Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	R 09/08/2022

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

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 09/07/22 through 09/08/22.	{D 000}	The following is the Plan of Correction for Patriot Living of Yadkinville regarding the Statement of Deficiencies for the Follow up Survey completed 9/8/22. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
{D 113}	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure hot water temperatures for 1 fixture (sink) used by a resident was maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are: Review of the facility's Water Temperature Report for 09/01/22 through 09/07/22 revealed there were water temperature checks conducted on 09/01/22, 09/02/22, and 09/06/22 on 6 faucets in the hallway bathroom and 5 residents' rooms that were available for resident use and the temperatures were between 100 degree F and 116 degrees F each day. Observation of the bathroom in Room #21 on 09/07/22 at 10:16am revealed: -There was visible steam coming from the sink	{D 113}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A. Parker — TITLE: EVP of Operations — (X6) DATE: 10/18/22

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{D 113}	Continued From page 1 faucet when the hot water was turned on. -The water temperature was 130 degrees F at the sink. Interview with the resident in Room #21 on 09/07/22 at 10:19am revealed: -The hot water at the sink got very hot. -She turned the faucet on the sink all the way to the left to let the water get hot and then she adjusted the temperature by moving the faucet to the middle. -She had never been burned by the hot water. Interview with the maintenance staff on 09/07/22 at 10:17am revealed: -He was provided a list of fixtures where the water temperatures needed to be checked and Room #21 was not listed on the list. -He had not checked the water temperature at the sink in Room #21 because it was not on the list to be checked. -He knew there was a sink in Room #21, but he had not thought to check the water temperature of the sink daily while checking water temperatures at other faucets in the facility. Interview with the Maintenance Director on 09/07/22 at 10:31pm revealed: -All hallway bathrooms, rooms with adjacent bathrooms, and all private room bathrooms should have had a water temperature check. -He did not know why the water temperature was not checked in Room #21, but staff would install a mixing valve to the sink in Room #21 to regulate the temperature. Observations of re-check of the hot water temperature in Room #21 on 09/08/22 revealed: -There was a sign posted on the bathroom sink above the faucet documenting high hot water	{D 113}	D113 Maintenance technician installed a mixing valve to sink in Room #21 on 9/7/2022 to regulate temperature. On 9/8/2022 recheck was completed on Room #21 and said room was in regulation range. Temperature checks on all sinks accessible to residents will be performed no less than weekly by Maintenance Technician and/or Designee. Out-of-range temperatures will be reported immediately to the Administrator and/or Designee to adjust within range. Administrator and/or Designee to review water temperature logs weekly for compliance. Completion date 9/7/2022	

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{D 113}	Continued From page 2 temperatures. -At 8:49am, the hot water temperature was 108 degrees F at the sink faucet. Interview with the Administrator on 09/07/22 at 1:41pm revealed: -Maintenance staff was supposed to check water temperatures at all faucets daily. -Maintenance staff had not reported any high hot water temperatures to her. -She did not know the water temperature in Room #21 had not been checked daily and that it was 130 degrees F.	{D 113}		
{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: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow up to meet the health care needs for 2 of 5 sampled residents (#1 and #2) related to a resident with orders for wound care who did not have a dressing over a wound for 4 hours (#1) and a resident who refused insulin (#2). The findings are: 1. Review of Resident #1's current FL2 dated 07/19/22 revealed diagnoses included hyperglycemia and a below knee amputation (BKA) of both legs.	{D 273}	D273 Facility shall ensure referrals and follow-ups meet routine and acute health care needs of the residents utilizing implemented "order logs". Order logs will track orders from start to completion to see that all orders are completed. Resident Care Coordinator and/or Designee will review Quick Mar and the order log daily to ensure completion of all orders and track order refusals. In service training with all medication aides relative to completion, recording and reporting all refusals of physician orders has been completed. The Resident Care Coordinator and/or Designee will report the review of order logs and Quick Mar reports to the Administrator and/or Designee weekly. Completion date 10/7/2022	

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{D 273}	Continued From page 3 Review of Resident #1's physician's order revealed there was an order to treat and evaluate by home health skilled nursing. Review of Resident #1's progress note dated 07/08/22 revealed: -Resident #1 was evaluated by a home health nurse. -There were instructions for wound care written by the home health nurse. -Both sites on the right BKA were cleaned with normal saline, xeroform was applied and wrapped with gauze. -The left BKA was cleaned with betadine, covered with a dry dressing, and wrapped with gauze. Observation of Resident #1's in the hallway on 09/07/22 at 9:23am revealed: -Resident #1 was sitting on the floor. -There was a wound on his left leg that was uncovered. -Two staff assisted Resident #1 back into his wheelchair. Observation of Resident #1 on 09/07/22 at 1:48pm revealed a medication aide (MA) was placing a new bandage over the left leg wound. Interview with a MA on 09/08/22 at 3:30pm revealed: -She was not sure what Resident #1's wound care order was. -She was not sure how often the home health nurse came to the facility for Resident #1's wound care. -If Resident #1's dressing came off, she would check the eMAR system for the order and call the Resident Care Coordinator (RCC) for guidance. -Resident #1's dressing frequently came off, but she was not sure how the dressing came off.	{D 273}		

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{D 273}	Continued From page 4 -She had never seen Resident #1's wounds completely uncovered. Interview with a second MA on 09/08/22 at 3:45pm revealed: -The home health nurse discontinued wound care on 09/08/22 because Resident #1 was non-compliant with wound care immediately following a dressing change. -She thought the home health nurse came to the facility either every other day or twice a week to do dressing changes. -Resident #1 sometimes refused wound care. -Resident #1 constantly pulled off his dressing. -Resident #1 tried to walk sometimes which made the dressing slide down. -There were times where Resident #1's dressing was left uncovered for a period of 3 or 4 hours. -Sometimes a MA would do a dressing change and Resident #1 would remove the new dressing immediately afterwards. Interview with Resident #1 on 09/08/22 at 5:19pm revealed: -The bandages on his legs that covered his wounds came off easily. -A home health nurse was changing his wound dressing twice a week. Telephone interview with a nurse from the facility's contracted home health agency on 09/08/22 at 2:29pm revealed: -She or another nurse from the home health agency came to the facility to do wound care for Resident #1 twice a week. -The initial wound care order for Resident #1 was to clean the right BKA wound with betadine, rinse with normal saline, xeroform, and place a dry dressing. -The current wound care order for Resident #1	{D 273}		

