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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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 a follow-up survey and a COVID-19 Focused Infection Control Survey 12/09/20-12/10/20.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, observations, and record review the facility failed to ensure referral and follow-up with the physician for 3 of 5 sampled residents (Residents #1, #4 and #2) as related to not following up with the physician regarding medications for anxiety, blood pressure and a phosphate binder that were not administered when the resident had dialysis treatment three times a week (#1);not informing the physician of refusals of an anticoagulant and a seizure medication three times a week before dialysis treatment (#4) and not following up with the physician regarding an order for the wound clinic (#2). The findings are: 1. Review of Resident #1's current FL2 dated 09/15/20 revealed diagnoses included human immunodeficiency virus (HIV), hepatitis B, end stage renal disease (ESRD) and immune deficiency disorder. a. Review of Resident #1 current FL2 dated 09/15/20 revealed there was an order for	{D 273}		

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{D 273}	Continued From page 1 hydroxine pamoate 50 mg, used to treat anxiety and tension, daily. Review of Resident #1's subsequent physician's order dated 10/20/20 revealed there was an order for hydroxine pamoate 50mg three times a day. Review of Resident #1's October 2020 electronic Medication Administration Records (eMARs), from 10/21/20 through 10/31/20 revealed: -There was an entry for hydroxine pamoate capsule, 50mg, one capsule three times daily, to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation hydroxine pamoate was not administered 10/23/20, 10/26/20 and 10/30/20 at 12:00pm. -Hydroxine pamoate was not administered to Resident #1 three of eleven possible opportunities at 12:00pm from 10/21/20 through 10/31/20. Review of Resident #1's Progress Notes from 10/21/20 through 10/31/20 revealed: -There was documentation Resident #1 was "unavailable", at dialysis. -There was no documentation the prescribing physician was notified the medication was not administered. Review of Resident #1's November 2020 eMAR revealed: -There was an entry for hydroxine pamoate capsule, 50mg, one capsule three times daily, to be administered at 8:00am, 12:00pm and 8:00pm. -There was documentation hydroxine pamoate was not administered on 11/02/20, 11/04/20, 11/06/20, 11/09/20, 11/10/20, 11/13/20, 11/16/20, 11/17/20, 11/18/20, 11/20/20, 11/23/20, 11/25/20,	{D 273}		

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{D 273}	Continued From page 2	{D 273}		

11/26/20, 11/27/20, 11/29/20 and 11/30/20 at 12:00pm.
-Hydroxine pamoate was not administered to Resident #1 sixteen of thirty possible opportunities at 12:00pm from 11/01/20 through 11/30/20.

Review of Resident #1's Progress Notes from 10/21/20 through 10/31/20 revealed:
-There was documentation Resident #1 was "unavailable", at dialysis.
-There was no documentation the prescribing physician was notified the medication was not administered.

Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed:
-There was an entry for hydroxine pamoate capsule, 50mg, one capsule three times daily, to be administered at 8:00am, 12:00pm and 8:00pm.
-There was documentation hydroxine pamoate was not administered on 12/02/20, 12/03/20, 12/04/20, 12/07/20 at 12:00pm.
-Hydroxine pamoate was not administered to Resident #1 four of eight possible opportunities at 12:00pm from 12/01/20 through 12/08/20.

Review of Resident #1's Progress Notes from 12/01/20 through 12/02/20 revealed:
-There was documentation Resident #1 was "unavailable", at dialysis.
-There was no documentation the prescribing physician was notified the medication was not administered.

Interview with Resident #1's primary care physician (PCP) on 12/10/20 at 11:39pm revealed:
-He did not know Resident #1 was not receiving

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hydroxine pamoate 50mg at 12:00pm three times a week while at dialysis.
-Resident #1's hydroxine was prescribed for anxiety.
-He had not had any reports of increased anxiety for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 12/10/20 at 1:35pm revealed:
-She did not know Resident #1 had medications scheduled during the time he was at dialysis treatment on Monday, Wednesday and Friday.
-She did not know Resident #1 did not receive hydroxine pamoate 50mg at 12:00pm three times a week while at dialysis.

Interview with the medication aide (MA) on 12/09/20 at 2:00pm revealed she did not administer hydroxine pamoate 50mg at 12:00pm when Resident #1 was at dialysis Monday, Wednesday and Friday.

Refer to interview with Resident #1 on 12/10/20 at 9:55am.

Refer to interview with the first shift medication aide (MA) on 12/09/20 at 2:00pm.

Refer to interview with a second shift MA on 12/09/20 at 2:30pm.

Refer to interview with the primary care physician (PCP) on 12/10/20 at 11:39am.

Refer to interview with the Executive Director on 12/10/20 at 12/10/20 at 1:52pm.

Refer to interview with the Resident Care Coordinator (RCC) on 12/10/20 at 2:40pm.

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{D 273}	Continued From page 4 Refer to interview with the Director of Resident Care (DRC) on 12/10/20 at 4:15pm. b. Review of Resident #1 current FL2 dated 09/15/20 revealed there was an order for sevelamer carbonate 800mg, used as a phosphate binder in residents with chronic kidney disease, 2 tablets (1600mg) three times daily with meals. Review of Resident #1's October 2020 electronic Medication Administration Record (eMAR), from 10/01/20 through 10/31/20 revealed: -There was an entry for sevelamer carbonate 800mg, 2 tablets three times daily, to be administered at 8:00am, 12:00pm and 5:00pm. -There was documentation sevelamer carbonate was not administered on 10/02/20, 10/05/20, 10/07/20, 10/09/20, 10/11/20, 10/12/20, 10/14/20, 10/16/20, 10/19/20, 10/23/20, 10/26/20 and 10/30/20 at 12:00pm. -Sevelamer was not administered to Resident #1 twelve of thirty-one possible opportunities at 12:00pm from 10/01/20 through 10/31/20. Review of Resident #1's Progress Notes from 10/01/20 through 10/31/20 revealed: -There was documentation Resident #1 was "unavailable", at dialysis. -There was no documentation Resident #1's physician was notified sevelamer 800mg was not administered twelve of thirty-one possible opportunities at 12:00pm Review of Resident #1's November 2020 eMAR revealed: -There was an entry for sevelamer carbonate 800mg, 2 tablets three times daily, to be administered at 8:00am, 12:00pm and 5:00pm. -There was documentation sevelamer carbonate	{D 273}		

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was not administered on 11/01/20, 11/03/20, 11/05/20, 11/06/20, 11/09/20, 11/10/20, 11/13/20, 11/16/20, 11/17/20, 11/18/20, 11/20/20, 11/23/20, 11/25/20, 11/26/20, 11/27/20, 11/29/20 and 11/30/20.
-Sevelamer was not administered to Resident #1 seventeen of thirty possible opportunities at 12:00pm.

