STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey onsite on 10/08/20 & 10/09/20 with a telephone exit on 10/12/20.	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 ensuring all staff perform COVID-19 testing when one or more case of COVID-19 was identified, appropriate use of personal protective equipment (PPE) by staff, and cohorting of staff and residents a COVID-19 outbreak dated 09/08/20 to reduce risk of transmission and infection. The findings are: Review of the COVID-19 Long Term Care Infection Control Assessment and Response (ICAR) Tool for Long Term Care facilities (LTCF) dated 05/08/20 revealed: -If COVID-19 was identified in the facility, restrict	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 1	D 338		

all residents to their room and have Health Care Personal (HCP) wear all recommended PPE for all resident care, regardless of the presence of symptoms.
-Residents were to be encouraged to remain in their rooms.
-If residents leave their room, they were to wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing.
-Cohort COVID-19 positive residents with dedicated staff in one area and COVID-19 negative residents with dedicated staff in a separate area.
-This approach was recommended to account for residents who are infected but not manifesting symptoms.
-Recent experience suggested that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.
-Residents with known or suspected COVID-19 should be cared for using recommended PPE including eye protection (goggles or face shield), gloves, gown, and a N95 respirator face mask.
-Cloth face coverings are not PPE and should not be used when a respirator or facemask was indicated.
-When a case was identified, the public health was to help with informed decisions about testing asymptomatic residents on the unit and in the facility.

Review of NCDHHS What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings dated 09/04/20 revealed:
-ALs were to follow NC DHHS and CDC guidance.
-The LHD was to guide ALs on when and how to ensure viral testing was required when two or more COVID-19 positive cases are identified.
-The LHD was to guide the AL on resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 2	D 338		

placement, and cohorting of residents and staff.
-ALs were to check CDC guidance for the most up-to-date infection prevention recommendations for long-term care settings.
-Symptomatic residents and asymptomatic residents who tested 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).

Review of the LHD guidelines for prevention and spread of the COVID-19 that was emailed to the Divisional Vice President of Operations (DVPO) on 09/23/20 revealed:
-Facilities with identified cases of COVID-19 were to perform testing on all residents and staff.
-Weekly testing was required for all staff and residents that had not previously tested positive in the past 3 months.
-Weekly testing was to continue until 14 days passed with no new identified positive residents and staff.
-The outbreak was considered resolved after 28 days passed with no new identified COVID-19 positive residents and staff.
-An internet link to the ICAR Tool for Long Term Care Facilities.
-An internet link to the NCDHHS document titled " What to Expect: Response to COVID-19 Cases in Long-Term Care Settings" was provided.

Review of the facility's COVID-19/Coronavirus Protocol dated 08/24/20 revealed there was no protocol for cohorting at the facility to identify a space in the facility that could be dedicated to the care for residents with confirmed COVID-19 and identify assigned staff who would be assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 3	D 338		

work only on the COVID-19 care unit when it was in use.

Review of the facility's 2020 license from the Division of Health Service Regulation revealed the facility was licensed for a capacity of 48 Special Care Unit (SCU) beds.

Review of the facility's current resident census list on 10/08/20 revealed the current census was 35 residents.

Review of the facility LHD COVID-19 Monitoring Log on 10/08/20 provided by the Administrator revealed:
-Forty residents had tested positive for COVID-19 beginning 09/08/20 to 09/22/20.
-Four staff had tested positive for COVID-19 on 09/14/20.
-Two residents had tested negative since 09/14/20.

