STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001128	A. BUILDING: _____ B. WING _____	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELON VILLAGE HOME	715 EAST HAGGARD AVENUE ELON, NC 27244

(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 and follow-up survey on November 23, 2021.	D 000		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to have a qualified activity director designated to the adult care home. The findings are: Review of the facility census revealed the current census was 9 residents. Observation of the facility hallway on 11/23/21 at	D 129		

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D 129	Continued From page 1 8:30am revealed: -An activity calendar was posted on a dry erase board that was attached to the wall. -There were 14 hours of activities documented per week. Interview with 3 of 3 residents on 11/23/21 revealed they preferred to do individual activities at the facility such as watching television, coloring pictures and listening to music. Interview with the Supervisor/Activity Director on 11/23/21 at 4:02pm revealed: -She and the Administrator became co-owners of the facility in 2002. -She began working more frequently at the facility as the Supervisor after her retirement. -She assumed the following duties at the facility as the Supervisor: yard work, seasonal decorations, meal preparation, and relief medication aide (MA). -The facility's previous Activity Director left in 2014. -She became the facility's Activity Director in November 2020. -She and the Administrator discussed the need for her to complete a basic activity course. -She had not enrolled into a course. -She did not know there was a time limit to acquire the activity course. -She did not hold a degree in recreation administration or therapeutic recreation. Interview with the Administrator on 11/23/21 at 4:45pm revealed: -The Supervisor was the Activity Director. -The Supervisor was responsible for completing the monthly activity calendar at the facility. -The Supervisor had not enrolled in a basic activity course.	D 129		

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D 129	Continued From page 2 -He did not know the Activity Director had nine months from the date of hire to complete the course. -He was responsible for ensuring the Activity Director completed the basic activity course within nine months of the hire date.	D 129		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by:	D 280		

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D 280	Continued From page 3 Based on observations, record reviews, and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 2 of 3 sampled resident (#2 and #3) with LHPS tasks for a subcutaneous injection (#2) and use of an assistive device for ambulation (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 08/25/21 revealed: -Diagnoses included psychosis, history of cerebral palsy, and history of hydrocephalus. -There was a medication order for Humira injection inject 0.8ml subcutaneous every 14 days. Review of Resident #2's record revealed there were no licensed health professional support (LHPS) evaluations. Interview with Resident #2 on 11/23/21 at 3:24pm revealed: -She received two injections. -One injection was administered at the provider's office and the other injection was administered at the facility by the medication aide (MA). -The MA injected Humira into her thigh every other week. Interview with Administrator on 11/23/21 at 4:45pm revealed: -Resident #2 received an intramuscular injection at the provider's office. -He knew Resident #2 received another injection, but he did not know subcutaneous injections were a LHPS task. -He had not told the LHPS nurse about Resident #2's subcutaneous injections.	D 280		

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D 280	Continued From page 4 Attempted telephone interview with the LHPS nurse on 11/23/21 at 3:57pm was unsuccessful. Refer to interview with the Administrator on 11/23/21 at 4:45pm. 2. Review of Resident #3's current FL-2 dated 08/25/21 revealed: -Diagnoses included cerebral palsy, hypertension, seizure disorder, mild mental retardation, osteoporosis, and mild hyperlipidemia. -Resident #3 was ambulatory. Observation of Resident #3's in the dining room on 11/23/21 at 10:37am revealed she ambulated with the use of a four-point cane. Review of Resident #3's record revealed there were no licensed health professional support (LHPS) evaluations. Interview with Resident #3 on 11/23/21 at 3:46pm revealed she used a cane to walk and had used a cane since her admission in 2007. Interview with the Administrator on 11/23/21 at 4:45pm revealed: -Resident #3 used a cane to ambulate. -He had not made the LHPS nurse aware that Resident #3 used a cane for ambulation. Attempted telephone interview with the LHPS nurse on 11/23/21 at 3:57pm was unsuccessful. Refer to interview with the Administrator on 11/23/21 at 4:45pm. _____ Interview with Administrator on 11/23/21 at 4:45pm revealed:	D 280		

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D 280	Continued From page 5 -The LHPS nurse came to the facility to complete the LHPS evaluations and her last visit to the facility was October 2021. -He told the LHPS nurse who she needed to evaluate. -If a resident had a LHPS task he would have to tell the LHPS nurse to make her aware. -He was responsible for ensuring the LHPS evaluations were completed for residents.	D 280		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to	D 363		

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D 363	Continued From page 6 Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 3 of 3 residents (#1, 2, and #3) during the morning medication pass on 11/23/21. The findings are: Observation of a medication aide (MA) in the dining room on 11/23/21 at 10:12 am revealed: -There were six residents sitting in the dining room eating breakfast. -The MA entered the dining room from the hallway carrying six medication cups containing medications. -The cups were not labeled with any information and the cups were not covered or sealed. -She took the medication cups to where 4 residents were seated and placed a medication cup in front of Resident #3, Resident #2 and then the other two residents sitting at the table. -She turned to another table where two residents sat and placed the remaining medication cups in front of Resident #1 and the other resident. -The residents did not immediately lift the medication cups to take their medications.	D 363		

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-The residents continued to eat their breakfast and the MA left the dining room.
-Resident #1, Resident #2 and Resident #3 took their medication before leaving the dining room table.
-The MA did not watch the residents take their medications before walking away.

