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D 000	Initial Comments The Adult Care Licensure Section conducted a State involved complaint investigation and a COVID-19 Infection Control Survey with an onsite visit on 08/17/20, a desk review survey on 08/17/20 - 08/19/20 and a telephone exit on 08/19/20.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION 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 rapidly taking action to re-test all residents and staff that tested negative for COVID-19, 3-7 days after an outbreak dated 07/01/20 to reduce risk of transmission and infection and properly screening staff upon entering the facility. The findings are: 1. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term	D 338		

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care (LTC) facilities revealed:
-Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (e.g., there is an outbreak in the facility).
-Perform expanded viral testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any Health Care Personnel (HCP) or any nursing home-onset SARS-CoV-2 infection in a resident).
-A single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be considered an outbreak.
-Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission.
-If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP).
-Repeat Testing in Coordination with the Health Department.
-After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below.
-Repeat testing should be coordinated with the local, territorial, or state health department.
-Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP

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for a period of at least 14 days since the most recent positive result.
-This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.
-If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.

Review of the COVID-19 Outbreak/Cluster Worksheet-Initial Notification form dated 07/17/20 at 10:00am revealed:
-The form was faxed to the NC Department of Health and Human Services (NCDHHS) on 07/17/20 at 10:00am.
-The form was from the Health and Wellness Director (HWD) notifying the NCDHHS out of 37 staff tested, 4 staff tested positive for COVID-19 and out of 61 residents tested, 0 tested negative for COVID-19.
-The first date of symptom onset was 06/28/20 and the most recent date of symptom onset was 07/07/20.
-The symptoms included cough, fatigue and loss of smell.
-The control measures noted on the form shared with the facility, were as follows; guidance shared with the facility, isolation/quarantine of all residents, cohorting residents/staff, staff wearing Personal Protective Equipment (PPE), signage

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posted, and visitor restrictions.
-The staff positive were listed with the testing dates of 06/28/20 for the first staff member, 07/01/20 for the second staff member. 07/02/20 for the third staff member and 07/08/20 for the fourth staff member.
-There was an additional note the contact person will change on 07/24/20 to the Administrator, name and number.

Review of the New COVID-19 Outbreaks in Congregate Living Settings Report (SitRep) dated 07/16/20 at 6:01pm to 07/17/20 at 6:00pm revealed:
-There were 61 total residents at the facility.
-There were 0 lab confirmed residents.
-There were 37 total staff at the facility.
-There were 4 lab confirmed staff.
-There were 0 hospitalized and 0 deaths reported at the facility.

Review of COVID-19 test results revealed:
-On 06/28/20, a COVID-19 test was collected on the first staff member, and the results were positive for COVID-19.
-On 07/01/20, a COVID-19 test was collected on a second staff member, and the results were positive for COVID-19.
-On 07/02/20, a COVID-19 test was collected on a third staff member, and the results were positive for COVID-19.
-On 07/08/20, a positive COVID-19 test result was given for a fourth staff member.
-On 07/15, a second positive COVID-19 test result was given to the first staff member.
-On 08/10/20, a positive Covid-19 test result was given to the first resident.
-On 08/10/20, a positive COVID-19 test result was given to a second resident.
-On 08/14/20, a negative COVID-19 test result

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was given to a third resident.
-On 08/14/20, a negative COVID-19 test results were given for 6 additional staff members.

Review of the Communicable Disease (CD) Nurse from the Local Health Department Communicable Disease Division emails revealed:
-On 07/17/20 at 4:47pm, an email was sent to the Administrator and the HWD, subject was, COVID-19 Outbreak Resources and attachments included; Line List (a document used to monitor COVID-19), and COVID-19 Testing Resources list (a document containing the current Covid-19 testing guidelines for LTCF) dated 06/20/20.
-On 07/17/20 at 8:06pm, she sent a "return to work note" to the Administrator.
-On 07/20/20 at 11:19am, she received an email from the HWD with the "Line List " on 07/17/20 at 4:47pm, of 4 staff members with test dates and results were positive on 06/27/20, 07/02/20, 07/03/20 and 07/07/20.
-On 07/21/20 at 10:32am, an email was sent to the HWD, "just checking in" to see if the HWD had any results back from the testing, and to see if the facility needed any resources or had any questions. There was no response from the HWD.
-On 07/21/20 at 2:31pm, a second email to the HWD, "just checking in" to see if the HWD had any results back from the testing, and to see if the facility needed any resources or have any questions. There was no response from the HWD.
-On 07/24/20 at 2:12pm, an email was sent to the Administrator, forwarding the email sent to the HWD on 07/21/20 at 10:32, and asking if the facility had any new positive COVID-19 cases after last week's testing, or have any questions. She did not realize the Administrator had been out and if there was anyone else she was to

