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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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 20, 2024 through August 22, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment hazard related to unsecured oxygen tanks. The findings are: Observation of a resident's room on 08/20/24 at 10:06am revealed: -There were fifteen portable oxygen cylinders sitting upright on the floor and ten of those tanks were not secured in a rack, cart, or holder. -There were six of the ten portable oxygen cylinders sitting next to the resident who was sitting in her recliner, and they were not secured in a rack, cart, or holder. -There were four of the ten portable oxygen cylinders sitting across the room from the resident next to a window and were not secured in a rack, cart, or holder. Observation of a second resident's room on 08/20/24 at 11:00am revealed:	D 079		

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D 079	Continued From page 1 -There were seven portable oxygen cylinders sitting upright on the floor. -There were three of the seven portable oxygen cylinders sitting next to an oxygen concentrator across the room from the resident which they were not secured in a rack, cart, or holder. -There were three of the seven portable oxygen cylinders sitting on the floor behind an oxygen cylinder cart, which was empty, and they were not secured in a rack, cart, or holder. -There were one of the seven portable oxygen cylinder sitting on the floor next to a closet door and it was not secured in a rack, cart, or holder. Observation of a third resident's room on 08/20/24 at 10:20am revealed there were four portable oxygen cylinders sitting upright on the floor and they were not secured in a rack, cart, or holder. Observation of a fourth resident's room on 08/20/24 at 2:40pm revealed there were three portable oxygen cylinders sitting upright on the floor and they were not secured in a rack, cart, or holder. Interview with a medication aide (MA) on 08/20/24 at 1:50pm revealed: -She went into the first resident's room to administer her medication at 7:10am and did not notice the oxygen cylinders were not in crates. -She went into the second resident's room to administer his medication at 8:00am and at 11:00am and did not notice the oxygen tanks were not in crates. -When the oxygen cylinders were empty, she would notify the lead care manager supervisor who would then contact the supply company and request a pickup of the empty containers.	D 079		

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D 079	Continued From page 2 Interview with the Assisted Living (AL) Care Manger Supervisor on 08/20/24 at 2:15pm revealed: -She was not aware that oxygen cylinders were unsecured in resident's room. -The MA and the AL Care Manager were responsible for checking the resident's oxygen cylinders and keep an eye on how many tanks were in the room. -When the supply company did not take out the empty containers, she would contact them to come and pick them up. -All oxygen cylinders should be secured in a crate or stand and not sitting on the floor. -She did not know why the oxygen cylinders were sitting on the floor. -If oxygen cylinders were not in a crate or stand, they could fall over and possibly explode. Interview with the Resident Care Director (RCD) on 08/20/24 at 3:20pm revealed: -She was not aware that oxygen cylinders were not secured in several resident's rooms. -She was responsible to check the oxygen tanks to be sure they were secured. -The AL Care Manager should notify the AL coordinator when the supply company delivered the oxygen cylinders with no cart. -She was unsure if the supply company had been notified of the empty cylinders sitting in the resident's rooms. -All staff were educated during orientation and annual training that oxygen must always be secured in a stand, crate, or holder. -Unsecured oxygen cylinders could fall and be catastrophic to the residents. Interview with the Administrator on 08/20/24 at 3:05pm revealed: -She was not aware that oxygen cylinders were	D 079		

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D 079	Continued From page 3 not secured in several resident's rooms. -The AL coordinator and the RCD were responsible for taking care of and checking the oxygen cylinders in the resident's rooms. -She did not know how often the staff checked the oxygen cylinders. -Unsecured oxygen cylinders were a safety concern because they could explode.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide personal care to residents who pressed pendants for staff assistance and did not receive a response from staff for hours. The findings are: Interview with a resident on 08/20/24 at 9:35am revealed when she pressed her pendant for assistance there was no response for at least 30 minuntes. Interview with a second resident on 08/20/24 at 9:40am revealed when he pressed his pendant it took staff over an hour to respond.	D 269		

