested negative on 11/01/20.

Observations of the 200-hall on 11/03/20 revealed:
-There were 2 white rectangular plastic tables pushed end to end in the middle of the living room at the end of the hall.
-At 11:07am, there were 6 residents sitting on one side of the table, side by side, approximately 1 to 2 feet apart.
-At 11:07am, there was 1 resident sitting on the

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other side of the table directly across from another resident.
-At 11:07am, there was 1 resident walking around the table and another resident sitting at a bedside table in the left corner of the room near the piano.
-At 11:07am, a personal care aide (PCA) was passing out drinks in the dining room.
-No residents were wearing masks.
-No staff attempted to have the residents to social distance or wear masks.
-At 11:10am and 11:12am, a PCA brought two other residents into the dining room and seated them at the table
-At 11:13am, a resident walked into the dining room with a mask on over her mouth but under her nose and the resident pulled the mask below her chin when she sat down at the table beside other residents.
-From 11:14am - 11:19am 3 other residents came into the dining room and sat down at the table beside other residents with only 1 to 2 feet of distance between them.
-At 11:41am, the PCA sat on the piano stool and pulled down her mask to talk and sing to the residents.
-The PCA was sitting approximately 2 to 3 feet from the resident beside the piano and the residents sitting near the end of the table.
-At 12:00pm, the PCA started passing plates to 16 residents in the small dining room with the mask under her nose.
-There were 14 residents seated at the table with 7 residents on each side sitting side by side within 1 to 2 feet of each other and they were sitting directly across from each other, not staggered.
-There was 1 of the residents sitting near the window and another resident sitting beside the piano.
-No staff attempted to social distance the residents or encourage them to wear masks while

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D 601	Continued From page 167 waiting for their food. Telephone interview with a personal care aide (PCA) on 11/09/20 at 5:50pm revealed: -Prior to positive COVID-19 cases, residents on the 200 hall used the living room to eat their meals. -When the number of positive COVID-19 cases increased in the facility, residents were not allowed to eat in the living room. -After the 200-hall residents completed quarantine, she began placing 12 to 14 residents in the television room again for meals. Telephone interview with the local health department (LHD) COVID-19 task force lead on 11/04/20 at 9:51 am revealed: -The facility was sent guidance concerning communal dining in May 2020 via email. -The task force encouraged for the facility to discontinue communal dining when the guidance was released by the CDC early in the pandemic. Interview with a medication aide (MA) on 11/03/20 at 10:46am revealed: -The residents on the 200-hall usually ate lunch between 11:30am - 12:00pm. -They used the common area/living room at the end of the 200-hall as a dining room. -Some residents stayed in their rooms to eat (whoever wanted to). -Other residents went to the small dining room at the end of the hall to eat. Interview with a PCA assigned to the 200-hall on 11/03/20 at 2:43pm revealed: -Staff usually stayed on their hall during their shift. -About 2 weeks ago, residents on the 200-hall started eating in the living room, prior to that all residents ate in their rooms.	D 601		

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	HAL032091	A. BUILDING: _____ B. WING _____	C 11/17/2020

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D 601	Continued From page 168 Interview with the MA assigned to the 200-hall on 11/03/20 at 12:25pm revealed: -The residents on the 200-hall had been eating in the living room since she returned to the facility around the last week of October 2020. -The residents could not social distance while eating in the living room because there was not enough room. Interview with the Business Office Manager (BOM) on 11/04/20 at 11:00am revealed: -In April or May 2020, instead of feeding all residents in the main dining room, they split residents up into groups. -They set up the living room/activity room on each hall as dining rooms so residents could still eat in small groups and social distance. -The LHD suggested the facility feed residents in shifts (3 seatings) in the main dining room. -Once the facility had a couple of residents test positive for COVID-19 (no date specified), the LHD wanted the residents back on their specific hall to eat. -The residents who tested negative for COVID-19 ate in shifts in the small dining rooms at the end of their halls and the residents who tested positive for COVID-19 ate in their rooms. -Currently, all residents were eating in their rooms except for the residents who lived on the 200-hall. -The residents on the 200-hall ate in the small dining room set up at the end of the hall because those residents were out of their 10 day quarantine. -The residents on the 200-hall were not able to eat at the same time in the small dining room because they were supposed to be at least 6 feet apart and spaced diagonally so residents were not sitting directly across from each other. -Some of the residents on the 200-hall also still	D 601		

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D 601	Continued From page 169	D 601		

ate in their rooms.
-Management staff were at the facility daily and watched and observed meal services and corrected anything that was not done correctly.
-Management staff educated staff and monitored to make sure dining was occurring the way it was supposed to.
-The residents on the 200-hall should have been social distanced when dining together for lunch on 11/03/20.