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communicate with. The next test event was scheduled for, if the facility needing any resources she could help with. She tried calling the Administrator that morning but the mailbox was full and could not leave a voice mail.
-On 07/27/20 at 8:35pm, an email was sent to the Administrator about attempting to reach the Administrator and to please contact her regarding the facility's outbreak as soon as she received the email.
-On the sane day at 9:49pm, she received an email from the Administrator requesting a number to contact her at.
-On 08/10/20, an email was set to the Administrator stating the Administrator's "mail box was full" and she was following up on the telephone conversation from 08/05/20 to inquire about the facility's testing status. The records showed only one test since the outbreak, and as the Administrator knew "the expectation is the facility-wide testing of all staff and residents during the outbreak", and could the facility let her know where they are at with testing and what the results were.

Telephone interview with the CD Nurse from the Local Health Department Communicable Disease Division on 08/18/20 at 10:00am revealed:
-On 07/17/20, she received a call from the Administrator, around 9:00am, related to her recent positive COVID-19 test dated 06/29/19.
-She gave the Administrator the clearance to go back to work since the Administrator was re-tested on 07/14/20 and was positive but that was considered a "persistent positive" and was ok to go back to work.
-On 07/17/20, at 10:00am a COVID-19 Outbreak/Cluster Worksheet-Initial Notification fax came through from the HWD at the facility, notifying her of 4 staff members with a symptom

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onset date of 06/28/20 of cough, fatigue and loss of smell.
-There were 0 out of 61 residents affected and 4 out of 37 staff with positive COVID-19 test results.
-On 07/17/20, she sent an email to the HWD and the Administrator with guidance on isolation/quarantine of all residents, cohorting residents/staff, staff wearing PPE, signage posted, visitor restrictions, a Line List (a document used to monitor COVID-19), and a COVID-19 Testing Resources list (a document containing the current COVID-19 testing guidelines for LTCF) dated 06/20/20.
-She considered the outbreak to have started on 07/01/20 when the second staff member tested positive for COVID-19.
-The facility was to continue COVID-19 viral testing of all previously negative residents and staff that were asymptomatic approximately "every 3-7 days for a period of at least 14 days since the most recent positive", per her recommendations sent in the email on 07/17/20 to the HWD and the Administrator.
-On 07/21/20, an attempt to contact the HWD resulted in no answer and a voice mail was left.
-On 07/24/20, an attempt to contact the Administrator resulted in no answer and a voicemail was left.
-On 07/25/20, an attempt to contact the Administrator resulted in no answer and the voicemail was full.
-From 07/25/20 to 08/05/20 there were multiple attempts by phone to contact the Administrator which resulted was no answer and the voicemail was full.
-On 08/05/20 at 11:50am she received a return call from the Administrator.
-On 08/05/20 she requested a list from the Administrator of all staff and residents test at the facility on 07/17/20.

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-On 08/05/20 she received the list of all staff and resident currently residing and working at the facility and the 4 staff that tested positive were back at work after only be tested once on 07/07/20.
-There should have been a re-test completed between 07/20/20 - 07/24/20 and a re-test between 07/27/20 - 07/31/20, since the initial test was completed on 07/17/20.
-The facility staff did not express the need for assistance to schedule testing.
-She did not know what the facility's policy was on testing after and outbreak was determined.
-She was not informed about the two residents that tested positive to COVID-19 on 08/10/20 after an exposure on 08/03/20.
-She should have been notified on 08/03/20, of the residents exposed to a positive COVID-19 HCP.
-She considered this a second outbreak and testing for the entire facility and staff should have happened.
-It was her expectation the facility staff and residents were to be re-tested and follow the guidance set forth concerning COVID-19 testing to reduce the risk of transmission and infection.
-With the re-testing not completed, the risk of COVID-19 transmission was "significantly increased" because of the negative residents and staff tested on 07/17/20, we do not know who would have tested positive for COVID-19 between 07/20/20 - 07/24/20.
-Anyone that is 60 years old or greater was at the most significant risk because they were the most vulnerable, which could lead to death if the COVID-19 virus was transmitted to them.