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D 269	Continued From page 4 Interview with a third resident on 08/20/24 at 9:50am revealed she did not press her pendant for assistance any longer because it took staff too long to respond. Interview with a personal care aide (PCA) on 08/21/24 at 8:15am revealed: -The facility did not have enough staff to tend to the needs of the residents. -Staff members did not react immediately when residents pressed their pendants for assistance. -Residents waited longer than 30 minutes for assistance when they pressed their pendants. Observation on 08/21/24 at 9:38am in room 340 revealed: -The resident call pendant was pressed at 9:38am. -After 15 minutes and no staff member responded to the pendant call. -One medication aide (MA) and one PCA were observed in the hall. Observation on 08/21/24 at 2:57pm in room 348 revealed: -The resident call pendant was pressed at 2:57am. -After 15 minutes and no staff member responded to the pendant call. -One MA was observed on the hall passing medications. -One PCA was observed in the hall. Review of device activity report from 08/15/24 through 08/16/24 revealed: -On 08/15/24 there were 19 pendant reset times of 30 minutes to an hour. -On 08/15/24 there were 15 pendant reset times of an hour or more with the longest being 12 hours.	D 269		

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D 269	Continued From page 5 -On 08/16/24 there were 15 pendant reset times of 30 minutes to an hour. -On 08/16/24 there were 40 pendant reset times of an hour or more with the longest being 14 hours. -On 08/17/24 there were 25 pendant reset times of 30 minutes to an hour. -On 08/17/24 there were 37 pendant reset times of an hour or more with the longest being 10 hours. Interview with a second PCA on 08/21/24 at 3:05pm revealed: -There was one pager on each floor that got alerts when a resident pressed their pendants. -It should take 5-7 minutes for staff to respond when a resident pressed their pendant. Interview with the Assisted Living Supervisor on 08/21/24 at 3:20pm revealed: -When a resident pressed their pendant a pager was alerted and the alert with the room number appeared on a monitor in the wellness office. -The lead on each floor carried the pager for the shift. -The alert from room 348 was still on the monitor and had not been attended to. -Staff members should have responded to the alert sooner. -Staff members may not always pay attention to their pagers. Interview with the Executive Director (ED) on 08/21/23 at 3:35pm revealed: -When a resident pressed their call pendants it appeared on a monitor in the Care Managers office and on the pagers that the PCAs carried. -There was one pager on each floor that was alerted when a resident pressed a call pendant. -If the staff member with the pager was assisting	D 269		

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D 269	Continued From page 6 another resident when alerted they were to get on the walkie talkie to make other staff members aware. -She expected staff members to respond to call pendants within 10 minutes. -Staff may not have had the pagers with them at all times.	D 269		
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 contact the primary care provider (PCP) for 1 of 5 sampled residents (#5) related to elevated blood pressures. The findings are: Review of Resident #5's current FL-2 dated 02/01/24 revealed diagnoses included Alzheimer's disease, femur fracture, muscle weakness, urine retention, cognitive communication deficit, hyperlipidemia, hypothyroidism, and long-term use of anticoagulants. Review of the American Heart Association "When to Call 911" dated 05/04/24 (Heart.org)revealed: -A blood pressure result of 180/120 should be rechecked after 1-2 minutes. -If the second result was as high, check for chest pain, shortness of breath, numbness, weakness, change in vision, difficulty speaking, confusion, dizziness and vomiting.	D 273		

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-Call 911 if symptoms these symptoms are present; this constitutes a hypertensive emergency.
-Call your provider if there are no symptoms; this constitutes a hypertensive crisis and might require medication adjustments.

Review of Resident #5's current FL-2 dated 02/01/24 revealed there was an order for metoprolol 25mg one half tablet (12.5mg) twice daily, hold for systolic blood pressure less than 120 or heart rate 55. (Metoprolol is used to treat hypertension.)

Review of Resident #5's primary care provider (PCP) visit note dated 06/13/24 revealed Resident #5 had systolic blood pressures greater than 140 since March 2024.

Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol 25mg one half tablet (12.5mg), hold for systolic blood pressure less than 120 or heart rate 55 twice daily at 7:00am and 7:00pm.
-There were 60 blood pressure results documented with systolic blood pressures ranging from 94 to 243.
-There were 17 systolic blood pressure results greater than 160.
-There were 5 systolic blood pressure results greater than 190 including the following: 243/97 at 7:00pm on 06/06/24, 192/89 at 7:00pm on 06/12/24, 195/98 at 7:00pm on 06/13/24, 200/97 at 7:00am on 06/17/24, and 194/106 at 7:00am on 06/28/24.

