

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 000	Initial Comments  The Adult Care Licensure Section conducted an annual survey on 07/12/22.	C 000		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <ol style="list-style-type: none"> <li>(1) resident's name;</li> <li>(2) name of the medication or treatment order;</li> <li>(3) strength and dosage or quantity of medication administered;</li> <li>(4) instructions for administering the medication or treatment;</li> <li>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;</li> <li>(6) date and time of administration;</li> <li>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and</li> <li>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</li> </ol> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1 and #2) related to oxygen.</p> <p>The findings are:</p>	C 342		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 342	<p>Continued From page 1</p> <p>1. Review of Resident #1's current FL2 dated 05/18/22 revealed: -Diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. -There was an order for continuous oxygen at 3 liters (L).</p> <p>Review of Resident #1's electronic Medication Administration Records (eMAR) for June 2022 and July 2022 revealed there was no entry for continuous oxygen at 3L on the eMAR.</p> <p>Observation of Resident #1 on 07/12/22 at 1:10pm revealed: -Resident #1 was in the family room and was using his portable oxygen tank. -The oxygen level on the portable oxygen tank was set at 6L.</p> <p>Interview with Resident #1 on 07/12/22 at 1:11pm revealed: -He used oxygen continuously. -He had an oxygen concentrator which was usually at 3L and he used his portable oxygen when he was out of his room. -He set his portable oxygen concentrator at levels between 4L and 6L when he was out of his room because he had trouble breathing. -Staff did not adjust the oxygen levels on his oxygen concentrator or portable oxygen tanks.</p> <p>Telephone interview with the Supervisor-in-Charge (SIC) on 07/12/22 at 2:26pm revealed: -Resident #1 used oxygen 24 hours a day, but he did not know how many liters the oxygen should be set to. -Oxygen was not listed on Resident #1's eMAR, but he documented Resident #1's oxygen use on</p>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 342	<p>Continued From page 2</p> <p>a notepad at times. -He did not know who was responsible for sending orders to the pharmacy.</p> <p>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/12/22 at 2:17pm revealed: -The pharmacy did not have an order for oxygen for Resident #1. -If the pharmacy had received an order for oxygen for Resident #1 the order would have been entered on his eMAR.</p> <p>Interview with the co-owner/SIC on 07/12/22 at 2:49pm revealed: -He worked as a medication aide (MA)/SIC when needed. -Resident #1 used oxygen and he thought the oxygen should be set no higher than 4L. -He had not documented Resident #1's oxygen use because he did not know he had to.</p> <p>Refer to interview with the Facility Manager on 07/12/22 at 3:02pm.</p> <p>Refer to interview with the Administrator on 07/12/22 at 4:23pm.</p> <p>2. Review of Resident #2's current FL2 dated 06/14/22 revealed: -Diagnoses included chronic obstructive pulmonary disease and asthma. -There was no documentation of oxygen.</p> <p>Review of Resident #2's previous FL2 dated 11/15/22 revealed an order for oxygen as needed.</p> <p>Review of Resident #2's physician's order dated 01/24/21 revealed an order for oxygen 2 Lliters (L) via nasal cannula at night for sleep and as</p>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fc1079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 342	<p>Continued From page 3</p> <p>needed for shortness of breath during the day.</p> <p>Review of Resident #2's licensed health professional support (LHPS) review dated 02/11/22 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 continued to use his oxygen at 2L via nasal cannula at night for sleep and as needed for shortness of breath during the day.</li> <li>-There was a recommendation to fax a copy of Resident #2's order for nighttime and as needed oxygen to the pharmacy so it could be placed on the electronic Medication Administration Record (eMAR) for continuous oxygen use.</li> </ul> <p>Review of Resident #2's eMARs for June 2022 and July 2022 revealed there was no entry for oxygen 2 Lliters (L) via nasal cannula at night for sleep and as needed for shortness of breath during the day on the eMAR..</p> <p>Interview with a pharmacy technician at the facility's contracted pharmacy on 07/12/22 at 2:17pm revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy did not have an order for oxygen for Resident #2.</li> <li>-If the pharmacy had received an order for oxygen for Resident #2 the order would have been entered on his eMAR.</li> </ul> <p>Observation of Resident #2's room on 07/12/22 at 12:34pm revealed Resident #2 had an oxygen concentrator beside his bed with a nasal cannula attached and it was set to 2 L.</p> <p>Interview with Resident #2 on 07/12/22 at 12:35pm revealed:</p> <ul style="list-style-type: none"> <li>-He used his oxygen every night because he had trouble breathing when he laid down.</li> <li>-He did not really need oxygen during the day unless he laid down.