Observations upon entry into the facility on 10/08/20 between 11:15am and 2:00pm revealed:
-The Administrator located two residents who tested negative for COVID-19 in room #61.
-Room #61 was located on a hallway where residents who tested positive for COVID-19 resided in rooms on the same side of the hall, and across the hall from room #61.
-Room #61 was not located in a dedicated area away from COVID-19 positive residents and their living spaces.
-There were three vacant rooms located at end of the "100" hall where a dedicated area was available to relocate the two COVID-19 negative residents.
-The Administrator identified one medication aide (MA) who was assigned to provide all personal care and administer all medications to the two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 4	D 338		

COVID-19 residents in room #61.
-The MA assigned to the two residents who tested negative for COVID-19 was wearing a cloth face covering, gown, shoe coverings, and face shield standing in the medication room located at the end of the "100" hall.
-The MA removed medications from the medication cart walked down the "100" hall passing COVID-19 positive residents walking in the halls to the end of the "200" hall where room #61 was located.
-The MA was wearing the same cloth face covering, gown, shoe coverings, and face shield, entered room #61, administered medications to a resident after walking down the hall among COVID-19 positive residents walking in the hall.
-The MA did not remove PPE and change it before or after entering room #61.
-The MA entered room #61 a second time wearing the same cloth face covering, gown, shoe coverings, and face shield, after the residents finished their lunch, removed the residents' disposable food containers, and did not change her PPE before or after entering room #61 after walking down the hall among COVID-19 positive residents walking in the hall.
-Both COVID-19 negative residents remained in room #61 with the door open.
-Three COVID-19 positive residents stopped in the doorway to room #61 to look into the room.
-A personal care aide (PCA) wearing dark safety glasses and a surgical mask was observed walking a COVID-19 positive resident to room #57.
-The Maintenance Director was observed wearing eye glasses, and two surgical masks walking through both hallways.
-The Maintenance Director removed his gown, placed it in the bottom drawer of the dresser, in the front lobby, went outside, and retrieved his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 5	D 338		

gown from the dresser when he returned inside the building.
-The dresser was storage for clean PPE for staff when they came to work.
-A gown, N95 mask, and face shield was observed on a bench sitting on the porch that was located at the entrance to the facility.
-Family members arrived for a window visit, enter the porch area and brushed against the gown lying on the bench.

Observation of the staff being tested for COVID-19 in the lobby on 10/09/20 from 1:00pm to 3:00pm revealed:
-There were three staff in the lobby of the front entrance of the facility wearing gowns, gloves, shoe covers, N95 masks, and eye protection performing COVID-19 testing.
-There was one COVID positive resident in the front lobby with the staff.
-One staff was being tested in the lobby exited the front door of the facility wearing a gown, face shield and N-95 mask.
-She did not wash her hands and she did not utilize hand sanitizer.
-She walked approximately 100 feet to her car, doffed her PPE and placed the PPE in the front seat of her car and drove away.
-A second staff exited the front door of the facility wearing a gown, face shield and N-95 mask, walked to her car located approximately 100 feet and doffed her PPE and placed the PPE in her car and drove off.
-The DVPO was standing across the small parking lot approximately 100 feet away and waited.
-A staff entered the front door of the facility into the lobby without PPE on.
-He walked around the lobby area, talking to staff for about 4 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 6	D 338		

-He sat down and was tested for COVID-19.
-After the test was completed, he got up and walked around some more in the lobby and talked with staff.
-The resident that was walking around in the lobby earlier returned and a staff hugged the resident and placed his lips and chin on her forehead.
-The staff member exited the facility after being in the lobby approximately 15 minutes.
-A staff exited the facility through the front door wearing a gown, face shield and N95 mask.
-The DVPO stated, to the staff "I know you are not getting into your car with your PPE on", the staff member said, "yes, I am in a hurry, It's my grandson's birthday".
-The DVPO stated again, "I know you are not getting into your car with your PPE on", and again the staff member stated "yes".
-The DVPO asked her where the dirty PPE was supposed to go and the staff stated, "in the trash".
-The DVPO asked why she did not do that, and the staff member replied. "there was no trash can" and continued to walk to her car.
-The DVPO told her to go to the proper place and dispose of the PPE.
-The staff member then entered the rear entrance to the facility and removed and disposed of her PPE.

Observation of the facility's PPE supply on 10/08/20 at 11:37am revealed:
-There were 2 boxes of disposable gowns containing 100 gowns in each box.
-There were 60 boxes of assorted sizes of gloves containing 100 gloves in each box.
-There were 21 boxes of surgical masks containing 100 masks per box.
-There were 7 boxes of N95 masks containing 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 7	D 338		

masks in each box.