1. Review of Resident #1's current FL-2 dated 11/16/20 revealed:
-Diagnoses included diabetes mellitus, mental retardation, and allergic rhinitis.
-There was a medication order for enteric coated aspirin 81mg daily.
-There was a medication order for vitamin B12 1000mcg daily.
-There was a medication order for Jentadueto 5mg-1000mg daily.
-There was a medication order for fluoxetine 20mg three capsules daily.
-There was a medication order for glipizide extended release 5mg daily with breakfast.
-There was a medication order for losartan potassium 25mg daily.
-There was a medication order for omeprazole 40mg daily.
-There was a medication order for loratadine 10mg daily.

Interview with Resident #1 on 11/23/21 at 2:20pm revealed:
-He received his medications in the dining room in the morning and at night.
-The MA administered his medications to him.
-His medication cup was not labeled with his medication names.
-His medication cup was not labeled with his name, and it was not sealed when she administered his medications.

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D 363	Continued From page 8 Refer to the interview with the medication aide (MA) on 11/23/21 at 5:39pm. Refer to the interview with the Administrator on 11/23/21 at 4:45 pm. 2. Review of Resident #2's current FL-2 dated 08/25/21 revealed: -Diagnoses included psychosis, history of cerebral palsy, and history of hydrocephalus. -There was a medication order for sertraline 100mg daily. -There was a medication order for Linzess 145mcg daily with breakfast. -There was a medication order for chlorpromazine 200mg every morning. -There was a medication order for metoprolol succinate extended release (ER) 25mg daily. -There was a medication order for aripiprazole 5mg daily. -There was a medication order for baclofen 10mg three times daily. -There was a medication order for baclofen 20mg three times daily. -There was a medication order for folic acid 1mg daily. -There was a medication order for omeprazole 20mg daily. -There was a medication order for vitamin B12 1000mcg daily. Interview with Resident #2 on 11/23/21 at 3:24pm revealed: -The medication aides (MA) administered morning medications. -She received her morning medication at the same time the other residents received medications in the dining room. -Her medication cup was not labeled with her name or names of her medications in the past.	D 363		

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-She was able to recognize some of her medications by the color of the tablets.
-Her medications were administered in the dining room, not in the medication room or her resident room.
-The MAs brought the medication cups to the dining room from the medication room.

Refer to the interview with the MA on 11/23/21 at 5:39pm.

Refer to the interview with the Administrator on 11/23/21 at 4:45pm.

3. Review of Resident #3's current FL-2 dated 08/25/21 revealed:
-Diagnoses included cerebral palsy, hypertension, seizure disorder, mild mental retardation, osteoporosis, and mild hyperlipidemia.
-There was a medication order for amlodipine besylate 10mg daily.
-There was a medication order for lamotrigine 100mg twice daily.
-There was a medication order for lamotrigine 25mg twice daily.
-There was a medication order for calcium 600mg and vitamin D 400 units twice daily.
-There was a medication order for buspirone 5mg two tablets twice daily.
-There was a medication order for risperidone 1mg daily.
-There was a medication order for losartan 100mg daily.
-There was a medication order for metoprolol succinate extended release (ER) 50mg one and a half tablets daily.
-There was a medication order for famotidine 20mg daily.

Interview with Resident #3 on 11/23/21 at 3:46pm

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D 363	Continued From page 10 revealed she received her medications in the dining room daily and her medication cup that morning was not labeled with her name. Refer to the interview with the MA on 11/23/21 at 5:39pm. Refer to the interview with the Administrator on 11/23/21 at 4:45pm. _____ Interview with the MA on 11/23/21 at 5:39pm revealed: -She prepared six residents' medications at the same time in the medication room because she had done it that way for a long time. -She took all residents their medications in one trip to the dining room. -She did not label the residents' medication cups with their names or medication names. -She had a method to determine which medication cup belonged to each resident. -She stacked the medication cups in her hand in the sequence of who she would administer medications to in the dining room. -She knew she was supposed to label the medication cups and that was what she was trained to do. -She was responsible for ensuring medications were administered accurately by labeling the medication cups. Interview with the Administrator on 11/23/21 at 4:45pm revealed: -He was aware each resident should have medication administered and documented before preparing and administering another resident's medications. -He held the MAs responsible for administering medications accurately. -He was overall responsible for ensuring staff	D 363		

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D 363	Continued From page 11 administering medications were aware when pre-pouring medications all requirements for labeling and documentation was completed.	D 363		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to 58 residents during the global coronavirus (COVID-19) pandemic as related to appropriate use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection and screening of visitors, staff and residents.	D 612		