Review of Resident #5's July 2024 eMAR revealed:

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D 273	Continued From page 8 -There was an entry for metoprolol 25mg one half tablet (12.5mg), hold for systolic blood pressure less than 120 or heart rate 55 twice daily at 7:00am and 7:00pm. -There were 61 blood pressure results documented with systolic blood pressures ranging from 98 to 210. -There were 17 systolic blood pressure results greater than 160. -There were 5 systolic blood pressure results greater than 190 including the following: 195/87 at 7:00pm on 07/06/24, 195/98 at 7:00am on 07/07/24, 205/102 at 7:00am on 07/10/24, 210/110 at 7:00pm on 07/17/24, and 191/68 at 7:00pm 07/28/24. Review of Resident #5's August 2024 eMAR revealed: -There was an entry for metoprolol 25mg one half tablet (12.5mg), hold for systolic blood pressure less than 120 or heart rate 55 twice daily at 7:00am and 7:00pm. -There were 39 blood pressure results documented with systolic blood pressures ranging from 111 to 211. -There were 10 systolic blood pressure results greater than 160. -There were 3 systolic blood pressure results greater than 190 including the following: 211/107 at 7:00am on 08/03/24, 195/89 at 7:00am on 08/04/24, and 191/97 at 7:00am on 08/13/24. Review of Resident #5's electronic progress notes dated 06/01/24 through 08/20/24 revealed: -On 06/12/24 at 6:36pm, the Wellness Nurse documented seeing Resident #5 for a fall follow up. -The Wellness Nurse documented the resident's vital signs were within normal limits including a blood pressure result of 192/89.	D 273		

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D 273	Continued From page 9 -On 06/17/24 at 7:38am, a medication aide (MA) documented Resident #5's blood pressure was high at 200/97 that morning. -There was no documentation of a blood pressure recheck or notification to the Wellness Nurse and PCP. -On 07/10/24 at 9:18am, a MA documented the resident had high blood pressure of 205/102 that morning. -The MA documented rechecking Resident #5's blood pressure one hour after administering medications and the blood pressure result was 160/76. -There was no documentation of notification to the Wellness Nurse or primary care provider (PCP). -There was no documentation of any other high blood pressure results, blood pressure rechecks or notifications to the Wellness Nurse or PCP. Interview with a MA on 08/22/24 at 10:28am revealed: -She was responsible for administering the prescribed medication to Resident #5 and talking to the Wellness Nurse when a resident's systolic blood pressure was greater than 160. -She sometimes documented talking to the Wellness Nurse, but not always. -She documented the blood pressure results on 06/06/24 at 7:00pm, 06/13/24 at 7:00pm, 06/17/24 at 7:00am, 06/28/24 at 7:00am, 07/07/24 at 7:00am, 07/10/24 at 7:00am, 08/04/24 at 7:00am, and 08/13/24 at 7:00am. -There was one time Resident #5's blood pressure was high, and the PCP was seeing the resident. -She reported Resident #5's high blood pressure to the PCP at that visit; she did not remember the blood pressure result or when that happened. -The PCP checked Resident #5's blood pressure	D 273		

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but the resident had already taken her medication.
-She always rechecked Resident #5's blood pressure when it was greater than 160/90.
-She did not always document rechecking Resident #5's blood pressure but she always made sure the resident's blood pressure was going down.
-The former Resident Care Director (RCD) instructed her to notify the Wellness Nurse for any vital sign that was out of the ordinary.
-She knew she rechecked Resident #5's blood pressure on 06/17/24 even though she did not document rechecking it.
-She probably did not document the rechecked blood pressure result because it was normal.
-On 07/10/24, Resident #5's blood pressure was "really high", and it had been high for 3 days.
-She documented rechecking Resident #5's blood pressure on 07/10/24 because it had been high for several days.
-Documenting an electronic progress note about the blood pressure electronically "flagged" the Wellness Nurse for follow up.