</li> </ul>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fc1079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 342	<p>Continued From page 4</p> <p>Telephone interview with the Supervisor-in-Charge (SIC) on 07/12/22 at 2:26pm revealed:                      -Resident #2 used 3L of oxygen when he went to sleep, but he had not seen him use oxygen any other time during the day.                      -Oxygen was not listed on Resident #2's eMAR, but he documented Resident #2's oxygen use on a notepad at times.                      -He did not know who was responsible for sending orders to the pharmacy.</p> <p>Interview with the co-owner/SIC on 07/12/22 at 2:49pm revealed:                      -He worked as a medication aide (MA)/SIC when needed.                      -Resident #2 used oxygen continuously at 3 L.                      -He had not documented Resident #1's oxygen use because he did not know he had to.</p> <p>Refer to interview with the Facility Manager on 07/12/22 at 3:02pm.</p> <p>Refer to interview with the Administrator on 07/12/22 at 4:23pm.</p> <p>Interview with the Facility Manager on 07/12/22 at 3:02pm revealed:                      -Oxygen should have been documented on the eMAR.                      -She was responsible for reviewing the eMARs and reviewed them at the end of each month.                      -She had not noticed oxygen was not on the eMAR for residents who used oxygen.                      -MAs did not document oxygen anywhere else.</p> <p>Interview with the Administrator on 07/12/22 at 4:23pm revealed:                      -She did not know oxygen was not on the eMAR</p>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 342	Continued From page 5  and she did not know oxygen should have been on the eMAR for MAs to document oxygen use. -The Facility Manager was responsible for reviewing the eMARs and she expected for them to be reviewed a few days a week.	C 342		
C 367	<p>10A NCAC 13G .1008(a) Controlled Substances</p> <p>10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily 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.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 1 of 3 sampled residents who had an order for clonazepam.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 06/14/22 revealed: -Diagnoses included chronic obstructive pulmonary disease and asthma. -There was an order for clonazepam (used to treat anxiety) 1mg 1 tablet at bedtime.</p> <p>Review of Resident #2's electronic Medication Administration Record (eMAR) for May 2022 revealed: -There was an entry for clonazepam 1mg 1 tablet</p>	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fc1079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 367	<p>Continued From page 6</p> <p>at bedtime scheduled for administration at 8:00pm.</p> <p>-There was documentation clonazepam was administered at 8:00pm from 05/01/22 through 05/31/22.</p> <p>Review of Resident #2's eMAR for June 2022 revealed:</p> <p>-There was an entry for clonazepam 1mg 1 tablet at bedtime scheduled for administration at 8:00pm.</p> <p>-There was documentation clonazepam was administered at 8:00pm from 06/01/22 through 06/30/22.</p> <p>Review of the controlled substance count sheet (CSCS) for clonazepam 1mg for Resident #2 revealed:</p> <p>-There was a pharmacy label on the CSCS that documented a quantity of 30 tablets of clonazepam 1mg was dispensed to the facility on 05/02/22.</p> <p>-The quantity of 30 was marked off and 31 was written in.</p> <p>-The first dose of clonazepam was dispensed on 05/10/22 and documentation the last dose was administered on 06/09/22.</p> <p>There were 18 dates that had be marked over and 3 changes in time of administration between 05/14/22 and 05/31/22.</p> <p>-There were documentation 2 doses of clonazepam were administered on 05/14/22 at 7:27pm and at 7:20pm.</p> <p>-There was no documentation clonazepam was administered on 05/16/22.</p> <p>-There were two entries on 06/04/22 documenting 1 tablet of clonazepam were administered at 8:00pm.</p> <p>-On 06/08/22, there was documentation 1 tablet of clonazepam was administered leaving a</p>	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fc1079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 367	<p>Continued From page 7</p> <p>balance of 0. -On 06/09/22, there was documentation 1 tablet of clonazepam was administered leaving a balance of 0.</p> <p>Observation of the medication on hand for Resident #2 on 07/12/22 at 3:47pm revealed: -Clonazepam 1mg 1 tablet at bedtime was available on the medication cart. -Clonazepam was dispensed to the facility on 07/07/22 and 29 tablets were remaining.</p> <p>Interview with Resident #2 on 07/12/22 at 12:35pm revealed he did not know all the medications he was administered, but he received them regularly.</p> <p>Interview with a pharmacy technician at the facility's contracted pharmacy on 07/12/22 at 2:17pm revealed: -Resident #2 had an order for clonazepam 1mg 1 tablet at bedtime. -Clonazepam was a cycle filled medication and was automatically delivered to the facility each month. -Clonazepam was cycle filled for 05/10/22, 06/10/22, and 07/10/22 with a quantity of 30 tablets for each date.</p> <p>Telephone interview with the Supervisor-in-Charge (SIC) on 07/12/22 at 2:26pm revealed: -When he administered controlled substances, he scanned the medication and checked the medication off on the computer. -He popped the medication from the bubble pack into a cup and filled out the CSCS. -He had not noticed any errors, but he had a few conversations with a previous staff about signing the CSCS.