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{D 273}	Continued From page 5 was to rinse with normal saline, xeroform, and wrap all wounds on both legs with kerlix gauze wrap. -When she came to the facility for wound care, Resident #1's wound care dressing was sometimes not in place. -Facility staff knew how to change Resident #1's dressing. -Facility staff was able to ask for more wound care supplies from the home health agency if needed. -Resident #1 would sometimes pull off his dressing. -Resident #1 was non-compliant with wound care. -Resident #1 walked on his legs even though he was not supposed to, which could dislodge the dressing and possibly open the wound. -Resident #1 liked to walk around sometimes even if his wound was uncovered. -The wounds had not improved recently. Interview with the RCC on 09/08/22 at 5:00pm revealed: -The home health nurse came out to the facility about every 3 days to change Resident #1's dressings. -Resident #1's dressings were supposed to stay on for about 3 days. -If the dressing was soiled, MAs were expected to put a new dressing in place if Resident #1 would allow them. -Resident #1 constantly pulled off his dressing. -The home health care agency had dropped Resident #1 from wound care on 09/08/22. Interview with the Administrator on 09/08/22 at 6:26pm revealed: -She was not aware there was a 4 hour time period on 09/07/22 where Resident #1's dressing on his left leg was not in place.	{D 273}		

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{D 273}	Continued From page 6 -She expected staff to put a new dressing over Resident #1's wound if they saw that it was uncovered. Attempted telephone interview with Resident #1's primary care provider on 09/08/22 at 7:33am was unsuccessful. 2. Review of Resident #2's current FL2 dated 08/22/22 revealed: -Diagnoses included bipolar disorder, depressed with psychotic features, borderline personality disorder, and chronic back pain. -There was an order for Levemir U-100 insulin (a medication used to lower blood sugar) 25 units twice daily. Review of Resident #2's electronic medication administration record (eMAR) for 08/23/22 through 08/31/22 revealed: -There was an entry for Levemir 100u/mL inject 25 units twice daily scheduled for administration at 6:00am and 6:00pm. -There was documentation Resident #2 refused Levemir 5 of 17 opportunities, between 08/23/22 and 08/31/22, on 08/25/22 at 6:00am, 08/26/22 at 6:00am, 08/29/22 at 6:00pm, 08/30/22 at 6:00pm, and on 08/31/22 at 6:00am. -Resident #2's fingerstick blood sugars (FSBS) ranged from 115 to 250. Review of Resident #2's eMAR for 09/01/22 through 09/07/22 revealed: -There was an entry for Levemir 100u/mL inject 25 units twice daily scheduled for administration at 6:00am and 6:00pm. -There was documentation Resident #2 refused Levemir 6 of 13 opportunities, between 09/01/22 and 09/07/22, on 09/01/22 at 6:00am and 6:00pm, 09/02/22 at 6:00am, 09/03/22 at 6:00pm,	{D 273}		

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{D 273}	Continued From page 7 09/06/22 at 8:00am, and on 09/07/22 at 8:00am. -Resident #2's fingerstick blood sugars (FSBS) ranged from 102 to 222. Review of Resident #2's record revealed there was no documentation Resident #2's primary care provider (PCP) was contacted regarding refusal of medication. Observation of medication available for Resident #2 on 09/08/22 at 2:30pm revealed there was one opened pen and 3 unopened pens of levemir insulin on the medication cart. Interview with a pharmacist from the facility's contracted pharmacy on 09/08/22 at 10:17am revealed: -Resident #2 had an order for Levemir 25 units twice daily. -Levemir was dispensed to the facility on 08/22/22 in a quantity of 15 mL (5 pens). Interview with Resident #2 on 09/08/22 at 5:22 revealed: -She was diabetic and was administered insulin. -She refused her insulin in the morning when her FSBS was below 150 because her FSBS had gotten too low once before and she did not like the way it made her feel. -She may have refused insulin at other times if her FSBS was low. Interview with a medication aide (MA) on 09/08/22 at 2:32pm revealed: -Resident #2 was diabetic and was administered insulin. -If Resident #2 did not eat supper and her FSBS was low, she refused Levemir. -Resident #2 did not eat breakfast a lot and refused Levemir when she did not eat breakfast.	{D 273}		

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{D 273}	Continued From page 8 -After a resident refused medication 3 times, the MAs were to let the Resident Care Coordinator (RCC) know, and the RCC would contact the resident's primary care provider (PCP). -She did not know if Resident #2's PCP had been contacted about her refusing Levemir. Interview with a MA/personal care aide (PCA) on 09/08/22 at 3:09pm revealed: -If a resident refused medication, the MA tried at least 3 times to administer the medication. -Sometimes the MA would get a different MA to attempt to administer the medication. -After 3 attempts to administer medication, the MA marked the medications as "refused." -If a resident refused medication 3 consecutive times, the RCC would be notified and the RCC notified the resident's PCP. -She did not know if Resident #2's PCP was notified of her insulin refusals. Interview with the RCC on 09/08/22 at 3:26pm revealed: -Resident #2 was new to the facility (admitted on 08/22/22) and first saw her PCP on 09/06/22. -The MAs were supposed to notify her after a resident refused medication for 3 consecutive days and she would notify the resident's PCP. -The MAs had not reported to her that Resident #2 refused Levemir. -Had the MAs notified her Resident #2 refused Levemir, she would have sent an electronic notification to Resident #2's PCP and left a notification in her folder to review when she visited the facility. -She was responsible for reviewing eMARs monthly, but she had not had an opportunity to Review Resident #2's eMARs yet because she was a new resident.	{D 273}		

