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D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with an onsite visit on December 15, 2020.	D 000		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) and the facility's Infection Control Coronavirus Policy and Procedures were	D 601		

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D 601	Continued From page 1 implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to improper use of personal protection equipment (PPE), staff not practicing hand hygiene, and precautions to reduce the risk of transmission and infection. The findings are: Review of the CDC Infection Control guidance updated 11/20/20 revealed: -Health care personnel should perform hand hygiene (considered a primary measure for reducing the risk of transmitting infection among residents and health care personnel) before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. -Make necessary PPE available in areas where quarantine resident care is provided. Review of the CDC guidance titled Strategies for Optimizing the Supply of Isolation Gowns dated 10/09/20 revealed: -Disposable gowns generally should not be re-used because reuse poses the risks for possible transmission among staff and residents that outweigh any potential benefits. -Repeated donning and doffing a contaminated gown may increase the risk of self contamination. -Consideration can be made to extend the use of isolation gowns during a crisis capacity (strategies that are not commensurate with standard U.S. standards of care but may need to be considered during periods of known gown shortages) so that the gown is worn by the same staff person when interacting with more that one resident housed in the same location and known to be infected with the same infectious disease.	D 601		

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D 601	Continued From page 2 Review of the CDC guidance titled Strategies for Optimizing the Supply of Facemasks dated 11/23/20 revealed: -Extended use of face masks is the practice of wearing the same face masks during encounters with several different residents without removing the facemasks between encounters. -The face masks should be discarded when removed, soiled, or damaged and always at the end of the workday. Review of the NCDHHS guidance for the core principles of COVID-19 infection prevention for larger residential settings, with seven or more bed, updated on 10/26/20 revealed staff should use the appropriate PPE when providing resident care. Review of the facility's Infection Control - Coronavirus Policy and Procedure dated 10/21/20 revealed: -Employees should sanitize their hands before entering the resident's room, before and after resident contact, and upon leaving the resident's room. -Change gloves and gowns after each encounter with an ill resident and perform hand hygiene (After removing the gloves, staff should immediately, without touching surfaces or objects, wash their hands with soap and water.) Review of the facility's Resident Roster dated 12/15/20 on 12/15/20 revealed the census was 64 residents. Review of a resident COVID-19 testing spreadsheet on 12/15/20 revealed: -There was no date on the spreadsheet. -The resident testing dates ranged from 11/25/20	D 601		

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D 601	Continued From page 3 to 12/02/20. -There were 19 residents who tested negative, 44 residents tested positive, and 1 resident's test result was pending. Observation of the 300 and 400 halls in the facility on 12/15/20 at 10:00am revealed: -There were plastic disposable isolation gowns hanging on all the doors of the residents' rooms. -There were pink stickers above the doors on 26 resident rooms indicating COVID-19 positive rooms Observation of two staff passing snacks to residents on the 300 hall on 12/15/20 at 10:30am revealed: -The Medication Aide (MA) had a disposable surgical face mask and plastic goggles on. -The MA donned gloves and the disposable isolation gown hanging on the door of a COVID-19 positive resident's room. -The MA entered the COVID-19 positive residents' room and passed out the snacks and drinks. -She left the room, removed the gown, and the personal care aide (PCA) sprayed the gown with a bottle labeled "alcohol". -The MA then hung the same gown back on the door and removed her gloves. -The MA placed her dirty gloves in her pocket. -She did not use hand sanitizer or wash her hands with soap and water. -She did not change her disposable surgical face mask. Continued observation of the two staff passing snacks to residents on 12/15/20 at 10:37am to 10:44am revealed: -The PCA had a disposable surgical face mask and goggles on.	D 601		