</p>	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 367	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-He counted controlled substances with oncoming staff.</li> <li>-The Facility Manager reviewed the CSCS, but he did not know how often.</li> </ul> <p>Interview with the Facility Manager on 07/12/22 at 3:02pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for reviewing the CSCS and she reviewed them around the 10th of each month at the beginning of the medication cycle.</li> <li>-She started working at the facility in May 2022 and did not start reviewing the CSCS until June 2022.</li> <li>-She had not noticed any issues with the CSCSs.</li> </ul> <p>Interview with the Administrator on 07/12/22 at 1:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aides (MA) were to count controlled substances together and ensure the CSCS matched the count.</li> <li>-The Facility Manager was responsible to review the controlled substance logs daily.</li> <li>-There were two residents with the same first name and were administering clonazepam, so the previous staff may have gotten confused when they documented.</li> </ul>	C 367		
C 612	<p>10A NCAC 13G .1701 (c) Infection Prevention &amp; Control Program (temp)</p> <p>10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 9</p> <p>guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.</p> <p>This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure recommendations and guidelines established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect 6 residents in the facility during the global coronavirus (COVID-19) pandemic as related to use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection and screening of staff, visitors, and residents.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel (HCP) during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting</li> </ol>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 10</p> <p>facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing.</p> <ul style="list-style-type: none"> <li>-Fully vaccinated HCP should wear source control (facemask) when they were in areas of the facility where they could encounter residents.</li> <li>-The facemask should cover the nose and mouth.</li> </ul> <p>Review of the NC DHHS COVID-19 (NC DHHS) Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed facilities, residents, families, and visitors were to adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.</p> <p>Observation of the facility on 07/12/22 between 8:55am and 9:40am revealed:</p> <ul style="list-style-type: none"> <li>-The Supervisor-in-Charge (SIC) answered the door to the facility and was not wearing a facemask.</li> <li>-The SIC went down the hallway into the kitchen area past resident rooms and the living room where a resident was seated.</li> <li>-There was a sign posted in the foyer of the facility which provided information on how to safely wear and take off a face covering.</li> <li>-The Administrator arrived at the facility and was not wearing a facemask.</li> <li>-The SIC was in the dining room as residents were finishing their breakfast and was wearing a facemask on his chin.</li> </ul> <p>Interview with 3 residents between 9:06am and 9:16am revealed:</p> <ul style="list-style-type: none"> <li>-One resident stated staff did not wear facemasks.</li> <li>-A second resident stated staff did not usually wear a facemask.</li> </ul>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 11</p> <p>-A third resident stated staff sometimes did not wear a facemask, but they stayed about 3 feet from the residents; if staff got too close to him without a facemask, he would complain.</p> <p>Interview with the SIC on 07/12/22 at 9:19am revealed: -He was not wearing a facemask because he had been vaccinated. -The Administrator preferred for staff to wear a facemask, but he could not breath with the facemask on.</p> <p>Interview with the Administrator on 07/12/22 at 9:14am revealed: -She required visitors to wear a facemask, but not staff. -She thought staff did not have to wear a facemask because the COVID-19 facemask mandates had been lifted for wearing facemasks.</p> <p>2. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection. -The options could include (but were not limited to): individual screening upon arrival to the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.</p> <p>Review of the North Carolina Department of</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 12</p> <p>Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19.</p> <p>Observation of the facility on 07/12/22 at 9:33am revealed: -A co-owner/Supervisor-in-Charge (SIC) entered the facility wearing a facemask, but he did not screen for signs and symptoms of COVID-19. -The co-owner/SIC walked down the hallway into two residents' rooms and interacted with residents.</p> <p>Interview with the co-owner/SIC on 07/12/22 at 9:41am revealed: -He did not screen for COVID-19 because he forgot. -He did not know the facility should continue to screen for COVID-19 since the state mandates had been lifted.</p> <p>Observation of the facility on 07/12/22 at 9:42am revealed: -The co-owner/SIC attempted to use the wall thermometer, but it did not work. -The co-owner/SIC opened the drawer stand in the foyer and pulled out a thermometer, and it read "Lo."