Review of Resident #1's Progress notes from 11/01/20 through 11/30/20 revealed:
-There was documentation Resident #1 was "unavailable", at dialysis.
-There was no documentation Resident #1's physician was notified sevelamer 800mg was not administered seventeen of thirty possible opportunities at 12:00pm.

Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed:
-There was an entry for sevelamer carbonate 800mg, 2 tablets three times daily, to be administered at 8:00am, 12:00pm and 5:00pm.
-There was documentation sevelamer carbonate was not administered on 12/02/20, 12/03/20, 12/04/20 and 12/07/20.
-Sevelamer was not administered to Resident #1 four of seven possible opportunities at 12:00pm.

Review of Resident #1's Progress notes from 12/01/20 through 12/02/20 revealed:
-There was documentation Resident #1 was "unavailable", at dialysis.
-There was no documentation Resident #1's physician was notified sevelamer 800mg was not administered four of seven possible opportunities at 12:00pm.

Interview with the first shift MA on12/09/20 at 2:00pm revealed she did not administer the

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{D 273}	Continued From page 6 12:00pm dose of sevelamer carbonate 800mg 2 tablets on Monday, Wednesday and Friday when Resident #1 was at dialysis treatment. Interview with Resident #1's primary care physician (PCP) on 12/10/20 at 11:39am revealed: -He did not know Resident #1 was not receiving sevelamer carbonate 800mg, 2 tablets three times daily at 12:00pm three times a week while at dialysis. -Resident #1's sevelamer was prescribed to patients with chronic kidney disease to prevent the absorption of phosphates. -Resident #1's most recent laboratory results did not showed phosphates within a normal range. Interview with the RCC on 12/10/20 at 1:35pm revealed she did not know Resident #1 did not receive sevelamer carbonate 800mg, 2 tablets at 12:00pm three times a week while at dialysis. Refer to interview with the first shift medication aide (MA) on 12/09/20 at 2:00pm. Refer to interview with a second shift MA on 12/09/20 at 2:30pm. Refer to interview with Resident #1 on 12/10/20 at 9:55am. Refer to interview with the PCP on 12/10/20 at 11:39am. Refer to interview with the Executive Director on 12/10/20 at 1:52pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/10/20 at 2:40pm.	{D 273}		

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{D 273}	Continued From page 7 Refer to interview with the DRC on 12/10/20 at 4:15pm. c. Review of Resident #1's physician's order dated 10/31/20 revealed an order for hydralazine 50mg, a medication used for high blood pressure, 2 tablets (100mg) every 8 hours. Review of Resident #1's November 2020 eMAR revealed: -There was an entry for hydralazine 50mg, 2 tablets three times daily, to be administered at 6:00am, 2:00pm and 10:00pm. -There was documentation hydrazaline was not administered on 11/02/20, 11/04/20, 11/06/20, 11/09/20, 11/13/20, 11/16/20, 11/20/20, 11/23/20, and 11/25/20 at 2:00pm. -Hydrazaline was not administered to Resident #1 nine of thirty possible opportunities at 2:00pm. Review of Resident #1's Progress Notes from 11/01/20 through 11/30/20 revealed: -There was documentation Resident #1 was "unavailable", at dialysis. -There was no documentation Resident #1's physician was notified hydrazaline 100mg was not administered nine of thirty possible opportunities at 2:00pm. Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed: -There was an entry for hydrazaline 50mg, 2 tablets three times daily, to be administered at 6:00am, 2:00pm and 10:00pm. -There was documentation hydrazaline was not administered on 12/02/20, 12/04/20 and 12/07/20. -Hydrazaline was not administered to Resident #1 three of seven possible opportunities at 2:00pm.	{D 273}		

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{D 273}	Continued From page 8 Review of Resident #1's Progress Notes from 12/01/20 through 12/08/20 revealed: -There was documentation Resident #1 was "unavailable", at dialysis. -There was no documentation Resident #1's physician was notified hydrazaline was not administered four of seven possible opportunities at 2:00pm. Interview with the first shift MA on 12/09/20 at 2:00pm revealed she did not administer the 12:00pm dose of hydrazaline 50mg to Resident #1 on Monday, Wednesday and Friday when he went to dialysis treatment. Interview with Resident #1's primary care physician (PCP) on 12/10/20 at 11:39pm revealed: -He did not know Resident #1 was not receiving hydrazaline at 2:00pm three times a week while at dialysis treatment. -Resident #1's hydrazaline was prescribed for an increase in his blood pressure. -He had not ordered daily blood pressure readings for Resident #1, so he did not know if the missed doses affected his blood pressure. Interview with the RCC on 12/10/20 at 1:35pm revealed she did not know Resident #1 did not receive hydrazaline 50mg two tablets at 2:00pm three times a week while at dialysis. Refer to interview with the first shift MA on 12/09/20 at 2:00pm. Refer to interview with a second shift MA on 12/09/20 at 2:30pm. Refer to interview with Resident #1 on 12/10/20 at 9:55am.	{D 273}		

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{D 273}	Continued From page 9 Refer to interview with the PCP on 12/10/20 at 11:39am. Refer to interview with the Executive Director on 12/10/20 at 1:52pm. Refer to interview with the Resident Care Coordinator (RCC) on 12/10/20 at 2:40pm. Refer to interview with the DRC on 12/10/20 at 4:15pm. 2. Review of Resident #4's current FL2 dated 09/15/20 revealed diagnoses included end stage renal disease (ESRD), thrombocytopenia, schizophrenia and acute respiratory infection. a. Review of Resident #4's subsequent physician's order dated 11/15/20 revealed an order for clopidogrel 75mg daily, a medications used to reduce the risk of heart attack and stroke. Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) from 11/15/20 through 11/30/20 revealed: -There was an entry for clopidogrel 75mg once daily to be administered at 8:00am. -There was documentation clopidogrel was not administered on 11/20/20, 11/23/20, 11/25/20, 11/27/20 and 11/30/20. -Clopidogrel was documented as not administered to Resident #4 five of sixteen possible opportunities. Review of Resident #4's Progress Notes from 11/15/20 through 11/30/20 revealed: -There was documentation Resident #4 was at "dialysis" or refused. -There was no documentation Resident #1's	{D 273}		

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physician was notified clopidogrel was not administered five of sixteen possible opportunities at 8:00am.