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D 601	Continued From page 4 -She donned gloves and the disposable isolation gown hanging on the door of a COVID-19 positive resident's room. -She entered the room and passed out a snack. -She left the room, removed the gown, and sprayed the gown with the bottle labeled "alcohol". -The PCA hung the same gown back on the door and removed her gloves. -She did not use hand sanitizer or wash her hands with soap and water. -She did not change her disposable surgical face mask. -She pushed the snack cart to the next resident's room. -The PCA put on gloves and a disposable isolation gown hanging on the door of another COVID-19 positive resident's room. -She entered the room to pass out the snack. -She exited the room, took off the gown, and the MA sprayed the gown with alcohol. -The PCA hung the same gown back on the door, removed her gloves, and put them in her pocket. -She did not use hand sanitizer or wash her hands with soap and water. -The PCA pushed the snack cart to a COVID-19 negative room. -She put on a new pair of gloves, scooped out ice from a cooler on the snack cart and handed it to the resident in the COVID-19 negative residents' room. Interview with the PCA on 12/15/20 at 10:55am revealed: -She had worked at the facility for two weeks. -She had received infection control training that included changing her gloves and washing her hands. -She had not used hand sanitizer or washed her hands while passing out snacks because she had	D 601		

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not been trained to do so while passing snacks.
-The pink stickers were above the doors of COVID-19 positive residents' room.
-The disposable isolation gowns that hung on the doors of all the residents' rooms were for any staff to put on that entered the room.
-She had been instructed during training to spray the gowns with alcohol.
-She was assigned to work with COVID-19 negative residents because she had tested negative.
-She had been going in and out of COVID-19 positive resident rooms because sometimes the facility was short staffed.
-She had been instructed to wear the same disposable surgical face mask for her entire shift.

Interview with the MA on 12/15/20 at 11:00am revealed:
-She had worked at the facility for approximately 5 years.
-She administered medications and passed out snacks to COVID-19 positive and negative residents since the outbreak occurred in November 2020.
-She had received infection control training that included hand hygiene, donning and doffing isolation gowns, and cleaning.
-The Executive Director (ED) had instructed her to spray the disposable isolation gowns for the COVID-19 negative and COVID-19 positive resident rooms with alcohol after each use.
-She had not used hand sanitizer or washed her hands with soap and water during the snack pass because she did not have any hand sanitizer with her.
-She knew she should have washed her hands or used hand sanitizer.
-A large bottle of hand sanitizer was kept on the medication cart and small bottles at the nurses'

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station.
-She had been instructed by the ED and the Special Care Coordinator (SCC) to wear the same disposable surgical face mask all day in both COVID-19 positive and COVID-19 negative residents' rooms.
-She would discard her disposable surgical face mask at the end of her shift but staff were allowed to wear the same disposable surgical face masks for two days.

Observations of the 300 hall on 12/15/20 at 10:57am revealed:
-There were COVID-19 positive and non-COVID-19 residents rooms on the hall.
-No staff were in the 300 hall at this time.
-A clean linen cart for the 300 hall was outside of resident room 300.
-There was a female resident with a disposable surgical face mask on but no gloves rummaging through the clean linen cart.
-The female resident acquired several wash cloths from the cart and returned to her room in 311.
-The room had a pink sticker above the door indicating the resident room was COVID-19 positive.

Observation of the hallway between the 300 and 400 hallway on 12/15/20 at 10:15am revealed:
-There were two medication carts in the hall by the nurses station.
-Both carts had pink stickers on the cart and a pink sticker on the computers attached to the carts.
-There was a treatment cart for non-COVID-19 residents, with no pink sticker, sitting beside the two meds carts in the hallway.

