| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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<br><br>The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 06/24/20 and a desk review survey on 06/25/20, 06/26/20, 06/29/20 - 07/02/20, 07/06/20, and 07/08/20 -07/10/20 with a telephone exit on 07/10/20. | D 000 | | |
| D 137 | 10A NCAC 13F .0407(a)(5) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure 3 of 6 sampled staff (Staff C, Staff E, and Staff F) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire, in accordance with G.S. 131E-256.<br><br>The findings are:<br><br>1. Review of Staff C, Environmental/Maintenance Director's, personnel record revealed:<br>-Staff C was hired on 02/11/14.<br>-There was no documentation of a Health Care Personnel Registry check (HCPR) being completed upon hire.<br>-There was documentation a HCPR check was completed on 07/09/20, during the survey, with no findings. | D 137 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 137 | Continued From page 1 | D 137 | | |

Telephone interview with Staff C on 07/10/20 at 1:39pm revealed:
-He assumed his HCPR check was completed upon hire.
-He had been told by the Business Office Manager (BOM) at the time of his hiring that "everything was good for him to start working."

Refer to telephone interview with the BOM on 07/10/20 at 1:30pm.

Refer to the telephone interview with the Administrator on 07/10/20 at 1:43pm.

2. Review of Staff E, personal care aide's (PCA), personnel record revealed:
-Staff E was hired on 06/19/15.
-There was no documentation a Health Care Personnel Registry check (HCPR) being completed upon hire.
-There was documentation a HCPR check was completed on 07/10/20, during the survey, with no findings.

Telephone interview with Staff E on 07/10/20 at 2:03pm revealed she did not know if a HCPR check had been completed for her.

Refer to telephone interview with the Business Office Manager on 07/10/20 at 1:30pm.

Refer to the telephone interview with the Administrator on 07/10/20 at 1:43pm.

3. Review of Staff F, dietary aide's, personnel record revealed:
-Staff F was hired on 12/16/19.
-There was no documentation a Health Care Personnel Registry check (HCPR) was completed upon hire.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 137 | Continued From page 2<br>-There was documentation a HCPR check was completed on 07/10/20, during the survey, with no findings.<br><br>Refer to telephone interview with the Business Office Manager on 07/10/20 at 1:30pm.<br><br>Refer to the telephone interview with the Administrator on 07/10/20 at 1:43pm.<br><br>_____<br>Telephone interview with the Business Office Manager on 07/10/20 at 1:30pm revealed:<br>-She had worked as the interim Business Office Manager since the beginning of May 2020.<br>-She was responsible for ensuring a HCPR check was completed for staff and for maintaining staff records.<br>-She had never completed an audit of staff records.<br>-She did not know staff were missing HCPR checks.<br>-She thought only staff who worked directly with residents were to have a HCPR check.<br><br>Telephone interview with the Administrator on 07/10/20 at 1:43pm revealed:<br>-The Business Office Manager was responsible for competing HCPR checks.<br>-The current Business Office Manager starting filling in with business office duties when the old Business Office Manager left in May 2020.<br>-She knew some staff did not have their HCPR check.<br>-It was her understanding at one time, that only the health care staff (MAs and PCAs) needed a HCPR check..<br>- A HCPR check should be completed for all staff upon hire. | D 137 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 3 | D 188 | | |
| D 188 | 10A NCAC 13F .0604(e) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.<br>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:<br>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)<br>(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility | D 188 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 4<br>is receiving enhanced Medicaid payments.<br>(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing at the facility for 3 of 45 shifts sampled for 15 days between 04/30/20 and 06/20/20.<br><br>The findings are:<br><br>Review of NCDHHS Emergency Staffing Recommendations during the COVID-19 pandemic revealed:<br>-Staff who test positive for COVID-19 will be unable to work until they meet the criteria for returning to work. This can cause sudden staffing shortages at a time when extra work is required to control the outbreak.<br>-Facilities should prepare for the possibility of staffing shortages and have a concrete plan with specific steps to take if they do need additional staff.<br>-The following options should be considered for emergency staffing:<br>-Allowing caregivers that are positive but asymptomatic to staff areas dedicated to caring for positive residents (while wearing appropriate PPE).<br>-Contacting temporary staffing agencies<br>-Contacting other sister agencies for temporary | D 188 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 5 | D 188 | | |

staffing support
-Contacting local hospitals for temporary staffing support
- If all these options have been exhausted and additional staffing is still needed, your local health department can request emergency staff from the state. Emergency staffing requests typically take several days to fill. Facilities should begin searching for additional staff as soon as staff are tested rather than waiting for test results to come back, so these emergency staffing requests can be filled if necessary.

Staffing and emergency staffing policies were requested on 06/30/20 at 9:05 am and on 07/01/20 at 10:28am but none were provided.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 69 beds and a Special Care Unit (SCU) with a capacity of 24 beds.

Review of the Resident Bed List Report dated 05/18/20 revealed:
-There was a census of 31 residents in the AL unit, which required 16 aide hours on second shift.
-There was a SCU census of 18 residents, which required 18 aide hours on second shift.
-There should have been a total of 34 aide hours between the AL unit and SCU on second shift.

Review of the Employee Time Detail dated 05/18/20 revealed:
-There were 21.75 total aide hours provided on second shift between the AL unit and SCU.
-There was a shortage of 12.25 aide hours.
-It could not be determined how many of the 21.75 total aide hours were worked in the AL unit

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 6 | D 188 | | |

on second shift.

Review of the Resident Bed List Report dated 05/18/20 revealed:
-There was a census of 31 residents in the AL unit, which required 16 aide hours on third shift.
-There was a SCU census of 18 residents, which required 14.4 aide hours on third shift.
-There should have been a total of 30.4 aide hours between the AL unit and SCU on third shift.

Review of the Employee Time Detail dated 05/18/20 revealed:
-There were 16 total aide hours provided on third shift between the AL unit and SCU.
-There was a shortage of 14.4 aide hours.
-It could not be determined how many of the 16 total aide hours were worked in the AL unit on third shift.

Review of the Resident Bed List Report dated 05/20/20 revealed:
-There was a census of 28 residents in the AL unit, which required 16 aide hours on second shift.
-There was a SCU census of 17 residents, which required 17 aide hours on second shift.
-There should have been a total of 33 aide hours between the AL unit and SCU on second shift.

Review of the Employee Time Detail dated 05/20/20 revealed:
-There were 11.75 total aide hours provided on second shift between the AL unit and SCU.
-There was a shortage of 21.25 aide hours.
-It could not be determined how many of the 11.75 total aide hours were worked in the AL unit on second shift.

Telephone interview with the former Resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 7<br><br>Care Director (RCD) on 07/08/20 at 11:13am revealed:<br>-She had worked on all shifts when there was a staffing need with residents with and without COVID-19.<br>-She did not clock in because she was salaried.<br>-She did not recall the days or nights in which she worked.<br>-She recalled working short staffed several times during the COVID-19 pandemic.<br>-She recalled working short on a third shift sometime in May, in which there was only one other staff member present.<br>-She had passed medications on both units.<br>-She and the interim Administrator had talked about using a staffing agency to help during their pandemic, but she did not know if the interim Administrator had called any agencies.<br><br>Telephone interview with a personal care assistant (PCA) on 07/08/20 at 11:30pm revealed:<br>-Since the COVID-19 pandemic, she recalled working short staffed several times (but was not able to provide dates).<br>-Some staff that tested positive for COVID-19 quit and some had to be quarantined for 14 days.<br>-She recalled working 2 nights with only one other staff member on third shifts and several times the facility only had 3 staff members on third shift for the building.<br>-When only 2 staff members worked, the medication aide would have to give medications to residents with and without COVID-19 on both units leaving some halls unsupervised.<br><br>Telephone interview with a PCA on 07/09/20 at 12:10am revealed:<br>-The facility had been short staffed due to the COVID-19 pandemic, especially in May 2020. | D 188 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 8 | D 188 | | |

-She recalled working several times with only one other staff member in the facility on third shift (unable to give specific dates).