Review of Resident #4's December 2020 eMAR from 12/01/20 through 12/10/20 revealed:
-There was an entry for clopidogrel 75mg once daily to be administered at 8:00am.
-There was documentation clopidogrel was not administered on 12/02/20, 12/03/20, 12/04/20, 12/07/20 and 12/09/20.
-Clopidogrel was documented as not administered to Resident #4 five of 10 possible opportunities.

Review of Resident #4's Progress Notes from 12/01/20 through 12/10/20 revealed:
-There was documentation Resident #4 was at "dialysis" or refused.
-There was no documentation Resident #1's physician was notified clopidogrel was not administered five of 10 possible opportunities at 8:00am.

Interview with the first shift medication aide (MA) on 12/09/20 at 2:00pm revealed:
-Resident #4 did not want to take clopidogrel before dialysis treatment. "That is her right."
-She did not inform the Director of Resident Care (DRC) or primary care physician (PCP) Resident #4 refused clopidogrel before dialysis treatment.
-She was not in the building when the resident returned from dialysis and did not communicate to the second shift staff to administer clopidogrel at a later time.
-She did not know she was to contact the physician after 1 refusal of clopidogrel per facility policy.

Interview with a second shift MA on 12/09/20 at

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{D 273}	Continued From page 11 2:30pm revealed: -Resident #4 returned from dialysis treatments on Monday, Wednesday and Friday at the end of first sift around 3:00pm. -The medications for her shift, 3:00pm-11:00pm, populated on the eMAR 1 hour before administration. -She did not know what medications were administered during first shift. -She had not received any directive from management to administer medications Resident #4 had missed while at dialysis when she returned on second shift. -If a resident refused medications 3 or more times they notified the DRC and the physician. Interview with Resident #4 on 12/10/20 at 3:50pm revealed: -She had dialysis treatments three times a week on Monday, Wednesday and Friday. -There was a problem with blood clotting at the site of the arteriovenous (AV) fistula in her right leg. -Her physician prescribed clopidogrel 75mg every day to prevent clotting at the AV fistula site. -She did not take the clopidogrel on the days she had dialysis treatment because she had a problem bleeding when she had injections. -She left a message with her physician last week to get an order to discontinue the clopidogrel on Monday, Wednesday and Friday, because she did not loke refusing her medications. -She had not heard back from her physician regarding this concern. Interview with the Director of Resident Care (DRC) on 12/10/20 at 4:15pm revealed: -She did not know Resident #4 was refusing clopidogrel three times a week when she had dialysis treatments.	{D 273}		

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{D 273}	Continued From page 12 -She did not know Resident #4 had trouble with clotting at her AV fistula site. -She did not know Resident #4 had bleeding issues with injections during her dialysis treatments. -She relied on the MAs to inform her of medication refusals. -The policy for immediate physician notification for certain drugs included anticoagulant drugs, such as clopidogrel. -The MAs should have notified her and the physician immediately. Interview with the primary care physician (PCP) on 12/10/20 at 4:28pm revealed: -She was aware Resident #4 was on clopidogrel to prevent blood clotting at the AV fistula site. -She did not know Resident #4 was refusing clopidogrel 3 times a week when she had dialysis treatments. -She did not have a message from Resident #4 to discontinue clopidogrel on Monday, Wednesday and Friday due to excessive bleeding when she has any injections at dialysis. -Her expectation was the facility staff should inform her when Resident #4's medications were refused, especially an anticoagulant. -Resident #4 could experience blood clotting at the AV fistula site again, or other side effects she as the primary care provider should be evaluating. Interview with the Executive Director (ED) on 12/10/20 at 1:52pm revealed: -The Resident Care Coordinator (RCC) and DRC were responsible for the residents' medications, treatments and appointments. -She did not review the eMARS or medication administration-that was the responsibility of the clinical staff (RCC and RCD).	{D 273}		

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{D 273}	Continued From page 13 -She expected the MAs to contact the physician if a resident refused medications, and follow their directive. -She did not know Resident #4 was refusing her clopidogrel three times a week before dialysis treatment. b. Review of Resident #4's current FL2 dated 09/22/20 revealed there was an order for primidone 50mg twice daily, a medication used to treat seizures. Review of Resident #4's November 2020 electronic Medication Administration Record (eMAR) from 11/01/20 through 11/30/20 revealed: -There was an entry for primidone 50mg twice daily to be administered at 8:00am and 8:00pm. -There was documentation primidone was not administered on 11/09/20, 11/13/20, 11/20/20, 11/23/20, 11/25/20, 11/27/20 and 11/30/20 at 8:00am. -Primidone was documented as not administered to Resident #4 seven of thirty possible opportunities at 8:00am. Review of Resident #4's December 2020 eMAR from 12/01/20 through 12/10/20 revealed: -There was an entry for primidone 50mg twice daily to be administered at 8:00am and 8:00pm. -There was documentation primidone was not administered on 12/02/20, 12/03/20, 12/04/20, 12/07/20 and 12/09/20. -Primidone was documented as not administered to Resident #4 five of ten possible opportunities at 8:00am. Interview with the first shift medication aide (MA) on 12/09/20 at 2:00pm revealed: -Resident #4 refused some of her medications on the days she had dialysis.	{D 273}		

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{D 273}	Continued From page 14 -A lot of residents do not take their medications before dialysis. -It was a resident's right to refuse medications. -The MA did not send Resident #4's medications with her to take after dialysis. -If a resident was out of the building at a physician's appointment or dialysis, she documented they were "unavailable." -She did not inform the DRC or the physician Resident #4's primidone medication was refused on Monday, Wednesday and Friday before she went to dialysis. Interview with the second shift MA on 12/09/20 at 2:30pm revealed: -She was working when Resident #4 returned from dialysis treatments. -She did not know what medications Resident #4 was administered during first shift. -She was not instructed to administer any morning medications Resident #4 may not have received when she returned from dialysis treatment. Interview with the Executive Director on 12/10/20 at 1:52pm revealed: -She did not know Resident #4 was refusing her primidone medication three times a week before dialysis treatments. -The facility had a policy regarding refusals of medications. The MAs were to contact the prescribing physician if medications were refused. -There was a document provided to the MAs listing the medications that required immediate notification to the physician. -All other medications, physicians were to be notified after 3 refusals Interview with Resident #4 on 12/10/20 at 3:50pm revealed:	{D 273}		