Telephone interview with the LHD communicable disease nurse on 10/08/20 at 9:02am revealed:
-She was notified by the Administrator on 09/10/20 of a COVID-19 outbreak after four hospitalized residents tested positive.
-She provided guidance on the telephone and by email to the DVPO for testing, PPE supplies, cohorting of residents and staff, and infection prevention measures to stop the spread of the virus.
-On 09/14/20 all residents and staff were tested, and on 09/16/20 thirty-nine residents and four staff COVID-19 test results were positive.
-On 09/16/20 three residents' COVID-19 test results were negative.
-One resident who was hospitalized and tested positive on 09/09/20 expired on 09/17/20 from COVID-19 related symptoms.
-One resident who was hospitalized and tested positive on 09/09/20 expired on 09/20/20 COVID-19 related symptoms.
-On 09/22/20 one more resident's COVID-19 test result was positive, and no additional staff had tested positive.
-The facility was to follow guidance provided to the DVPO by email to test weekly all negative residents and staff.
-Weekly testing was required for all staff and residents that had not previously tested positive in the past 3 months.
-COVID-19 testing was last completed on 10/02/20.
-The LHD had the ability to obtain testing results from the facility's testing provider.
-The Administrator reported two COVID-19 negative residents remained at the facility on 10/02/20.
-On 09/18/20, she visited the facility with the LHD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 8 Environmental Health Specialist (EHS). -On 09/18/20, she observed improper use of PPE by staff although there was an ample supply, she observed in a building located on the property. -On 09/18/20, she observed staff not wearing N95 masks, and face shields. -On 09/18/20, she observed staff smoking in an outside area wearing PPE gowns, no masks and not social distancing. -On 09/18/20, she observed the facility did not have an identified space in the facility that could be dedicated to the care for residents with confirmed COVID-19 and identified staff who would be assigned to work only on the COVID-19 care unit. -On 09/18/20, she observed residents participating in a group activity involving singing and dancing, but she was not certain the group consisted of both COVID-19 positive and negative residents. -On 09/18/20, she observed the residents participating in group activities were not wearing masks or practicing social distancing. -On 09/18/20, she did not observe staff prompting residents to put on face masks or social distance. -On 09/18/20, she spoke to the DVPO who was onsite on 09/18/20, and she offered additional guidance with proper wearing of PPE, social distancing of staff, cohorting of residents and staff. Interview with the Maintenance Director on 10/08/20 at 11:30am revealed: -He did not wear additional eye protection along with his glasses and a N95 mask because he was continuously in and out of the facility throughout the day and it was not required. -He continuously wore the same gown and shoe coverings because be he did not want to change them all the time.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 9	D 338		

-He was required to make repairs to all maintenance problems that occurred in the facility including room #61 where COVID-19 negative residents resided.
-He was trained by the Regional Nurse on proper use of PPE and when to put it on and take it off.
-He was no longer concerned about contracting the virus because the facility was now on the "downhill side" of the outbreak and there had been no additional positive residents for the last two weeks.
-He never provided any personal care to the residents so there was no need to change his PPE when he went from a COVID-19 positive resident's room to a COVID-19 negative resident's room.

Interview with the Maintenance Director on 10/08/20 at 11:37am revealed:
-He was told by the Administrator he could not wear PPE outside of the facility so he put his PPE that he had on in the bottom dresser drawer so he could take care of his outside duties.
-He put the gown back on when he came back inside.
-He knew the dresser was for clean PPE and staff put it on when they arrived at work.
-There was only enough PPE for staff when they got to work so after the beginning of each shift it was empty.
-He did not disinfect the bottom drawer after placing a worn gown in the bottom drawer.
-He did not think there would be an issue to place a used PPE gown back into the dresser drawer that he had worn in the facility since 9:00am.
-No one told him to put the used PPE in that bottom drawer.