Telephone interview with Resident #5's PCP on 08/22/24 at 3:12pm revealed:
-Resident #5's visit note dated 06/13/24 was by another provider that covered the facility while she was out of work from April-July 2024.
-She typically checked Resident #5's blood pressure when she visited.
-She did not have the time to thoroughly review each resident's record at the facility with each visit.
-Resident #5 should have had blood pressure reporting parameters ordered.
-She would have wanted notification for systolic blood pressures over 190.
-She would not have written an order for diastolic

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blood pressure reporting parameters.
-She had not received a request for blood pressure reporting parameters.

Interview with the Special Care Unit Coordinator (SCUC) on 08/22/24 at 11:43am revealed:
-MAs were responsible for reporting changes in condition and resident concerns to her and the Wellness Nurse.
-The RCD in Training told her yesterday (08/21/24) about Resident #5's high blood pressure results.
-Resident #5's high blood pressures should have been reported to the Wellness Nurse for follow up the same day.

Interview with a Wellness Nurse on 08/22/24 at 1:17pm revealed:
-She worked at the facility as the Wellness Nurse since the end of April or the beginning of May 2024.
-She was responsible for processing medication orders, and anything related to medical care of the residents.
-She was not responsible for reviewing eMARs; the RCD reviewed eMARs.
-MAs were responsible for following the PCPs order for reporting high blood pressure results.
-There was no standard for reporting blood pressure results over or under normal range without written parameters by the PCP.
-None of Resident #5's high blood pressure results were reported to her.
-She was not trained on reviewing any of the tracking reports in the electronic charting system.

Interview with the RCD on 08/22/24 at 9:05am revealed:
-Staff were not responsible for notifying the PCP of Resident #5's elevated blood pressures

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because that was not the written order.
-The order was to hold a medication if the systolic blood pressure was less than 120.
-Resident #5's PCP reviewed blood pressure results when she saw the resident at visits.
-There was no documentation Resident #5's PCP reviewed blood pressure results.

Interview with the RCD in Training on 08/22/24 at 1:40pm revealed the former RCD would have been responsible for reviewing the eMARs with documentation of elevated blood pressure results for Resident #5.

Interview with the Regional Director of Resident Care on 08/22/24 at 1:40pm revealed:
-The order for Resident #5's blood pressure results was probably not clarified because her PCP was at the facility twice a week.
-The facility did not have a policy on blood pressure reporting when there were no written parameters.
-MAs were trained according to state guidelines for MAs regarding reporting abnormal blood pressure results to the PCP.

Interview with the Administrator on 08/22/24 at 2:33pm revealed:
-She was responsible for overall oversight of care and services at the facility.
-The RCD and Wellness Nurses were responsible for clinical oversight and MAs.
-The Regional Director of Resident Care was responsible for oversight of the RCD and Wellness Nurses.
-The MA, Wellness Nurse or RCD should have talked to Resident #5's PCP regarding blood pressure reporting parameters.

Attempted telephone interview with Resident #5's

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D 273	Continued From page 13 covering PCP on 08/22/24 at 3:54pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.	D 273		
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 to 1 of 7 sampled residents (#5) including a medication used to treat severe pain. The findings are: Review of Resident #5's current FL-2 dated 02/01/24 revealed: -Diagnoses included Alzheimer's disease, femur fracture, muscle weakness, urine retention, cognitive communication deficit, hyperlipidemia, hypothyroidism, and long-term use of anticoagulants. -There was an order for oxycodone 5mg every 8 hours. (Oxycodone is an opioid used to treat severe pain.)	D 358		

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D 358	Continued From page 14 Review of Resident #5's prescription orders dated 07/15/24 and 08/12/24 revealed: -On 07/15/24, there was an order for oxycodone 5mg every 8 hours and instructions to dispense 90 tablets. -On 08/12/24, there was an order for oxycodone 5mg every 8 hours and instructions to dispense 90 tablets. Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 5mg every 8 hours scheduled at 7:00am, 3:00pm and 11:00pm. -"MD" was documented for 14 doses of oxycodone 5mg from 3:00pm on 06/09/24 through 11:00pm on 06/13/24. -The reference at the bottom of the page indicated "MD" equaled medication pending delivery. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for oxycodone 5mg every 8 hours scheduled at 7:00am, 3:00pm and 11:00pm. -"MD" was documented for 5 doses of oxycodone 5mg from 11:00pm on 07/14/24 through 11:00pm on 07/16/24 and "3" documented for one dose at 7:00am on 07/16/24. -The reference at the bottom of the page indicated "MD" equaled medication pending delivery. -The reference on the last page indicated "3" equaled leave of absence. Observation of Resident #5's medications on hand on 08/22/24 at 10:19am revealed:	D 358		