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{D 273}	Continued From page 15 -She had a seizure at dialysis last summer and was prescribed primidone daily. -When she was administered primidone it made her very sleepy. -At dialysis, she needed to be alert during the treatment for the nursing staff to evaluate her. -She refused the primidone on Monday, Wednesday and Fridays when she went to dialysis. -She was not offered primidone when she returned from dialysis. -She did not inform her PCP she was refusing primidone 3 times a week. Interview with the DRC on 12/10/20 at 4:15pm revealed: -She did not know Resident #4 was refusing her primidone three times a week before dialysis treatments. -She did not know primidone made her sleepy and she needed to be alert during dialysis treatment for evaluation by the nursing staff. Interview with Resident #4's PCP on 12/10/20 at 4:28pm revealed: -She had prescribed primidone 50mg twice a day for seizures. -She did not know Resident #4 was refusing primidone on the mornings she had dialysis, three times a week. -She had expected the facility staff to inform her if Resident #4 refused her medications. -She expected the staff to administer medications as ordered or contact her if there was a contraindication to the medication. -Resident #4 could be more vulnerable to a seizure if she was not receiving primidone as prescribed. _____ Interview with the first shift medication aide (MA)	{D 273}		

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{D 273}	Continued From page 16 12/09/20 at 2:00pm revealed: -Resident #1 left the facility on Monday, Wednesday and Friday at 10:00am for dialysis treatment and returned to the facility at approximately 3:30 pm. -Resident #1 had scheduled medications at 12:00pm and 2:00pm daily. -On Monday, Wednesday and Friday when Resident #1 was at treatment she documented medications at 12:00pm and 2:00pm as not administered since he was not in the building. -Management and his physician knew he had dialysis treatments, so she did not see the need to inform the physician. -When a resident was not in the building when their medication was scheduled, she documented "not available". Interview with a second shift MA on 12/09/20 at 2:30pm revealed: -Resident #1 returned from dialysis treatments on Monday, Wednesday and Friday around 3:30pm. -She did not know of any medications he was not administered during first shift. -She had not received any directive from management to administer medications he had missed while at dialysis when he returned. Interview with Resident #1 on 12/10/20 at 9:55am revealed: -He went to dialysis treatment on Monday, Wednesday and Friday. -He left the facility around 10:00am and returned around 4:00pm. -He did not bring any medications with him to dialysis and he did not receive the missed doses of medications when he returned. -He thought the mediction times could be adjusted on his treatment days so he would not miss any doses of medication.	{D 273}		

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{D 273}	Continued From page 17 -He had not spoken to his physician regarding changing the times of administration on treatment days. Interview with the PCP on 12/10/20 at 11:39pm. -Resident #1 was compliant with his medications. -He had several co-morbidities which made it important he received all his medications as ordered. -The facility staff had not notified him that Resident #1 was not receiving medications while he was at dialysis. -If he had been notified, he would have altered the times of administration so Resident #1 could have received medications as prescribed. -He expected medications to be administered by the staff as ordered. Interview with the Executive Director on 12/10/20 at 1:52pm revealed: -She did not know Resident #1 was not receiving all prescribed medications on his dialysis treatment days. -The DRC and RCC provided oversight for the residents' medications. -She did not review the residents' eMARS. That was the responsibility of the DRC and RCC. -She would have expected the physician to be notified of missed medications and provided direction to the staff on the days Resident #1 was at treatment. Interview with the Resident Care Coordinator (RCC) on 12/10/20 at 2:40pm revealed: -She was responsible for the residents and their medications on the 100 hall of the facility. -She knew Resident #1 went to dialysis treatment on Monday, Wednesday and Friday. -Medications that were scheduled while Resident #1 was at dialysis treatment should have been	{D 273}		

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administered when he returned or at the direction of the physician.
-It was not her responsibility to review the residents' electronic Medication Administration Record (eMAR).
-She expected the MAs to inform her if residents were routinely not receiving their medications for any reason.
-She would discuss the reason with the resident and then notify the physician.

Interview with the DRC on 12/10/20 at 4:15pm revealed:
-She was responsible for the medication administration for the residents in the community.
-She relied on the MAs to inform her if a resident's medications were not administered.
-There was a report she could access if medications were refused or missed.
-If a resident was out of the facility and missed a medication, there was no report to alert her of this.
-She would have expected the MA to inform her Resident #1 was missing medications three times a week while at dialysis treatment.
-She would have notified the physician and requested a time change for these medications so Resident #1 would receive his medications as ordered.

3. Review of Resident #2's current FL2 dated 03/10/20 revealed diagnoses included Alzheimer's dementia, chronic obstructive pulmonary disease and osteoarthritis.

Review of Resident #2's primary care provider (PCP) visit notes revealed:
-On 08/19/20, there was a note for the resident to continue home health skilled nursing for care to lower extremities edema/wound, the resident

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continued to remove wraps on legs; will keep trying to control and make sure his wounds or edema did not get worse.
-On 09/08/20, there was a note that an anti-itch medication was increased to help with itching and to prevent excessive walking which makes it very difficult for his lower extremity wound healing.
-On 09/16/20, there was a note for Resident #2 to continue skilled nursing with home health.
-On 10/07/20, there was a note the home health skilled nursing informed the PCP that the patient's legs were improving but still "had a long way to go", the resident continued to be non-complaint given his Alzheimer's disease progression.
-On 10/27/20, there was a note indicating the resident should continue with the home health nurse.
-On 11/25/20, there was a note that the PCP will talk to staff about the possibility of the resident going to the wound clinic.

Review of the Resident #2's home health progress notes dated 10/08/20 revealed skilled nursing home health services were discharged due to goals being met.

Observation of Resident #2 on 12/09/20 at 2:47pm revealed:
-Resident #2's left lower leg was reddened.
-His left lower leg was dry, scaly, with dark red closed sores that were scabbed.

Interview with a personal care aide (PCA) on 12/09/20 at 12:40pm revealed:
-Resident #2 constantly scratched and picked at the skin on his left lower leg.
-Resident #2 previously wore a sleeve on his leg to help with wound healing, however since the home health nurse stopped coming, the sleeves

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were no longer available.
-His legs were "really bad", he constantly walked which cause him to put pressure on his legs.
-The resident also scratched his legs which cause the sores to be worse.

Interview with the medication aide (MA) on 12/09/20 at 12:35pm revealed:
-Resident #2's left lower leg "would leak" and then get better, "it's complicated".
-Resident #2's left lower leg was not currently leaking but the resident would frequently scratch his legs.
-Resident #2 often times did not want staff to touch his leg and would often kick.