Observation of the Housekeeper on 12/15/20 at

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D 601	Continued From page 7 10:19am revealed: -He was in the common bathroom on 300/400 hallway. -He had on a disposable surgical face mask but no gloves. -He was picking up a white bag appearing to be trash, tied the bag, placed it on his housekeeping cart and proceeded to push the housekeeping cart with the trash bag off the hall down the back hallway of the facility. Observation of staff making rounds on the 400 hallway on 12/15/20 from 10:25am - 11:00am revealed: -There was a pink sticker above the resident door indicating it was a COVID-19 positive room. -There was a PCA changing the linen in resident room #407 with a pink sticker above the door. -There was a PCA wearing a disposable surgical face mask, a disposable isolation gown not tied and a face shield, and she was not wearing gloves in the room and she was stripping the bed. -There was a second PCA, wearing a disposable surgical face mask, no gloves, standing outside the doorway by the clean linen cart holding clean bed linen. -The first PCA brought the dirty bed linen out of the room with no gloves on putting it in the dirty laundry barrel just outside the door and turned to face the second PCA. -The second PCA handed her the clean bed linen. -The PCA took the clean linen and made up the bed. -The second PCA took the dirty linen barrel and left. -The PCA left the room, hung the disposable isolation gown she had worn on the door to room #407. -She went to the resident common bathroom	D 601		

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down the hall, washed her hands and went directly to resident room #414, a COVID-19 positive room.
-Prior to entering the room, the PCA took down the disposable isolation gown hanging on the door and put it on but did not tie it in the back after putting it on and entered the resident room.
-When she exited resident room #414, approximately 9 minutes later she took off the gown , and hung it up on the door.
-She preceded down the hall to where the medication carts were and spoke to another staff member.
-She did not change her disposable surgical face mask, nor use hand sanitizer or wash her hands.

Interview with a PCA on 12/15/20 at 10:40am revealed:
-She had the infection control training in the last 6 months and was aware she should wear gloves when changing linen.
-She did not have any gloves with her, but gloves were available at the nurse's station.
-She had just forgotten to tie the gown.
-She was assisting the residents and changing their linens.

Observation of the Housekeeper entering each resident room on the 400 hall in the facility on 12/15/20 from 10:30am-11:00am revealed:
-There were 14 rooms on the 400 hallway, 4 rooms were reported as negative for COVID-19 per Administration.
-There were 13 pink stickers above the doors on the 400 hallway.
-Only one room did not have a pink sticker above the door on the 400 hall.
-The housekeeper entered each room on the 400 hall with a disposable surgical face mask.
-He would take the disposable isolation gown off

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the resident door, go in the resident room and then hang the gown back on the door and proceed to the next room.
-He did not put on any gloves during this time.
-He did not spray the gowns after he hung them back up on the door.
-He did not change his disposable surgical face mask.
-He did not use hand sanitizer or wash his hands in between rooms.

Interview with the Housekeeper on 12/15/20 at 10:41am revealed:
-He was the only housekeeper for the facility.
-He had the infection control training but could not remember the date.
-The disposable isolation gowns hanging on the resident doors were for anyone who needed to enter the residents room to put on before they entered.
-The gowns were to be hung back up on the door after the gown was used.
-The nursing staff was responsible for changing the gowns on the door.
-He was not sure how often the gowns were changed.
-The facility had plenty of supplies.
-He was checking the rooms to make sure the resident's had paper towels.

Observation of the Special Care Unit (SCU) 200 Hallway on 12/15/20 at 10:14am revealed there were 8 out of 11 resident rooms that had pink stickers posted above the door of the residents' rooms.

Observation of the SCU MA on 12/15/20 between 10:16am through 10:20am revealed:
-He was administering medication to a resident inside the resident's room with a pink sticker

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posted above the door indicating it was a COVID-19 positive room.
-He was wearing prescription glasses, disposable surgical face mask, gloves, and a disposable isolation gown that was not fastened around the neck or tied in the back and was hanging down to the abdomen and bunched around the elbows; exposing the scrub top clothing on the chest and upper arms.
-He exited the resident room, removed the disposable isolation gown, and hung the gown on the outside of the door.
-He removed a pink colored bottle labeled "alcohol" from the medication cart and sprayed 3 times on the disposable isolation gown hanging on the door of the residents room.

