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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with onsite visit dates on October 5, 2020 and October 6, 2020 and a desk review survey on October 5, 2020 to October 9, 2020 and October 12, 2020 to October 16, 2020, with a telephone exit on October 16, 2020.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the facility was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #16 and #17 resulting in one resident suffering a bedbug bite to her right calf (Resident #4). The findings are: Observation of resident room #16 on 10/06/20 at 1:50pm revealed: -There was a white flaky substance noted on the dark blue mattress cover. -There were bedbug casings in the corners of the dark blue mattress cover at the head and the foot of the bed.	D 079		

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D 079	Continued From page 1 -There were multiple dead bedbugs in the corner of the blue mattress near the head and the foot of the bed. Interview with the resident in room #16 on 10/06/20 at 1:50pm revealed: -She had bed bugs in her room. -She saw live bedbugs in her room on 10/05/20. -She told the staff about the bedbugs a couple of months ago. Review of the pest control invoice dated 06/09/20 revealed: -Resident rooms #12, #16, #17, #21 and #22 were treated by the technician for bedbugs. -Bedbug activity was found in resident rooms #16 and #17. -The kitchen and the apartments were treated for general pests. Review of the pest control invoice dated 08/14/20 revealed: -Resident rooms #12, #14, #16, #17, and #18 were treated by the technician for bedbugs. -The kitchen and the apartments were treated for general pests. Review of the pest control invoice dated 09/15/20 revealed: -Resident rooms #12, #14, #16, #17, #22, and #24 were treated by the technician for bedbugs. -The kitchen, the apartments, and resident rooms 55, 56, 58 were treated for general pests. Telephone interview with a technician with the facility pest control company on 10/14/20 at 10:10am revealed: -The facility had a problem with bedbugs mainly in the resident rooms on the hallway on the right side of the main entrance.	D 079		

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-There had been complaints about bedbug activity in resident rooms on that hallway but he could not remember which rooms.
-The bedbug activity "was not as bad as they say it was".
-He had only seen one or two live bugs since the facility allowed the pest control company to come back in August 2020 due to COVID-19.
-The facility was on a monthly schedule for treatment of bedbugs and general pest.
-The facility stopped the extermination treatments in May or June 2020 due to COVID-19.
-They resumed extermination treatments in August 2020 when complaints started about bedbug activity in the facility and their company was called to resume their services.
-They sprayed the baseboards, bed frames, dressers, behind pictures on the wall, and they sprayed mattresses if there was heavy infestations in the facility.
-The pest control company last sprayed the mattresses in the facility on 10/10/20, but he could not specify in which rooms the mattresses were sprayed.
-Bedbugs would be seen on the residents's beds because bedbugs were attracted to the residents when their heart rate goes down when the residents go to sleep.
-Bedbugs would also be attracted to recliners when residents slept in them.
-Residents' recliners at the facility were also sprayed on 10/10/20.
-Their company had instructed the facility if they saw bedbugs on the sheets or linens that the staff should wash the linens and then dry them on high heat.
-The facility should also vaccuum to remove dead bedbugs once they died.

Review of Resident #4's current FL-2 dated

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D 079	Continued From page 3 12/20/19 revealed diagnoses included atrial fibrillation, hypothyroidism and chronic kidney disease. Observation of resident room #17 on 10/06/20 at 2:00pm revealed: -There was a grouping of bright red blood stains on the white blanket covering the resident's recliner near the seat. -There was a bright blood stained tissue with a dead bedbug wrapped in the tissue. Interview with Resident #4 on 10/06/20 at 2:00pm revealed: -Resident #4 had been bitten by a bedbug on the calf of her right leg today at lunch time. -Resident #4 had killed the bed bug wrapped in a napkin today at lunch time. -Resident #4 was trying to eat her lunch and had to stop eating her lunch because something was biting her leg. -The bed begs in Resident #4's room bit her every day. -She had told the current acting Administrator about the bedbugs in her room when the Administrator started. -She did not like to have to live with these bugs in her room and they were biting her. -She was not used to living like that. Observation of Resident #4's right leg on 10/06/20 at 2:03pm revealed a bug bite on the back of her leg above her right calf that was red, raised, and was approximately two inches in diameter. Telephone interview with Resident #4's family member on 10/13/20 at 2:21pm revealed: -Resident #4 had complained about the bedbugs in her room biting her.	D 079		

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D 079	Continued From page 4 -Resident #4's room had a lot of bedbugs. -Resident #4 was not used to living with bugs, she was very clean. Interview with a housekeeper on 10/06/20 at 2:14pm revealed: -She did not treat the rooms for bedbugs. -She mopped and vacuumed the resident's rooms. -She did not wipe down the resident's mattress. Telephone interview with a personal care aide (PCA) on 10/08/20 at 11:15am revealed: -She saw bedbugs in resident rooms #12, #16, #17, #18, #20, #22, and #24. -The exterminator came to the facility to spray for bedbugs when the exterminator was called to come. -The exterminator suggested to the previous acting Administrator that the carpet in the facility be removed because he believed the bedbugs were in the carpet. -She saw bedbugs in the crevices of the mattresses. -When she saw bedbug activity, she reported it to the supervisor on duty. -The supervisor told her she would let someone know. -She saw live bedbugs in resident room #16 on 10/06/20. Telephone interview with a medication aide on 10/09/20 at 10:51am revealed: -She spoke with the facility's exterminator about three weeks ago when the exterminator called for follow-up after spraying of the facility. -She told him the entire right hall of the assisted living side of the facility was "terrible" with bedbugs, but especially in resident rooms #6, #12, #16, #17, #18, and #22.	D 079		

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-About two weeks ago, a resident in room #18 complained of itching to her back.
-When she went to help the resident from her recliner, she saw live bedbugs in the resident's recliner and bedbug bites on the resident's arms.
-She washed the resident's clothes and put them in the dryer on high heat because "high heat was supposed to kill bedbugs".
-She reported the finding the live bedbugs in the recliner in resident room 18 to the Special Care Unit Director the next day.

Confidential interview with a staff member revealed:
-The facility had a problem with bedbugs since January or February 2020.
-The staff saw live bedbugs in resident rooms #12, #16, #17, #18, #21, and #24.
-The staff saw live bedbugs on the mattresses and bedding of resident rooms #16 and #17 about a week ago and the staff wiped the mattresses with green rubbing alcohol.
-The staff removed the linen from the beds and put the linens in a black trash bag to be washed.
-The laundry attendant knew how to handle linens with the bedbugs.
-The staff knew the facility was sprayed by an exterminator, but the staff was not sure when the facility was last sprayed or what the exterminator sprayed for.

Confidential interview with a staff member revealed:
-The staff saw live bedbugs within the last two weeks in resident rooms #17 and #18.
-The staff saw live bedbugs on a recliner in resident room #18 and saw bite marks on the resident's arms about two or three weeks ago.
-The staff reported finding the bedbugs and bitemarks on the residents to the acting

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D 079	Continued From page 6 Administrator (date not specified). -The staff took the resident's clothes and put them in the dryer on high heat and then washed the resident's clothes and dried them again. -The staff thought that was what was supposed to be done to kill bedbugs; the staff had not been instructed how to kill bedbugs. -A resident in resident room #17 had shown live bedbugs to the staff that the resident had captured in a container. -The resident and her family were supposed to speak to the acting Administrator about the bedbugs (date not specified). -Housekeeping staff were supposed to spray the rooms for bedbugs, the staff were not sure what the housekeeping staff used to kill the bedbugs. Interview with the Acting Administrator on 10/06/20 at 2:37pm revealed: -She knew the facility had bed bugs. -The residents started complaining about bed bugs around June and July. -The facility's pest control was contacted and resumed services monthly. -The pest control treats room #12, #14, #16, #17, #22, and #24 all on the assisted living side and room #55, #56, and #58 on the Special Care Unit. -Pest control was last out to the facility on 09/15/20. -She expected the staff to vacuum, clean and wipe down the room where bedbugs were seen. _____ The facility failed to ensure the resident rooms were clean and free of hazards as evidenced by the presence of bedbugs in resident rooms #17 and #18 which resulted in one resident being bitten and other residents having to live in an environment with bed bugs. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.	D 079		

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D 079	Continued From page 7 The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/12/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2020.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#1, #5) who had multiple falls and hospital evaluations for arm and leg pain (#5) and hospital evaluation and admission (#1) following a fall. The findings are: 1. Review of Resident #5's current FL-2 dated 03/18/20 revealed: -Diagnoses included fracture of the radius, muscle weakness, lack of coordination, chronic obstructive pulmonary disease, seizure disorder, and schizoaffective disorder. -Resident #5 was semi-ambulatory with a	D 270		

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wheelchair.
-Resident #5 had some functional limitations with her sight and labored breathing.
-There was an order for weekly blood pressure checks and as needed blood pressure checks related to dizziness.
-Resident #5's recommended level of care was domiciliary.