Interview with the Memory Care Manager (MCM) at 12/10/20 at 12:30pm revealed:
-Resident #2 constantly picked at his skin and was not always complaint with home health.
-Resident #2 previously had an open wound on his left lower leg and was receiving treatment through home health.
-Resident #2 was discharged from home health services because goals were met.
-She knew Resident #2's left lower leg continued to be warm, red, and now had closed sores.
-She knew the PCP wanted Resident #2 to been seen by the wound clinic during a conversation on 11/25/20, however she never received a signed order only a verbal order.
-She scheduled the appointment on 12/09/20 with the wound clinic.
-The PCP came to the facility weekly, however she did not know why the order was not signed before he left the facility on 11/25/20, or when he came to the facility the following week.
-Physician's orders were written the day the PCP discussed the treatment with the staff.
-She asked the PCP twice when he was in the

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facility if he wanted to proceed with wound clinic services and she did not get a response or an order.
-She did not document her communication with the PCP.

Telephone interview with the scheduler at the Wound Clinic on 12/10/20 at 12:36pm revealed:
-She scheduled an appointment for Resident #2 on 12/09/20 to be seen on 12/21/20.
-She received the referral information on 12/09/20 for Resident #2 from the RCC.
-She could not provide the date on the order for the referral.

A second interview with the MCM on 12/10/20 at 1:54pm revealed:
-She faxed the verbal order to the wound clinic on 12/09/20 because it had not yet been singed by the physician.
-The PCP did not come into the facility until 12/10/20 and she was able to get the order signed on that date.

Review of a signed physician's order for Resident #2 on 12/10/20 revealed there was a referral for the wound clinic.

Interview with the Resident Care Coordinator (RCC) on 12/10/20 at 1:35pm revealed:
-She was responsible for the clinical operations of the facility.
-She worked closely with the MCM to meet the health care needs of the residents.
-She and the MCM both received PCP visit notes immediately after the PCP conducts his visits.
-The visit notes were available via email from the provider.
-She and the MCM received the notes and followed through with orders and

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recommendations.
-She participated in the conversation with the PCP on 11/25/20 when Resident #2 was discussed regarding the wound clinic.
-The PCP gave a verbal order on 11/25/20 and she put the physician order form into a folder for him to sign during his next visit.
-The MCM would have been responsible for making sure the order was signed on 11/25/20 and faxed the same day to the wound clinic.

Interview with the PCP on 12/10/20 at 11:39pm revealed:
-He knew Resident #2 was previously receiving home health services for a left lower leg wound.
-He spoke with the RCC "a couple of weeks ago" and it was determined Resident #2 needed to be treated by the wound clinic.
-He expected Resident #2 to have been scheduled to be seen the wound clinic for further treatment and to prevent the resident from having increased swelling to possibly prevent fluid from leaking from the skin.
-He wanted Resident #2 to be seen as he was hard to treat by home health and wanted to see if there was any other treatment offered by the wound clinic.
-He would expect the facility to reach out to him the next day to get an order if it was not received during the visit.

Interview with the Administrator on 12/10/20 at 1:52pm revealed:
-She knew Resident #2 was discharged from home health services because his goals were met 10/08/20.
-She physically met with the PCP, RCC, and MCM to discussed next treatment options for Resident #2's left lower leg on 11/25/20.
-The PCP gave a verbal order for the resident to

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{D 273}	Continued From page 23 be seen by the wound clinic on 11/25/20. -The RCC and MCM would have been responsible for making sure the signed order was obtained and information was faxed to the wound clinic. -She would expect the MCM and RCC to follow-up with the physician immediately after the conversation and get an order for the resident to be seen. Based on observations, interviews and record review, Resident #2 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 ensure medications were administered as ordered for 1 of 5 residents (#4) for medications used to control an immune deficiency disorder, gastro-esophageal reflux disorder (GERD) and dry eyes. The findings are: Review of Resident #1's current FL2 dated 09/15/20 revealed diagnoses included 2 separarte conditions resulting from viral blood	D 358		

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borne pathogens, end stage renal disease (ESRD) and immune deficiency disorder.

a. Review of Resident #1 current FL2 dated 09/15/20 revealed there was an order for Ritonavir 100mg, an antiviral medication used to treat HIV, one tablet daily.

Review of Resident #1's October 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Ritonavir 100mg one tablet to be administered at 8:00am daily.
-There was documentation Ritonavir was administered daily from 10/01/20 through 10/31/20.
-Thirty one tablets of Ritonavir were documented as administered from 10/01/20 through 10/31/20.

Review of Resident #1's November 2020 eMAR revealed:
-There was an entry for Ritonavir 100mg one tablet to be administered at 8:00am daily.
-There was documentation Ritonavir was administered daily from 11/01/20 through 11/30/20.
-Thirty tablets of Ritonavir were documented as administered from 11/01/20 through 11/30/20.

Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed:
-There was an entry for Ritonavir 100mg one tablet to be administered at 8:00am daily.
-There was documentation Ritonavir was administered daily from 12/01/20 through 12/08/20.
-Eight tablets of Ritonavir were documented as administered from 12/01/20 through 12/08/20.

Observation of Resident #4's medications on

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hand on 12/10/20 at 1:27pm revealed:
-There was a prescription bottle of Ritonavir 100mg with a pharmacy generated label and directions to administer one tablet every day.
-The fill date on the label was 09/30/20, with 31 tablets.
-There were 7 tablets remaining in the prescription bottle.

Interview with a pharmacist at the facility's contracted pharmacy on 12/10/20 at 8:45am revealed:
-Resident #1 had an active order for Ritonavir 100mg once daily.
-This was not an automatic weekly cycle fill medication.
-The facility staff had to request a refill for the medication.
-The last fill date for Ritonavir 100mg once daily was 09/30/20 for a 30 day supply.

Interview with Resident #1's primary care physician (PCP) on 12/10/20 at 11:39pm revealed:
-Ritonavir was prescribed for Resident #1 as an antiretroviral medication used along with another medication to treat HIV.
-Both medications work in conjunction to slow the progression of the HIV virus.
-It was important to use both medications in combination daily.
-If Resident #1 did not receive the antiretroviral medications as prescribed his immune system could become compromised.
-This would open him to the possibility of the virus spreading and Resident #1's immune system would be less effective in protecting him from other viruses and bacterial infections.
-His expectation was that the staff administer medications as prescribed.