Review of the facility's Associate Guidance for COVID-19 dated 08/06/20 revealed:
-This was the new CDC guidance, except as

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noted below, the CDC no longer recommends using a test-based strategy because, in the majority of cases, it results in excluding associate from work who continue to shed detectable COVID-19 RNA (a nucleic acid present in all living cells. Its principal role is to act as a messenger carrying instructions from DNA for controlling the synthesis of proteins) but are no longer infectious.
-In the symptom-based strategy for determining when an associate can return to work with mild to moderate illness who are not immunocompromised: at least 10 days have passed since symptoms first appeared; and at least 24 hours have passed since the last fever without the use of fever-reducing medications; and symptoms (e.g., cough, shortness of breath) have improved.
-The associates who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test.
-In some instances, a test-based strategy may be considered to allow associates to return to work earlier than the allowed under certain symptom-based strategy; however, as described in the "decision memo", this approach will not be applied broadly.
-The test-based strategy may also be considered for some associates (e.g., those who are severely immunocompromised), in consultation with the local infectious diseases' expert, if there are concerns the associates may still be infectious.

Review of the Community Disease Outbreak Committee Policy dated March 2020 revealed the Communicable Disease Outbreak Committee, Corporate Support and State/Local Health Departments will determine the need to activate the Communicable Disease Outbreak Protocol at

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D 338	Continued From page 9 the first area confirmed case is reported. Interview with the Administrator on 08/17/20 at 8:18am revealed: -On 07/17/20 the facility had a Corporate mandatory community wide testing of approximately 60 residents and approximately 40 staff due to four staff testing positive for COVID-19 on 06/29/20, 07/01/20, 07/02/20 and 07/08/20. -She was out of the facility due to her COVID-19 positive test results from 06/29/20 - 07/18/20. and had issues with access to emails. -The HWD was responsible for notifying the LHD after the second staff tested positive on 07/02/20. -The HWD was responsible for handling the COVID-19 issues with the direction of the LHD and assistance from the Regional Director of Clinical Operations (RDCO). -The RDCO directed her to follow the "test-based policy" or the "time-based strategy" to return to work per the LHD directions. -She was not aware of any follow up testing per the LHD recommendations, only the first testing per the RDCO. -She talked to a representative from the LHD on a weekly basis, but she did not find out until today, (08/17/20) that was the Adult Home Specialist (AHS). -She did inform the AHS about the positive COVID-19 residents and staff. -She did not receive any recommendations from the AHS. Interview with the Business Office Manager (BOM) on 08/17/20 at 8:34 revealed: -She assisted the HWD with COVID-19 if the HWD required help. -She would report any issues concerning COVID-19 t the HWD.	D 338		

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-The HWD was responsible for the communication with the LHD, Regional Director and the Administrator.
-She tested COVID-19 negative on 07/17/20 during the Corporate mandatory testing.
-She was instructed by the HWD to have the Corporate mandatory COVID-19 test on 07/17/20.
-The Corporate office required community wide testing anywhere from monthly to every other month.
-She was not tested after the 07/17/20 COVID-19 negative test.

Interview with a Housekeeper on 08/17/20 at 9:15am revealed:
-She was instructed to take a Corporate mandatory COVID-19 test on 07/17/20 and her results were negative for COVID-19.
-She did not take another COVID-19 test after 07/17/20.