Telephone interview with a PCA on 07/09/20 at 12:38am revealed:
-Since the pandemic, the facility had been short staffed because some staff tested positive and had to be quarantined for 14 days at home, especially in May 2020.
-Normally, there were 3 staff members for the SCU on third shift but since the pandemic they have only had 1 staff in the SCU.
-She recalled multiple nights in which she worked with only 1 other staff member on third shift (unable to give specific dates).
-When only 2 staff members worked on third shift, they had to switch back and fourth so that all the residents, both with and without COVID-19, received their medications.
-Sometimes, the halls when unattended for short periods if the PCA was busy and could not switch at the time the MA needed to switch.

Telephone with the Special Care Unit (SCU) Coordinator on 07/02/20 at 1:30 pm revealed:
-She was responsible for scheduling the PCA's and MA's.
-Staff receives their schedule a "few" days in advance.
-If a staff member called out, she had to find coverage for their shift.
-If there was not any staff available to cover the shift then she and the RCD took turns covering the shift.
-The facility had been hit hard since the COVID-19 pandemic in mid-May and early June 2020.
-If a staff member was symptomatic or tested positive for COVID-19, they had to quarantine at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 9 | D 188 | | |

home for 14 days.
-There were usually 1 MA and 3 PCA's on third shift since the pandemic began.
-At one point the facility was unable to meet the staffing ratio they typically had.
-The shortest the facility had been was 1 MA and 1 PCA and she believed that had only happened 3 times on third shift but she could not recall specific dates.
-There had been some instances in which she was not made aware of staffing issues until her arrival the next morning, due to staff not notifying her.

Telephone interview with a MA on 07/09/20 at 9:50am revealed:
-She had picked up some extra shifts during the COVID-19 pandemic.
-She recalled working with only 2 staff on a second shift, so 1 staff was on each unit.
-She did not work the full shift when it was only 2 staff because she had worked first shift that day.
-She believed the RCD had come in but did not know for sure.
-The MCU Coordinator was responsible for making the schedule and finding coverage if someone called out.

Second Telephone interview with the former RCD on 07/09/20 at 11:15 am revealed:
-She handled the quarantine issues with staff who were symptomatic or who had tested positive for COVID-19 and ensured the SCU Coordinator removed that staff from the schedule.
-The SCU Coordinator was responsible for scheduling staff.

Telephone interview with the interim Administrator on 07/10/20 at 12:07pm revealed:
-She did not provide hands on care to the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 188 | Continued From page 10 | D 188 | | |

residents due to her health status.
-There was no current process for the facility to show when a salaried employee worked on either the SCU or the AL unit.

Interview with a PCA on 07/10/20 at 12:29pm revealed:
-She had worked over on the evening of 05/20/20 and a second staff worked over.
-The RCD came in to help by passing meds on both units to residents with and without COVID-19.
-She did not know how long the RCD worked.
-The SCU Coordinator was responsible for making the schedule.

Telephone interview with the Interim Administrator on 07/10/20 at 3:46 pm revealed:
-She did not have any other documentation for staffing.
-She knew the RCD had covered several shifts, but she did not document when she worked on the floor.
-She had not been made aware of any shifts in which the facility was short staffed.
-The SCU Coordinator was responsible for making the schedule, having adequate staff, and for filling call-outs.
-If she would have known, she would had made sure there was adequate coverage.
-Prior to 06/25/20 the SCU Coordinator had not been communicating with her.
-She educated the SCU Coordinator on proper communication regarding staffing and filling call-outs.
-As of 06/25/20, the schedule had to be approved by the Administrator.
-She expected all schedules to be complete with adequate coverage and all employees to show up for their scheduled shifts.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of staff and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and practicing infection control procedures and screenings to reduce the risk of transmission and infection.<br><br>The findings are:<br><br>Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed:<br>-Facilities should limit access points and ensure that all accessible entrances have a screening station.<br>-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift, actively take their temperature and document absence of symptoms consistent with | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 12<br><br>COVID-19<br>-Residents should be screened daily for fever and symptoms of COVID-19.<br>-Social distancing among residents should be implemented.<br>-If COVID-19 is identified in the facility, restrict all residents to their rooms.<br>-Residents with known or suspected COVID-19 should be cared for using recommended PPE including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available.<br>-A surgical mask can be used if a N95 mask is not available.<br>-Social distancing should be implemented among the residents<br>-Gloves should be removed and discarded before leaving the patient room or care area, and immediately perform hand hygiene.<br>-Assign dedicated Health Care Personnel (HCP) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.<br>Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room.<br>-Develop plans to mitigate staffing shortages from illness or absenteeism.<br><br>Review of a copy of a letter addressed to the facility's former Resident Care Director (RCD) dated 06/15/20 from the LHD revealed:<br>-The letter was sent to the facility on 06/16/20 by the LHD Medical Director after a visit on 06/15/20.<br>-There was an overall lack of structure of the facility's Infection Control Plan.<br>-There was no dedicated space in the facility nor designated staff to care for residents with | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 13<br>confirmed COVID-19.<br>-COVID-19 positive residents were living across the hallway from the COVID-19 residents and there was one community bathroom.<br>-The patient room doors of COVID-19 positive residents should have been closed and the residents should have worn masks at all times unless eating.<br>-Staff were not being screened upon entry into the facility.<br>-Communication to the LHD has been inconsistent including reporting of deaths.<br>-Additional actions, such as additional staff, should be implemented for residents with dementia to ensure they wear masks and do not wander.<br>-There was no standardized staff development training or ongoing training for proper PPE usage or hand sanitizing.<br>-The facility lacked sufficient signage in support of education around COVID-19 signs and symptoms, ways to avoid, social distancing, hand washing, face covers, and respiratory etiquette.<br>-Staff should not store PPE in personal lockers and PPE should be removed when staff took breaks.<br>-The letter provided directives for the facility on repeat testing of negative residents.<br>-The letter provided directives for the facility to access the Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19. (This tool is also applicable to Assisted Living Facilities.)<br>-There was deficient practice in the following areas: visitor restrictions and non-essential personnel restrictions; education monitoring and screening of health care personnel; education monitoring and screening and cohorting of residents, availability of PPE and supplies, infection prevention, and communication. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 14<br><br>Telephone interview with the Local Health Department Communicable Disease Registered Nurse (RN) on 06/25/20 at 12:17pm revealed:<br>-The health department was notified by the hospital on 05/06/20 of the first case of COVID-19 at the facility. A resident had been tested at the hospital.<br>-The facility had not performed any COVID-19 testing prior to the resident being tested at the hospital.<br>-The facility used state labs through the LHD for testing residents for COVID-19 on 05/14/20 and 05/20/20.<br>-COVID-19 tests were sent to the facility to test residents on 05/14/20 and the remaining residents were tested on 05/20/20.<br>-Once the tests had been administered, the test were sent to the state lab and the LHD notified the facility of the residents' test results.<br>-Residents should have been quarantined for 2 incubation periods, (28 days) according to guidance for LTC facilities.<br>-Residents who tested negative within the 28-day period should be tested again to see if the resident was still tested negative.<br>-The facility did not complete any additional testing completed for residents who previously tested negative.<br>-The facility was required to report to the LHD any residents who died within two weeks after being tested and diagnosed with COVID-19.<br>-The facility had not reported deaths to the LHD in a timely manner.<br>-Deaths should have been reported to the LHD within 24 hours and this had been communicated in writing to the facility.<br>-Resident deaths had not been reported until the LHD requested a list of resident deaths from the facility. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 15 | D 338 | | |

-She spoke with the former Resident Care Director (RCD) on 05/28/20 and requested an update and death notices for all residents who died after being diagnosed with COVID-19.
-Information regarding facility expectations related to infection control had been communicated to the facility via email and telephone contact with the former RCD.
-There had been 61 positive cases for COVID-19 (residents and staff) at the facility. The current facility census was 43 residents.

A second telephone interview with the LHD communicable disease RN on 07/01/20 at 5:04pm revealed:
-The LHD provided information to the facility regarding cohorting residents who were COVID-19 positive, and isolating residents 28 days from the last positive test.
-Information communicated to the facility was taken from guidance from the NC Communicable Disease website.

Interview with the LHD Medical Director on 07/08/20 at 10:10am revealed:
-Guidance and expectations regarding COVID-19 Infection Control was provided to the facility in May 2020 when the COVID-19 outbreak first started at the facility.
-The facility was given recommendations and CDC website links regarding cohorting to prevent the spread of COVID-19.
-The facility had not sent in deaths of residents diagnosed with COVID-19 and the LHD had to request a list deaths at the facility.