Interview with a PCA on 10/08/20 at 11:45am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 10	D 338		

-She wore the same PPE consisting of a gown, surgical mask, and dark safety goggles throughout the day because she was assigned to the COVID-19 positive residents.
-She routinely passed room #61 where the door remained opened and two negative COVID-19 residents stayed.
-Room #61's door remained open so when staff passed by the door, they could see the residents.
-She was trained by the Regional Nurse to wear a N95 masks and face shield, but these were too uncomfortable for her to wear all day.
-Staff was not attempting to keep face mask on any of the residents because they agreed it was too stressful for them.
-All the residents had some form of dementia and would not wear a face mask properly or keep it in place.

Interview with the Activity Director on 10/08/20 at 12:00pm revealed:
-She provided activities for all the residents consisting of singing, dancing, painting, and devotions.
-She encouraged both positive and negative COVID-19 residents to participate together in small groups to allow social distancing.
-She was not successful in getting the residents to wear face masks because of their cognitive decline.
-Since the outbreak at the facility, one of the COVID-19 negative residents joined group activities on infrequent occasions.

Interview with the MA on 10/08/20 at 12:20pm revealed:
-She was assigned to COVID-19 negative residents to provide all personal care needs and administer their medications.
-She was screened at the beginning of her shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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 11	D 338		

and put on her PPE consisting of a gown, cloth or surgical face mask, and face shield.
-She wore the same PPE throughout the shift without removing or changing it.
-She walked from the medication room on the "100" hall that ran continuously into the "200" hall in order to get to room #61 where the COVID-19 negative residents resided numerous times a day.
-She wore the same PPE upon entering and exiting room #61.
-She was trained by a regional nurse to wear a N95 mask, gown, gloves, and face shield if she was taking care of COVID-19 positive residents.
-She was told by the Memory Care Manger (MCM) when she was assigned to COVID-19 negative residents to wear a gown, cloth or surgical face mask, and face shield throughout her shift.
-She started working at the facility approximately 2-3 weeks ago.
-She was not tested for COVID-19 when she was hired or since she started working.
-She was told to screen daily for signs and symptoms of COVID-19.
-If she developed any signs or symptoms of COVID-19 she was to report them to the MCM.

Telephone interview with the first shift Supervisor on 10/12/20 at 10:39am revealed:
-She transferred from another sister facility on 09/19/20.
-She last tested negative for COVID-19 on 08/07/20.
-She had not been tested again since she started working at the facility.
-She provided personal care assistance and administered medications to all the residents during her shift.
-She was told by the Administrator she did not need to test.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

(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	D 338		

-The Administrator was told by upper management that she did not need to test for COVID-19.
-Since she started working at the facility the COVID-19 negative residents remained in room #61 on the same hall as the COVID-19 positive residents on the same hall.
-One additional resident tested positive on 09/22/20 for COVID-19 on the same hall.
-On 10/08/20, the COVID-19 negative residents were moved to the end of the "100" hallway, and a barrier was put in place to separate them from the COVID-19 positive residents.
-Staff who were now assigned to the COVID-19 negative residents entered and exited a separate entrance to access those residents.
-Prior to 10/08/20 the COVID-19 negative residents' rooms remained intermingled with the COVID-19 positive residents' rooms.
-Management made decisions about residents' room location and staff assignments.

Telephone interview with a second shift Supervisor on 10/12/20 at 11:25am revealed:
-She started working at the facility the second week of September 2020.
-She was not tested for COVID-19 when she was hired.
-She had not been required to test since she began working at the facility.
-She was told by the Administrator she was not required to test according to upper management.
-She went to the hospital on 10/01/20 after she was experiencing nausea/vomiting and tested negative for COVID-19.
-At the beginning of her shifts she was screened for COVID-19, put on PPE consisting of an N95 mask, gown, gloves, face shield, and remained in it until end of her shift.
-When she was assigned to the COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036031	A. BUILDING: _____ B. WING _____	C 10/12/2020

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WELLINGTON HOUSE	850 MAJESTIC COURT GASTONIA, NC 28054

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D 338	Continued From page 13	D 338		

negative residents their rooms were located throughout the COVID-19 positive residents' room since she began working at the facility.