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D 358	Continued From page 26 Interview with a medication aide (MA) on 12/10/20 at 1:27pm revealed: -The MAs performed medications cart audits weekly. -The resident's physician order summary was printed and the MAs would ensure the medications for those orders were on the medication cart. -They did not check for the number of tablets remaining, or the amount of liquid remaining in a prescription bottle, during a cart audit. -It was the responsibility of the MA to order medications as needed that were not on a weekly cycle fill from the pharmacy. -Ritonavir was a medication that required ordering from the pharmacy when there were 10 or less pills in the bottle. -She had not contacted the pharmacy recently to request a refill of Ritonavir. -She administered all of Resident #1's medications when she worked. -Resident #1 was very compliant with his medications. -She did not know why there were seven tablets remaining in the bottle of Ritonavir that was filled on 09/30/20 for a 30 day supply. -There were no other bottles of Ritonavir in the facility. Interview with the Director of Resident Care (DRC) on 12/10/20 at 12:40pm revealed: -She knew Resident #4 was prescribed Ritonavir in combination with another medication to control his HIV. -Most of Resident 4's medications were sent weekly in a multi dose blister pack. -She knew Ritonavir was not sent in the weekly cycle of medications, but must be ordered for refill by the staff.	D 358		

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-It was the responsibility of the MAs to order medications when needed, or leave a request for a new prescription for a medication refill in the physicians box.
-She did not know Resident #4's Ritonavir was last ordered from the pharmacy on 09/30/20 for a 30 day supply.
-She did not know Resident #4's Ritonavir, with a fill date of 09/30/20, had 7 remaining tablets in the prescription bottle.

Interview with the Executive Director on 12/10/20 at 1:52pm revealed:
-The DRC and Resident Care Coordinator (RCC) were responsible for the clinical needs of the residents.
-The MAs were responsible for ensuring medications were administered as ordered and refilled when needed.
-She did not know the documentation of the Ritonavir administration did not match the fill history from the pharmacy.
-She expected the MAs to administer the medications as ordered and document any exceptions that may occur.

b. Review of Resident #1 current FL2 dated 09/15/20 revealed there was an order for Pantoprazole 40mg twice daily, (a medication used to treat GERD).

Review of Resident #1's October 2020 eMARs revealed:
-There was an entry for Pantoprazole 40mg, one tablet twice daily, to be administered at 8:00am and 8:00pm.
-There was documentation Pantoprazole was administered twice daily from 10/01/20 through 10/31/20.
-Sixty-two tablets of Pantoprazole were

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D 358	Continued From page 28 documented as administered from 10/01/20 through 10/31/20 Review of Resident #1's November 2020 eMAR revealed: -There was an entry for Pantoprazole 40mg, one tablet twice daily, to be administered at 8:00am and 8:00pm. -There was documentation Pantoprazole was administered twice daily from 11/01/20 through 11/30/20. -Sixty-two tablets of Pantoprazole were documented as administered from 11/01/20 through 11/30/20. Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed: -There was an entry for Pantoprazole 40mg, one tablet twice daily, to be administered at 8:00am and 8:00pm. -There was documentation Pantoprazole was administered twice daily from 12/01/20 through 12/08/20. -Thirty one tablets of Pantoprazole were documented as administered from 12/01/20 through 12/08/20. Observation of Resident #4's medications on hand on 12/10/20 at 1:27pm revealed: -There was a prescription bottle of Pantoprazole 40mg with a pharmacy generated label and directions to administer one tablet twice daily. -The fill date on the label was 11/09/20, with 60 tablets, a 30 day supply. -There were 24 tablets remaining in the prescription bottle, a 12 day supply. Interview with Resident #1's PCP on 12/10/20 at 11:39pm revealed: -Resident #1 was prescribed Pantoprazole twice	D 358		

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a day for GERD.
-Resident #1 had complained of acid reflux and gastric distress after meals.
-Excess acid in the esophagus due to reflux can damage the lining of the esophagus over time.
-His expectation was that the staff administer medications as prescribed.

Interview with a pharmacist at the facility's contracted pharmacy on 12/10/20 at 8:45am revealed:
-Resident #1 had an active order for Pantoprazole 40mg one tablet twice daily.
-Pantoprazole was not automatically filled weekly by the pharmacy staff.
-The facility staff had to request a refill for the medication.
-The last fill date for Pantoprazole 40mg, one tablet twice daily, was 11/09/20 for a 30 day supply.

Interview with a MA on 12/10/20 at 1:27pm revealed:
-Pantoprazole was not a medication that was sent from the pharmacy as a weekly cycle fill medication.
-Staff were required to request a refill of Pantoprazole from the pharmacy when there were 14 or less pills in the prescription bottle.
-She had not contacted the pharmacy recently to request a refill of Pantoprazole.
-She did not know why there were 24 tablets remaining in the prescription bottle of Pantoprazole that was filled on 11/09/20 for a 30 day supply.
-There were no other bottles of Pantoprazole in the facility.

Interview with the DRC on 12/10/20 at 12:40pm revealed:

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D 358	Continued From page 30 -She did not know Resident #4's Pantoprazole 40mg was last filled at the facility's pharmacy on 11/09/20 for a 30 day supply. -She did not know Resident #4's Pantoprazole with a fill date of 11/09/20 had 24 remaining tablets in the prescription bottle. -Resident #4's Pantoprazole should have been refilled on 12/08/20. Interview with the Executive Director on 12/10/20 at 1:52pm revealed she did not know the documentation of thr Pantoprazole administration did not match the fill history from the pharmacy. c. Review of Resident #1 current FL2 dated 09/15/20 revealed there was an order for Advanced Eye Relief 1-0.3%, 1 drop in each eye every day, used for dry eye. Review of Resident #1's October 2020 eMARs revealed: -There was an entry for Advanced Eye Relief 1-0.3%, 1 drop in each eye, to be administered at 8:00am daily. -There was documentation Advanced Eye Relief was administered daily from 10/01/20 through 10/31/20. -Thirty one tablets of Advanced Eye Relief were documented as administered from 10/01/20 through 10/31/20. Review of Resident #1's November 2020 eMAR revealed: -There was an entry for Advanced Eye Relief 1-0.3%, 1 drop in each eye, to be administered at 8:00am daily. -There was documentation Advanced Eye Relief was administered daily from 11/01/20 through 11/30/20. -Advanced Eye Relief was documented as	D 358		