Review of the NC DHHS Division of Public Health Communicable Disease Manual Corona Virus Resources Toolkit for Long-term Care Facilities (This toolkit is applicable to Assisted

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 16 | D 338 | | |

Living Facilities) revealed:
-Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff (i.e. the same staff interact with symptomatic residents and residents who test positive for COVID-19 on an ongoing basis, and do not interact with uninfected residents).
-If testing of all residents is not feasible, transmission-based precautions should be implemented for asymptomatic residents until two incubation periods (28 days) have passed since the most recent case onset.
-Encourage social distancing among residents.
-Implement universal facemask use by all people in the facility, including all staff, residents, and visitors.

Review of the facility Resident Roster revealed as of 06/24/20, there were 3 residents who tested positive for COVID-19 on 05/27/20 sharing a room with residents who had tested negative (One resident tested negative on 05/19/20 and the other two residents tested negative on 05/27/20).

Review of the facility's Infection Prevention and Control Program Interim Guidance (Subject to change) dated 04/30/20 revealed:
-The Infection Prevention Oversight Committee consisted of the Medical Director, Administration and the RCD.
-The RCD or the facility Administrator provided overall administrative guidance for the function of infection prevention/control.
-The LHD would be notified of an outbreak and adhere to their recommendations.
-Education would be provided to employees, residents and families which included use of and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 17 | D 338 | | |

appropriate technique for hand hygiene, when and how to use PPE, and respiratory hygiene/cough etiquette.
-Policies and procedures regarding infection prevention which outlined strategies designed to reduce the risk of transmission of infectious agents among healthcare workers, residents, and visitors have been implemented.

Review of the COVID-19 Control Measures for the facility (undated) revealed:
-All residents should be screened for symptoms and temperature, heart rate, respirations (vital signs and pulse oximetry every 8 hours (once a shift).
-If a resident has been screened and their testing is positive for COVID-19 or if the resident has signs/symptoms of a respiratory viral infection the resident should be in a private room or cohort with another symptomatic /positive resident.
-Staff should maintain standard contact and droplet precautions, consider that staff caring for positive or symptomatic patients do not care for negative or asymptomatic patients.
-Positive or symptomatic residents should be given a surgical mask and encouraged to wear the mask at all times.
-Any residents identified with symptoms of fever and lower respiratory illness (cough, shortness of breath, sore throat) should be immediately placed in both contact and droplet transmission-based precautions.
-Residents with confirmed COVID-19 or displaying respiratory symptoms should receive all services in their room with the door closed. (There was no documentation how staff would ensure residents would stay in their room with the door closed.)
-Environmental services should ensure appropriate PPE is worn during cleaning and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 18 | D 338 | | |

disinfection work.
-All employees should be prescreened for fever and symptoms prior to shift and at mid-shift.
-Employees may utilize extended use or reuse techniques with masks and eye protection when PPE supply is low. Masks must be changed when visibly soiled.
-PPE should not be worn off affected units or area unless approved as enhanced control measure.
-When COVID-19 is suspected to be or known to be the cause of death in an individual, this should be reported to the local health department. (There was no time frame indicated.)

Review of the facility's Guidance for Daily COVID-19 Screening of Staff and Visitors (undated) revealed:
-Screen all staff and visitors who enter the facility.
-Staff should be screened before the start of each work shift.
-Screening questions should be asked to everyone: Since your last day of work, or last visit at the facility, have you had cough, shortness of breath or difficulty breathing, or at least two of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, family members with symptoms, or new loss of taste or smell.
-If the answer was YES to any of the screening questions, the facility's COVID-19 emergency plan should be used. (The emergency plan was not provided.)
-The staff who screened the visitor or staff may want to review the results and may not want to let the staff or visitor enter the facility. (There was no documentation of when staff could return to work if they were screened to have symptoms of COVID-19.
-There was no information regarding taking

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 19<br>temperatures of staff or visitors.<br><br>Review of three lists of COVID-19 tested residents and staff provided by the interim Administrator revealed:<br>-COVID-19 tests were completed for residents on 05/14/20; 35 out of 41 positive results were received on 05/19/20.<br>-COVID-19 tests were completed for residents on 05/20/20; 13 out of 17 positive results were received on 05/27/20.<br>-Three residents who were not listed were tested on 05/14/20 and received positive test results.<br>-There were 48 residents who had tested positive for COVID-19. (The interim Administrator provided 3 more names which were not on either list bringing the total to 51 of 61 residents between the Memory Care Unit (MCU) and Assisted Living (AL).)<br>-There were 11 residents who passed away after being diagnosed with COVID-19. (The interim Administrator provided 1 more name that was not on the list to bring the total to 12 resident deaths after being diagnosed with COVID-19.)<br>-There were 13 staff who tested positive for COVID-19.<br><br>1. Observation of the facility on 06/24/20 between 12:00pm and 1:20pm revealed:<br>-There was a designated hallway (400 hall) for COVID-19 positive residents, but there were no residents currently residing on that hallway.<br>-There was no signage posted throughout the facility regarding wearing face masks, use of hand sanitizer or appropriate use of PPE.<br>-All staff were wearing masks, but residents were observed on the AL side of the facility walking outside of their rooms and sitting in a common area without a mask on.<br>-No residents in the MCU had a mask on. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 20<br>-There was an ample supply of PPE including gloves, face masks, face shields, and gowns in two offices and 2 storage closets on the AL side and in the Medicatin Aide (MA) closet in the MCU.<br>-There was a supply of face masks on the medication carts.<br>-There were no designated trash receptacle for used PPE in the MCU or on the AL side of the facility.<br><br>Observations in AL on 06/24/20 between 12:00pm and 1:20pm revealed<br>-At 12:35pm, 1 resident was observed on the 100 hall without a mask. Staff was nearby and did not encourage the resident to wear a mask.<br>-At 12:37pm, 1 resident was observed sitting in a common sitting area without a mask.<br>-At 1:05pm, 1 resident with a mask and 1 resident without a mask were observed sitting in a common sitting area. Staff as nearby and did not encourage the resident, without a mask, to wear a mask.<br>-At 1:07pm, 1 resident was observed coming from another resident's room without a mask.<br>-At 1:17pm, 1 resident was observed being escorted down the 400 hall and out of a back door to a smoking area. The resident did not have a mask on and the staff did not encourage the resident to wear a mask.<br>-At 1:20pm, 3 residents were observed walking in the 400 hall after coming in from smoking and were not social distancing. One resident had a mask on and 2 residents were not wearing a mask. Staff was near by and did not encourage the 2 residents to wear a mask or social distance.<br><br>Observations of the memory care unit MCU on 06/24/20 at 12:45pm revealed:<br>-There were 4 female residents seated at a table directly beside each other without any social | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 21 | D 338 | | |

distancing or face coverings.
-The staff member was wearing a mask and gloves.
-There was a second table with 1 female resident sitting on the front side by herself without a face covering.

Observations of the MCU on 06/24/20 at 12:50pm revealed:
-There were 9 resident room doors open and 2 did not have a resident in the room.
-Residents in their rooms with the doors open were not wearing face coverings.
-There were no designated trash receptacles for used PPE in the MCU.

Interview with a MA on 06/24/20 at 12:41pm revealed:
-Residents at the facility had tested positive for COVID-19, but she did not think there were currently any active cases.
-Some residents wore masks and some did not.
-Residents had to ask for masks and MAs would give them one.
-Staff did not encourage residents to wear masks outside of their rooms.

Interview with a second MA on 06/24/20 at 12:42pm revealed:
-There were no residents who were positive for COVID-19 in the facility.
-Testing had been provided for residents on two dates in May 2020.
-No additional testing had been performed after the two test dates in May 2020.
-Residents who tested positive quarantined in their rooms for two weeks or were sent to the hospital.
-There were no residents who were currently being quarantined.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 22 | D 338 | | |

-Residents stayed in their original rooms to quarantine.
-There were 4 common bathrooms on the 100 hall for residents to share.
-The other halls had private bathrooms in the rooms.
-Residents were not encouraged to wear face masks when outside of their room.
-If a resident wanted a mask when outside of their room, they had to ask a MA for one.
-Masks were stored in a locked drawer on the medication cart.