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{D 273}	Continued From page 9 Interview with Resident #2's PCP's supervisor physician on 09/08/22 at 11:04am revealed: -He was not aware of Resident #2 refusing Levemir. -His assistant saw Resident #2 on today (09/08/22) and was not notified of Resident#2 refusing Levemir. -He would have to check with the nurse practitioner, Resident #2's PCP, and check messages to see if the facility contacted the PCP regarding Resident #2 refusing Levemir. Interview with the Administrator on 09/08/22 at 4:56pm revealed: -After a resident refused medication for 3 days in a row, the MAs should have informed the RCC and the RCC should have notified the resident's PCP. -The MAs should have made contact with the resident's PCP if the RCC was not available. -She knew Resident #2 refused Levemir, but she did not know Resident #2 had refused Levemir as many times as she had. -She did not know staff had not followed up with Resident #2's PCP regarding her refusing Levemir.	{D 273}		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310	D310 Facility to have dietary staff re-trained on modified diets and texture consistencies by facilities food service vendor. In-service training will be completed twice a year with all dietary staff and online training will be provided throughout the year. Resident Care Coordinator/and or Designee to review special diet report and monitor order log to ensure all diet orders are being followed. Administrator and/or Designee to review diet orders and view the presentation for at least one meal weekly. Completion date 11/02/2022.	

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D 310	Continued From page 10 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record observations, record reviews, and interviews, the facility failed to ensure a therapeutic diet was served for 1 of 1 sampled resident (#4) with an order for a no concentrated sweets (NCS), pureed diet with no bread. The findings are: Review of Resident #2's current FL2 dated 05/24/22 revealed: -Diagnoses included vascular dementia, cerebral infarction, essential hypertension, below the knee amputation, and diabetes mellitus. -There was an order for a no concentrated sweets (NCS)/puree diet with no bread and thin liquids. Review of Resident #2's diet order dated 05/24/22 revealed an order for a NCS/puree diet with thin liquids. Review of Resident #2's diet order dated 07/19/22 revealed an order for a NCS/puree diet with no bread. Review of the facility's therapeutic diet list on 09/07/22 posted in the kitchen revealed Resident #4 was to be served a NCS, puree diet with no bread. Review of the facility's therapeutic menu for a NCS diet for the lunch meal on 09/07/22 revealed Resident #4 should have been served hamburger steak, roasted potatoes, broccoli florets, dinner roll, reduced calorie dessert, reduced calorie	D 310		

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D 310	Continued From page 11 beverage, and water. Review of the facility's therapeutic menu for a puree diet for the lunch meal on 09/07/22 revealed Resident #4 should have been served pureed ground hamburger steak, pureed roasted potatoes, pureed broccoli florets, pureed dinner roll, pureed cake, beverage, and water. Observation of Resident #4's lunch meal service on 09/07/22 at 12:11pm revealed: -Resident #4 began coughing during his meal. -Resident #4 had been served a bowl of a white pureed food item, a bowl of a thick, chunky green food item, and a bowl of a thick brown meat like food item, and ice cream. -Resident #4 was eating the green food item and the meat-like food item with a fork. -After Resident #4 began coughing, a personal care aide (PCA) went over to him, patted him on the back, told him to spit the food out onto a plate, and told him to slow down. Interview with the PCA on 09/07/22 at 12:19pm revealed: -Resident #4 put so much food in his mouth and tried to swallow it all at once. -Resident #4 got choked pretty much every day. -Sometimes the consistency of Resident #4's food was very thin and sometimes it was much thicker. -She though Resident #4 choked on his food because he ate too fast. -Resident #4 choked mostly when he ate meats; meats looked like they were mashed rather than pureed. Interview with the Resident Care Coordinator on 09/07/22 at 12:13pm revealed: -Resident #4 was supposed to be served a	D 310		

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(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 310	Continued From page 12 pureed diet. -The lunch meal that he was served on 09/07/22 did not look pureed. Interview with a medication aide (MA) on 09/08/22 at 3:04pm revealed: -Resident #4 had physician's orders for a pureed meal. -She assisted in the dining hall when needed and observed Resident #4 choked when served a pureed meal because he rushed while eating his food. -Pureed meals should have looked like rice or pudding. Interview with a PCA on 09/07/22 at 5:36pm revealed: -Resident #4 coughed with his meals at least twice a day. -She thought he choked because he ate his food too quickly. -She thought Resident #4 received the correct consistency for a puree diet. Second interview with the RCC on 09/07/22 at 5:40pm revealed: -The dietary manager (DM) was responsible for preparing puree meals and ensuring they were served as ordered. -She thought the DM worked with a dietician through the facility's food service company. -The PCP changed Resident #4's diet order to mechanical soft, but she could not remember when, because Resident #4 refused a pureed diet. -Resident #4 could not tolerate a mechanical soft diet as he coughed and choked with his meals., so the PCP changed his diet back to puree. -Some of Resident #4's lunch food items looked more mechanical soft than they did pureed.	D 310		

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D 310	Continued From page 13 Interview with Resident #4 on 09/08/22 at 8:42am revealed: -He was on a pureed diet because it was hard for him to chew his food. -He got choked sometimes when he ate his food. -When he got choked on his food, staff patted him on the back until he stopped coughing and gave him a drink of water. -He thought all food items were pureed for his meals. Interview with Resident #4's PCP's supervising physician on 09/08/22 at 11:04am revealed: -Resident #4 was seen by the nurse practitioner. -If Resident #4 had an order for a pureed diet and was not served according to the order, he would be at risk for aspiration or a mechanical blockage. Interview with the DM on 09/08/22 at 11:41pm revealed: -Resident #4 was served hamburger helper, peas, mashed potatoes, and ice cream for the lunch meal on 09/07/22. -Resident #4 was not allowed to have bread according to his diet order. -He pureed all of Resident #4's food using a food blender and water. -He pureed the food at the kitchen shared with the sister facility and there was not a blender available in the kitchen in the facility. -He realized the pureed hamburger helper was thick when he got to the facility; he thought the pureed noodles absorbed the moisture. -He was not sure why other food items were thick or chunky. Interview with the facility's contracted speech therapist on 09/08/22 at 1:05pm revealed: -She did not currently have Resident #4 has a	D 310		