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D 358	Continued From page 31 administered from 11/01/20 through 11/30/20. Review of Resident #1's December 2020 eMAR, from 12/01/20 through 12/08/20 revealed: -There was an entry for Advanced Eye Relief 1-0.3%, 1 drop in each eye, to be administered at 8:00am daily. -There was documentation Advanced Eye Relief was administered daily from 12/01/20 through 12/08/20. -Advanced Eye Relief was documented as administered from 12/01/20 through 12/08/20 Observation of Resident #1's medications on hand on 12/10/20 at 1:27pm revealed: -There was a 15ml bottle of Advanced Eye Relief in a container labeled with Resident #1's name. -There was approximately 5ml remaining in the bottle. -There was no date when the bottle was opened. Interview with a pharmacist at the facility's contracted pharmacy on 12/10/20 at 8:45am revealed: -Resident #1 had an active order for Advanced Eye Relief 1-0.3%, 1 drop in each eye daily. -This was not a weekly cycle fill medication. -The facility staff had to request a refill for the medication. -The last fill date for Advanced Eye Relief was 06/30/20, a 30 day supply. Interview with Resident #1's PCP on 12/10/20 at 11:39pm revealed: -Resident #4 complained of dry itchy eyes. -He was prescribed Advanced Eye Relief for this condition. -Dry eye was an ongoing condition and Resident #4 should be receiving Advanced Eye Relief drops daily to prevent irritation.	D 358		

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D 358	Continued From page 32 -His expectation was that the staff administer medications as prescribed. Interview with a MA on 12/10/20 at 1:27pm revealed: -Advanced Eye Relief was a medication that required staff to request a refill from the pharmacy when there was less than a quarter of the drops left in the bottle. -She had not contacted the pharmacy recently to request a refill of Advanced Eye Relief. -She did not know the current bottle of Advanced Eye Relief was filled by the pharmacy on 06/30/20 for a 28 day supply. -She did not know why there was approximately one quarter of the bottle of medication remaining. -There were no other bottles of Advanced Eye Repair in the facility. Interview with the DRC on 12/10/20 at 12:40pm revealed: -She did not know Resident #4's Advanced Eye Relief was last ordered from the pharmacy on 06/30/20 for a 28 day supply. -She did not know Resident #4's Advanced Eye Relief with a fill date of 06/30/20 had one quarter of the prescription bottle remaining. -She expected the MAs to administer medication as prescribed. Interview with the Executive Director on 12/10/20 at 1:52pm revealed she did not know Advanced Eye Relief's documentation of administration did not match the fill history from the pharmacy. Attempted interview with Resident #1 on 12/10/20 at 2:40pm was unsuccessful.	D 358		

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D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. 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 of the residents during the global coronavirus (COVID-19) pandemic as related to staff not prompting residents to social distance at least six feet apart, staff not encouraging residents to wear masks, and staff not wearing required personal protective equipment (PPE) while providing care to a resident who had been placed in quarantine after	D 601		

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D 601	Continued From page 34 a hospital stay. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facilities last updated 11/20/20 revealed: -Create a plan for managing new Admissions and readmissions whose COVID-19 status is unknown. -Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. -Staff should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. -Health care personnel should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. -Make necessary PPE available in areas where quarantined resident care is provided. -Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff. -Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. -Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after	D 601		

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their admission.
-Testing at the end of this period can be considered to increase certainty that the resident is not infected.
-Health care personnel should implement social distancing among residents (remain at least six feet apart).

Review of the NC DHHS guidance for long-term care setting Considerations for Residents Admission/Readmission during COVID-19 dated May 8, 2020 revealed:
-Residents with negative or unknown COVID-19 status should be kept in quarantine until 14 days after admission/readmission.
-Newly admitted and readmitted residents should be placed in quarantine, away from the general facility population, for 14 days after admission to assure they are not in the incubation phase.
-Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom.

Review of the facility's COVID-19 infection control policy dated 10/14/20 revealed:
-Residents were to maintain social distancing when outside of their room of at least six feet.
-Staff providing care for residents who are suspected to be infected with COVID-19 should wear PPE consisting of gloves, gown, N95 or surgical mask, and eye protection.
-The facility's COVID-19 infection control policy did not address the quarantine of newly admitted or readmitted residents.

1. Review of Resident #3's current FL-2 dated 12/04/20 revealed diagnoses included abdominal pain, lumbar spondylolisthesis, and acute multiple sclerosis.

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Review of Resident #3's current care plan dated 09/16/20 revealed Resident #3 required limited assistance with eating, ambulation, bathing, dressing, grooming, and transfers.

Review of Resident #3's hospital discharge summary revealed:
-Resident #3 was hospitalized after her gall bladder was removed.
-Resident #3 was hospitalized 11/30/20 to 12/05/20.

Observation of Resident #3 on 12/09/20 between 9:00am and 12:00pm revealed:
-Resident #3 was in room #110 next to room #111 on the assisted living (AL) side.
-Resident #3's door was open, and she was laying on her bed watching television.
-There was no signage on Resident #3's door indicating she was on quarantine precautions.
-Resident #3's bathroom was located outside of her room across the hall between her room and next to room #111.
-A resident exited the bathroom across from Resident #3's room and entered room #111.
-A personal care aide (PCA) entered Resident #3's room wearing a surgical mask with a cloth face covering the surgical mask, face shield, and gloves.
-The PCA removed Resident #3's trash from her table and placed it into a trash bag.
-The PCA did not remove her gloves and exited Resident #3's room.
-The PCA carried the trash from Resident #3's room with her gloves on to a storage room located on the next hall.
-The PCA opened the door to the storage room with her gloved hand, entered the room and discarded the trash and gloves into a trash bin.
-A medication aide (MA) entered Resident #3's

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room wearing a surgical mask, face shield, and gloves.
-The MA assisted Resident #3 to get into a sitting position allowing Resident #3 to grab her by the forearm.
-The MA gave Resident #3 her medications, left Resident #3's room and returned to the medication cart without changing her gloves.
-The MA returned to the medication cart with the same gloves on to chart Resident #3's medication on the computer.
-The MA removed her gloves and disposed of them in the trash on the medication cart and used hand sanitizer and documented Resident #3's medication on the computer.