Interview with a personal care aide (PCA) on 06/24/20 at 12:46pm revealed:
-Residents at the facility had tested positive for COVID-19.
-A couple residents asked for masks, but masks were not automatically passed out to all residents.

Interview with a third MA on 06/24/20 at 12:58 pm revealed:
-Residents who tested positive for COVID-19 were quarantined in their rooms.
-Residents whom had a temperature of 100.4 were sent to the hospital.
-Residents who were negative were temporarily moved to the 400 hall with close observation to minimize their exposure.
-There were no residents currently on the 400 hall.
-Initially, no rooms in the memory care unit had been designated as quarantine rooms.
-Since their census dropped in the memory care unit, the rooms at the end of the hall were designated as quarantine rooms.
-Staff removed their PPE either in the bathroom or outside.
-There was not a designated trash receptacle in the memory care unit to place used PPE.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 23 | D 338 | | |

-Used PPE was placed in bathroom trashcan and used gloves were disposed of in the residents' room in which they were used.

Telephone interview with a fourth MA on 07/01/20 at 4:11pm revealed:
-She worked on both the MCU and AL.
-Staff quarantined residents in their rooms for 14 days when they showed signs and symptoms or tested positive for COVID-19.
-The MA's knew which residents were COVID-19 positive by reading the shift report.
-Mostly everyone tested positive for COVID-19 but the residents who tested negative were transferred to 400 hall to minimize their exposure.
-The 400 hall was now designated for residents with any new cases of COVID-19.
-Staff would place a mask covering residents' mouth and nose but the residents took them off.
-There were not currently any residents that had signs and symptoms of COVID-19.
-Staff initially used masks and gloves. Gloves were changed after every resident.
-After the first resident tested positive for COVID-19, staff had to wear gowns or jumpsuits, masks, and gloves.
-Masks were used once and discarded in the trash bin outside.
-Staff had to keep their gowns and or jumpsuits to reuse as supplies were limited.
-She doffed her jumpsuit outside, sprayed it with disinfectant solution, placed it in a bag, and stored it in her locker to reuse her next shift when she had worn it to provide resident care.
-Some staff took their jumpsuits home, washed it, and brought them back to wear again.
-The facility contracted registered nurse held an in-service for COVID-19 training in April 2020.
-When a resident tested positive for COVID-19, the MA's had to check their vital signs 3 times a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 24 | D 338 | | |

day.
-Shared equipment such as the blood pressure cuff had to be sanitized using a large alcohol wipe after each resident.
-MA's had to sanitize medication carts, common areas, and the phones at the beginning and end of each shift.

Telephone interview with a fifth MA on 07/01/20 at 4:53 pm revealed:
-Prior to 06/24/20, all residents were quarantined to their rooms.
-Only 2 residents in the MCU wore masks unless they went out for an appointment because the residents would not keep them on.
-MCU residents, who were positive for COVID-19 were quarantined in their rooms
-Communication related to COVID-19 and the residents was poor. Staff was not made aware of the results unless they asked.
-The former RCD was responsible for anything related to COVID-19 and when she was not there, we reported concerns to the interin Administrator.

Telephone interview with the MCU Coordinator on 07/02/20 at 1:30pm revealed:
-She wore a mask, washed her hands, and used PPE when needed.
-She wore her mask the entire shift except when she ate lunch and changed her mask at least every 2 days.
-She stored her mask in a disposable brown paper bag after spraying it with Lysol to sanitize it.
-No one instructed her to reuse or sanitize her mask.
-She attended COVID-19 training with the previous Administrator , in April 2020, when COVID-19 first started and again with the former RCD a few weeks ago.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 25<br>-The training for COVID-19 included signs and symptoms of COVID-19 and use of PPE per CDC guidelines.<br>-She had worn a mask and face shield, at times when she provided personal care to a resident.<br>-Staff were instructed to throw PPE away after use.<br>-She was not aware of any staff that may have reused PPE.<br>-MCU residents who were independent with eating, ate in their rooms and those who needed assistance sat 6 feet apart at the dining table.<br>-Residents on AL and MCU sat 6 feet apart and wore masks for activities.<br>-Staff in MCU placed masks on the residents but some would take them off.<br>-Residents continued to wear masks.<br>-Staff continued to wear masks and used PPE.<br><br>Telephone interview with the former RCD on 07/08/20 at 11:14am revealed:<br>-She was in contact with the LHD nurse about twice a week.<br>-The LHD notified her of positive cases of COVID-19 after testing.<br>-She had not received anything from the LHD as guidance for prevention of COVID-19.<br>-She started getting emails from the LHD after the first resident tested positive at the beginning of May 2020.<br>-The facility ran out of gowns the second week of May 2020.<br>-Staff had to reuse mask so they did not run out. They were instructed to place their mask in a bag and place it in their locker.<br>-She utilized COVID-19 guidelines that were posted on the CDC website as well as the LHD.<br>-She communicated information received from the LHD to staff through in-services and handouts. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 26 | D 338 | | |

-Once residents tested positive, the residents quarantined for 14 days.
-After 14 days, residents were able to come out of their rooms as long as they have not had signs or symptoms of COVID-19.
-She had not been told that residents needed to quarantine for longer than 14 days.
-Residents who resided in the MCU were hard to quarantine.
-Residents who were mobile in the MCU could not remember to stay in their rooms.
-All residents who tested negative were moved to the 400 hall, but the 400 hall was now reserved for COVID-19 positive residents.
-She did not know if there were any COVID-19 positive cases in the facility because no residents who had tested positive had been retested.

Telephone interview with a sixth MA on 07/08/20 at 11:30pm revealed:
-She had brought her own N95 mask, but staff were instructed to reuse their masks, so they placed them in a plastic bag.
-The facility had run out of gowns, so staff sprayed them with disinfectant solution and reused them.
-The facility now has gowns available.

Telephone interview with a second PCA on 07/09/20 at 12:10am revealed:
-Before COVID-19 started, the contracted registered nurse, held an in-service on proper se of PPE with demonstrations of how to put on and how to remove.
-There was no designated place to discard used PPE.
-Some staff threw the used PPE in the big trash bin in the back.
-There were some nights that masks were not available as they were locked in the office and no

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 27 | D 338 | | |

one on third shift had access, so we had to provide care without them.
-Staff should not have to search for PPE; it should be readily available.
-Staff could not minimize the risk of spreading COVID-19 without PPE.

Telephone interview with a third PCA on 07/09/20 at 12:38am revealed:
-PPE was issued to staff and the facility (RCD) required them to reuse instead of throwing away.
-She was issued a jumpsuit. When she wore it to work, she took it off at the facility and placed it in a bag then took it home and washed it so she could wear it again.
-She washed her jumpsuit because she wanted to protect herself from COVID-19.
-Two weeks later, staff was issued new PPE as the facility had obtained some through the health department.

A second telephone interview with the former RCD on 07/09/20 at 11:13am revealed:
-She was responsible for managing COVID-19 questions and issues when she worked at the facility.
-She had never seen any facility infection control policies and procedures.
-She went to the CDC website for videos to conduct in-services for staff.
-There was no staff designated to work only with COVID-19 negative or COVID-19 positive residents due to staff shortages.
-She and the interim administrator were responsible for ensuring the facility had PPE.
-The facility did not run out of mask but due to the nationwide shortage, masks were reused for 1 week.
-Staff were instructed to place their mask in a paper bag and place in their locker or their car so

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 28 | D 338 | | |

they could reuse it.
-Staff were not instructed to spray their masks with any sanitizer.
-The facility ran out of gowns in mid-May and did not have anything to wear except a mask and gloves.
-The PPE supplier had gowns on back order, but the contracted pharmacy assisted the facility to get gowns.
-The facility was out of gowns approximately 1 week.
-Some staff reused their gowns, but they were not instructed to do so.
-Used PPE were thrown away in a trash receptacle at the end of the hall.
-AL residents were given cloth masks, that were donated, if they requested one.
-Staff never offered masks to the residents if they were out of there room while inside the facility.
-Only 1 resident in the MCU wore a mask. Masks were put on all the residents, but they would not keep them on.
-Once the facility obtained more masks, they were made available on the medication carts.
-Staff changed gloves between each resident.
-The facility had plenty of gloves and did not run out.
-She believed the contracted registered nurse for the facility and the interim administrator were responsible for infection control.
-She did not know she was supposed to report deaths to the LHD until she was told by the LHD Medical Director.