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D 310	Continued From page 14 patient, but she was working with other residents at the facility. -She observed the prepared texture modified meals, including the puree meals, and they were prepared correctly. -She reviewed the photos of lunch meal prepared on 09/07/22 and the photo of the (pureed) hamburger helper; the hamburger helper was not pureed and resembled more of a ground texture. Interview with the Administrator on 09/07/22 at 5:46pm revealed: -The DM was responsible for preparing meals and ensuring residents were served according to their diet orders. -She did not know food items served to Resident #4 were not served with a pureed consistency. -A food served with a pureed consistency should not be too thin or too thick. -A corporate consultant trained the DM on therapeutic diets including texture modified diets; -The DM manager provided training to staff regarding therapeutic diets including texture modified diets. -She expected Resident #4 to be served his meal pureed as ordered. The facility failed to ensure a therapeutic diet was served as ordered to a resident (Resident #4) who had an order for pureed food and was served food items that were not at a pureed consistency resulting in the resident coughing during meal service which could result in the resident aspirating. This failure was detrimental to the health, safety and welfare of Resident #4 which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/07/22 for this violation.	D 310		

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D 310	Continued From page 15 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2022.	D 310		
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 B VIOLATION Based on observations and interviews, the facility failed to ensure resident rights were maintained related to providing unrestricted access for all residents to go outside of the facility when they requested and for residents to smoke when they requested. The findings are: Review of the facility's census report updated on 08/10/22 revealed a census of 44 residents. Observation of the facility on 09/07/22 between 9:15am and 5:15pm revealed: -There were two paned glass doors at the end of the left hall of the facility. -On one of the doors was a sign that read: "Patio closed due to repairs." -There was another sign that Read: Times that the door will be open for you to go out and smoke: 9:30am-10:00am, 11:30am-12:00pm, 2:30pm-3:00pm, 4:30pm, 5:00pm, 7:30pm -8:00pm, and 9:30pm-10pm. Any other time you	D 338	D338 The facility shall assure that the rights of all residents which are guaranteed under the "Declaration of Resident's Rights" are maintained and exercised without hindrance. The facility installed a doorbell on each side of the front door, with distinct sounds, which will indicate to staff whether a resident wants in or out. This will allow the residents the freedom to come in and out as they desire. Staff was trained in the importance of responding to residents' requests on 10/14/2022. The Resident Care Coordinator and/or Designee will ensure residents are able to exercise their rights as requested. Completion date 10/14/2022	

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D 338	Continued From page 16 want to smoke, you will need to go to the patio. If the medication aide (MA) or personal care aides (PCA) are busy, they will let you out as soon as possible. -There was a deck observed from the two paned glass doors and there were multiple boards missing throughout the deck. -There were weeds that had grown up through the holes where some of the boards were missing and the some of the weeds had grown up at least 4 feet above the level of the deck. -There was a fence around the deck and the fence door had been removed. -There was also a smoking schedule posted on the inside of the door at the entrance of the facility and on the door of the medication room. -The scheduled on the doors at the entrance and the medication room included third shift times as follows: 9:30pm-10:00pm, 11:30pm-12:00am, 2:30am-3:00am, 4:30am-5:00am, and 6:30am-7:00am. Interview with a resident on 09/07/22 at 5:20pm revealed: -The residents could only go outside to smoke at certain times. -The residents could not go outside to smoke if they wanted to in between the set smoking times. -Residents used to be able to go outside on the back patio to smoke, but it had been closed for repairs for about eight months. -Staff were not always available to let residents outside to smoke at the set times. -Sometimes residents had to wait for staff to open the door to go outside to smoke. Observation of the lobby area on 09/08/22 at various times between 9:10am and 1:45pm revealed: -At 9:10am there were 8 residents in the lobby	D 338		

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D 338	Continued From page 17 area waiting to be let outside by staff to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 9:30am). -At 1:15pm, there were 4 residents waiting in the lobby to go outside to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 2:30pm). -At 1:43pm, there were 9 residents in the lobby entrance of the foyer area waiting to be let outside to smoke (The next scheduled smoking time posted on the inside of the entrance door was at 2:30pm). -At 1:45pm, residents were let out of the facility by staff. Interview with 2 residents on 09/08/22 at 1:15pm revealed: -The residents were waiting in the lobby area to be let out of the facility by staff. -The last smoke break for the residents was from 11:30am to 12:00pm, before lunch, and the next one was not until 2:30pm. -Residents usually waited in the lobby area for a long time until the staff opened the front door at the scheduled smoke times. -A resident stated he did not smoke, but he liked to sit outside; "I had more freedom living on the streets." Observation of the area outside the front of the facility on 09/08/22 between 1:45pm and 2:30pm revealed there were 12 residents outside of the facility and 2 of the residents were not smoking. Interview with a third resident on 09/08/22 at 1:46pm revealed: -"Thank you ma'am for helping us to get out to smoke." -She had been out for a smoke break at 11:30am on 09/08/22, but she had to come back in at	D 338		

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D 338	Continued From page 18 12:00pm for lunch. -Residents usually had to wait 2 hours after lunch to go outside to smoke, but the staff let them out early today. -The staff had to let residents out to smoke because the doors to the facility were locked and required a code to get out. -She and the other residents who smoked usually sat in the lobby area until staff opened the door for them to go out to smoke. -It hurt her pride to have to sit there and wait because they (staff) knew why they were sitting there and what they wanted. -Residents used to be able to go out the side door and smoke any time they wanted too, because the side door stayed unlocked. -The deck at the side door was rotting so the staff closed the deck; residents were told the deck was going to be repaired. Interview with a fourth resident on 09/08/22 at 1:52pm revealed: -He thought residents should have been able to go out to smoke when they wanted to. -He did not like the fact that he could not go out to smoke when he wanted to. -He was a grown man and felt like he should have been able to go out to smoke when he wanted to and come back in when he wanted to. Interview with a fifth resident on 09/08/22 at 1:55pm revealed: -She loved being able to go out on the side deck, when it was open, because she could go outside when she wanted to. -She hated having to wait for certain times to go outside to smoke. -If she just wanted to go outside to get some fresh air, she had to wait until the scheduled smoke breaks when staff opened the door.	D 338		