Interview with the SCU MA on 12/15/20 at 10:20am revealed:
-The pink colored bottle used to spray the disposable isolation gown hanging on the outside of the resident's door was alcohol and was used to keep the gown "sanitary".
-The pink sticker posted above the doorway to the resident's room was to indicate the resident had tested positive for COVID-19.
-The ED had told the staff to reuse the disposable isolation gowns and to spray them with alcohol between uses.
-All staff used the same gown hanging from the door of the residents room because it was the facility's policy to reuse gowns until they were changed by the ED to new gowns.
-All staff use the same gown for each resident residing in the room.
-The Infection Control Training provided to all staff included wearing safety glasses or goggles, wearing gloves, how to properly apply and remove personal protective equipment (PPE), sanitizing PPE, wearing a mask properly, placing

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dirty PPE in a trash bag in the black barrel and throwing that trash in the dumpster in the back.
-He did not know how often the disposable isolation gowns hanging from the doors of the resident rooms were changed.
-The ED was responsible for removing the dirty gowns and hanging new gowns on the doors.
-Extra gowns were kept at the nurses station if another one was needed.
-New disposable surgical face masks were kept on the medication cart, in the front office, and in the supply closet.
-He would re-use his disposable surgical face mask and change it to a new one every other day.
-The policy for changing to a new disposable surgical face mask was every 3 days.
-He would remove his disposable surgical face mask when he got to his car, sprayed it with alcohol, would let it air dry, and reuse the mask for his next shift.
-The facility provided all PPE supplies to staff and had an adequate amount for staff use.

Observation on the SCU on 12/15/20 at 10:13am revealed:
-On 100 hall there was a disposable isolation gown on the exterior door leading into each resident's bedroom for rooms 100-105 and 107 -109.
-Pink stickers were observed above the door of rooms 101, 103, 104 and 106.
-Residents identified as COVID-19 positive in rooms 101 and 104 were observed with their bedroom doors open to the exterior hallway.

Interview with a SCU PCA on 12/15/20 at 10:20am revealed:
-The disposable isolation gowns on the outside of each resident room were cleaned by spraying alcohol on them.

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-Upon exiting a resident's room, the staff member removed the gown, sprayed it with alcohol and placed it on the exterior door for re-use.
-When a staff member entered the room of a resident who had the virus or did not have the virus the process for cleaning the disposable isolation gowns was the same.
-The ED directed him to clean the gowns this way.

Interview with a second SCU PCA on 12/15/20 at 10:32am revealed:
-The disposable isolation gowns on the outside of the resident's rooms were put on before entering and taken off and placed on the outside of the resident's room when exiting.
-She was not using alcohol to clean the gowns after removing and placing the gown on the outside of the resident's door.
-No instructions had been given to her about how to clean the gowns.
-No instructions had been given to her about using PPE differently between COVID-19 positive and COVID-19 negative residents.
-She would discard the gown if it was soiled and replace it on the outside of the door for the next staff member.
-She and the other PCA could be wearing the same gown because they both go in and out of the same rooms.
-Residents who were COVID-19 positive could have their bedroom doors open to the exterior hallway.

Observation of the distribution of snacks on 12/15/20 beginning at 10:51am by a PCA on the SCU revealed:
-The PCA had a disposable surgical face mask and a face shield on.
-The PCA donned gloves and the disposable

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isolation gown from the outside door of a room noted to have a COVID-19 positive resident and entered the room with a snack for the resident.
-He came out of the room, removed the gown, placed it on the exterior door, and used an alcohol spray pump five times on the interior of the gown.
-He then went back to the snack cart, removed his gloves, and threw them away in a trash can on the bottom shelf of the snack cart.
-He then donned new gloves without washing his hands or using hand sanitizer.
-He did not remove his disposable surgical face mask.
-He pushed the cart to the next resident room.
-The PCA then donned the disposable isolation gown from the door of the next room noted to be COVID-19 negative and entered the room with a snack for the resident.
-He came out of the room, removed the gown, placed it on the exterior door, and used an alcohol spray pump five times on the interior of the gown.
-He then went back to the snack cart, removed his gloves, threw them away, and donned new gloves without washing his hands or using hand sanitizer.
-He did not remove his disposable surgical face mask.
-He pushed the cart to the next resident room.