Telephone interview with a seventh MA on 07/10/20 at 12:29pm revealed:
-There was no designated staff to work with either residents who were positive or negative for COVID-19
-Residents who tested positive for COVID-19

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 29 | D 338 | | |

were roomed together and residents who tested negative for COVID-19 were moved to the 400 hall in May 2020.
-The 300 hall was at the opposite end of the 400 hall and the same MAs and PCAs assigned to care for negative residents on the 300 hall also cared for positive residents on the 400 hall.

Telephone interview with the facility Nurse Practitioner (NP) on 07/06/20 at 12:49 pm revealed:
-A few residents in the facility were tested negative for COVID-19 and were moved to the 400 hall in May 2020.
-Everyone was isolated to their room and had to wear a mask when they came out of their rooms.
-It was difficult to quarantine residents to a "quarantine hall" because there was not enough space in the facility.
-Everyone should have quarantined in their rooms and staff was to wear PPE.
-Residents were to isolate for 14 days after testing and then another 14 days to ensure they were not symptomatic.
-She communicated with the former RCD about the 28-day isolation period and she also communicated that residents needed to be clinically cleared.
-It should not have been communicated that there were no COVID-19 positive residents at the facility because all residents have not been clinically cleared from COVID-19.
-The residents who have not been clinically cleared should be considered as positive for COVID-19 and should be quarantined.
-The last group of residents who tested positive should have isolated until 06/26/20 and should have been clinically cleared at that time.
-Residents were not clinically cleared around 06/27/20 because there were changes with the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 30 | D 338 | | |

former RCD.
-Residents should currently wear masks while outside of their room.
-She had discussed residents wearing masks with the former RCD.

Interview with the facility physician on 06/25/20 at 11:31am revealed:
-Almost every resident in the facility had tested positive for COVID-19. (She could not recall the exact number.)
-There were only about 7 residents who were not positive for COVID-19.
-If residents who tested positive for COVID-19, spiked fevers and were symptomatic, they were sent to the hospital.
-Residents whose family did not want them to be sent out to the hospital were admitted to hospice services at the facility.
-There had been no repeat tests because they were unable to get enough tests.
-Residents would have to be clinically cleared for COVID-19 and no resident had been cleared as of this date, 06/25/20.
-There were a few residents who went to rehab and tested negative for COVID-19 prior to returning to the facility.
-She would still consider all residents who had not been clinically cleared to still be positive for COVID-19 since follow-up testing was not done.
-All residents have gotten through their 14-day quarantine period, but she wanted residents to quarantine an additional 14 days (28 days total) before clinically clearing the residents.
-All residents should wear a mask when outside of their room.

Telephone interview with the interim Administrator on 06/24/20 at 12:10pm revealed:
-She had been the interim Administrator since

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 31<br><br>05/07/20.<br>-There were no residents who were COVID-19 positive in the facility.<br>-All residents had gone through their 14-day quarantine period and there had not been any positive COVID-19 test results in 28 days.<br>-Many residents had tested positive but were asymptomatic.<br>-There had been no repeat testing after the initial testing for residents to ensure residents were no longer positive for COVID-19.<br>-There had been no repeat testing of resident negative for COVID-19 to ensure they were still negative.<br>-Follow up tests had been requested from the facility physician, but the facility did not give an order for repeat testing.<br><br>Telephone interview with the Interim Administrator on 07/10/20 at 2:31pm revealed:<br>-The contracted registered nurse for the facility held an in-service for training staff on donning and doffing PPE, handwashing, and contamination.<br>-The former RDC oversaw the video training related to COVID-19. She realized the in-service had not been completed.<br>-The facility training policy was that when someone was not able to attend the scheduled in-service, they had to call their supervisor and let them know so the training could be made up.<br>-Some staff made up their missed trainings on pay-day.<br>-She expected staff to wear their PPE.<br>-There were days when MAs and PCAs worked with both COVID-19 positive and negative residents during their shifts.<br>-The total number of residents who tested positive for COVID -19 was 51 out of 61 with 13 resident deaths after COVID-19 diagnoses. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 32 | D 338 | | |

-The total number staff who tested positive for COVID-19 was 13.
-All staff and residents in the facility were tested for COVID-19 on 07/06/20, but the facility had not received the results back yet.

Observation of the 100 hall on 06/24/20 at 12:55 revealed:
-A house keeper left a resident's room with cleaning supplies and place them in a cleaning cart which was sitting in front of the doorway of the resident's room.
-The housekeeper was wearing a pair of gloves when she left out of the resident's room with the cleaning supplies.
-With same pair of gloves on, the housekeeper reached in her pocket, pulled out a key, unlocked and opened a storage closet by turning the door handle.
-The housekeeper went back to cleaning cart without changing her gloves.

Review of the Infection Control training sign-in sheet dated 04/23/20 revealed the housekeeper was not listed as attending the Infection Control training.

Review of the Use of Personal Protective Equipment PPE-Correctly for COVID-19 video training sign-in sheet dated 06/16/20 revealed the housekeeper was not listed as attending thePPE training.

Interview with the housekeeper on 07/02/20 at 10:48am revealed:
-She cleaned each resident's room twice daily by sanitizing, mopping, and dusting.
-She also sanitized the railings and door handles twice a day.
-She had just cleaned a resident's room on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 33<br><br>06/24/20.<br>-She realized she did not take her gloves off after exiting the resident's room.<br>-She once changed her gloves after cleaning each resident's room, but in June 2020 she took it upon herself to start changing gloves after cleaning every 2 rooms.<br>-She used the same gloves for 2 rooms because there normally was not much cleaning to do in the rooms.<br>-She had infection control training regarding COVID-19 that includes use of masks, gloves and gowns, but she did not remember when.<br>-She did not know of any facility policy related to use of gloves.<br>-She should have known to change her gloves after cleaning each resident's room.<br>-She kept extra gloves in her clothing pockets.<br><br>Interview with the Environmental/Housekeeping Director on 07/02/20 at 1:25pm revealed:<br>-The housekeeping staff all had infection control training related to COVID-19, but he had not had any provided by the facility.<br>-He had scheduling conflicts during the infection control training, so he did his own research and watched videos.<br>-He expected housekeeping staff to use gloves while cleaning resident rooms and to remove the gloves after cleaning the room.<br>-He had observed housekeeping staff removing their gloves after cleaning resident rooms, but he did not know if they removed their gloves each time.<br>-Housekeeping staff should put on a new set of gloves before moving on to clean any other areas.<br><br>Interview with the Administrator on 07/10/20 at 2:31pm revealed: | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 34 | D 338 | | |

-Housekeeping staff should have changed their gloves when they finished working in a particular area including after cleaning each resident room.
-The policy was to frequently change gloves during the day.
-When residents took trash out or left for the day, they were to drop their gloves in the dumpster on the outside of the facility.
-Housekeeping had their own gloves and kept gloves with them on the cleaning cart.
-She did not know there was a housekeeper who changed her gloves after cleaning every other resident room rather than after cleaning each resident's room.

2. Observation of staff entrance on 06/24/20 at 12:23pm revealed:
-The staff entrance was at the end of the main hallway on the left side of the facility.
-There was no one stationed at the staff entrance to screen staff.
-There was a different entrance for visitors.

Review of staff screening logs for April 2020 revealed:
-Staff were to be screened for fever, sore throat, cough, close contact with COVID-19 within 14 days of symptoms, travel to China, Iran, S. Korea, Italy, or Japan, worked in health care setting with confirmed COVID-19, resolved date and whether testing was completed.
-The April 2020 screenings only had documentation of staff temperatures and there was no documentation that screening questions were asked.
-There was no daily indication of shifts or times staff were screened.
-There were 10 days between 04/20/20 and 04/30/20 where less than 18 staff were screened. (The Administrator indicated there should be 18

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 35 | D 338 | | |

staff working on 1st and 2nd shifts and 4 staff working on 3rd shift.)