Review of Resident #5's current care plan dated 07/16/20 revealed:
-Resident #5 was oriented; but forgetful and needed reminders.
-Resident #5 was able to communicate (not specified how) her personal care needs to the staff and had occasional bladder incontinence.
-She was ambulatory with a wheelchair and had limited range motion to her upper extremities.
-Resident #5 had shortness of breath.
-Resident #5 required supervision with eating; limited assistance with toileting, ambulation, bathing, grooming, and transferring; and extensive assistance with dressing.
-There was no assessment of Resident #5's needs related to fall precautions.

Review of Resident #5's current licensed health professional support evaluation dated 09/08/20 revealed:
-Resident #5 used a wheelchair for locomotion due to falls.
-Staff aided with mobility and transfers for Resident #5 as needed.
-Resident #5 was able to self-propel herself in her wheelchair using her feet.
-Two falls during the last quarter and the resident was seen in the emergency room for at least one of those.
-Staff should monitor Resident #5 for falls (frequency was not specified).

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D 270	Continued From page 9 Review of the facility's falls policy revealed: -This policy aimed to provide guidance to residents and staff on fall prevention and education and steps to take when a fall occurs and actions for proper reporting. -When a fall occurs, an incident report will be completed. -Procedures for what do after a fall occurs will be on a case by case basis. Review of a progress note for Resident #5 dated 07/19/20 revealed: -Resident #5 was found in the restroom "after she tried to get on the toilet and fell on the floor" (no time was specified). -Staff took Resident #5's vital signs and called Resident #5's primary care provider (PCP) and her responsible party. -Resident #5's vitals were not documented in this progress note. Review of a progress note for Resident #5 dated 08/05/20 revealed: -Another resident was in Resident #5's room and yelled down the hall for staff to Resident #5's room (no time was specified) -Staff went to Resident #5's room and found Resident #5 on the floor. -Staff asked Resident #5's what happened and Resident #5 responded she "was trying to go to the bathroom". -Staff helped Resident #5 up and asked if Resident #5 was alright and Resident #5 responded "yeah". -Staff left messages for Resident #5's PCP and responsible party. Attempted telephone interview with the staff who wrote the progress notes dated 07/19/20 and	D 270		

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D 270	Continued From page 10 08/05/20 revealed the staff was unavailable on 10/15/20 at 4:20pm. Review of a progress note for Resident #5 dated 08/07/20 revealed: -Resident #5 was found on the floor of her bathroom by staff (no time was specified). -Resident #5 reported she hit her head on the floor and could not move. -Staff called 911 and notified Resident #5's PCP and responsible party. Review of an accident/incident report for Resident #5 dated 08/07/20 revealed: -Resident #5 was found on the floor of her bathroom by staff on 08/07/20 at 8:45pm. -There was no documentation Resident #5 suffered an injury or required first aid from staff. -Her blood pressure was documented as 135/80. -Resident #5 was transported to the emergency room for evaluation. -Resident #5's physician and responsible party were notified. Review of the Resident #5's emergency room summary note dated 08/07/20 revealed: -Resident #5 was seen in the emergency room for an unwitnessed fall. -Resident #15 reported that she felt unsteady; leaned against the wall; and then slid to the floor. -Resident #5 was diagnosed with an unspecified fall with no injury noted. Review of Resident #5's psychiatric visit note dated 08/12/20 revealed: -Resident #5 had a fall on 08/07/20; hit her head; could not move; and was sent to the emergency room. -Resident #5 had falls on 08/05/20 and 07/19/20 and sustained no injuries.	D 270		

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-She had limited mobility and a cognitive decline associated with dementia.
-Resident #5 had impaired judgment and poor concentration.
-Resident #5 should be monitored for risks for falls.

Review of Resident #5's physician's consultation report dated 09/01/20 revealed:
-Resident #5's was being seen for a three-month follow-up visit.
-Resident #5's blood pressure was 87/55 and it was determined to be the cause of Resident #5's unsteady gait.
-There was an order to discontinue her blood pressure medications and call the primary care provider (PCP) with Resident #5's BP log in two weeks.
-There was no documentation of the need to document the need to monitor Resident #5 for falls.

Review of Resident #5's tele-health neurology consultation visit note dated 09/02/20 revealed Resident #5 had reportedly increased balance problems and recent systolic blood pressure readings less than 90.

Review of a progress note for Resident #5 dated 09/14/20 revealed:
-Another resident entered Resident #5's room and found Resident #5 on the floor of her bedroom at approximately 12:30am on 09/14/20 and Resident #5 began to call for staff.
-Staff asked if Resident #5 had hit her head and Resident #5 denied hitting her head.
-Resident #5 complained of pain to her arms and legs and staff administered acetaminophen for pain.

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Review of Resident #5's psychiatric visit note dated 09/16/20 revealed:
-She had limited mobility and a cognitive decline associated with dementia.
-Resident #5 had impaired judgment and poor concentration.
-Resident #5 should be monitored for risks for falls.

Observation of Resident #5 on 10/06/20 at 4:40pm revealed:
-Resident #5 was sitting in her wheelchair in the main hallway of the facility across from the Administrator's office.
-Resident #5 yelled out occasionally.

Interview with Resident #5 on 10/06/20 at 4:40pm revealed:
-Staff treated her well and "sometimes helped her to bathe, dress, and go the bathroom if needed".
-There was a problem with getting staff to come to provide her with assistance sometimes.
-She "just did the best she could on her own" when that happened.
-She was not able to specify a time frame when staff would not come to provide her with assistance.

Telephone interview with a personal care aide (PCA) on 10/09/20 at 10:15am revealed:
-Resident #5 used a wheelchair for mobility and required one-person assist for transfers.
-Staff assisted Resident #5 to change her clothes if needed when she went to bed; helped to pull down her clothes when Resident #5 went to the bathroom and helped Resident #5 to get to the bathroom because she fell sometimes.
-Resident #5 had a few recent falls, but she was not sure what the dates were.
-Resident #5's falls occurred because Resident

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#5 tried to go to the bathroom without staff's assistance and fell.
-Resident #5 was not a high risk for falls because she "just needed to ask staff to help her so she would not fall getting to the bathroom".
-Staff had not been told to increase supervision of Resident #5 after any of her falls.
-Staff continued to check on Resident #5 every 2 hours and staff did not increase assistance for Resident #5 for toileting.
-Staff had not been told to implement any interventions for Resident #5 related to her falls.

Telephone interview with a medication aide (MA) on 10/09/20 at 10:51am revealed:
-Staff usually checked on Resident #5 every two hours and they encouraged Resident #5 to use the call bell to ask for assistance if needed.
-Resident #5 currently used a wheelchair for mobility and required a one person assist for transfers.
-Staff assisted Resident #5 with bathing, dressing, and toileting unless Resident #5 refused to let staff help her.
-She did not document when Resident #5 refused staff's assistance and she was not sure if Resident #5's PCP was aware of the refusals.
-Resident #5 was alert but forgetful and her forgetfulness seemed worse in the evenings.
-She had not reported increased forgetfulness in evening.
-Resident #5 had two falls that she could recall in last two months; on 08/07/20 and 09/14/20.
-Both of these falls were unwitnessed, and it was either staff or another resident who found Resident #5 on the floor.
-Each of these falls involved Resident #5 trying to get to the bathroom with staff assistance.
-Staff reminded Resident #5 to call for help to go the bathroom, but Resident #5 was "stubborn"

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and refused.
-Staff had not been told to increase supervision of Resident #5 related to her falls or to check to see if Resident #5 required more frequent toileting.

Attempted telephone interview with Resident #5's family member on 10/13/20 at 2:17pm was unsuccessful.