Interview with the Administrator on 08/17/20 at 9:32am revealed:
-On 07/27/20, a Hospice HCP provided care in the facility for 4 residents.
-On 08/05/20, she was informed by Hospice, that HCP tested positive for COVID-19.
-On 08/06/20, the facility nurse tested 3 residents for COVID-19 that were exposed to the Hospice HCP and one resident was not tested because she was actively dying on 08/05/20 and passed 08/05/20.
-There were 2 out of the 3 residents that tested positive for COVID-19 on 08/10/20.
-On 08/11/20 there were 6 out of 6 staff members tested for COVID-19 because of direct care that tested negative for COVID-19 on 08/14/20.
-She did not report the 2 residents to the LHD because one of the residents died before their results came back and she did not know she was

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supposed to.
-She reported the 1 resident with the positive COVID-19 test result and the 1 resident that died before his positive test result came back to the RDCO on 08/10/20, and was not directed to do any further reporting, only to test the staff members that were in direct care of the positive COVID-19 residents.
-There was no further testing completed on the staff and residents after 08/11/20.

Attempted telephone interview with the HWD on 08/17/20 at 9:40am was unsuccessful.

Telephone interview with the AHS on 08/17/20 at 2:55pm revealed:
-She called the Administrator last on 08/12/20 and was informed of a resident that tested positive for COVID-19 and was on quarantine for 14 days.
-She called the Administrator on a weekly basis to get a report on the status of residents and staff in relation to COVID-19.
-The facility was listed in her reports as still in "outbreak status".
-On 07/15/20, she called the Administrator and was informed there were 3 staff that tested positive for COVID-19 on 07/08/20, 07/10/20, and 07/11/20.
-On 06/30/20, she called the Administrator and was informed that 1 staff member tested positive on 06/29/20.
-She informed the Administrator to make sure the Administrator followed the recommendations of the LHD.
-She expected the Administrator to follow the recommendations from the LHD.

Telephone interview with the Administrator on 08/18/20 at 1:05pm revealed:

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-There was a Corporate mandatory COVID-19 test preformed on 07/17/20, and she was tested on 07/14/20 and was able to use that test for the mandatory testing.
-Her 07/14/20 COVID-19 was positive.
-She notified the RDCO about all residents and staff that tested positive for COVID-19 and received direction from the RDCO about any testing to be completed by the lab.
-She also completed the "Service Now Tracker System" for all residents and staff that tested positive for COVID-19.
-The RDCO contacted the LHD about any residents or staff that tested positive for COVID-19 from the information she added to the Service Now Tracker System.

Telephone interview with a second shift Medication Aide (MA) on 8/19/20 at 10:31am revealed:
-She last worked second shift in the building on last week.
-She got tested on 07/17/20 because a couple of co-workers were positive.
-She tested negative when she was tested on 07/17/20.
-She was re-tested on 08/16/20 because she had not been feeling well.
-She had not yet received her results on the test.
-She had not worked in the building since last week.

Telephone interview with a third shift PCA on 08/19/20 at 10:33am revealed she had only worked at the facility for about of month and had not been tested for COVID-19.

Telephone interview with the RDCO on 08/19/12:30pm revealed:
-During 07/01/20 - 07/18/20, while the

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D 338	Continued From page 13 Administrator was out of the facility due to the Administrator's positive COVID-19 test results on 06/29/20, the HWD and the BOM oversaw the daily duties at the facility. -The HWD and the BOM should have reported to the Administrator any COVID-19 issues. -She considered one or more positive cases of COVID-19 as an outbreak. -The HWD was to notify the LHD and the AHS as well as her any exposures to COVID-19, or positive COVID-19 test results. -When she was notified about the exposures and the positive COVID-19 staff on 07/01/20, she informed the HWD to contact the LHD. -It was her understanding the HWD did inform the LHD but she did not know what the recommendations were. -She did know there was a Corporate required community COVID-19 test preformed on 07/17/20 and there were no positives COVID-19 results from that test date. -There was no re-testing done in the facility after 07/17/20. -She was not informed of the LHD recommendations to re-test all COVID-19 negative staff and residents every 3-7 days until there were no new COVID-19 positive test results. -The Administrator reported to her and exposure on 08/05/20 after a Hospice HCP was in the facility on 07/27/20 and saw 3 residents. -One of the residents was married and shared the room with his wife so they counted 4 residents exposed. -Two of the 4 residents were positive for COVID-19, and 1 of the 2 residents that tested positive died before his test result came back on 08/10/20, -One of the 4 residents died the night of 07/27/20 and was not tested and 1 of the 4 residents	D 338		

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tested negative on 08/10/11.
-It was the responsibility of the Administrator to make sure to CDC recommendations given by the LHD was followed.