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D 358	Continued From page 15 -There were 3 bubble packs with pharmacy labels which had Resident #5's name and instructions for oxycodone 5mg every 8 hours. -The pharmacy label indicated 90 tablets were dispensed on 08/12/24 and there were 71 tablets remaining. Interview with a medication aide (MA) on 08/22/24 at 10:28am revealed: -MAs were responsible for requesting refills from the pharmacy when there were 5-10 doses remaining. -MAs kept requesting refills form the pharmacy for Resident #5's oxycodone between 06/09/24 and 06/12/24. -The pharmacy told the MAs a new prescription order was needed for Resident #5's oxycodone. -MAs were responsible for contacting the pharmacy when a refill request was not delivered to the facility. -MAs went to the Wellness Nurse when the pharmacy said a prescription order was needed. -She told the former Resident Care Director (RCD) that Resident #5 needed a new prescription order for oxycodone between 06/09/24 and 06/12/24. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/21/24 at 4:21pm revealed: -Staff faxed orders to the pharmacy or the primary care provider (PCP) sent a prescription order electronically (escript). -Class II narcotics such as oxycodone were not refillable and required a written prescription for each fill. -The pharmacy was able to send a refill prescription template to the PCP to complete when staff requested a refill of oxycodone. -The PCP was responsible for completing the	D 358		

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refill prescription template and faxing it to the pharmacy.
-The pharmacy sent the refill prescription to the PCP and faxed a copy to the facility.
-Staff requested a refill of oxycodone on 06/07/24 for resident #5 and the pharmacy sent a refill prescription template to the resident's PCP on 06/07/24.
-The pharmacy received a second refill request from staff on 06/12/24 at 11:00am and a third request from staff on 06/12/24 at 1:00pm for Resident #5's oxycodone.
-The pharmacy received a prescription order from the PCP on 06/13/24.
-There were no notes of refill requests or refill prescription templates generated between 06/07/24 and 06/12/24.

Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 08/22/24 at 3:59pm revealed:
-The pharmacy received a refill request from staff for Resident #5's oxycodone 5mg every 8 hours scheduled on 07/09/24.
-The pharmacy sent a refill request template on 07/09/24 and received a written order on 07/09/24.
-There was no notation of a refill request around 07/14/24 for Resident #5's oxycodone.
-The pharmacy had a prescription order dated 07/15/24 and dispensed the oxycodone for Resident #5 on 07/15/24.
-Staff at the facility were responsible for getting prescription orders from the PCP for Resident #5's scheduled oxycodone.
-The pharmacy faxed a refill request template to the PCP and the facility as a courtesy.
-It was up to the facility and provider to return a prescription order once the refill request template was sent.

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D 358	Continued From page 17 Interview with the Special Care Unit Coordinator (SCUC) on 08/22/24 at 11:43am revealed: -She did not know the details of what happened with Resident #5's oxycodone. -She only knew the MAs had made several refill requests from the pharmacy. -One of the former RCDs was notified about needing a prescription order for Resident #5's oxycodone. -She did not remember the dates or which former RCD because there had been several recent changes in RCDs. Telephone interview with Resident #5's PCP on 08/22/24 at 3:12pm revealed: -Normally, staff notified her a prescription for oxycodone was needed and she sent an electronic prescription (escript) to the pharmacy. -She did not see requests from staff in her office notes from June 2024 to present. -Refill requests did not normally come through the system that generated a note. -Staff normally made refill requests through telemed messaging that went directly to the provider without a note in the system. -She had not received any telemed messaging refill requests since she returned to work in July 2024. Interview with a Wellness Nurse on 08/22/24 at 1:17pm revealed: -The PCP needed to write a prescription order for Resident #5's oxycodone every month. -The bubble packs dispensed by the pharmacy had markers on the side of the bubble pack on when to request a refill. -MAs were responsible for requesting refills from the pharmacy. -She vaguely remembered there were issues with	D 358		

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the pharmacy and getting Resident #5's oxycodone refilled in June 2024.
-She did not document her contact with the pharmacy between 06/07/24 and 06/12/24.
-She contacted the pharmacy, and the pharmacy sent the refill request directly to Resident #5's PCP.
-Any contact she had with Resident #5's PCP would have been verbal and not documented.