Telephone interview with Resident #5's psychiatric provider on 10/14/20/20 at 10:42am revealed:
-She wrote the psychiatric notes for Resident #5 on 08/12/20 and 09/16/20.
-She considered Resident #5 to have an increased risk for falls due to the resident's recent falls and due to Resident #5's lack of coordination and muscle weakness.
-She believed Resident #5's seizure medications also contributed to increased Resident #5's lack of coordination and unsteadiness.
-She discussed that Resident #5 needed to be monitored for fall risks with the Special Care Unit (SCU) Director on 08/12/20 and 09/16/20.
-She did not recommend any fall interventions for Resident #5 because she left that for the facility to discuss with Resident #5's PCP since she did not prescribe the medications.

Telephone interview with the SCU Director on 10/15/20 at 1:05pm revealed:
-She knew Resident #5 had a couple of falls, but Resident #5 "needed to use her call bell to ask staff for assistance rather than try going to the bathroom alone".
-Staff checked on Resident #5 and assisted her with toileting every 2 hours and did not check to see if Resident #5 needed to go the bathroom more often.
-She did not remember discussing with the

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psychiatric provider that Resident #5 was a fall risk related to her medications or the need for Resident #5 to be monitored for falls.
-Resident #5 was not under increased supervision related to her falls.

Telephone interview with the acting Administrator on 10/15/20 at 10:35am revealed:
-She did not know the level of supervision provided to Resident #5 by staff.
-She "had not been working at the facility long enough to say what to do".
-She did not know what the facility's supervision policy was so she did not know what staff were supposed to be doing.

Telephone interview with Resident #5's PCP on 10/16/20 at 4:23pm revealed:
-She did know if Resident #5 was at risk for falls or if Resident #5 required increased supervision because she did not remember the facility contacting her regarding any falls for Resident #5.
-She did not know about the psychiatric provider's concerns about Resident #5's medications and the need to monitor for risks for falls.
-If Resident #5 was having frequent falls, she would probably need some type of increased supervision to ensure her safety.
-She did not know what level of supervision Resident #5 required without reviewing Resident #5's information.

2. Review of Resident #1's current FL-2 dated 01/29/20 revealed:
-Diagnoses included dementia, atrial fibrillation, anemia, diabetes mellitus II, gout, long term use of anticoagulant, and pedal edema.
-The resident was documented as intermittently disoriented.
-The resident was documented as ambulatory

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with a walker.
-The resident was documented as continent of bowel and bladder.
-The resident was documented as having functional limitations with sight (glasses) and hearing.

Review of Resident #1's current assessment and care plan dated 03/10/20 revealed:
-The resident was documented as ambulatory with a rollator walker.
-The resident was documented as oriented.
-The resident used glasses.
-The resident's vision was adequate for daily activities.
-The resident could hear loud sounds/voices.
-The resident was documented as independent with transferring.
-There was documentation the resident required supervision with eating, toileting, ambulation, bathing, dressing, and grooming.

Review of progress notes for Resident #1 revealed:
-On 08/07/20, 11pm-7 staff documented the resident woke up in the middle of the night stating he had a dream about snakes and was looking for snakes. The resident eventually laid down.
-On 09/13/20 (no time documented), staff documented the resident came down the hallway looking for his brother and stated his brother lived there.
-On 09/14/20 at 11:25am, staff documented the resident came to the medication room asking the staff if it was time to pack up his room because it was time for him to go home.
-On 09/22/20 (no time documented), staff documented received a call from the resident's family member stating the resident was on the floor. Staff (named) went into the resident's room

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and found the resident next to the bed sitting on the floor, not hurt but a little confused. Staff documented "15-minute watch was put into play".
-On 09/23/20 (no time documented), staff documented the resident was found on the floor in front of his door laying on his right side. The resident complained of his knees and buttocks hurting. The resident's family member was called. The family member suggested to give the resident Tylenol to help with soreness from the fall and the family member would contact the resident's physician in the morning. The resident was placed on every 15-minute checks for 24 hours.
-On 09/23/20 (no time documented), staff documented the resident went to the emergency room due to fall.

Review of photographs of the inside of the Resident #1's room revealed:
-On 09/22/20 at 17:22:05pm, the resident room door was closed. There was a rollator in front of a black table. The resident's forearm was visible in the photograph and one of the resident's legs was extended out toward the front wheel of the rollator. The resident was positioned by a table and the end of the bed.
-On 09/22/20 at 17:22:07pm, the resident was in the middle portion of the room sitting up on the floor on his buttocks with his legs bent at the knees. There was a staff person standing in the doorway of the room.

Review of a video clips of Resident #1 revealed:
-On 09/22/20 beginning at 8:04:04pm and ending at 8:04:39pm the resident was standing in the room close to a black TV dinner table. The resident backed the rollator into the table and the wheel of the rollator caught the leg of the TV dinner table. The resident stumbled backwards

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and fell on his left side next to the sofa while dragging the rollator and table with him.
-On 09/23/20 beginning at 02:31:37am and ending at 02:31:44am the resident was standing in the room in front of the sofa holding onto the rollator. The resident stumbled backward and fell in front of the room door on his back and rolled over onto his left side.

Review of documentation for 15-minute checks on Resident #1 for 09/22/20 revealed:
-On 09/22/20, there were 15-minute checks documented from 7:00am to 3:00pm, from 7:00pm to 10:45pm, and from 2:15am to 6:45am.
-There were no 15-minute checks documented on 09/22/20 beginning at 11:00pm to 2:00am.

Review of documentation for 15-minute checks on Resident #1 for 09/23/20 revealed:
-On 09/23/20, there were 15-minute checks documented from 7:00am to 11:45am.
-At 12:00pm staff documented on the 15-minute check sheet the resident was out of facility in hospital.

Review of a hospital discharge summary death note for Resident #1 dated 10/01/2020 revealed:
-Resident #1 was seen in the hospital emergency department on 09/23/20 with a chief complaint of falls.
-The resident's hospital admission diagnosis included acute hypoxic respiratory failure due to COVID-19.

Interview with the Management Liaison (ML) on 10/07/20 at 11:51am revealed:
-She had reviewed the every 15-minute checks for Resident #1 and noticed there were missing signatures.
-She spoke to one of the personal care aides who

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performed 15-minute checks for Resident #1 on 09/22/20 and the staff remembered completing the 15-minute checks on Resident #1.

Telephone interview with a personal care aide (PCA) on 10/07/20 at 3:40pm revealed:
-She worked on the second shift on 09/22/20.
-She did not remember Resident #1 being on every 15-minute checks.
-Resident #1 had not fallen while she was in the resident's room.
-She did not know of and had never been told Resident #1 was on every 15-minute checks.
-When she performed every 15-minute checks, she documented the time she saw the resident and wrote her initials.
-She was trained to check on a resident every 15-minutes if the resident had a fall.
-She did not remember signing that she had performed every 15-minute checks for Resident #1 on 09/22/20.
-She did not have an idea how her initials would have been documented on the every 15-minute checks for Resident #1 on 09/22/20.
-She remembered having a meeting where lifting, turning, falls, and supervision were discussed.
-She was trained on the fall policy and was to report the fall, do not pick the resident up, and to wait for the supervisor.
-Staff were supposed to "keep your eyes on them" [residents], which meant to "make sure they don't have no more falls".
-Staff were supposed to check on the residents "every 5 10 minutes everyday until they got better" and it "depend[ed] on how they fell as to how long, maybe 2-3 days".

Telephone interview with a second PCA on 10/07/20 at 4:00pm revealed:
-The fall policy for the facility was to get the

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medication aide.
-The PCAs were not allowed to pick the resident up after a fall, but could help the MA pick the resident up after the MA performed an assessment.
-She knew the supervision policy was to "keep an eye on them" which meant to "take care of a person like taking care of a child".
-She had been told one time when she worked on the assisted living hall that Resident #1 was on every 15-minute checks.
-She worked on the third shift (11:00pm to 7:00am).
-Resident #1 wanted to get something and "flipped out of chair".
-She was standing by Resident #1's door, heard a thump, went to his room, and he was laying on the floor with the rollator walker flipped over on the side.
-She could not recall the exact date of the incident.
-She remembered documenting every 15-minute checks on Resident #1.
-She could not explain why there were no documented every 15-minute checks from 11:00pm to 2:00am during the third shift beginning on 09/22/20.

Interview with a third PCA on 10/08/20 at 11:15am revealed:
-She was a PCA and worked the first shift (7:00am to 3:00pm).
-She worked on the hall where Resident #1 resided.
-She had been told that Resident #1 had a fall on the second shift, and she was not in the facility when the fall occurred.
-She did not remember who told her Resident #1 had a fall.
-She did not know the exact date Resident #1

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had the fall.
-If a resident had a fall, the resident was placed on every 15-minute checks for 72 hours, which were documented.
-The PCAs were responsible for performing the every 15-minute checks.
-She first stated she was not told about 15-minute checks for Resident #1 when the resident had the fall but clarified later that she remembered performing 15-minute checks on Resident #1 "the day he got sent out".
-There were times the MAs would perform every 15-minute checks on a resident if the PCA was busy doing something else.