Observation on the SCU 200 hallway on 12/15/20 at 11:04am revealed:
-There was a COVID-19 positive male resident standing in the doorway of his room with his hand resting on the disposable isolation gown hanging from the door and he told the Special Care Coordinator (SCC) passing by there was a problem and "someone is in my bed".
-There was a female resident lying in the bed of

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	HAL050017	A. BUILDING: _____ B. WING _____	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERMITAGE	185 BRICKFARM ROAD DILLSBORO, NC 28725

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D 601	Continued From page 14	D 601		

the male resident's room.
-There was a pink sticker posted above the door of the male resident's room indicating it was a COVID-19 positive room.

Interview with the facility's contracted LHPS nurse on 12/15/20 at 10:40am revealed:
-She had provided additional Infection Control Training to staff on 12/14/20 after they were tested for COVID-19.
-The training was a "refresher" and included washing hands before and after resident care, changing gowns, wearing a mask, and wearing gloves.
-She had been working at this facility everyday since the COVID-19 outbreak and the disposable isolation gowns hanging from the door of resident rooms were sprayed with alcohol and reused.
-The disposable isolation gowns were changed to new gowns every "few days" by the ED.
-Staff shared the gowns hanging from the doors of resident rooms.
-If a gown was to become visibly soiled or dirty, staff were supposed to get "rid" of the gown and get a new one.
-She provided the first Infection Control Training to staff when the facility had the first positive COVID-19 case around the end of November 2020 or beginning of December 2020.
-The Corporate Office had provided the Infection Control Training material to go over with staff at the facility.
-She taught staff how to properly wash their hands, wear gloves, mask, face shield or goggles, and gloves in resident rooms, how to remove PPE, washing hands again or using hand sanitizer, and changing gloves between residents.
-She did not know how often staff were changing their disposable surgical face mask, but staff "should get a new mask everyday".

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D 601	Continued From page 15 -Staff were taught how to apply and remove PPE appropriately to prevent the transmission of COVID-19. Interview with the SCC on 12/15/20 at 11:34am revealed: -The facility had been informed on 11/25/20 that a resident had tested positive for COVID-19 at a local hospital. -The facility had notified the local health department (LHD) of their first outbreak on 11/25/20 and the LHD had tested 4 residents. -The LHD tested all the residents in the facility on 12/02/20. -The LHD retested all COVID-19 negative residents on 12/09/20 -All staff had COVID-19 infection control training at the first outbreak of the virus in November 2020. -Infection control training was conducted every Monday and on paydays. -The training included donning gowns, face shields or goggles. -The facility had been instructed by their corporate office to spray the disposable isolation gowns with alcohol and change out the gowns every two days or if visibly soiled. -That guidance had been received from the CDC. -The facility required the staff to change the disposable surgical face masks daily or if visibly soiled. -The facility had a "substantial supply" of disposable isolation gowns and surgical face masks. -Staff should have used hand sanitizer or washing their hands with soap and water when going from room to room passing out snacks. -She did not know why some staff had not tied their disposable isolation gowns or wore them incorrectly while in resident rooms since they had	D 601		