</p> <p>Telephone interview with the Supervisor-in-Charge (SIC) on 07/12/22 at 2:26pm revealed: -He did not self-screen for COVID-19 each day he worked, but he did self-screen from time to time. -When he self-screened, he checked his temperature, but he did not complete a screening</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 13 questionnaire.</p> <p>Interview with the Facility Manager on 07/12/22 at 3:02pm revealed: -Staff had not been screening prior to working their shift in the facility. -She thought the CDC mandate for COVID-19 screenings had been lifted.</p> <p>Interview with the Administrator on 07/12/22 at 9:14am revealed: -Staff had not been screening for signs and symptoms of COVID-19 when entering the facility or prior to their shift. -She did not know staff needed to continue to screen for signs and symptoms of COVID-19</p> <p>3. Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for healthcare personnel (HCP) during the coronavirus disease 2019 (COVID-19) pandemic dated 02/02/22 revealed: -Facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has any one of the following three criteria so that they can be managed: a positive viral test for COVID-19, symptoms of COVID-19, or close contact with someone with COVID-19 infection. -The options could include (but were not limited to): individual screening upon arrival to the facility or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.</p> <p>Review of the Department of Health and Human Services (DHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 revealed: -Facilities should continue to screen all who</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 14</p> <p>enter for visitation. Individuals describing new onset of mild symptoms should be excluded from visitation, as even mild symptoms may be a sign of COVID-19 infection.</p> <p>-Visitors should wear face coverings or facemasks when around other residents or healthcare personnel, regardless of vaccination status.</p> <p>Observation of the facility on 07/12/22 between 8:55am and 9:00am revealed:</p> <p>-There was a sign posted on the front door of the facility which read: Ring the doorbell and wait outside until staff comes to the door.</p> <p>-There was a desk with a visitor sign in book, gloves, and facemasks on a table in the foyer, and there was a drawer stand beside the table.</p> <p>-There was a body temperature chart above the drawer stand, but there were no signs posted regarding COVID-19 screening.</p> <p>-There was a thermometer on the wall behind the door and opposite the desk and drawer stand, but it did not work.</p> <p>Interview with a Supervisor-in-Charge (SIC) on 07/12/22 at 9:19am revealed:</p> <p>-There was a screening station in the front hall.</p> <p>-He forgot to screen the surveyor with temperature and screening questions upon entrance to the facility.</p> <p>Interview with the Administrator on 07/12/22 at 9:14am revealed:</p> <p>-She thought the requirement for screening visitors for COVID-19 had been lifted.</p> <p>-She had screening forms, but the last one completed was dated 05/05/22.</p> <p>-She had not directed staff to continue to screen visitors for COVID-19.</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 15</p> <p>4. Review of the CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes dated 02/02/22 revealed: -Residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. -Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. -Monitor residents at least daily for fever (temperature greater than or equal to 100 degrees F) and symptoms consistent with COVID-19.</p> <p>Review of the Department of Health and Human Services (DHHS) COVID-19 Infection Prevention Guidelines for Long-Term Care Facilities dated 02/10/22 revealed: -DHHS continues to recommend facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. -Monitor residents daily for signs and symptoms of COVID-19.</p> <p>Interview with 4 residents on 07/12/22 between 4:35pm and 4:39pm revealed: -All the residents stated staff did not take their temperatures daily or ask screening questions. -One resident stated it had been a long time since staff had taken the residents' temperatures.</p> <p>Telephone interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 07/12/22 at 2:26pm revealed: -When he worked multiple days in a row and stayed overnight in the facility, he screened residents by checking their temperatures when he first arrived at the facility.</p>	C 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>fcI079113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HARRISONS CARING HANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>814 LINDSEY STREET REIDSVILLE, NC 27320</b>
---	---

(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
C 612	<p>Continued From page 16</p> <p>-He did not check resident temperatures daily.</p> <p>Interview with the co-owner/SIC on 07/12/22 at 2:49pm revealed: -Staff had been checking the residents' temperatures, but they currently were not. -He did not know staff should have continued to check residents' temperatures after COVID-19 mandates were lifted.</p> <p>Interview with the Facility Manager on 07/12/22 at 3:02pm revealed as far as she knew, the MAs screened the residents, but she did not know where they documented the screenings.</p> <p>Interview with the Administrator on 07/12/22 at 9:14am revealed: -Staff were not currently screening residents for signs and symptoms of COVID-19 with temperature or screening questions. -She did not know the staff needed to continue to screen residents.</p>	C 612		