Telephone interview with a MA on 10/08/20 at 1:06pm revealed:
-She had been employed since July 2020 and she started on second shift but for about three weeks she had been working on first shift.
-The facility's fall policy was to check the residents who had fallen every 15 minutes to prevent the residents from falling.
-Staff were supposed to "lay eyes on them", document the 15-minute checks, and initial they laid eyes on the resident.
-The 15-minute checks "usually last 24 hours" unless the resident had falls before, and staff would "closely monitor" the resident.
-"Closely monitor" meant observing the resident. and the MA/PCA would go through the facility "every couple of hours" to see that the resident was in the facility or make sure the resident was somewhere staff could see the resident.
-She was last in-serviced on the fall policy by the Special Care Unit (SCU) Director on 09/16/20 and was told to monitor residents every two hours.
-She was told about every 15-minute checks when she first started working as a MA and was

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D 270	Continued From page 22 trained by another MA. -She received a shift report from the off-going staff and was told if a resident had a fall. -She conducted 15-minute checks because that was how she was trained, she thought 15-minute checks were safer, and performing every 15-minute checks covered every two-hour requirement. -She had never questioned why there were differences in the frequency for checking on the residents who had fallen. -She did not know the supervision policy but knew there was one in the policy manual kept in the medication rooms. -The PCAs completed documentation for every 15-minute checks on the 15-minute check form. -If she was present with a resident at the time a 15-minute check was scheduled, she would complete the documentation on the 15-minute check form for that specific time. -She remembered a staff member reporting to her on 09/23/20 that Resident #1 had fallen. -She remembered conducting 15-minute checks on Resident #1 during the shift. -She remembered going into the resident's room to check on the resident. She remembered finding Resident #1 in his recliner chair. Telephone interview with a second MA on 10/09/20 at 8:19am revealed: -She administered medication to Resident #1 when she worked 7:00pm - 7:00am. -She was working when Resident #1 had a fall in his room on 09/23/20 around 1:00am or 2:00am. -The staff started every 15-minute checks on Resident #1 after the fall. -The change of shift process was supposed to include letting each other know if anybody went to the hospital, had a fall, or were on every 15-minute checks.	D 270		

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D 270	Continued From page 23 -She denied getting any report when she started her shift on 09/22/20 about a resident fall or a resident being on every 15-minute checks. -She reported to the SCU Director the morning of 09/23/20 that Resident #1 had fallen. -The SCU Director asked her if staff were checking on Resident #1 every 15-minutes. -She told the SCU Director that she was not aware Resident #1 was on every 15-minute checks or that the resident had a fall prior. -Resident #1 was supposed to have been on every 15-minute checks because when a resident had a fall, the resident was supposed to be placed on every 15-minute checks for three (3) days. Telephone interview with a third MA on 10/09/20 at 4:37pm revealed: -She worked on the second shift (3:00pm - 11:00pm) in the facility. -She was not sure if she worked on 09/22/20 but could have worked on that date. -Resident #1 had "a couple falls" before he went to the hospital. -Resident #1 had a fall that occurred on second shift. -She recalled the SCU Director instructed her to start every 15-minute checks for Resident #1. -The shift supervisor was responsible to complete an incident report and fall investigation which entailed what happened and what was put in place. -The resident was placed on 15-minute checks. -The PCAs were responsible for performing the every 15-minute checks. -The shift supervisor was responsible to let the PCAs know if a resident was supposed to be on every 15-minute checks. -She let the supervisor, who came in to work for third shift, know that Resident #1 had a fall and	D 270		

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was on every 15-minute checks.
-She reported to the oncoming supervisor verbally, and there were no shift-to-shift written notes.
She or another supervisor that was working documented in Resident #1's progress notes for that shift but did not recall what had been documented.
-The SCU Director or Resident Care Director monitored the PCAs documentation for every 15-minute check and she was not sure when that monitoring was done.

Telephone interview with the SCU Director on 10/09/20 at 12:29pm revealed:
-The supervisor reported to her on 09/22/20 that Resident #1 had a fall on 09/22/20 that occurred around 5pm - 6pm.
-She was not sure of the exact time of the fall.
-The resident had another fall within the 24-hour timeframe that was reported to her by the third shift supervisor.
-She instructed the supervisor to start every 15-minute checks for the resident.
-The every 15-minute checks were "like a safety watch - sometimes it goes on 24 hours, 48 hours, 72 hours."
-Every 15-minute checks were "normally set" for three days to make sure nothing was going on, and the length of the 15-minute checks depended on the severity of what was going on.
-She was aware there were no every 15-minute checks performed on the third shift from 11:00pm to 2:00am.
-She could not speak to what happened with the every 15-minute checks during that timeframe.
-If something was not passed on to the oncoming shift supervisor, that supervisor should have referred to the progress notes for the resident.
-If there was an incident going on with the

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resident, it was protocol for the supervisor to check the previous shift supervisor's progress notes.
-She expected staff to "lay eyes" on the resident every 15-minutes, document on the every 15-minute safety watch, and to provide extra safety for the resident.

Interview with the Management Liaison (ML) on 10/13/20 at 11:50am revealed:
-The fall policy included assessing the resident for injuries, notifying the physician, and safety checks of the resident at a "determined frequency" which could be different times..
-There was no expected frequency for the safety checks.
-The frequency for safety checks were determined on a "case by case" basis.
-The physician would determine the frequency of safety checks sometimes.
-The supervising manager was also responsible for determining the frequency of safety checks.
-Every 15-minute checks may or may not be conducted.
-Reasons for conducting 15-minute checks could be if the resident was "extremely unstable, very sick, something out of the ordinary, maybe the doctor said every 15-minute checks".

_____

The facility failed to provide supervision to residents including Resident #5 who had multiple falls resulting in hitting her head, and pain to her arms and legs; and Resident #1 who suffered multiple falls within a twelve hour timeframe and required hospitalization. The failure of the facility to provide supervision was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.

_____

The facility provided a plan of protection in

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D 270	Continued From page 26 accordance with G.S. 131D-34 on 10/12/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2020.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure physician notification for 2 of 5 sampled resident (#4) of a wound on the right lower leg and for a second resident (#5) of the need to assess for increased supervision related to falls. The findings are: 1. Review of Resident #4's current FL-2 dated 12/20/19 revealed diagnoses included atrial fibrillation, hypothyroidism and chronic kidney disease. Review of Resident #4's care plan dated 02/27/20 revealed limited assistance required with eating and bathing. Review of Resident #4's progress note dated 09/09/20 revealed the resident had a skin tear on her right leg.	D 273		

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D 273	Continued From page 27 Review of Resident #4's progress note dated 09/28/20 revealed an order for home health to evaluate and treat was sent to home health. Observation of Resident #4 on 10/06//20 at 2:00pm revealed there was a kling bandage wrapped around the resident's lower right leg. Interview with Resident #4 on 10/06/20 at 2:00pm revealed: -She had hit her leg against something in her room about a month ago. -Staff would dress her wound. -She had not seen her doctor about the wound on her leg. -She thought a nurse was supposed to come see about her leg. -She did not know when the nurse was coming. Telephone interview with a supervisor/medication aide on 10/09/20 at 11:10am revealed: -Resident #4 had a skin tear on her right lower leg since 09/09/20. -She performed the wound care to Resident #4's leg but could not describe what the wound looked like. -All contact with the Resident #4's Primary Care Provider (PCP) was documented in the residents' care notes. -She had called the PCP on 09/09/20 when the wound was identified. -The Special Care Unit (SCU) Director was responsible for contacting home health. Review of Resident #4's progress note dated 09/09/20 revealed: -Resident #4's daughter was notified of the wound. -There was no documentation of the PCP being	D 273		

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notified of the wound on Resident #4's right lower leg from 09/09/20 through 10/07/20.

Telephone interview with Resident #4's family member on 10/13/20 at 2:21pm revealed:
-The wound on Resident #4's right lower leg started about a month ago.
-The nurse from the facility called the day it happened and said it was a small wound.
-Resident #4's family member was concerned that the wound had not been taken care of properly.
-Resident #4's family spoke with Resident #4 every night via telephone.
-Resident #4 would call the family member crying because of the pain in Resident #4's leg.