Review of staff screening logs for May 2020 revealed:
-Staff were to be screened for fever, sore throat, cough, close contact with COVID-19 within 14 days of symptoms, travel to China, Iran, S. Korea, Italy, or Japan, worked in health care setting with confirmed COVID-19, resolved date and whether testing was completed.
-The May 2020 screenings only had documentation of staff temperatures and there was no documentation that screening questions were asked for most days.
-There was no daily indication of shifts or times staff were screened.
-There were 16 days between 05/01/20 and 05/31/20 where less than 18 staff were screened. (The Administrator indicated there should be 18 staff working on 1st and 2nd shifts and 4 staff working on 3rd shift.)
-There were 3 days between 05/01/20 and 05/31/20 when there was no documentation any staff were screened.

Review of staff screening logs for June 2020 revealed:
-On 06/01/20 through 06/19/20, staff were to be screened for fever, sore throat, cough, close contact with COVID-19 within 14 days of symptoms, travel to China, Iran, S. Korea, Italy, or Japan, worked in health care setting with confirmed COVID-19, resolved date and whether testing was completed.
-From 06/01/20 through 06/19/20 2020 screenings only had documentation of staff temperatures and there was no documentation that screening questions were asked for most days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 36<br>-On 06/25/20 through 06/29/20 there was a new screening log and staff were to be screened for two of the following symptoms: temperature (stop if over 99.5), cough, shortness of breath, fever, shills, shaking, muscle pain, headache, sore throat, family member with symptoms, and loss of taste or smell.<br>-There was no daily indication of shifts or times staff were screened for 06/01/20 through 06/19/20.<br>-There were 19 days between 06/01/20 and 06/19/20 where less than 18 staff were screened. (The Administrator indicated there should be 18 staff working on 1st and 2nd shifts and 4 staff working on 3rd shift.)<br>-There was no documentation of staff screenings for 06/20/20 through 06/24/20.<br>-There were 3 days between 06/25/20 and 06/30/20 where less than 18 staff staff were screened. (The Administrator indicated there should be 18 staff working on 1st and 2nd shifts and 4 staff working on 3rd shift.)<br><br>Interview with a MA on 06/24/20 at 12:42pm revealed:<br>-Prior to 06/24/20, there was no COVID-19 screening station at the staff entrance.<br>-Staff walked to where a MA was to have their temperature checked.<br>-Screening questions were not documented.<br><br>Telephone interview with a PCA on 07/01/20 revealed:<br>-Prior to 06/24/20, staff were not screened for COVID-19 at the staff entrance.<br>-Staff were screened on the hallway where they were working.<br>-The staff who worked in the MCU had to walk through the AL side of the facility to get to the MCU. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 37<br><br>Interview on with a second PCA on 07/02/20 at 10:59am revealed:<br>-Prior to 06/24/20, staff were not screened for COVID-19 at the staff entrance.<br>-She usually went to the first MA she saw for screening, but there were times when she would have to go to several halls before getting her temperature checked.<br>-The MA did not ask her any screening questions and only checked her temperature.<br>-Some days, she did not get her temperature checked.<br><br>Interview with a second MA on 07/09/20 at 10:09am revealed:<br>-When she arrived for work each day, she walked to the MCU at the back of the building to be screened.<br>-If she saw a MA on the way to the MCU, she would stop and have that MA screen her.<br>-Most staff including some kitchen staff came to the MCU to be screened.<br>-She did not know if staff was directed to screen in the MCU or not.<br><br>Interview with the receptionist on 07/09/20 at 1:09pm revealed:<br>-She came into work between 9:00am and 9:30am and there was no one at the staff entrance to screen her for COVID-19.<br>-She usually went to the MA on the 100 hall (the hall closest to the staff entrance) to be screened.<br>-If she did not see the MA on the 100 hall, she went to the MCU for a MA to screen her because there was usually always a MA in the MCU.<br><br>Interview with the former RCD on 07/09/20 at 11:13am revealed:<br>-The staff screening process were implemented | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 38 | D 338 | | |

in the facility by the previous Administrator prior to the COVID-19 outbreak in the facility.
-The MAs were responsible for screening staff for temperature, signs and symptoms and asked screening questions regarding COVID-19.
-Staff were screened by the MA on whatever hall they were working on that shift.
-Staff screening logs were given to her or put under her door daily for review.
-She noticed the questionnaire portion of the screening logs were not completed.
-She told MAs they only needed to document responses to questions only if staff had symptoms.
-She did not know why there was not a screening station at the staff entrance or why staff were not being screened when they entered the facility.

Interview with the interim Administrator on 06/24/20 at 1:15pm revealed:
-Staff entered the facility the staff entrance on the side of the facility.
-After entering the facility, staff went to a MA to get their temperatures checked.

Telephone interview with the interim Administrator on 06/26/20 at 9:08am revealed:
-She thought it was a housekeeping staff who brought COVID-19 into the facility.
-She found out the housekeeping staff had been exposed to COVID-19 at another place of employment and continued to work at the facility without testing.
-The housekeeping staff last worked in the facility on 05/01/20.
-On 05/01/20, the housekeeper was assigned to the room of the first resident who tested positive at the facility.
-She did not know if the housekeeper had symptoms while at work, but the staff called her

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 39 | D 338 | | |

supervisor on 05/02/20 to inform that she was not feeling well.
-The staff was instructed to get tested for COVID-19.
-The staff notified her supervisor on Saturday, 05/09/20, she had tested positive for COVID-19.

Telephone interview with interim Administrator on 07/10/20 at 2:03pm revealed:
-She was responsible for ensuring staff screening was implemented.
-Prior to 06/25/20 staff were mainly being screened on the 100 hall which is the closest hall to the staff entrance.
-Staff screenings included getting their temperature checked and if staff temperatures exceeded 99 degrees, they were not to be let in the facility or work, because that temperature was considered borderline.
-Staff were also screened for cough, headache, sore throat, feeling under the weather, lack of smell and taste, and anyone in the household tested positive or quarantined.
-Staff had not been focusing on screening questions prior to 06/24/20 because staff was frequently reminded to call in if they were under the weather or had symptoms of COVID-19.
-There were usually 18 staff working daily on first and second shifts and 4 staff working daily on third shifts. (Staff numbers included housekeepers, dietary staff, managers, MAs, and PCAs.)
-She did not know there multiple days when there was documentation of less than 18 staff screenings in April and May 2020.

Review of the undated document COVID-19 Control Measures for the facility revealed "All residents should be screened for symptoms AND temperature, heart rate, respirations (Vital signs)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 40<br>AND pulse oximetry every 8 hours (Q8 hours)".<br><br>Review of the COVID-19 Resident Check-off screening documents between 04/11/20 and 06/23/20 revealed:<br>-Each resident was listed on the form.<br>-There were columns for resident symptoms; specifically, fever, sore throat and cough.<br>-There was a series of COVID-19 questions listed on the form.<br>-There were columns for "Tested?" and "Resolved Date".<br>-The resident's temperature was documented in the "Tested?" column.<br><br>Review of the resident screening documents for the 100-hall revealed:<br>-The first documented screening date was 04/20/20.<br>-Documents were received for 52 of 222 shifts.<br>-The symptoms and screening questions were completed 3 of 222 shifts.<br><br>Review of the resident screening documents for the 200-hall revealed:<br>-The first documented screening date was 04/11/20.<br>-Documents were received for 62 of 222 shifts.<br>-The symptoms and screening questions were completed 1 of 222 shifts and partially completed 2 of 222 shifts.<br><br>Review of the resident screening documents for the 300/400 halls revealed:<br>-The first documented screening date was 04/19/20.<br>-Documents were received for 75 of 222 shifts.<br>-The symptoms and screening questions were completed 2 of 222 shifts. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 41 | D 338 | | |

Telephone interview with the Memory Care Unit (MCU) Coordinator on 07/02/20 at 1:25pm revealed:
-The resident screening forms for COVID-19 started sometime in April 2020.
-The MAs were responsible to complete the form each shift.
-The completed forms were given to the former RCD at the end of each week.
-The former RCD was responsible to ensure the forms were completed each shift.