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D 601	Continued From page 16 been trained. -She expected staff to wear the proper PPE and apply it correctly. -She expected staff to wear gowns, gloves and face shields when changing linens. -Staff should also be washing their hands after they finish in each room. -The staff had training on donning and doffing PPE. Observation of the available PPE in the facility on 12/15/20 from 12:50pm - 1:14pm revealed: -There were 1200 disposable surgical face masks, 600 gloves, 400 face shields and 273 disposable isolation gowns in a storage building. -There were 6100 gloves and 3 disposable isolation gowns on the assisted living side of the facility. -There were 350 disposable surgical face masks, 5125 gloves, 20 face shields and 3 disposable isolation gowns on the SCU. -There were 79 face shields in the business office. Interview with the ED on 12/15/20 at 12:04pm revealed: -Infection control training was conducted daily and weekly by the LHPS nurse. -The training included handwashing and spraying the disposable isolation gowns with 70% alcohol. -The isolation gowns were replaced with new gowns three times a week. -Any staff entering a room would put on the same gown dedicated to that room. -The disposable surgical face masks were changed every other day. -A staff person that had been in a COVID-19 positive resident room would not need to change their face mask before entering a COVID-19 negative resident room.	D 601		

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D 601	Continued From page 17 -The guidance was received from their corporate office. -The facility had a substantial amount of PPE. -The guidance received from the LHD was ensuring the facility had enough PPE and isolating positive residents. -Staff should have disposed of their gloves in the residents' trashcans and washed their hands before leaving the room. -She expected staff to wear PPE and wear it appropriately. -She would have expected staff to wear "full" PPE when entering a resident room. -Staff had been trained multiple times about donning and doffing PPE. Telephone interview with the Divisional Vice President of Operations on 12/15/20 at 12:22pm revealed: -She had given guidance to the facility regarding spraying the disposable isolation gowns with alcohol, when to change out the gowns, and how long to wear the disposable surgical face masks. -She had received the guidance about spraying the disposable isolation gowns from the COVID-19 positive and COVID-19 negative rooms with alcohol from the CDC. -The isolation gowns should be changed out if visibly soiled or every 2 days. -The ED or the SCC were responsible for changing out the gowns. -The disposable surgical face masks should be changed if visibly soiled or 2 to 3 times weekly. -It was not appropriate for staff to enter into COVID-19 positive and then COVID-19 negative rooms with the same mask on. -The facility had an abundance of PPE but it was a way to preserve the PPE because no one knew how long the virus would last.	D 601		

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D 601	Continued From page 18 Request for the CDC guidance the facility had been following related to spraying disposable gowns with alcohol was not provided. Telephone interview with the Local Health Department (LHD) nursing supervisor on 12/15/20 at 12:30pm revealed: -She had spoken to the ED after the first positive case of COVID-19 in November 2020. -She had spoken with the ED about reusing disposable isolation gowns only in the event of a shortage. -She was not aware the facility was spraying the disposable isolation gowns with alcohol. -The ED had no need for more isolation gowns as there was an abundant supply. -There should never be more than one staff person wearing the same gown as that would increase the risk of transmission and infection. -Disposable isolation gowns should be changed 2 or 3 times a week or when visibly soiled. -She had not spoken specifically about masks but masks should be changed daily or when visibly soiled. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and the facility's Infection Control Coronavirus Policy and Procedures for infection prevention and transmission during the COVID-19 pandemic related to staff not practicing hand hygiene, multiple staff reusing the same disposable isolation gowns, staff not wearing gloves in COVID-19 positive resident rooms, and staff wearing disposable surgical facemasks for multiple days. The facility's failure to follow the guidance related to infection prevention for COVID-19 increased the risk for	D 601		

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D 601	Continued From page 19 the virus to spread in the facility, resulting in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 14, 2021.	D 601		
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 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 resident rights. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) and the facility's Infection Control Coronavirus Policy and Procedures were implemented and maintained to provide	D912		

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D912	Continued From page 20 protection of the residents during the global coronavirus (COVID-19) pandemic as related to improper use of personal protection equipment (PPE), staff not practicing hand hygiene, and precautions to reduce the risk of transmission and infection. [Refer to Tag 601, 10A NCAC 13F .1801(a)(b) Infection Prevention and Control (Type A2 Violation)].	D912		