Interview with the former Administrator on 11/04/20 at 11:00am revealed:
-He could not recall the last time he observed dining on the 200-hall.
-It "seems" like there were some residents sitting at the tables in the small dining room on the 200-hall when he was on the 200-hall at lunchtime yesterday, 11/03/20, but he did not pay any attention to it.
-It was concerning to him that the residents on the 200-hall were communal dining without social distancing during the lunch meal on 11/03/20.
-He observed the residents in the small dining room on the 200-hall during lunch today, 11/04/20, and they were "setting too close for sure".
-He instructed staff to take the residents on the 200-hall who could eat safely to their rooms and to spread out the other residents in the small dining room.

Observations of the living room at the end of the 200-hall on 11/10/20 at 5:07pm revealed:
-There were 5 residents sitting at the tables in the area set up for dining.
-There were 4 residents on one side of the table siting side by side within 1 to 2 feet from each other.
-There was 1 resident on the other side of the

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D 601	Continued From page 170 table sitting directly across from one of the other residents. -There was a dining cart with 12 disposable cups with an orange liquid, uncovered sitting on top of the drink cart. -There was a metal container with silverware uncovered on top of the cart. Telephone interview with the Administrator on 11/17/20 at 8:08am revealed: -Staff should change gloves between each resident and they should be gloved when passing out food. -It was her understanding that as long as residents were 6 feet apart, they could participate in communal dining. Telephone interview with the BOM on 11/17/20 at 9:48am revealed: -For communal dining, residents should have been appropriately social distanced with at least 6 feet apart or more and there should have not been so many residents in there at one time. -For 11/10/20, the resident in the dining room on the 200-hall should still have been social distancing. -The former Administrator was supposed to be checking on meals and dining on a daily basis. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which staff did not know which residents tested positive or negative for COVID-19; staff did not wear face masks within the facility consistently; staff did not change gloves between tasks and resident care;	D 601		

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D 601	Continued From page 171 and conducted communal dining without proper social distancing the residents 6 feet apart from one another. In October 2020, 91 residents tested positive for COVID-19, at least 18 residents were hospitalized, and 3 residents died with COVID-19 as the cause of death; a newly admitted resident was placed in a room with a resident who tested positive for COVID-19 and was not quarantined. These failures placed the residents at increased risk for transmission and infection from COVID-19, resulting in substantial risk of serious physical harm, and serious neglect, and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2020.	D 601		
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 record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to health care, residents rights infection prevention and control program, and special care unit staffing. The findings are:	D914		

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D914	Continued From page 172 1. Based on observations, interviews, and record reviews, the facility failed to ensure coordination of health care for 5 of 5 residents sampled (#2, #4, #8, #12, #13) related to failing to notify the primary care provider (PCP) for a resident with a broken hip (#2); to notify the PCP concerning a resident with discolored and long toenails who was not added to the facilty podiatrist visit list (#12); to notify the PCP and seek immediate medical evaluation for a resident with symptoms of COVID-19 who was later hospitalized, diagnosed with COVID-19 and passed away (#4); to notify the PCP of an attempted elopement by a resident with a history of eloping at other facilities (#8); and failing to notify the PCP of a fall for a resident with a history of falls with injuries including a fractured arm (#13). [Refer to Tag D0273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to cohort staff and residents, quarantine staff as indicated by the local health department (LHD) once they tested positive for COVID-19; and failed to provide residents on two hallways with over the bed tables for in-room meal service after stopping communal dining, as recommended by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), and directives from the LHD.[Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the	D914		

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D914	Continued From page 173 Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to staff being unaware of which residents tested positive for COVID-19 thereby failing to use personal protective equipment (PPE) as directed by CDC guidelines; gloves not changed appropriately by staff to reduce the risk of transmission and infection; a resident admitted on 10/23/20 and placed in the room of a resident who tested positive for COVID-19; and communal dining without social distancing 6 feet on one hallway of the facility. [Refer to Tag D0601, 10A NCAC 13F .1801 Infection Prevention and Control Program (Type A2 Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the Special Care Unit (SCU) with a census of 106 to 118 were met for 25 of 57 shifts sampled for 10/05/20, from 10/11/20 to 10/25/20, and from 11/06/20 to 11/08/20 after assistance with staffing was offered to the facility by the local county health department task force and another local county government agency [Refer to Tag D0465, 10A NCAC 13F .1308 (a) Special Care Unit Staff (Type B Violation)].	D914		