Telephone interview with a second shift PCA on 10/12/20 at 12:10pm revealed:
-She was hired on 09/19/20.
-She was not required to test for COVID-19 since she was hired.
-When she arrived to work on Saturday (10/10/20) she self-screened for COVID-19 symptoms and took her temperature with a touchless thermometer.
-Her temperature was 99.1 degrees on Saturday (10/10/20).
-She was not feeling well on Saturday at the end of her shift and contacted the Supervisor.
-When she explained to the Supervisor, she felt like she was coming down with a cough and felt short of breath she was sent home.
-She was going to test for COVID-19 today (10/12/20) for the first time.

Telephone interview with the Business Office Manager on 10/12/20 at 12:39pm revealed:
-All staff were trained and checked off for COVID-19 infection prevention in April 2020, September 2020, and October 2020 by a divisional Health and Wellness Nurse (HWN).
-She was told by the regional upper management team that all newly hired staff which included transfers and rehires were not required to obtain COVID-19 testing upon hire or weekly since the outbreak began on 09/08/20.
-She was told by the regional upper management team all staff working at the facility when the outbreak began on 09/08/20 were to be tested weekly if they remained COVID-19 negative.
-All staff were required to be screened for signs and symptoms prior their shift daily.

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D 338	Continued From page 14	D 338		

-If any of the staff developed symptoms, they were to be tested for COVID-19.
-All staff were educated on the signs and symptoms they might experience related to COVID-19 and remain at home from work if they became sick.
-She did not know why new hires, transfers, or rehires were not required to COVID-19 test during an outbreak if the LHD gave the guidance to the facility that all staff was to test weekly.

Telephone interview with the Environmental Health Specialist (EHS) on 10/12/20 at 10:00am revealed:
-On 09/18/20 at 11:00am she and the LHD completed an onsite COVID-19 inspection because of the COVID-19 outbreak in the facility.
-Her biggest concern at the facility was the staff not wearing PPE correctly.
-She observed 3 staff outside smoking with their PPE gowns on.
-There was a staff member observed in the hallway with their mask below her nose.
-She spoke with the DVPO after the onsite visit and informed the DVPO and the Administrator of the concerns.
-She also informed the DVPO and the Administrator about the PPE not being worn correctly.
-The recommendations were given to change PPE between residents.
-She informed the DVPO and the Administrator the COVID-19 positive and negative residents were not separated as discussed earlier in the outbreak.
-The recommendation was the COVID-19 negative residents should be at the end of the hall with a separate entrance and exit.

Telephone interview with the Administrator on

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D 338	Continued From page 15 10/12/20 at 1:52pm revealed: -She read and received all communications from the CDC, NCDHHS, and the LHD. -The COVID-19 negative residents were moved to rooms located at the end of the building to isolate and protect them from exposure to the COVID-19 positive residents since our visit on 10/08/20. -The facility's COVID-19 infection prevention protocol did not include a plan to cohort the COVID-19 negative residents away from the COVID-19 positive residents prior to the outbreak. -After the LHD visit on 09/18/20 COVID-19 positive and negative residents were relocated and separated them from residing one positive and one negative in the same room or sharing the same bathroom. -The COVID-19 negative residents remained on the same hall among COVID-19 positive residents until 10/08/20. -Staff were to provide care for all positive COVID-19 residents or all negative COVID-19 residents but they were not separated into two separate grouped locations in the building. -She expected all staff to wear the appropriate PPE consisting of a N95 mask, gown, gloves, shoe coverings, and face shield while caring for COVID-19 positive residents -Staff was not to wear dark safety glasses, cloth face coverings, or surgical masks. -She expected all staff to properly remove their PPE, change it between residents, and dispose of it prior to leaving the facility. -She toured the facility and observed staff and residents when she had the opportunity daily. -A divisional HWN provided numerous trainings since March 2020 and monthly since the outbreak. -She was not present when upper management	D 338		

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D 338	Continued From page 16	D 338		

informed the BOM new hires, rehires, and transfers were not required to complete weekly testing when the outbreak started because she was positive with COVID-19.
-The communication from upper management came she thought because they felt these staff fell into a "gray area" of the interpretation of whether to test these staff from the people performing their onsite COVID-19 testing.