Interview with the Regional Director of Resident Care on 08/22/24 at 1:40pm revealed:
-The MAs or the Wellness Nurse were responsible for notifying the PCP when a written prescription order was needed for a medication refill.
-Normally, the MA went to the Wellness Nurse and the Wellness Nurse contacted the PCP.
-Staff did not follow up with contacting the PCP when the pharmacy sent a refill prescription request to the PCP.
-The refill prescription template sent by the pharmacy on 06/07/24 was a Friday and was probably not seen by staff or the PCP's office until the following Monday (06/10/24).
-On 06/12/24 there was a progress note written by the MA that the pharmacy was contacted on Friday (06/07/24), Monday (06/10/24), Tuesday (06/11/24) and Wednesday (06/12/24), the PCP was contacted on Friday (06/07/24), and the Wellness Nurse would follow up.
-There was no documentation that the PCP was contacted 06/08/24 through 06/12/24.

Interview with the Administrator on 08/22/24 at 2:33pm revealed:
-She was responsible for overall oversight of care and services at the facility.
-The RCD and Wellness Nurses were responsible for clinical oversight and MAs.

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D 358	Continued From page 19 -The Regional Director of Resident Care was responsible for oversight of the RCD and Wellness Nurses. -MAs were responsible to ensure medications were available to administer as ordered by the PCP. -MAs were responsible for requesting medication refills when there was a 5 day or less supply left. -MAs were responsible for following up with the Wellness Nurse or RCD if requested medication refills were not received from the pharmacy within 2 days. Attempted telephone interview with Resident #5's covering PCP on 08/22/24 at 3:54pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.	D 358		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene;	D 611		

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D 611	Continued From page 20 (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement policies and procedures related to a COVID-19 outbreak. Review of the facility COVID-19 Mitigation and	D 611		

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D 611	Continued From page 21 Response Plan dated 03/18/24 revealed signage was to be posted notifying visitors of the Covid-19 policy in place. Interview with the Executive Director on 08/20/24 at 8:50pm revealed: -The facility had 15 positive COVID-19 cases in the special care unit. -The first positive case was on 08/15/24. Observation of the entrance to the facility on 08/20/24 at 9:00am revealed there was no signage posted notifying visitors of the COVID-19 outbreak in the facility. Observation during facility tour on 08/20/24 at 9:30am revealed there were three residents that had tested positive for COVID-19 on the assisted living side. Interview with the Assisted Living Supervisor on 08/21/24 at 11:10 revealed: -Assisted living had two COVID-19 positive residents on the third floor and one COVID-19 positive resident on the second floor. -There should be signage posted at the entrance of the facility letting visitors know there were COVID-19 positive cases in the building. Interview with the Resident Care Coordinator (RCC) on 08/21/24 at 11:25am revealed the facility had not posted any signage at the entrance of the facility. Interview with the local Health Department Infection Control Nurse on 08/21/24 at 1:45pm revealed: -The facility had contacted the Wake County Health Department about the positive COVID-19 cases in the building.	D 611		

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D 611	Continued From page 22 -The facility needed to post signage at the entrance so visitors were aware there were COVID-19 positive cases in the facility. -The facility was given guidance to post signage at the entrance of the facility notifying visitors of the COVID-19 outbreak on 08/19/24. Second interview with the Executive Director on 08/22/24 at 3:35pm revealed: -She notified the local Health Department Infection Control Nurse on 08/16/24 about the COVID-19 positive cases in the facility. -She was not given guidance by the Health Department to post signage at the entrance notifying visitors of the COVID-19 outbreak. -She did not post signage at the entrance of the facility notifying visitors of the COVID-19 outbreak because she believed she only needed to post signage on the residents' doors who had tested positive.	D 611		