Attempted telephone interview with the HWD on 08/19/220 at 15:55pm was unsuccessful.

Telephone interview with the Hospice Employee Health Nurse on 08/19/20 at 2:27pm revealed:
-She notified the Administrator on 08/0/20 of a Hospice HCP that was seeing residents in the facility on 07/27/20, tested positive for COVID-19 on 08/03/20.
-On 07/27/20, was the only time the HCP was in the facility and tested negative on her weekly COVID-19 test on 07/27/20 but developed symptoms on 07/29/20.

Telephone interview with the Administrator on 08/19/20 at 4:27pm revealed:
-The receptionist was responsible for screening 3rd party HCPs from 9:00am to 5:00pm when she was at work Monday - Friday.
-The 3rd party HCPs were expected to report to the 2nd floor medication aide (MA) or the Memory Care Unit MA anytime no one was at the desk, to be screened.
-Screening for the 3rd party HCPs were to be recorded by the Receptionist or the MAs and answer all the questions on the form in its entirety.
2. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term care (LTC) facilities revealed:
-It was recommended that LTC facilities should immediately implement screening which includes temperature check and should be asked about COVID-19 symptoms for every individual

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D 338	Continued From page 15 regardless of the reasoning for entering the facility including residents, staff, visitors, outside healthcare workers, vendors etc. -Facilities should limit access points and ensure all accessible entrances have a screening station. Review of the facility's COVID-19 screening log for associates and health care providers revealed: -There was an entry for identification information and temperature to be recorded. -There were list of signs and symptoms and risks of exposure for staff to COVID-19, and a space for additional information. -There was a space to indicate response to the signs and symptoms and possible risk to exposure. Review of the facility's COVID-19 screening log for the associates revealed: -On 07/20/20, there were 6 out of 8 associates with name, date, time, temperature, 8 out of 8 questions were blank. -On 07/21/20, there were 5 out of 8 associates with name, date, time, temperature, 8 out of 8 questions were blank. -On 07/22/20, there were 7 out of 12 associates with name, date, time, temperature, 12 out of 12 questions were blank. -On 07/23/20, there were 7 out of 9 associates with name, date, time, temperature, 9 out of 9 the questions were blank. -On 07/24/20, there were 6 out of 10 associates with name, date, time, temperature, 10 out of 10 questions were blank. -On 07/25/20, there were 1 out of 8 associates with name, date, time, temperature, there were 2 and 8 out of 8 with name only, and 8 out of 8, the questions were blank. -On 07/26/20, the associate log was unavailable.	D 338		

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D 338	Continued From page 16 -On 07/27/20, there were out of 8 associates with name, date, time, temperature, 8 out of 8 questions were blank. Review of the facility's COVID-19 screening log for the 3rd party HCPs dated 07/21/20 revealed the Hospice HCW was not on the log and was not screened. Observation of the front desk on 08/17/20 from 9:35am to 9:48am revealed: -There was a receptionist located at the front desk. -There were two staff who entered the facility. -The receptionist took the temperature of the staff and recorded the temperature on the COVID-19 screening log. -After their temperature was taken, staff proceeded to proceed with their job duties. -The receptionist did not ask staff about signs and symptoms or risk of exposure related to COVID-19. -One staff informed the receptionist that she had been out of town for the weekend, however there were no questions asked about her exposure to COVID-19. Interview with the Receptionist on 08/17/20 at 9:40am revealed: -She was responsible for screening the staff and providers who entered the building when she worked. -She typically worked between the hours of 8:00am-5:00pm. -When staff entered the facility, she would take their temperature, she would record on screening log and staff would begin work. -Staff members who worked in the building on a regular basis were not asked screening questions each time they came into work.	D 338		