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D 612	Continued From page 12 The findings are: 1. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Long-Term Care Facilities dated 09/10/21 revealed: -The guidance referred to Interim Infection Control Recommendations for Healthcare Personnel during the COVID-19 Pandemic. -The guidance indicated that source control should be implemented for healthcare personnel. -Source control included a well-fitting face mask, N95 face mask or respirator. Review of the NC DHHS Guidance for Best Practices for Infection Prevention in Long Term Care Facilities (LTC) dated 02/10/21 revealed LTC facilities should follow the CDC guidance for appropriate selection and use of PPE. Observation of the facility upon entrance into facility on 11/23/21 at 8:16am revealed the medication aide (MA) was not wearing a face mask. Observation of the Administrator in the facility on 11/23/21 at 9:43am revealed he entered the facility without a face mask. Observations throughout the facility on 11/23/21 at various times revealed: -At 10:00am the MA served the breakfast meal to six residents and was not wearing a facemask. -At 12:05pm the Supervisor entered the facility without wearing a facemask. -At 4:30pm the MA re-entered the facility without wearing a facemask.	D 612		

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D 612	Continued From page 13 Interview with a resident on 11/23/21 at 2:20pm revealed: -Staff did not wear a face mask inside the facility. -Staff wore face masks when he was transported to the physician's office. Interview with a second resident on 11/23/21 at 3:24pm revealed: -She wore a facemask when she went to her physician's office. -Staff did not wear a face mask when inside the facility, but they wore a face mask in the vehicle when transporting residents. Interview with a MA on 11/23/21 at 5:39pm revealed: -Staff knew the proper way to wear facemasks. -The Administrator trained staff concerning COVID-19. -She did not know the date of the last training session. -She did not know she was supposed to wear a face mask while in the facility, because she and the residents were vaccinated. -The facility had several face masks that were provided to the staff. Interview with the Supervisor on 11/23/21 at 4:02pm revealed: -She worked as a relief MA and was responsible for yard work, seasonal decorations, and meal preparation. -She did not know the CDC guidelines for COVID-19 were that face masks should be worn in the facility. -The facility had an ample supply of face masks and other PPE. -The Administrator had coordinated training concerning COVID-19. -She did not have a face mask on while in the	D 612		

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facility because she did not know she had to wear it.

Interview with the Administrator on 11/23/21 at 4:45pm revealed:
-He did not know that staff had to wear face masks inside the facility.
-He wanted to make the facility feel like a home not an institution.
-Staff were expected to wear face masks outside the facility.
-He did not know the CDC guidelines concerning staff wearing face masks in the facility.

2. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed residents should be actively monitored daily for fever, and symptoms consistent with COVID-19.

Review of the North Carolina Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for local health department (LHD) dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19.

Review of three residents' September 2021, October 2021 and November 2021 medication administration records (MARs) revealed there was no documentation of any temperatures.

Observation upon entrance to the facility on 11/23/21 at 8:16am revealed:
-No screening was provided upon entrance to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001128	A. BUILDING: _____ B. WING _____	11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELON VILLAGE HOME	715 EAST HAGGARD AVENUE ELON, NC 27244

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 15 -There was no screening station set-up at the entrance of the facility. Based on observations and record reviews, the facility did not have any screening logs for visitors or staff. Interview with a resident on 11/23/21 at 2:20pm revealed: -Staff had not obtained his temperature daily and no one had asked him questions concerning COVID-19 symptoms. -Staff did not obtain a temperature unless a resident complained of not feeling well. Interview with another resident on 11/23/21 at 3:24pm revealed she did not have her temperature checked daily. Interview with a medication aide (MA) on 11/23/21 at 5:39pm revealed: -She did not take the residents' temperatures daily. -She took residents' temperatures if they complained of not feeling well. -There was a thermometer for use at the facility. -Previously, she obtained resident temperatures daily in 2020 but she did not document the resident's temperatures. -She received training concerning COVID-19 in 2020 from the Administrator. -She did not take her temperature daily while at work. -She did not know she needed to take the residents' and her temperature daily. -She had not read the CDC guidelines concerning COVID-19. -She did not offer screening on 11/23/21 because there had been very few visitors to the facility. -The facility previously was not accepting any	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 16 visitors into the facility until May 2021. Interview with the Supervisor on 11/23/21 at 4:02pm revealed: -The residents' temperatures were not being taken daily because the residents were vaccinated. -A resident's temperature would be taken if the resident displayed symptoms of COVID-19. -Staff reported when a resident did not feel well or had a fever. -Staff did not check their temperatures daily and all staff were vaccinated. -She did not know residents and staff should check their temperatures daily while at work. -She had not screened herself when she entered the facility. Interview with the Administrator on 11/23/21 at 4:45pm revealed: -He used the North Carolina Department of Health and Human Services (NC DHHS) website as the source of COVID-19 guidance. -He received emails from NC DHHS containing updates about guidance for COVID-19. -Visitors were not allowed in the facility until recently. -He did not know the CDC guidelines related to resident, staff or visitor screening for COVID-19. -The facility did not have a COVID-19 policy. -Residents were screened for COVID-19 by testing them if they had complaints of any COVID-19 symptoms. -He was responsible for ensuring the CDC guidelines for COVID-19 screenings for residents and staff with daily temperatures and screening for visitors were followed.	D 612		