Attempted telephone interview with a supervisor/medication aide on 10/13/20 at 3:07pm unsuccessful.

Telephone interview with a representative from Resident #4's Primary Care Provider (PCP) office on 10/13/20 at 3:07pm revealed:
-Resident #4 was last seen by the provider on 08/03/20.
-The last home health referral for Resident #4 was in 2015.
-The home health agency had called asking for home health orders to be signed to treat and evaluate for Resident #4 at the end of September.
-The PCP's office informed home health that Resident #4 would need to be seen in the office for a face to face visit prior to any orders being signed for home health.
-The home health agency was to inform the facility that Resident #4 would need to come in to the office to be seen prior to any orders for home health would be signed.

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D 273	Continued From page 29 -The PCP did not know why Resident #4 needed home health. -Resident #4 never showed up for an appointment with the PCP. -The PCP had not seen Resident #4's wound on her leg. -There was no appointment made for the PCP to assess Resident #4's leg wound. -The facility informed the PCP's office that Resident #4 needed home health for help with her legs. -The facility did not inform the PCP's office of the wound on Resident #4's lower right leg. -The PCP was not aware Resident #4 had a wound on her leg. Telephone interview with a nurse at the home health agency on 10/09/20 at 2:37pm revealed: -The home health agency received a referral on 09/28/20 to evaluate and treat for Resident #4 from the facility. -There were no orders for wound care. -The referral that was sent from the facility was not signed by the PCP. -Home health contacted Resident #4's PCP's office to get complete orders and received general information on the resident on 09/29/20. -Resident #4 needed to be seen by the PCP for a face to face visit before PCP would sign for home health to see the resident. -On 09/29/20 a nurse from home health contacted the facility and spoke with the Special Care Unit (SCU) Director. -On 09/29/20 the SCU Director was informed that the orders sent to home health to treat and evaluate were not complete and were not signed by the PCP. -On 09/29/20 The SCU Director was informed that Resident #4 would have to have a face to face visit with the PCP before orders would be	D 273		

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signed.
-The SCU Director informed home health that no residents were allowed to come in or go out of the facility due to COVID-19.
-The home health agency recommended a tele visit for Resident #4 to be assessed by the PCP office.

Review of Resident #4's home health visit note dated 10/13/20 revealed:
-Orders for wound care were signed by the PCP on 10/09/20.
-Resident #4 had a venous stasis ulcer on her right lower leg.
-The wound was partial thickness.
-Resident #4 rated pain as a 6 on a 0 to 10 pain scale.
-Resident #4 reported pain as aching pain.
-The wound was tender to the touch.
-The wound was indicated as a chronic wound.

Attempted telephone interview with the SCU Director on 10/13/20 at 3:44pm was unsuccessful.

Telephone interview with the Acting Administrator on 10/14/20 at 10:11am revealed Resident #4 was to be receiving home health for the wound on her right leg but was not aware of when the order was given.

Telephone interview with the Management Liaison on 10/14/20 t 11:13am revealed:
-The SCU Director or the supervisor/medication aide were responsible for contacting the PCP related to changes in the resident's status.
-She expected the PCP to be notified within 48 hours of resident's status change.

2. Review of Resident #5's current FL-2 dated

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D 273	Continued From page 31 03/18/20 revealed: -Diagnoses included fracture of the radius, muscle weakness, lack of coordination, chronic obstructive pulmonary disease, seizure disorder, and schizoaffective disorder. -Resident #5 was semi-ambulatory with a wheelchair. -Resident #5 had some functional limitations with her sight and labored breathing. Review of Resident #5's current care plan dated 07/16/20 revealed: -Resident #5 was oriented; but forgetful and needed reminders. -Resident was able to communicate (not specified how) her personal care needs to the staff and had occasional bladder incontinence. -She was ambulatory with a wheelchair and had limited range motion to her upper extremities. -Resident #5 had shortness of breath. -Resident #5 required supervision with eating; limited assistance with toileting, ambulation, bathing, grooming, and transferring; and extensive assistance with dressing. -There was no assessment of Resident #5's needs related to fall precautions. Review of Resident #5's current licensed health professional support evaluation dated 09/08/20 revealed: -Resident #5 used a wheelchair for locomotion due to falls. -Staff aided with mobility and transfers for Resident #5 as needed. -Resident #5 was able to self-propel herself in her wheelchair using her feet. -Two falls during the last quarter and the resident was seen in the emergency room for at least one of those.	D 273		

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D 273	Continued From page 32 Review of a progress note for Resident #5 dated 07/19/20 revealed: -Resident #5 was found in the restroom "after she tried to get on the toilet and fell on the floor" (no time was specified). -Staff took Resident #5's vital signs and called Resident #5's primary care physician (PCP) and her responsible party. Review of a progress note for Resident #5 dated 08/05/20 revealed: -Another resident was in Resident #5's room and yelled down the hall for staff to Resident #5's room (no time was specified) -Staff went to Resident #5's room and found Resident #5 on the floor. -Staff asked Resident #5's what happened and Resident #5 responded she "was trying to go to the bathroom". -Staff helped Resident #5 up and asked if Resident #5 was alright and Resident #5 responded "yeah". -Staff left messages for Resident #5's PCP and responsible party. Review of a progress note for Resident #5 dated 08/07/20 revealed: -Resident #5 was found on the floor of her bathroom by staff (no time was specified). -Resident #5 reported she hit her head on the floor and could not move. -Staff called 911 and notified Resident #5's PCP and responsible party. Review of an accident/incident report for Resident #5 dated 08/07/20 revealed: -Resident #5 was found on the floor of her bathroom by staff on 08/07/20 at 8:45pm. -There was no documentation Resident #5 suffered an injury or required first aid from staff.	D 273		

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D 273	Continued From page 33 -Her blood pressure was documented as 135/80. -Resident #5 was transported to the emergency room for evaluation. -Resident #5's physician and responsible party were notified. Review of the Resident #5's emergency room summary note dated 08/07/20 revealed: -Resident #5 was seen in the emergency room for an unwitnessed fall. -Resident #15 reported that she felt unsteady; leaned against the wall; and then slid to the floor. -Resident #5 was diagnosed with an unspecified fall with no injury noted. Review of Resident #5's psychiatric visit note dated 08/12/20 revealed: -Resident #5 had a fall on 08/07/20; hit her head; could not move; and was sent to the emergency room. -Resident #5 had falls on 08/05/20 and 07/19/20 and sustained no injuries. -She had limited mobility and a cognitive decline associated with dementia. -Resident #5 had impaired judgment and poor concentration. -Resident #5 should be monitored for risks for falls. Review of Resident #5's physician's consultation report dated 09/01/20 revealed: -Resident #5's was being seen for a three-month follow-up visit. -Resident #5's blood pressure was 87/55 and it was determined to be the cause of Resident #5's unsteady gait. -There was an order to discontinue her blood pressure medications and call the primary care provider (PCP) with Resident #5's BP log in two weeks.	D 273		

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D 273	Continued From page 34 -There was no documentation of the need to document the need to monitor Resident #5 for falls or increased supervision. Review of Resident #5's tele-health neurology consultation visit note dated 09/02/20 revealed Resident #5 had reportedly increased balance problems and recent systolic blood pressure readings less than 90. Review of a progress note for Resident #5 dated 09/14/20 revealed: -Another resident entered Resident #5's room and found Resident #5 on the floor of her bedroom at approximately 12:30am on 09/14/20 and Resident #5 began to call for staff. -Staff asked if Resident #5 had hit her head and Resident #5 denied hitting her head. -Resident #5 complained of pain to her arms and legs and staff administered acetaminophen for pain. Review of Resident #5's psychiatric visit note dated 09/16/20 revealed: -She had limited mobility and a cognitive decline associated with dementia. -Resident #5 had impaired judgment and poor concentration. -Resident #5 should be monitored for risks for falls. Attempted telephone interview with Resident #5's family member on 10/13/20 at 2:17pm was unsuccessful. Telephone interview with Resident #5's psychiatric provider on 10/14/20/20 at 10:42am revealed: -She wrote the psychiatric notes for Resident #5 on 08/12/20 and 09/16/20.	D 273		

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-She considered Resident #5 to have an increased risk for falls due to the resident's recent falls and due to Resident #5's lack of coordination and muscle weakness.
-She believed Resident #5's seizure medications also contributed to increased Resident #5's lack of coordination and unsteadiness.
-She discussed that Resident #5 needed to be monitored for fall risks with the Special Care Unit (SCU) Director on 08/12/20 and 09/16/20.
-She did not recommend any fall interventions for Resident #5 because she left that for the facility to discuss with Resident #5's PCP since she did not prescribe the medications.