Observation of Resident #3 on 12/10/20 at 11:30am revealed:
-The memory care manager (MCM) walked from her office to the entrance of the facility to get gloves, a trash bag, and a gown from a supply cabinet.
-The MCM put on goggles, gloves, and a gown prior to entering Resident #3's room.
-When the MCM entered Resident #3's room she did not ask Resident #3 to put on a face mask.
-Resident #3 was laying on her bed and the MCM assisted the Resident #3 to remove her blankets and lift her gown to expose her stomach.
-The MCM touched Resident #3's stomach where Resident #3 had an incision that was closed with 12 staples.
-The MCM replaced Resident #3's gown and blankets on top of Resident #3.
-The MCM came to the threshold of the door to Resident #3's room and removed her gown and gloves then placed them into a trash bag.
-Without utilizing an alcohol-based hand sanitizer (ABHS) or washing her hands she walked from Resident #3's room down the hallway with the

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trash bag of soiled PPE.
-The MCM walked to two different storage rooms that were locked after she attempted to open the doors.
-The MCM walked to the nurse's station to the bathroom, discarded the trash bag with soiled PPE, and washed her hands.

Interview with Resident #3 on 12/09/20 at 11:00am revealed:
-Resident #3 was in the hospital from 11/30/20 to 12/05/20 to get her gallbladder removed.
-She had an incision on her stomach with staples after the surgery.
-She did not leave her room except to use the bathroom located across the hallway.
-She shared the bathroom across the hall with the resident in room #111.
-When staff came in her room to help her get up or look at her incision, they wore face shields and masks.
-Sometimes the staff wore gloves but not all the time.
-She did not see staff wear gowns when they came into help her get up, change her bed, or look at her stomach where she had her incision.

Interview with a first shift PCA on 12/09/20 at 9:00am revealed:
-Resident #3 was on quarantine to her room after returning from the hospital last week.
-She assisted Resident #3 with setting her up for meals in her room, emptying her trash, changing her linens, straightening her personal items, and a shower.
-When she provided Resident #3 with these care needs, she wore face mask, face shield and gloves.
-She did not wear a gown because she was told Resident #3 was not COVID-19 positive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060136	A. BUILDING: _____ B. WING _____	R 12/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINT HILL SENIOR LIVING	10830 LAWYERS ROAD CHARLOTTE, NC 28227

(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
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-The MCM told her Resident #3 was not COVID-19 positive because the hospital tested Resident #3 before she left the hospital.
-She did not get any specific training on quarantining residents when they returned from the hospital.
-When Resident #3 was placed on quarantine it was communicated during stand-up staff meetings.
-She was not told when and what PPE to wear when taking care of Resident #3 during stand-up staff meetings.

Interview with a first shift MA on 12/09/20 at 9:20am revealed:
-She was told at a staff stand-up meeting that Resident #3 was on a 14-day quarantine after she returned from the hospital on 12/05/20.
-She received training on proper use of PPE for COVID-19 positive residents by the regional nurse in October 2020.
-The MCM told the staff that Resident #3 was not COVID-19 positive.
-Because Resident #3 was not COVID-19 positive she did not have to wear PPE consisting of a gown, gloves, face mask, and face shield.

Interview with the MCM on 12/10/20 at 11:00am revealed:
-She was responsible for the care of the residents on the memory care unit and the 100 halls.
-She supervised the staff on the memory care unit and the 100 halls.
-She was trained by the Regional Nurse to wear a gown, goggles, face mask and gloves for positive COVID-19 residents.
-She did not know residents on a 14-day quarantine after a hospitalization that tested negative for COVID-19 required complete PPE consisting of gown, goggles, face mask and

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gloves when providing direct care to them.
-She tried to encourage the residents on the 100 halls of the AL to wear masks and social distance.
-All staff and residents were expected to practice social distancing and staff should encourage the residents to social distance at least six feet apart.

Interview with the Regional Nurse on 12/10/20 at 12:00pm revealed:
-She provided training to all staff on 10/14/20 on the most recent updates to the COVID-19 infection control policy and checked off staff on the appropriate use of PPE (consisting of gown, gloves, masks, and eye protection) when caring for residents with COVID-19.
-She did not remember specifying considerations for the PPE used to care of residents on 14-day quarantine after a hospitalization on 10/14/20.
-There was a more recent update to the facility's COVID-19 policy on or around 10/23/20 that addressed the 14-day quarantine of residents out for hospitalizations and holiday visits.
-The 10/23/20 update was distributed from the regional office to all Administrators.
-She was not asked by the Administrator to provide any additional training or real-time visits to the facility to assess the staff's understanding of specifics of use of PPE for 14-day quarantined residents.
-All staff was expected to encourage the residents to social distance.

Interview with the Administrator on 12/10/20 2:15pm revealed:
-Residents that received a negative COVID-19 test in the hospital remained on a 14-day quarantine.
-She communicated with the staff during daily staff stand-up meetings on all updates concerning the 14-day quarantine of hospitalized

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residents concerning PPE.
-She expected staff to wear a mask, gown, gloves, and face shields to Residents on the 14-day quarantine when being provided personal care.
-She expected the staff to ask her or the Regional Nurse specific questions on proper use of PPE.
-She did not ask the Regional Nurse to assess staff appropriate use of PPE to determine any corrections needed to be addressed on the guidance for the 14-day quarantine.

2. Observations of the AL side of the facility on 12/09/20 between 8:30am to 4:15pm revealed:
-There were two residents seated at the end of a dining room table without face masks on holding each other's hands with their faces within approximately 3 inches of each other's face talking to each other.
-A personal care aide (PCA) was helping other residents refill their drink glasses.
-A resident in a wheelchair entered the dining room and exited to the outside patio smoking area.
-The resident in the wheelchair obtained a lighter from another resident, lit his cigarette and smoked his cigarette approximately two feet from the other resident.
-The Administrator directed a male resident to the location of a female resident sitting on a loveseat in a common television room on the 100 halls.
-The Administrator watched the male resident seat himself on the loveseat next to the female resident on the loveseat in front of the television.
-The Administrator did not redirect the male resident to sit in another empty chair in the television room.
-The two residents remained on the loveseat together watching television.

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D 601	Continued From page 42 Interview with the PCA assigned to the dining room on 12/09/20 at 8:55am revealed: -She did not try to separate the male and female couple sitting on one end of the table. -When she tried to separate the couple or explain they needed to eat at each of the table they would not listen. -She did not tell anyone like the MA, MCM or Administrator the couple would not social distant because they all knew the couple would not separate. -She tried to tell the residents in the smoking area on the patio to separate six feet apart all the time, but they did not listen. -She did not see the resident in the wheelchair go out on the patio and smoke within six feet of the other resident. Interview with the Administrator on 12/10/20 2:15pm revealed: -She expected all staff to encourage the residents to social distance and wear masks. -She expected all staff to ask the residents if they were not wearing a mask if the resident had a mask available to put on. -There was one couple that did not reside in the same room together that did not practice social distancing and wear masks when outside their rooms.	D 601		