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D 338	Continued From page 19 -Smoke breaks were at 6:30am, 9:30am, 11:30am, 2:30pm, 4:30pm, 6:30pm, and 9:30pm and each smoke break lasted 30 minutes. -She got angry having to wait to go outside and not being able to go out when she wanted to. -The side door was once unlocked and led to a deck where residents could go outside any time they wanted to. -Staff sometimes threatened residents with not being able to smoke. -She was told once by staff that if she did not go to bed, she would not get to go out to smoke. Interview with a sixth resident on 09/08/22 at 2:08pm revealed: -It felt good to be outside. -He did not like waiting to go out to smoke on a schedule. -The door to the side deck was once unlocked so residents could go outside to smoke any time they wanted to. -The side door was blocked off to residents a few months ago to repair the deck and it had not been repaired yet. -He liked when the door to the side deck was unlocked for residents to go outside because it was like having freedom. -Now the residents were not able to go outside when they wanted to, not even if they were not smoking, because all the other doors in the facility were locked; residents had to wait on staff to let them outside only during the scheduled smoke breaks. Interview with a seventh resident on 09/08/22 at 2:10pm revealed: -He smoked, but he had to wait until smoking times to go outside even if he did not want to smoke at the time. -It made him feel mad because he could not go	D 338		

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D 338	Continued From page 20 outside when he wanted to. -It made him feel like a kid. Interview with an eighth resident on 09/08/22 at 2:11pm revealed: -Today after lunch, residents were let out early for their smoke breaks. -Usually residents had to wait 2 hours after lunch to go outside to smoke. -She got a little edgy having to wait. -It was not fair having to wait because there were 1 or 2 people who were allowed outside any time they wanted to be outside. Interview with a ninth resident on 09/08/22 at 2:12pm revealed: -Staff "hung cigarettes over their heads" by threatening to take away residents' smoke breaks. -There were not enough cans for cigarette butts outside so residents had to throw their butts on the ground. -Staff went outside to smoke any time they wanted to, and it made her feel like she was 2 years old having to wait until a certain time to go outside. Observation of the facility on 09/0/22 at 2:55pm revealed: -A resident asked a personal care aide (PCA), who was sitting at the staff desk, to be let out of the front door. -The PCA responded to the resident, "When I'm done with this, I will let you out." Interview with a medication aide (MA) on 09/08/22 at 2:54pm revealed: -Residents were going out on the deck at the side of the facility to smoke. -The deck was falling apart and was a hazard to	D 338		

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D 338	Continued From page 21 the residents. -The deck had been closed for about 5 months for repairs. -All the other doors in the facility were locked and could only be opened with a code, and none of the residents were supposed to have the code. -The smoking schedule was implemented because after the deck was closed, the residents were asking every 5 minutes to go outside, and it was taking the MAs an hour to complete a 15-minute medication pass. -The corporate office was supposed to be getting quotes for repairs; she had not seen any repairs completed yet. -Residents went out to smoke every two hours. -Staff did not let residents out to smoke between the scheduled smoking hours because when one resident was let out, all of them wanted to go out. -If a resident did not smoke and just wanted to go outside, the resident had to wait until the scheduled smoking times to go outside so smoking residents would not try to push their way outside. -Residents complained daily about the smoking times and not being able to go outside to smoke when they wanted to. -Residents had stated to her that they felt like they were in a prison and it was not fair that they could not smoke when they wanted to. Observation of the facility on 09/08/22 at 3:04pm revealed: -A resident asked a medication aide (MA) for a cigarette to go smoke. -The MA told her it was after 3:00pm. -The resident asked a PCA to wake her up at 4:30pm (the next smoke break was scheduled for 4:30pm). Interview with a MA/PCA on 09/08/22 at 3:09pm	D 338		

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D 338	Continued From page 22 revealed: -Residents were caught smoking in the facility and were put on restrictions. -Staff held the residents' cigarettes so staff could make sure they were smoking outside instead of in the facility. -Residents were let out of the facility to smoke every 2 hours for 30 minutes each time. -She let them outside between the scheduled times if she had time to. -Residents asked to go outside all day every day. -The scheduled smoking times were put in place because staff were not able to get anything done except for letting residents outside and letting them back inside. -Some residents complained to her, but she reminded them of the scheduled times. -There used to be a deck where residents could go outside when they wanted to and the door to the deck stayed unlocked. -The deck had been closed before she began working at the facility in May 2022. -The facility was currently getting quotes to get the deck fixed. Interview with a PCA on 09/08/22 at 3:20pm revealed: -On day shift, there were certain times residents could go outside. -Residents were let out 30 minutes before meals and then they had to wait 1 to 2 hours after meals for the next smoke break. -Residents were constantly hounding staff to let them outside. -Residents asked her to go outside to smoke prior to the scheduled time and she told them she could not; she could only let them outside during the scheduled times. -The scheduled times were to ensure that residents were administered their medications	D 338		

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D 338	Continued From page 23 before they went outside. Interview with the RCC on 09/08/22 at 3:26pm revealed: -Residents were on a smoking schedule. -Smoking was a privilege and not a necessity. -MAs and PCAs were not able to get anything done because residents kept asking them to go outside to smoke. -Residents got really mad because they wanted to go outside when they want to. -Residents used to go out on the deck on the side of the facility to smoke, but the deck had been closed off since May or June 2022 due to needed repair. -There were boards in the deck that had been pulled up and there were weeds growing up through the deck that needed to be cut. -Residents always complained about not being able to go outside and have stated to her that going outside was their freedom. -She expressed resident and staff concerns to management and management stated that the deck would be fixed. Interview with the Maintenance Director on 09/08/22 at 5:49pm revealed: -The deck on the side of the facility was closed off so residents could not go out the side door; the deck needed repairs. -He had only worked at the facility for a month and the first thing he was asked to do was to look into getting quotes to repair or replace the deck. -He provided quotes to the corporate office. -The last time he spoke to someone at the corporate office, he was told they decided not to rebuild the deck. -The plan was to pour a concrete slab and fence the area in. -He was told there was someone who would	D 338		