Telephone interview with the SCU Director on 10/15/20 at 1:05pm revealed:
-She knew Resident #5 had a couple of falls, but Resident #5 "needed to use her call bell to ask staff for assistance rather than try going to the bathroom alone".
-Staff checked on Resident #5 and assisted her with toileting every 2 hours and did not check to see if Resident #5 needed to go the bathroom more often.
-She did not remember discussing with the psychiatric provider that Resident #5 was a fall risk related to her medications or the need for Resident #5 to be monitored for falls.
-Resident #5's PCP had been notified of her falls when they occurred.
-She had not discussed the psychiatric provider concerns with the PCP because she did not remember discussing them with the psychiatric provider.

Telephone interview with Resident #5's PCP on 10/16/20 at 4:23pm revealed:
-She did know if Resident #5 was at risk for falls or if Resident #5 required increased supervision

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D 273	Continued From page 36 because she did not remember the facility contacting her regarding any falls for Resident #5. -She did not know about the psychiatric provider's concerns about Resident #5's medications and the need to monitor for risks for falls. -If Resident #5 was having frequent falls, she would probably need some type of increased supervision to ensure her safety. -She did not know what level of supervision Resident #5 required without reviewing Resident #5's information. _____ The facility failed to notify the PCP of a wound to the right lower leg resulting in a skin tear developing into a partial thickness, chronic wound (Resident #4) and failed to notify a second PCP of a psychiatric provider's concerns of Resident #5's increased unsteadiness and frequent falls. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on OCTOBER 14, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2020.	D 273		
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:	D 338		

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D 338	Continued From page 37 TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance for screening, use of personal protective equipment (PPE)/masks, social distancing, and infection control measures, established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect residents during a COVID-19 outbreak in the facility. The findings are: 1. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities last updated 04/30/20 revealed: -Personnel should always wear a face mask in the facility. -Residents should wear a cloth face covering or face mask whenever they leave their room in the facility. -Face masks should not be worn under the nose or mouth. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Personnel should be screened for fever and symptoms of COVID-19 before starting each shift. -Screen residents daily for fever and symptoms of COVID-19. -All personnel should practice social distancing (remain at least six feet apart) when in common areas. -Implement social distancing among residents (remain at least six feet apart).	D 338		

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D 338	Continued From page 38 -If COVID-19 is identified in the facility, restrict all residents to their rooms. -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 N95 mask is not available. -Make necessary PPE available in areas where resident care is provided and consider designating staff responsible for restocking those supplies. -Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. -Personnel who are expected to use PPE should receive training on selection and use of PPE, including demonstrating competency with putting on and removing PPE in a manner to prevent self-contamination. Review of the facility's COVID-19 policy revealed: -There was no date when the facility's COVID-19 policy was implemented. -PPE will be available in the areas where resident care is provided. -Place a trash can near the exit inside the resident room to make for staff to discard PPE prior to exiting the room, or before providing care for another resident in the same room. -Facilities will have a supply of facemasks, gowns, and eye protection (goggles or face shields). -Staff should perform hand hygiene before and after all resident contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. -For the duration of the state of emergency, all staff should wear a facemask while they are in the facility.	D 338		

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D 338	Continued From page 39 -If COVID-19 transmission occurs in the facility, staff should wear full PPE for the care of all residents. Review of documentation of COVID-19 test results for the facility revealed 30 residents and 13 staff tested positive for COVID-19 between 09/27/20 and 10/11/20. Review of a list of deceased residents provided by the facility revealed there was one resident documented as expired in October 2020 and review of the resident's hospital records revealed the cause of death was documented as acute respiratory failure, COVID-19 infection, and coronary artery disease. a. Observation of the Special Care Unit (SCU) on 10/05/20 at 2:29pm revealed: -Resident rooms #41 and #47 had pink signs on their doors that read, "Isolation: All staff are required to wear all PPE when entering this room!" -A personal care aide (PCA) exited from resident room #47 and was wearing a blue isolation gown, a mask, face shield, and gloves. -The PCA removed her gloves and disposed of them in the trash can inside of the resident room #47. -The PCA put on a new pair of gloves from the medication cart in the hallway but was not observed doing any type of hand hygiene prior to putting on the new gloves. Observation of the SCU on 10/05/20 between 4:22pm and 4:25pm revealed: -The PCA entered resident room #47, which was identified as COVID-19 positive, wearing a gown, mask and gloves. -The PCA left the door half-opened; leaned	D 338		

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against the COVID-19 positive resident's bed; and applied the face mask to the resident lying in the bed.
-The PCA exited resident room #47 without removing her gown, gloves, or face mask after leaving the resident's room.
-The same PCA walked down the hallway and entered another resident's room, who was identified as COVID-19 negative, still wearing the same PPE from the COVID-19 positive room.
-The PCA then applied a face mask to a resident while wearing the same gloves used to care for the resident with COVID-19 in room #47.
-The PCA exited the resident room and attempted to proceed to another resident room without changing her PPE.
-The PCA was stopped by a member of the state survey team before she entered another resident room while still wearing the same PPE.

Interview of the PCA, seen exiting resident room #47, on 10/05/20 at 4:26pm revealed she forgot to change her PPE before exiting a COVID-19 positive resident's room, #47.

Observation on the SCU on 10/06/20 at 3:44pm revealed:
-A medication aide (MA) left a resident room, who was identified as COVID-19 positive, wearing PPE including gloves and gown, walked down the hallway of the SCU passed the living room and into the medication room to remove the PPE.
-The MA did not remove the PPE when exiting the resident room.

Interview with a second PCA on 10/05/20 at 2:45pm revealed:
-There were at least three residents on the SCU who were positive for COVID-19.
-The staff had started wearing additional PPE

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other than masks including gown, gloves, and face sheild on 09/30/20 once the residents tested COVID-19 positive.
-There was not enough PPE including gown, gloves, mask and face sheild in the SCU for the staff to change when going from the residents' rooms who were COVID-19 positive to COVID-19 negative.
-She had to go to the front office to get PPE to work in prior to her shift.
-She worked with both residents who were COVID-19 positive and COVID-19 negative and she only changed her gloves between the resident rooms.
-She sanitized her hands with her own personal hand sanitizer if she did not use the hand sanitizer that was on the medication cart when she changed her gloves.
-She had received training about COVID-19, infection control, and wearing PPE about a week and half ago during a meeting with the acting Administrator.
-The training was provided verbally by the acting Administrator and there was no demonstration provided regarding the donning or doffing PPE.
-Staff were not required to do return demonstration on how take off or on PPE during the meeting.

Interview with third PCA on 10/05/20 at 3:39pm revealed:
-The facility had not trained her on how to use PPE.
-The acting Administrator just told the staff to "put the PPE on".
-PPE was kept in the front office on the assisted living (AL) side of the facility in the office by the front door.
-PPE was not kept in the SCU.
-She had to leave the SCU to go to the AL side to

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D 338	Continued From page 42 get more PPE. Observation on the SCU on 10/05/20 at 3:50pm revealed there was no PPE available for staff in the SCU. Interview with a fourth PCA on 10/05/20 at 3:40pm revealed: -She had received the report from the previous shift that there were three residents who were positive in the SCU. -She knew which resident rooms were COVID-19 positive because they had pink signs on the door. -If there were pink signs on the doors, then staff should change their PPE when they left the room. -Staff usually disposed of used PPE in the biohazard boxes in the medication room because there were no biohazard boxes on the residents' rooms. -She was not sure if there were biohazard boxes in the residents' rooms who were COVID-19 positive. -She had to go to the front of the facility to look for PPE at the beginning of her shift because there was no PPE for her to put on. -PPE for the SCU was normally kept in the medication room of the SCU and she did not know what happened to the PPE supply today. -The SCU Director was in charge of maintaining the PPE supply in the SCU. -Staff was supposed to change their PPE when going from COVID-19 positive rooms to COVID-19 negative rooms; "but that was hard to do if there was no PPE for staff to change into". Interview with the acting Administrator on 10/05/20 at 3:53pm revealed: -It was her expectation that PPE should be available in the SCU and readily accessible to staff.	D 338		