Telephone interview with a MA on 07/09/20 at 9:10am revealed:
-The resident screening forms for COVID-19 started back in late March or early April 2020.
-The forms were on the medication cart and were to be filled out each shift by the MA.
-She did not work the day the screening forms were started.
-She got the form instructions verbally from another MA.
-She was told by another MA she was not required to ask the screening questions if the resident's temperature was less than 99 degrees Fahrenheit.
-When she filled out the form, she documented the resident's temperature and if it was 99 degrees Fahrenheit (F) or above, she would ask the screening questions.
-She said she usually filled in the symptoms boxes even if the resident had no symptoms but there may have been times she left them blank.
-There may have been times she did not fill the form out at all on her shift, especially if she had to work both the MCU and the AL halls.

Telephone interview with the former RCD on 07/09/20 at 11:10am revealed:
-The resident screening forms for COVID-19

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 42 | D 338 | | |

began sometime in April 2020.
-The former Administrator implemented the screening form.
-The MAs were responsible to complete the resident screening form each shift.
-There was an in-service for the MAs on how to complete the screening form before it was implemented but she could not recall the date.
-She and the former Administrator presented the in-service to the MAs working at that time.
-If a MA was not at the in-service, they received direction verbally on how to fill out the form during shift report, from another MA.
-She instructed the MAs to only check the symptom box if the symptom was present.
-She could not verify the MAs had asked the residents the symptom and screening questions since there was no documentation.
-She reviewed the forms but mainly to assure follow up had been done for any resident temperatures above 100.0 degrees F.
-She tried to review them daily, but she did not always do it.
-If an MA did not complete the form, she re-educated the staff member.

Telephone interview with the Administrator on 07/10/20 at 2:30pm revealed:
-She was unsure when resident screenings for COVID-19 began because she was not the Administrator until 05/12/20.
-The screenings were to be done on all shifts since she took over as the Administrator.
-She expected the form to be filled out completely and on each shift.
-She expected something to be documented in each box on the form.
-She was not aware the screenings were frequently not done or incomplete.
-She was not aware of any audits done to ensure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 43 | D 338 | | |

the screenings were completed.
-She began reviewing and monitoring the resident screenings daily around 06/24/20 when she discovered the screenings were not being completed each shift.
-The former RCD and her assistant had some responsibility to ensure resident screenings were done but ultimately, it was her responsibility to make sure they were done.

3. Observations of the MCU on 06/24/20 at 12:45pm revealed:
-There were 4 female residents seated at a table directly beside each other without any social distancing or face coverings.
-One resident was at the end of the table; 2 residents were on the back side of the table and 1 resident was on the front side of the table.
-A staff member was in a chair angled at the corner of the table, between the resident at the end and the first resident on the backside, feeding the resident on the end vanilla ice cream.
-The first resident on the backside of the table was eating vanilla ice cream.
-The 2 other residents at the table were just sitting there.
-The staff member was wearing a mask and gloves.

Telephone interview with a MA on 07/01/20 at 4:11pm revealed:
-She worked on both the MCU and AL.
-Staff quarantined residents in their rooms for 14 days when they showed signs and symptoms or tested positive for COVID-19.
-The MA's knew which residents were COVID-19 positive by reading the shift report.
-It was difficult to keep residents in the MCU socially distanced due to their cognition.
-Mostly everyone tested positive for COVID-19

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 44 | D 338 | | |

but he residents whom tested negative were transferred to 400 hall to minimize their exposure.
-During their COVID-19 crisis, residents ate in their room.
-There were not currently any residents that had signs and symptoms of COVID-19.
-When a resident tested positive for COVID-19, the MA's had to check their vital signs 3 times a day.
-Shared equipment such as the blood pressure cuff had to be sanitized using a large alcohol wipe after use with each resident.
-MA's had to sanitize medication carts, common areas, and the phones at the beginning and end of each shift.
-The residents whom needed assistance with their meals, resumed dining together at the dining table about a week and a half ago.
-Residents also started watching television together about a week and a half ago. Staff tried to keep them socially distanced.
-The facility contracted registered nurse held an in-service for COVID-19 training.

Telephone interview with a MA on 07/01/20 at 4:53pm revealed:
-Prior to 06/24/20, all residents were quarantined to their rooms.
-Residents who required assistance with eating was socially distanced at the dining room tables.
-The former RCD was responsible for anything related to COVID-19 and when she was not there, we reported concerns to the interim administrator.
-She attended the facility's COVID-19 training.

Telephone interview with the MCU Coordinator on 07/02/20 at 1:30pm revealed:
-MCU residents who were independent with eating, ate in their rooms and those who needed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 45 | D 338 | | |

assistance sat 6 feet apart at the dining table.
-Residents on AL and MCU sat 6 feet apart and wore masks for activities
-Staff in MCU placed masks on the residents but some would take them off.
-Staff had to redirect MCU residents when they got up and started wondering around, due to their cognition.

Telephone interview with the former RCD on 07/08/20 at 11:13am revealed:
-Activities were done one on one with the activity coordinator.
-There were no activities in the main area and face time with residents' families were done in the residents' rooms.
-For social distancing, AL residents stayed in their rooms, but it was hard to keep MCU residents in their rooms.
-It was difficult to quarantine residents in the MCU.
-The first resident that tested positive in the MCU was quarantined in her room for 14 days.
-After the 14 days, the once positive resident was not retested.
-The facility physician said to just quarantine and made no mention of retesting.

_____

The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic in which there were 51 residents residing in the facility diagnosed with COVID-19, 12 resident deaths, 13 staff diagnosed with COVID-19 and 1 staff death. The facility's failure placed the residents at increased risk for transmission and infection from

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 338 | Continued From page 46<br>COVID-19, resulting in serious neglect which constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/20 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 9, 2020 | D 338 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) for 4 of 45 shifts sampled for 15 days between 04/30/20 and 06/20/20.<br><br>The findings are:<br><br>Review of NCDHHS Emergency Staffing Recommendations during the COVID-19 | D 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 465 | Continued From page 47 | D 465 | | |

pandemic revealed:
-Staff who test positive for COVID-19 will be unable to work until they meet the criteria for returning to work. This can cause sudden staffing shortages at a time when extra work is required to control the outbreak.
-Facilities should prepare for the possibility of staffing shortages and have a concrete plan with specific steps to take if they do need additional staff.
-The following options should be considered for emergency staffing:
-Allowing caregivers that are positive but asymptomatic to staff areas dedicated to caring for positive residents (while wearing appropriate PPE).
-Contacting temporary staffing agencies
-Contacting other sister agencies for temporary staffing support
-Contacting local hospitals for temporary staffing support
- If all these options have been exhausted and additional staffing is still needed, your local health department can request emergency staff from the state. Emergency staffing requests typically take several days to fill. Facilities should begin searching for additional staff as soon as staff are tested rather than waiting for test results to come back, so these emergency staffing requests can be filled if necessary.

Staffing and emergency staffing policies were requested on 06/30/20 at 9:05am and on 07/01/20 at 10:28am but none were provided.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of 24 beds and Assisted Living with a capacity of 69 beds.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 465 | Continued From page 48<br><br>Review of the Resident Bed List Report dated 05/18/20 revealed:<br>-There was a SCU census of 18 residents, which required 18 aide hours on second shift.<br>-There was a census of 31 residents in the AL unit, which required 16 aide hours on second shift.<br>-There should have been a total of 34 aide hours between the SCU and AL unit on second shift.<br><br>Review of the Employee Time Detail dated 05/18/20 revealed:<br>-There were 21.75 total aide hours provided on second shift between the SCU and AL unit.<br>-There was a shortage of 12.25 aide hours.<br>-It could not be determined how many of the 21.75 total aide hours were worked in the SCU unit on second shift.<br><br>Review of the Resident Bed List Report dated 05/18/20 revealed:<br>-There was a SCU census of 18 residents, which required 14.4 aide hours on third shift.<br>-Review of individual time cards dated 05/18/20 revealed 8 aide hours were provided on third shift, leaving the shift short 6.4 aide hours.<br><br>Review of the Resident Bed List Report dated 05/20/20 revealed:<br>-There was a SCU census of 17 residents, which required 17 aide hours on second shift.<br>-There was a census of 28 residents in the AL unit, which required 16 aide hours on second shift.<br>-There should have been a total of 33 aide hours between the SCU and AL unit second shift.<br><br>Review of the Employee Time Detail dated 05/20/20 revealed: | D 465 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

| (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 465 | Continued From page 49 | D 465 | | |

-There were 11.75 total aide hours provided on second shift between the SCU and AL unit.
-There was a shortage of 21.25 aide hours.
-It could not be determined how many of the 11.75 total aide hours were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 05/21/20 revealed:
-There was a SCU census of 17 residents, which required 13.6 aide hours on third shift.
-Review of individual time cards dated 05/21/20 revealed 8 aide hours were provided on third shift, leaving the shift short 5.6 aide hours.