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D 338	Continued From page 24 complete the project and they were waiting on them to come out to the facility. Interview with the Administrator on 09/08/22 at 4:56pm revealed: -She was aware of the scheduled smoking times for residents. -She did not know the scheduled smoking times did not fall right after meals. -She was a smoker and smokers usually wanted a cigarette after meals. -She would look at the smoking times and see if they could be more accommodating for residents. -She knew residents had issues with the scheduled smoking times. -The residents complained all the time and asked when the deck would be fixed. -She had been in discussions with corporate office about getting the deck on the side of the facility fixed so the smoking issues could be alleviated. -The corporate office did not want to rebuild the deck, but they wanted to redo the whole side area to create a space where residents could gather and do activities. -The corporate office had been getting estimates and working on a site plan for the area on the side of the facility. The facility failed to provide unrestricted access for residents to go outside of the facility for leisure or to smoke except at scheduled times which resulted in residents becoming edgy, mad, angry, feeling like children, and feeling like their freedom was compromised. This failure was detrimental to the welfare of all residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/22 for	D 338		

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(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 338	Continued From page 25 this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2022.	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 (#5, #6) observed during the medication pass including errors with an antidepressant medication (#6) and errors with crushing medications that should not be crushed (#5); and for 1 of 5 sampled residents (#1) for record review including errors with an as needed order for fast acting insulin. The findings are: 1. The medication error rate was 9.6% as evidenced by the observation of 3 errors out of 31 opportunities during the 8:00am medication pass on 09/08/22. a. Review of Resident #6's current FL2 dated	{D 358}	D358 Facility will ensure preparation and administration of medication, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by licensed prescribing practitioner which are maintained in the resident's record; (2) rules in this section along with the facilities policies and procedures. Medication aides will be re-trained in medication administration rules, policies and procedures, by RN Consultant on 10/20/22. New medication aides will be trained on facility policies and procedures and obtain required certifications before administering medication/treatments. Resident Care Coordinator and/or Designee to observe at least one med pass weekly at random, review MARS weekly at random, and monitor for non-compliance and re-train as necessary. Completion date 10/20/2022	

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{D 358}	Continued From page 26 08/12/22 revealed: -Diagnoses included diabetes, gastroesophageal reflux disease (GERD), anxiety disorder, and bipolar disorder. -There was an order for desvenlaxafine ER 50mg take 1 tablet daily. Observation of the medication pass for Resident #6 on 09/07/22 at 8:15am revealed: -The medication aide (MA) prepared and scanned Resident #6's medications into the electronic medication administration record (eMAR). -The MA scanned desvenlaxafine ER 50mg into the eMAR. -Desvenlaxafine ER 50mg was not administered to Resident #6. -Desvenlaxafine ER 50mg was documented as administered on the eMAR, but it was not administered to Resident #6 during the medication pass. -The MA prepared and administered 17 oral medication tablets to Resident #6. -The MA should have prepared and administered 18 total oral medication tablets to Resident #6. Observation of the medications on hand for Resident #6 on 09/08/22 at 4:00pm revealed that there was one desvenlaxafine ER 50mg bubble pack medication card dispensed on 09/02/22 and there were 19 of 28 tablets that remained. Attempted telephone interview with the MA observed during the medication pass on 09/08/22 at 11:24am was unsuccessful. Attempted interview with Resident #6 on 09/08/22 at 5:17pm unsuccessful. Interview with the Resident Care Coordinator	{D 358}		

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{D 358}	Continued From page 27 (RCC) on 09/08/22 at 5:15pm revealed: -She expected MAs to administer medications as ordered. -The MAs were responsible for ensuring that Resident #6's desvenlaxafine was administered as ordered. Interview with the Administrator on 09/08/22 at 6:25pm revealed: -She expected MAs to administer medications to the residents as they were ordered by the provider. -She was not aware that desvenlaxafine was not administered to Resident #6 during the medication pass even though it was documented as administered. -The MAs were responsible for ensuring that Resident #6's desvenlaxafine was administered as ordered. Attempted telephone interview with Resident #6's mental health provider on 09/08/22 at 8:07am unsuccessful. b. Review of Resident #5's current FL2 dated 05/24/22 revealed: -Diagnoses included arthritis, hearing loss, traumatic brain injury, vascular dementia, and major neurocognitive disorder due to multiple etiologies. -There was an order for aspirin EC (enteric coated) 81mg take one tablet daily. Observation of the medication pass for Resident #5 on 09/08/22 at 8:36am revealed: -The medication aide (MA) prepared and scanned Resident #5's medications into the electronic medication administration record (eMAR). -The MA crushed the aspirin EC 81mg tablet,	{D 358}		

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{D 358}	Continued From page 28 placed the crushed tablet in applesauce and administered the applesauce to Resident #5 at 8:36am. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for aspirin EC 81mg, take 1 tablet once daily scheduled at 8:00am and "do not crush" was listed on the eMAR entry. -There was documentation aspirin EC 81mg was administered on 09/08/22 during the 8:00am hour. Observation of the medications on hand for Resident #5 on 09/08/22 at 8:30am revealed that there was one aspirin EC 81mg bubble pack medication card dispensed on 09/02/22 and there were 19 of 28 tablets that remained. Attempted telephone interview with the MA observed during the medication pass on 09/08/22 at 11:24am was unsuccessful. Interview with a second MA on 09/08/22 at 10:50am revealed: -She was aware that aspirin EC was not supposed to be crushed. -She crushed most of Resident #5's medications that were able to be crushed. -Resident #5 was able to swallow a few whole tablets at a time. Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/08/22 at 10:25am revealed: -Aspirin EC could not be crushed.	{D 358}		

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{D 358}	Continued From page 29 -Aspirin EC may not be as effective if it was crushed and administered. -The order for aspirin EC tablets could be changed to a chewable aspirin tablet and then it would be able to be crushed. Interview with Resident #5's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed: -He would not expect there to be any side effects if aspirin EC was crushed and administered. -He thought that aspirin EC would be less effective if it was crushed and administered. Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed: -If the medication order indicated "do not crush," she would expect the MAs not to crush those medications. -The MAs were responsible for ensuring that Resident #5's aspirin EC was administered as ordered. Interview with the Administrator on 09/08/22 at 6:26pm revealed: -She was not aware that aspirin EC was crushed and administered to Resident #5 during the medication pass. -She expected MAs to administer medications to the residents as they were ordered by the provider. -The MAs were responsible for ensuring that Resident #5's aspirin was administered as ordered. c. Review of Resident #5's current FL2 dated 05/24/22 revealed that there was an order for potassium ER (extended release) 20mEq take 1 tablet daily.	{D 358}		