Telephone interview with the Director of Medical Practice Operations at the facility's COVID-19 testing provider on 10/12/20 at 2:30pm revealed:
-They began providing COVID-19 testing for the facility after they were notified of the outbreak that began 09/10/20.
-They were not affiliated with the LHD, but the COVID-19 testing results were linked to a system that interfaces with the LHD.
-They did not provide any guidance to the facility about who was required to test for COVID-19 but told the DVPO when the outbreak began the LHD would be providing guidance for COVID-19 testing.

Telephone interview with the DVPO on 10/12/20 at 3:08pm revealed:
-She had not been inside of the facility since the outbreak began on 09/08/20 because she managed other facilities within the area.
-She visited the outside of the facility almost daily to hold meetings with the Administrator, staff, or deliver supplies in order to limit her exposure to COVID-19.
-All Staff were trained and checked off on the proper use of PPE and infection control measures since March 2020 and most recently this month by the division HWN.
-Her directive was the staff were to wear PPE to consist of a N95 masks, gowns, gloves, and face

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D 338	Continued From page 17	D 338		

shields.
-At no point was any staff told to wear PPE out of the facility, leave it on the porch, exit the front of the facility wearing PPE, or wear it home.
-She obtained plenty of PPE from emergency management, and local vendor.
-She received all forms of communications from the CDC, NCDHHS, and the LHD.
-On 10/08/20 the two COVID-19 negative residents that remained in the facility were moved to isolate them to an area away from the COVID-19 positive residents.
-When the outbreak began, the negative COVID-19 residents were supposed to have been placed on the end of the facility where staff providing care for them could enter and exit through the door at the end of the facility.
-Prior to the outbreak (09/08/20) the facility did not have a plan to cohort the group of COVID-19 negative residents separate from the COVID-19 positive group of residents.
-She was aware there were forty residents and four staff who tested positive for COVID-19 since 09/08/20.
-She was aware four COVID-19 positive residents were hospitalized and two of the four hospitalized expired with related COVID-19 symptoms.
-She did not include new hires, rehires, and transferred staff in those who were required to be tested or retested at the facility or since the outbreak started.
-She sent an email on 09/22/20 to the medical director at the facility's COVID-19 testing provider asked for clarification if they were to test all staff, because she needed to know the specifics about testing of new hires, rehires, or transferred staff.
-The response she received was all staff were to test initially at the time of the outbreak and then all negative staff would be tested weekly.
-She did not know the facility's COVID-19 testing

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D 338	Continued From page 18 provider was not a part of the LHD. -She did not reach out to the LHD to ask if the new hires, rehires, or transferred staff should be tested after the COVID-19 outbreak started. _____ The facility failed to ensure staff were following infection control guidelines during a global pandemic related to ensuring all staff perform COVID-19 testing when one or more case of COVID-19 were identified, appropriate use of personal protective equipment (PPE) by staff, and cohorting of staff and residents for COVID-19 after an outbreak on 09/08/20 as instructed to reduce risk of transmission and infection. These failures placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 violation. _____ The facility provided a directed plan of protection on 10/08/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 7, 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 observations, interviews, and record reviews, the facility failed to ensure residents were provided the necessary care and services to maintain their physical health as related to	D914		

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D914	Continued From page 19 resident rights. The findings are: 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 ensuring all staff perform COVID-19 testing when one or more case of COVID-19 was identified, appropriate use of personal protective equipment (PPE) by staff, and cohorting of staff and residents a COVID-19 outbreak dated 09/08/20 to reduce risk of transmission and infection. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D914		