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D 338	Continued From page 43 -She did not know staff were not changing their PPE when going between COVID-19 positive to COVID-19 negative rooms due to unavailability of the PPE in the SCU. -She expected the staff to change their PPE when they went between COVID-19 positive to COVID-19 negative rooms and to perform hand hygiene. -Someone should always be designated to ensure there was PPE available for SCU. -She did not specify who was responsible for securing the PPE supply in the SCU. -Staff should not be going down the hall wearing PPE after leaving COVID-19 rooms because there should be biohazard boxes in the COVID-19 positive rooms for staff to remove their PPE when they leave. -She thought the biohazard boxes were already in the COVID-19 positive rooms. -All staff received training on COVID-19, infection control, the donning and doffing of PPE, and when to use PPE within the last two weeks. -She was not sure if staff performed a demonstration with the PPE training, but "staff were told what to do". Observation of a red biohazard box stored in between two medication carts in the medication room on the SCU on 10/05/20 at 4:01pm revealed it was over flowing with used gowns touching the sides of both medication carts. Observations of resident rooms #41 and #47 on 10/05/20 from 4:14pm to 4:16pm revealed there no biohazard boxes or trash cans visible from the doorways of each room. Observation of the medication room in the SCU on 10/06/20 at 3:40pm revealed: -There no masks available.	D 338		

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D 338	Continued From page 44 -There was a red biohazard box between two medication carts that was overflowing with used blue isolation gowns that were in contact with the outer sides of both medication carts. Interview with SCU Director (SCU) on 10/05/20 at 4:12pm revealed: -The medication aides (MAs) were responsible for informing her when there was no PPE in the SCU. -She would check the SCU's PPE supply periodically depending on who was working. -She last checked the SCU's supply of PPE on 10/03/20. -No staff had reported there was no PPE stored in the SCU on 10/05/20. Interview with the SCU Director on 10/06/20 at 3:46pm revealed: -The MAs were responsible for getting the PPE restocked for the SCU from the assisted living (AL) side at the beginning of their shift. -The MAs and housekeepers were responsible for changing the red biohazard boxes when they were full. Observation of a medication aide on 10/05/20 at 4:36pm revealed she was wearing protective white body suit, face mask, face shield, and gloves. Interview with a medication aide (MA) on 10/05/20 at 4:36pm revealed: -She was the only MA working in the SCU and she gave medications to both COVID-19 positive and COVID-19 negative residents in the SCU. -She wore a protective body suit to work every day since the first resident tested positive for COVID-19 at the end of September 2020. -She only sprayed the protective body suit before	D 338		

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she started her shift to disinfect before entering the facility and she took off the protective body suit at the end of her shift and threw it away.
-She did not change the protective body suit between administering medications to COVID-19 positive and COVID-19 negative residents.
-She did not disinfect protective body suit between entering and exiting the COVID-19 positive resident rooms and the COVID-19 negative resident rooms.
-She did not use the isolation gowns provided by the facility.
-She felt her protective body suit provided more protection for her than the gown the facility provided.

Interview with the SCU Director on 10/05/20 at 4:46pm revealed:
-She expected for staff to take care of the COVID-19 negative resident first then the COVID-19 positive residents.
-She expected staff to treat all the residents as though they were COVID-19 positive.
-She expected staff to pull off the used PPE in the resident's room, dispose of the used PPE in the red biohazard box in the COVID-19 positive resident's room, sanitize and put on clean PPE prior to entering the next resident's room.
-There was a red biohazard box in the medication room on the SCU and she thought red biohazard boxes were in the COVID-19 positive rooms for the staff to use.
-The supervisor was responsible for putting the red biohazard boxes in the COVID-19 positive residents' rooms.

Interview with the acting Administrator on 10/05/20 at 4:50pm revealed:
-She expected staff to provide care for the COVID-19 negative residents first then provide

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care for the positive COVID-19 residents.
-She expected staff to wear full PPE when caring for COVID-19 positive residents and to dispose of the dirty PPE in the red biohazard box prior to leaving the resident rooms.
-She did not know about staff wearing a protective body suit.
-Staff should wear the PPE provided by the facility for protection.

b. Review of photographs of the inside of a facility resident's room revealed the photographs included the following observations:
-On 06/12/20 at 12:16pm the resident was sitting in a chair. A staff was inside the room kneeling in front of the resident. The staff had her left hand next to the resident's right wrist area. The staff was not wearing a face mask. It could not be determined if the staff was wearing gloves.
-On 07/12/20 at 6:29pm, a staff was inside the resident room holding a cup in her hand and was approaching a resident whose legs were extended on the bed. The staff was not wearing a face mask.
-On 08/15/20 at 6:07pm the resident was sitting in a recliner chair inside the room. A staff was standing to the left side of the resident with her head down. The staff was holding onto the resident's left wrist area. The staff was not wearing gloves. There was a second staff standing beside a table positioned next to the recliner chair. That staff was not wearing a mask.
-On 09/08/20 at 8:47pm, a staff was bending over the side of the bed in the resident room. A second photo at 8:48pm showed the staff standing beside the bed. The staff was not wearing a face mask. The staff was not wearing gloves.
-On 09/08/20 at 9:43pm, a staff was standing beside the resident's bed. The resident was

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laying in the bed. The staff was not wearing a face mask.
-On 09/19/20 at 5:09pm, there was a person standing in the middle of the floor in the resident room behind a second person. The person was not wearing a face mask.
-On 09/19/20 at 5:45pm, there was a male, who was not the resident, sitting on the resident's bed. The male had his arm extended out with an object in his closed hand. The person was not wearing a face mask or gloves.
-On 09/22/20 at 5:22pm, there was a staff standing in the doorway of the resident room with their face mask strapped around their ears, pulled down under their chin, and not covering their nose and mouth. The resident was in the middle of the room.
-On 09/22/20 at 7:48pm, there was a staff standing in front of the resident's rolling walker that was positioned in front of the resident sitting on the bed. The staff had a face mask with the straps around the ears and the face cover positioned under the chin and not covering the staff's nose or mouth. The staff was not wearing gloves. There was a second staff standing in the doorway of the room with her right hand on the door casing. The second staff's mask was positioned under her chin and was not covering her mouth or nose.
-On 09/23/20 at 2:32am, there was a staff standing inside the resident room doorway with her left hand on the wall. The resident was lying on the floor next to the door. The staff was not wearing a face mask or gloves.

Confidential telephone interview with a personal care aide (PCA) revealed:
-She had been in Resident #1's room when her face mask had been pulled "down to catch my breath."

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-She could not remember the exact date.
-She had worked on second shift (3:00pm - 11:00pm).
-She was trained by another staff that worked in another area of the facility.
-All staff were supposed to wear face masks and gloves.
-She had been wearing a face mask and gloves "since last month".
-She did not remember having any training on infection control.

Confidential telephone interview with a second PCA revealed:
-She had worked on the third shift (11:00pm - 7:00am).
-She was not sure when she had received training on the use of face mask.
-She remembered being in a meeting about two weeks ago and staff had to wear mask, "thick ones pinched over nose and mouth".
-There was a time when she first started working that her mask would be over her mouth, but the top of her nose was exposed.
-The only time she had seen face mask not on mouth and nose was when staff were talking with each other but never with residents.
-She had "positive symptoms that could be COVID".

Confidential telephone interview with a third PCA revealed:
-Staff wore face masks and had been doing so for months.
-Most of first shift wore face masks.
-She had seen staff on third shift not wearing face mask a few times but could not remember exact dates.
-The facility had been very strict on face mask use.