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{D 358}	Continued From page 30 Observation of the medication pass for Resident #5 on 09/08/22 revealed: -The medication aide (MA) prepared and scanned Resident #5's medications into the electronic medication administration record (eMAR). -The MA crushed the potassium ER 20mEq tablet, placed the crushed tablet in applesauce and administered the applesauce to Resident #5 at 8:36am. Review of Resident #5's September 2022 eMAR revealed: -There was an entry for potassium ER 20mEq, take 1 tablet once daily scheduled at 8:00am and "do not crush" was listed on the eMAR entry. -There was documentation that potassium ER 20mEq was administered on 09/08/22 during the 8:00am hour. Observation of the medications on hand for Resident #5 on 09/08/22 at 8:30am revealed that there was one potassium ER 20mEq bubble pack medication card dispensed on 09/02/22 and there were 19 of 28 tablets that remained. Attempted telephone interview with the MA observed during the medication pass on 09/08/22 at 11:24am was unsuccessful. Interview with a second MA on 09/08/22 at 10:50am revealed: -She was aware that potassium ER should not be crushed. -She crushed most of Resident #5's medications that were able to be crushed. -Resident #5 was able to swallow a few whole tablets at a time. Based on observations, interviews, and record	{D 358}		

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{D 358}	Continued From page 31 reviews, it was determined that Resident #5 was not interviewable. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/08/22 at 10:25am revealed: -Potassium ER could not be crushed. -Potassium ER may not be as effective if it was crushed and administered. -The order for potassium ER tablets could be changed to a potassium capsule which could be opened for administration. Interview with Resident #5's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed: -He would not expect there to be any side effects if potassium ER was crushed and administered. -He thought that potassium ER would be less effective if it was crushed and administered. Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 5:16pm revealed: -If the medication order indicated "do not crush," she would expect the MAs not to crush those medications. -The MAs were responsible for ensuring that Resident #5's potassium ER was administered as ordered. Interview with the Administrator on 09/08/22 at 6:26pm revealed: -She was not aware that potassium ER was crushed and administered to Resident #5 during the medication pass. -She expected MAs to administer medications to the residents as they were ordered by the provider. -The MAs were responsible for ensuring that Resident #5's potassium was administered as	{D 358}		

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{D 358}	Continued From page 32 ordered. 2. Review of Resident #1's current FL2 dated 07/19/22 revealed: -Diagnoses included hyperglycemia and a below knee amputation of both legs. -There was an order for Humalog (a fast-acting insulin to treat high blood sugar) kwikpen 100units/ml inject 3 units subcutaneously 4 times daily as needed (PRN) for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. Review of Resident #1's July 2022 electronic medication administration record (eMAR) from 07/05/22 to 07/31/22 revealed: -There was an entry for Humalog kwikpen 100units/ml, inject 3 units subcutaneously 4 times PRN for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. -On 07/15/22, PRN Humalog was not administered, but should have been for a blood glucose result of 589. -On 07/16/22, PRN Humalog was not administered, but should have been for a blood glucose result of 512. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Humalog kwikpen 100units/ml, inject 3 units subcutaneously 4 times PRN for blood sugar greater than 450, recheck in 1 hour, if not lower notify MD. -On 08/04/22, PRN Humalog was not administered, but should have been for a blood glucose result of 464. -On 08/06/22, PRN Humalog was not administered, but should have been for a blood glucose result of 471. -On 08/10/22, PRN Humalog was not	{D 358}		

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{D 358}	Continued From page 33 administered, but should have been for a blood glucose result of 477. -On 08/16/22, PRN Humalog was not administered, but should have been for a blood glucose result of 557. -On 08/17/22, PRN Humalog was not administered, but should have been for a blood glucose result of 583. -On 08/19/22, PRN Humalog was not administered, but should have been for a blood glucose result of 597. -On 08/26/22, PRN Humalog was not administered, but should have been for a blood glucose result of 479. Observation of the medications on hand for Resident #1 on 09/08/22 at 3:58pm revealed that there was one Humalog kwikpen available for administration. Interview with a medication aide (MA) on 09/08/22 at 3:30pm revealed: -She was not aware there was a PRN Humalog order for Resident #1. -If a resident had a PRN Humalog order, it was normally administered in addition to their regularly scheduled Humalog. -PRN Humalog would be recorded on the eMAR if it was administered to Resident #1. Interview with a second MA on 09/08/22 at 3:40pm revealed: -She was not aware there was a PRN Humalog order for Resident #1. -PRN Humalog would be recorded on the eMAR if it was administered to Resident #1. Interview with Resident #1 on 09/08/22 at 5:18pm revealed: -He thought he was administered insulin PRN	{D 358}		

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{D 358}	Continued From page 34 and scheduled insulin three times a day. -His blood sugar was normally high. Interview with Resident #1's primary care provider's supervisor physician on 09/08/22 at 11:04am revealed: -He would expect the MAs to administer the PRN Humalog as ordered if it was ordered. -He did not know if the facility had contacted Resident #1's PCP (primary care provider) about Resident #1's blood sugar being greater than 450. Interview with the Resident Care Coordinator (RCC) on 09/08/22 at 4:40pm revealed: -She was aware of the PRN Humalog order for Resident #1. -She did not notify Resident #1's PCP of the blood sugar being greater than 450, because she was not aware of the high blood sugars. -MAs were responsible to administer medications as ordered to include Resident #1's PRN Humalog order. -MAs were expected to be aware of the PRN Humalog order for Resident #1. Interview with the Administrator on 09/08/22 at 6:25pm revealed: -She was not aware there were two instances in July 2022 and seven instances in August 2022 where Resident #1 had a blood glucose of greater than 450 and PRN Humalog was not given as ordered. -MAs were responsible to administer medications as ordered. Attempted telephone interview with Resident #1's PCP on 09/08/22 at 7:33am unsuccessful.	{D 358}		