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D 338	Continued From page 17 -If staff had any changes or had been exposed, it was expected that staff tell her upon entering the building. -The Administrator informed that she did not have to ask the screening questions each time. Interview with a first shift medication aide (MA) on 08/17/20 at 9:13am revealed: -When she came to work, she proceeded to the second floor to check and record her temperature and proceed to work. -She did not answer any screening questions as listed on the screening form. -She only thought that she needed to take and record her temperature upon entering the building. Telephone interview with a second shift MA on 8/19/20 at 10:31am revealed: -She last worked second shift in the building on last week. -Upon arrival at work she would check her temperature and record on the screening form in the binder located on the second floor of the facility. -She would review screening questions, but she did not indicate a response unless her answer was yes. Telephone interview with a third shift personal care aide (PCA) on 08/19/20 at 10:33am revealed: -When she came into work in the building there was no one at the front desk to check her in. -She would go to the 2nd floor and check her temperature, record on the screening log and proceed to work. -She would record her temperature on the screening form in the binder located on the second floor of the facility.	D 338		

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-If she was exposed to COVID-19 or displayed symptoms of illness she would not come to work.
-She did not know what would be considered a high temperature.
-She did not know who to report her temperature to if it was too high.

Interview with the Administrator on 08/17/20 at 9:50am revealed:
-Staff were responsible for checking their temperature and recording on the screening log before beginning their shift.
-Staff who worked regularly were not required to answer the screening questions each time they entered the facility.
-Staff were responsible for notifying management if they were displaying symptoms or had been exposed to COVID-19 before starting work.
-She did not know staff needed to be screened each time they entered the facility.
-She received the screening forms the following day and would be able to review if there were any issues.

Telephone interview with a second shift Medication Aide (MA) on 8/19/20 at 10:31am revealed:
-She last worked second shift in the building on last week.
-Upon arrival at work she would check her temperature and record on the screening form in the binder located on the second floor of the facility.
-She would review screening questions, but she did not indicate a response unless her answer was yes.

Telephone interview with a third shift PCA on 08/19/20 at 10:33am revealed:
-When she came into work in the building there

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was no one at the front desk to check her in.
-She would go to the second floor and check her temperature and proceed to work.
-She would record her temperature on the screening form in the binder located on the third floor of the facility.
-If she was exposed to COVID-19 or displayed symptoms of illness she would not come to work.
-She did not know what would be considered a high temperature.
-She did not know who to report her temperature to if she felt that it was too high.

Telephone interview with the Hospice Employee Health Nurse on 08/19/20 at 2:27pm revealed:
-All HCP preformed a self temperature and filled out the self screening form prior to entrance into a facility because of the possibility the facility staff may not be available to do the screening related to the time a HCP entered the facility.
-She had documentation of the HCP temperature and screening form in her records dated 07/27/20.

Telephone interview with the Administrator on 08/19/20 at 4:27pm revealed:
-The receptionist was responsible for screening 3rd party HCPs from 9:00am to 5:00pm when she was at work Monday - Friday.
-She informed all 3rd party HCP were notified in March 2020, to be screened prior to seeing residents, by the receptionist or the MAs located on the second floor or the MCU MA.
-The 3rd party HCPs were expected to report to the 2nd floor MA or the Memory Care Unit MA anytime no one was at the desk, to be screened.
-Screening for the 3rd party HCPs were to be recorded by the Receptionist or the MAs and answer all the questions on the form in its entirety.

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D 338	Continued From page 20 --- The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of COVID-19. The facility failed to ensure staff were following infection control guidelines during a viral pandemic related to rapidly taking action to re-test all residents and staff that tested negative for COVID-19, 3-7 days after an outbreak dated 07/01/20 to reduce risk of transmission and infection (57 Residents and 40 Staff), and properly screening employees upon beginning work which placed the residents at risk of contracting a serious viral illness constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 08/18/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2020.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview, and record	D914		

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D914	Continued From page 21 review, the facility failed to ensure all residents were free from neglect related to Resident Rights. The findings are: 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 rapidly taking action to re-test all residents and staff that tested negative for COVID-19, 3-7 days after an outbreak dated 07/01/20 to reduce risk of transmission and infection and properly screening staff upon entering the facility. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A2 Violation)].	D914		