Telephone interview with the former Resident Care Director (RCD) on 07/08/20 at 11:13am revealed:
-She had worked on all shifts when there was a staffing need.
-She did not clock in because she was salaried.
-She did not recall the days or nights in which she worked.
-She recalled working short staffed several times during the COVID-19 pandemic.
-She recalled working short on a third shift sometime in May, in which there was only one other staff member present.
-She had passed medications on both units.

Telephone interview with a personal care assistant (PCA) on 07/08/20 at 11:30pm revealed:
-Since the COVID-19 pandemic, she recalled working short staffed several times (but was not able to provide dates).
-Some staff that tested positive for COVID-19 quit and some had to be quarantined for 14 days.
-She recalled working 2 nights with only one other staff member on third shifts and several times the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

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|---|---|---|---|---|
| D 465 | Continued From page 50 | D 465 | | |

facility only had 3 staff members on third shift for the building.
-When only 2 staff members worked, the medication aide would have to give medications on both units to residents with and without COVID-19, leaving some halls unsupervised.

Telephone interview with a PCA on 07/09/20 at 12:10am revealed:
-The facility had been short staffed due to the COVID-19 pandemic, especially in May 2020.
-She recalled working several times with only one other staff member in the facility on third shift.
-The MA on duty handled any call outs.
-The MCU Coordinator was responsible for making the schedule.

Interview with a PCA on 07/09/20 at 12:38am revealed:
-Since the pandemic, the facility had been short staffed because some staff tested positive and had to be quarantined for 14 days at home.
-Normally, there were 3 staff members for the SCU on third shift but since the pandemic they have only had 1 staff in the SCU.
-She recalled multiple nights in which she worked with only 1 other staff member on third shift (unable to give specific dates).
-When only 2 staff members worked on third shift, they had to switch back and fourth so that all the residents, both with and without COVID-19, received their medications.
-Sometimes, the halls when unattended for short periods if the PCA was busy and could not switch at the time the MA needed to switch.

Telephone with the Special Care Unit (SCU) Coordinator on 07/02/20 at 1:30 pm revealed:
-She was responsible for scheduling the PCA's and MA's.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

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|---|---|---|---|---|
| D 465 | Continued From page 51 | D 465 | | |

-Staff receives their schedule a "few" days in advance.
-If a staff member called out, she had to find coverage for their shift.
-If there was not any staff available to cover the shift then she and the former RCD took turns covering the shift.
-The facility had been hit hard since the COVID-19 pandemic in mid-May and early June 2020.
-If a staff member was symptomatic or tested positive for COVID-19, they had to quarantine at home for 14 days.
-There were usually 1 MA and 3 PCA's on third shift since the pandemic began.
-At one point the facility was unable to meet the staffing ratio they typically had.
-The shortest the facility had been was 1 MA and 1 PCA and she believed that had only happened 3 times on third shift but she could not recall specific dates.
-There had been some instances in which she was not made aware of staffing issues until her arrival the next morning, due to staff not notifying her.

Telephone interview with a MA on 07/09/20 at 9:50am revealed:
-She had picked up some extra shifts during the COVID-19 pandemic.
-She recalled working with only 2 staff on a second shift, so 1 staff was on each unit.
-She did not work the full shift when it was only 2 staff because she had worked first shift that day.
-She believed the RCD had come in but did not know for sure.
-The MCU Coordinator was responsible for making the schedule and finding coverage if someone called out.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| D 465 | Continued From page 52 | D 465 | | |

Second Telephone interview with the former RCD on 07/09/20 at 11:15 am revealed:
-She handled the quarantine issues with staff who were symptomatic or who had tested positive for COVID-19 and ensured the SCU Coordinator removed that staff from the schedule.
-The SCU Coordinator was responsible for scheduling staff.

Telephone interview with the interim Administrator on 07/10/20 at 12:07pm revealed:
-She did not provide hands on care to the residents due to her health status.
-There was no current process for the facility to show when a salaried employee worked on either the SCU or the AL unit.

Interview with a PCA on 07/10/20 at 12:29pm revealed:
-She had worked over on the evening of 05/20/20 and a second staff worked over.
-The RCD came in to help by passing meds on both units to residents with and without COVID-19.
-She did not know how long the RCD worked.
-The SCU Coordinator was responsible for making the schedule.

Telephone interview with the Interim Administrator on 07/10/20 at 3:46 pm revealed:
-She did not have any other documentation for staffing.
-She knew the RCD had covered several shifts, but she did not document when she worked on the floor.
-She had not been made aware of any shifts in which the facility was short staffed.
-The SCU Coordinator was responsible for making the schedule, having adequate staff, and for filling call-outs.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| D 465 | Continued From page 53<br>-If she would have known, she would had made sure there was adequate coverage.<br>-Prior to 06/25/20 the SCU Coordinator had not been communicating with her.<br>-She educated the SCU Coordinator on proper communication regarding staffing and filling call-outs.<br>-As of 06/25/20, the schedule had to be approved by the Administrator.<br>-She expected all schedules to be complete with adequate coverage and all employees to show up for their scheduled shifts. | D 465 | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided with the necessary care and services to maintain their physical health as related to resident rights and implementation.<br><br>The findings are:<br><br>1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of | D914 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL041010 | A. BUILDING: _____ B. WING _____ | 07/10/2020 |

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|---|---|---|---|---|
| D914 | Continued From page 54<br>staff and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and practicing infection control procedures and screenings to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A1 Violation)].<br><br>2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. | D914 | | |
| D980 | G.S. § 131D-25 Implementation<br><br>G.S. 131D-25 Implementation<br><br>Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult | D980 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| D980 | Continued From page 55 | D980 | | |

care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect.

The findings are:

Interview with the interim Administrator on 06/24/20 at 12:10pm revealed:
-She had been working as the interim Administrator since 05/07/20.
-She had worked as an Administrator previously, but her most recent work prior to 05/07/20 was in facility marketing.

Interview with the interim Administrator on 07/02/20 at 12:53pm revealed:
-The former Resident Care Director (RCD) had been responsible infection control, prevention, and trainings, but she no longer worked at the facility. The former RCDs last day of work was 06/18/20.
-The former RCD had been in communication with the health department as well as facility medical providers, but she did not know all the details of communication with outside sources regarding COVID-19.
-The former RCD had been responsible for communicating to staff regarding COVID-19 updates, trainings, and positive cases.
-The former RCD had been responsible for staff and resident screenings.
-She was responsible for making sure infection control procedures were in place, PPE was provided for staff and all aspects of infection control.
-She was in the facility Monday through Friday and sometimes on Saturdays.
-She was responsible for the oversight of all departments and for working with the management team to ensure services were

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|---|---|---|---|---|
| D980 | Continued From page 56<br>provided to residents.<br><br>Interview with the interim Administrator on 07/10/20 at 2:31pm revealed:<br>-A total of 51 residents and 13 staff tested positive for COVID-19 in May 2020.<br>-One staff tested positive for COVID-19 in June 2020.<br>-There was a total of 13 resident deaths and 1 staff death.<br><br>Non-compliance was identified at violation level in the following rule areas:<br><br>1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to screening of staff and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and practicing infection control procedures to reduce the risk of transmission and infection.<br><br>_____<br>The Administrator failed to ensure the facility's infection control policy was maintained, and staff adhered to the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and the North Carolina Department of Health and Human Services (NC DHHS) to protect the residents from infection and transmission of Coronavirus (COVID-19) during the global pandemic. The Administrator's failure resulted in serious neglect | D980 | | |

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|---|---|---|---|---|
| D980 | Continued From page 57<br>of the residents which constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/20 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED August 9, 2020. | D980 | | |