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{D 612}	Continued From page 35	{D 612}		
{D 612}	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to screening of staff. The findings are: Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status,	{D 612}	D612 When a communicable disease outbreak has been identified, or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's Infection Prevention and Control Program, related policies, and procedures, and follow published guidance issued by the CDC, NCDHHS, and local health department. Based on CMS and CDC guidance updated on September 30, 2022, facility will discontinue screening stations at both front and side entrances of the building. In accordance with the CDC/CMS recommendation the facility will: provide guidance (e.g., posted signs at entrances) about recommended actions for visitors and employees who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Resident Care Coordinator and/or Designee will ensure recommended guidance remains posted at the facility and is followed. Completion date 10/7/2022	

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{D 612}	Continued From page 36 who has a positive test for COVID-19, symptoms of COVID-19, or close contact/higher risk exposure to COVID-19. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22: -NCDHHS recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. -Facilities shall continue to screen all who enter for signs and symptoms of COVID-19. Observation of the lobby area of the facility revealed: -There was a self-screening station between the men's and women's bathrooms in the lobby. -There was hand sanitizer, masks, a thermometer, and a staff/visitor screening notebook on the screening station. Review of the staff/visitor screening log in the lobby area of the facility revealed: -On 09/01/22, there were 3 COVID-19 screening forms completed and there was no documentation whether the person who screened was a staff or visitor. -On 09/02/22, there were 2 COVID-19 screening forms completed and there was no documentation whether the person who screened was a staff or visitor. -On 09/03/22, there were no COVID-19 screening forms completed. -On 09/04/22, there were no COVID-19 screening forms completed. -On 09/05/22, there was 1 COVID-19 screening forms completed and there was no documentation whether the person who screened	{D 612}		

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{D 612}	Continued From page 37 was a staff or visitor. -On 09/06/22, there were 5 COVID-19 screening forms completed and there was no documentation whether the person who screened was a staff or visitor. -On 09/07/22, there were 2 COVID-19 screening forms completed and there was no documentation whether the person who screened was a staff or visitor. Observation of the facility on 09/07/22 between 9:15am and 10:30am revealed: -There were 6 staff in the facility. -Staff were utilizing the main front door a side door of the facility to enter and exit. Interview with a PCA on 09/07/22 at 11:47am revealed: -She did not screen when she first came into the facility on 09/07/22. -She knew she needed to screen prior to starting her shift, but she forgot to screen. Interview with the Resident Care Coordinator, (RCC) on 09/07/22 at 11:49am revealed: -Staff should have screened in the front lobby prior to their shift. -She was responsible for ensuring staff screened for COVID-19, but she did not know staff had not been screening daily. -There was a COVID-19 testing log in the medication room where they may have been screening for COVID-19. Review of the COVID-19 testing and temperature log revealed: -There was a place to enter the date, staff's name, COVID-19 test results, and temperature. -There were no screening questions for staff on the testing and temperature log.	{D 612}		

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PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 612}	Continued From page 38 Interview with a medication aide (MA) on 09/07/22 at 11:58am revealed: -She came into the facility through the side door; a lot of staff came into the facility through the side door. -There was no COVID-19 screening station at the side door. -She forgot to screen for COVID-19 when she started her shift because she usually worked at the sister facility. Interview with the Executive Vice President of Operations on 09/07/22 at 12:04pm revealed: -She forgot to screen for COVID-19 because she entered the facility through the side door. -Staff told her they had been screening for COVID-19 at the facility; she did not know staff had not screened prior to starting their shift on 09/07/22. -The Administrator had planned for all staff to enter the facility through the front door where the COVID-19 screening station was set up. -There were staff who entered the facility through the side entrance, but they should enter through the front entrance. -There was a screening station set up in the lobby at the front entrance to the facility, but there was not a screening station set up for staff at the side entrance. Interview with a housekeeper on 09/07/22 at 12:24pm revealed: -She did not screen for COVID-19 when she came in the facility today on 09/07/22. -She had been screening for COVID-19 by checking her temperature and completing a questionnaire, but she stopped about a month ago when staff started taking a weekly COVID-19 test.	{D 612}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	R 09/08/2022

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{D 612}	Continued From page 39 -When staff completed the weekly COVID-19 test, staff had to check and record their temperatures and their COVID-19 test results; they were not screening for any other signs or symptoms. -She thought she only needed to screen for temperature on the COVID-19 testing form. -She did not know she needed to continue to complete the COVID-19 screening questionnaire daily prior to working her shift. Interview with the Administrator on 09/07/22 at 1:41pm revealed: -Staff was supposed to screen for COVID-19 daily before starting their shift. -She expected staff to continue to screen for COVID-19 although they were documenting their temperatures on the COVID-19 testing log. -She thought she instructed staff to enter the front door to screen. -Staff set up a screening station today on 09/07/22, for staff to self-screen if they enter the facility through the side door. -She did not know staff had not been screening for COVID-19 daily. -The RCC was responsible for ensuring staff screened for COVID-19 prior to starting their shift.	{D 612}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	{D912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D912}	Continued From page 40 Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to nutrition and food and residents' rights. The findings are: 1. Based on record observations, record reviews, and interviews, the facility failed to ensure a therapeutic diet was served for 1 of 1 sampled resident (#4) with an order for a no concentrated sweets (NCS), pureed diet with no bread. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition & Food Service (Type B Violation)]. 2. Based on observations and interviews, the facility failed to ensure resident rights were maintained related to providing unrestricted access for all residents to go outside of the facility when they requested and for residents to smoke when they requested. [Refer to Tag 338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].	{D912}	D912 Facility to have dietary staff re-trained in person on modified diets and texture consistencies by facilities Food Service Vendor on 11/02/2022. Dietary Manager viewed online training for modified diets and texture consistencies on 10/12/2022. In-service training to be done twice yearly and with all dietary staff and online training will be provided throughout the year. The Dietary supervisor has also worked with Speech Pathologist, with Yadkin Valley Home Health on puree textures and consistencies. Resident Care Coordinator and/or Designee to review special diet report and/or new diet orders. Administrator and/or Designee to review diet orders and view the presentation for at least one meal weekly. Completion date 11/02/2022.	