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D 338	Continued From page 49 -She knew of one staff [named] who worked third shift who had been without a face mask and that staff had tested positive for COVID-19. -There were new hired staff that had been seen without a face mask, and that staff had tested positive for COVID-19. Confidential interview with a medication aide/supervisor (MA/S) revealed: -There had been one time the staff had on a face mask, but it "was not on properly". -The face mask was on the staff's face but was not over the staff's nose. -Staff were always supposed to wear a face mask inside the facility. -Management had instructed staff to wear their face mask so it covered both mouth and nose. -The staff remembered one time when her face mask was not over her nose when she went into a resident room to administer the resident medication. -The staff had been in a resident room to administer medications without wearing gloves. Confidential interview with a second MA/S revealed: -The MA/S did not remember having any training on COVID-19 performed in person. -The MA/S remembered having a telephone conversation with the Management Liaison (ML) about the use of personal protective equipment (PPE). Telephone interview with the Management Liaison (ML) person on 10/13/20 at 11:10am revealed: -Infection Control training had been conducted by her and the Acting Administrator. -Prior infection control training had been conducted in April 2020. -Staff had been instructed in use of PPE.	D 338		

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-Staff had been instructed to wear face mask over nose and mouth.
-When she was in the facility, staff were wearing face mask appropriately.
-She had been informed there were staff not wearing face mask appropriately and those staff were disciplined and retrained.
-There had been one time it had been reported staff were not wearing face mask.
-A resident's family member sent her pictures of staff not wearing face mask while in the resident's room.
-There could be reasons such as "cleaning, making bed, various things," when staff may be in a resident room when the resident was not in the room.

c. Review of Resident #2's previous FL-2 dated 09/10/20 revealed:
-Diagnoses included mild cognitive impairment, chronic obstructive pulmonary disease, and hypertension.
-Resident #2's recommended level of care was domiciliary.

Review of Resident #2's current FL-2 dated 10/06/20 revealed:
-Diagnoses included dementia, mild cognitive impairment, chronic obstructive pulmonary disease, and hypertension.
-Resident #2 was ambulatory and wandered.
-Resident #2's recommended level of care changed from domiciliary to special care unit (SCU).

Review of Resident #2's progress notes revealed Resident #2 was placed on isolation for COVID-19 on 09/30/20.

Observation of the SCU on 10/06/20 at 2:55pm

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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revealed:
-Two staff exited from resident room #41 wearing full PPE, including gowns, masks, gloves, and face shields.
-Resident #2 was sitting on the bed inside the room with the door of her room completely opened.
-There was no pink isolation sign on her door.
-Staff who exited Resident #2's room did not change their PPE or perform hand hygiene.

Interview with a personal care aide (PCA) on 10/06/20 at 3:06pm revealed she and the SCU Director moved Resident #2 to the SCU from the COVID-19 positive wing of the assisted living (AL) facility about an hour ago.

Interview with the supervisor/medication aide on 10/06/20 at 2:58pm revealed:
-The Resident #2 was moved from the assisted living (AL) side to the SCU about an hour ago.
-The Resident #2 was moved by the SCU Director and a PCA.
-She did not know anything about Resident #2.
-No one had informed her if Resident #2 was COVID-19 positive or COVID-19 negative.
-The SCU Director was responsible for informing staff of the residents' COVID-19 status.

Interview with a second PCA on 10/06/20 at 3:11pm revealed:
-He only worked with the COVID-19 positive residents on the SCU.
-The pink signs on the resident's room door indicated the residents were COVID-19 positive.
-There was no pink sign on Resident #2's room door and no one told him to work with Resident #2.
-He did not know who was in resident room #41 and had not been given report on that resident at

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	HAL058010	A. BUILDING: _____ B. WING _____	C 10/16/2020

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D 338	Continued From page 52 shift change. Interview with a second supervisor/MA on 10/06/20 at 3:35pm revealed; -The pink signs on the resident room doors indicated the resident was COVID-19 positive. -There was no pink sign on Resident #2's room door. -There was nothing in the electronic medical records (eMARs) that indicated Resident #2's COVID-19 status. -"If there is no sign on the resident's room door, then I would not know if the resident is COVID-19 negative or positive." Interview with the SCU Director on 10/06/20 at 3:46pm revealed: -She and PCA moved the Resident #2 to the SCU from the assisted living side of the facility on 10/06/20. -Resident #2 was positive for COVID-19. -Staff were supposed to place pink signs on the resident's room doors to indicate who was COVID-19 positive. -All supervisors/MAs in the entire building knew who all the COVID-19 positive residents were. -The supervisors/MAs were responsible to ensure the pink COVID-19 signs were posted on Resident #2's room door when she moved to the SCU on 10/06/20. -She told the supervisor/MA when she moved Resident #2's bed into the room that Resident #2 was positive for COVID-19 on 10/06/20. -She expected for the COVID-19 positive residents to have a pink COVID-19 sign on their room door. Telephone interview with the acting Administrator on 10/15/20 at 11:35am revealed: -It was the responsibility of the SCU Director to	D 338		

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ensure Resident #2 was placed on isolation when she was moved from the COVID-19 positive hall on the assisted living side of the facility to the SCU.
-The SCU Director should have ensured the isolation sign was posted on the resident's room door and the door was closed.
-The SCU Director should have notified the staff and communicated to the medication aide that Resident #2 was positive.

d. Observation of a sitting area on the Special Care Unit (SCU) on 10/05/20 at 2:32pm revealed:
-There was a resident sitting in a rocking chair and second resident, standing approximately two feet from the rocking chair, was talking to the first resident.
-Staff did not encourage the residents to social distance.

Observation of the living room on the Special Care Unit (SCU) on 10/05/20 from 2:50pm to 2:55pm revealed:
-There were five residents sitting in the living room area.
-Two residents were leaned toward each asleep on a loveseat.
-A third resident was seated in her wheelchair approximately two feet from the loveseat.
-A fourth and a fifth resident were sitting approximately four feet apart across the room on a loveseat.
-Staff did not encourage the residents to social distance.

Observation of the living room on the Special Care Unit (SCU) on 10/06/20 at 3:42pm revealed:
-There were two residents sitting approximately three feet apart and facing each other asleep.
-Staff did not encourage the residents to social

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D 338	Continued From page 54 distance. Observation of the hallway on the SCU on 10/05/20 3:51pm revealed: -There was a resident standing in the hallway talking with the acting Administrator. -The resident was not wearing a mask and stood approximately three feet from the acting Administrator. Interview with a personal care aide (PCA) on 10/05/20 at 2:58pm revealed: -The SCU Director told staff to keep the residents in their room, but "you see how that has worked out". -Staff sometimes brought the residents out of their rooms and allowed them to sit in the common areas. -It was hard for the staff to monitor the residents if the residents were in their rooms. -It was hard for staff to keep the residents apart (social distance) or wear masks when they were in the common areas because the residents did not understand the need to social distance or wear masks. Interview with a second PCA on 10/05/20 at 3:40pm revealed: -Residents were supposed to stay in their rooms because of COVID-19, but it was hard keeping residents in their rooms if staff were expected to monitor them. -Staff brought those residents out to the common areas so they could watch them; but then the residents did not understand the need to social distance or wear masks because of their cognitive statuses. -Staff did not attempt to keep the residents social distanced because "they came back together again" without social distancing.	D 338		

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D 338	Continued From page 55 Interview with the acting Administrator on 10/05/20 at 3:53pm revealed: -She did not know why residents were not social distanced in the SCU. -It was her expectation for staff to encourage the residents to practice social distancing when not in their rooms. Observation of the special care unit (SCU) living room on 10/06/20 at 3:40pm revealed two residents sitting shoulder to shoulder on the couch and staff did not redirect the residents to social distance. _____ The facility failed to ensure staff were following infection control guidelines during a viral pandemic by staff not wearing masks, not appropriately wearing PPE, not implementing social distancing guidelines for residents, not designating staff to work with COVID-19 positive and COVID-19 negative residents, lack of signage to notify staff of the need to isolate one resident (#2), who was COVID-19 positive, on the Special Care Uuit, inappropriate disposable of PPE, and a lack of PPE available in the SCU to reduce the risk of transmission and infection of a serious viral illness. This failure resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/16/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2020.	D 338		

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D912	Continued From page 56	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review, observation, and interview of staff and residents, the facility failed to assure provision of adequate and appropriate care and services to residents regarding housekeeping and furnishings, health care, and personal care and supervision. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure the facility was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #16 and #17 resulting in one resident suffering a bedbug bite to her right calf (Resident #4). [Refer to Tag D079, 10A NCAC 13F .0306(A)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to ensure physician notification for 2 of 5 sampled resident (#4) of a wound on the right lower leg and for a second resident (#5) of the need to assess for increased supervision related to falls. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B	D912		

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D912	Continued From page 57 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 residents sampled (#1, #5) who had multiple falls and hospital evaluations for arm and leg pain (#5) and hospital evaluation and admission (#1) following a fall. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		
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 record review, observation, and interview of staff and residents, the facility failed to assure residents were free from abuse and neglect regarding residents' rights. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance for screening, personal protective equipment (PPE)/masks, social distancing, and infection control measures, established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to protect residents during a COVID-19 outbreak in the facility. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Right (Type A2 Violation)].	D914		

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