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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 11/10/20 and a desk review survey on 11/12/20 to 11/13/20 and 11/16/20 to 11/17/20 and a telephone exit on 11/17/20.	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 by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS) and directives from the local health	D 601		

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department (LHD) were implemented and maintained to provide protection to the residents in the facility during the global Coronavirus (COVID-19) pandemic related to the accessibility and use of personal protective equipment (PPE) by staff and residents.

The findings are:

Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long term care (LTC) facilities revealed:
-Personnel should always wear a face mask in the facility.
-Face masks should not be worn under the nose or mouth.
-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 personal protective equipment (PPE) including eye protection, gloves, gown, and a N95 respirator face mask.
-A surgical mask can be used if a N95 mask is not available.
-If a gown is available, a gown should be warn for activities where splashes are sprays are anticipated,or high-contact resident care activities.
-High contact activities include transferring, dressing, showering, changing linens and providing toileting assistance.
-When a resident is awaiting transfer, resident should separated from others and should wear a cloth face covering or
or facemask.
-Appropriate PPE should be used by personnel when coming in contact with the resident.

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D 601	Continued From page 2 Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed: -Facility staff should wear appropriate personal protective equipment (PPE) when caring for patients with undiagnosed respiratory infection or confirmed COVID-19. -All facility staff should wear a face mask while in the facility. -Facility staff should wear all recommended PPE, including a surgical mask or N95 mask, gown, gloves and face shield when caring for all residents whether they have tested positive for COVID-19 or not. Review of the facility's Infection Control Policy revealed: -Adequate PPE should always be available. -Staff should wear gloves, facemasks (surgical or N95 masks), eye shield or goggles and gowns when touching an ill resident, potentially contaminated environmental surfaces, or items potentially contaminated with respiratory secretions, contaminated tissues, vomit or fecal matter. -Change gloves and gowns after each encounter with an ill resident and perform hand hygiene. -Place a surgical or procedure mask over the ill resident's now and mouth, if tolerated, when transport or movement of the resident is necessary outside of their room. Interview with the "acting" Resident Care Coordinator (RCC) on 11/10/20 at 11:30am revealed there were currently 47 residents and 10 facility staff who had tested positive for COVID-19 as of the last testing date of 11/09/20. Telephone interview with the "acting' RCC on	D 601		

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D 601	Continued From page 3 11/12/20 at 3:45pm revealed there were five residents who had tested positive for COVID-19 had passed away since 10/28/20. Observation of a personal care aide (PCA) exiting a resident's room on 11/10/20 at 10:45am revealed: -She was wearing a mask, goggles, gown, and gloves. -She removed her gown and gloves, disposing them into a trash bag hanging from the hand rail outside the room. -She removed the trash bag with the dirty gown and gloves and placed it in a large trash can in the hallway. -She applied hand sanitizer to her hands. Observation of the activity room on 11/10/20 at 10:56am revealed there were two residents sitting more than 6 feet apart from each other not wearing masks. Interview with the MA on 11/10/20 at 11:00am revealed: -She was using a spray bottle filled with alcohol to spray and wipe down high-touch surface areas. -The clear trash bags hanging from the hand rail outside each resident room was for disposing of dirty PPE when exiting resident rooms. -Staff had been wearing masks and goggles since the beginning of COVID-19. -After the first resident was diagnosed as positive with the COVID-19 virus, staff wore gowns and gloves in addition to face masks and goggles. -New gowns and gloves were applied between each resident. -The Corporate Nurse provided additional infection control training to all staff, which included applying and taking off PPE and washing hands.	D 601		

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D 601	Continued From page 4 -All residents vital signs were checked once a shift and observed for signs and symptoms or worsening symptoms of COVID-19. -There were only 2 of 44 residents that had not been diagnosed as positive for COVID-19 and staff encouraged them to stay in their room. -Staff were being monitored for COVID-19 by having their temperature and oxygen level checked and were asked screening questions that were recorded in a electronic device at the beginning of their shift. -If staff developed signs and symptoms of COVID-19 while working, they were sent home. -Staff were tested twice a week at the facility with a rapid COVID-19 test. Observation of the laundry room on 11/10/20 at 11:05am revealed a staff member exiting the laundry room without wearing a mask, goggles or face shield, or gown. Interview with the staff member responsible for the laundry on 11/10/20 at 11:08am revealed: -She did not wear a mask inside the laundry room because it was very hot from all the dryers. -There were never residents down the hallway where the laundry room was located. -She wore her mask and goggles when she went down the hallways where the residents lived. Observation of the 200 hallway on 11/10/20 at 11:11am revealed there was a small cart with drawers that had a box of gloves setting on top, one roll of clear trash bags in the top drawer, and shoe covers in the bottom drawer. Observation of the 100 hallway on 11/10/20 at 11:13am revealed: -There were 2 large trash cans outside resident's rooms.	D 601		

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-One trash can was labeled "trash" and had a bottle of alcohol and box of gloves setting on the lid.
-The second trash can was labeled "soiled laundry" with a stack of new gowns wrapped in plastic setting on the lid.

Telephone interview with the Health Inspector for Environmental Services on 11/12/20 at 11:06am revealed:
-His last inspection at the facility was on 10/23/20.
-He had observed 2 staff members not wearing their masks correctly and had them pulled down while talking to residents standing "probably 3 feet or less" from the residents.
-He reported to the Administrator that staff were not wearing their PPE correctly and informed him staff needed to wear PPE correctly at all times.
-There was not a place to document PPE on his inspection report so he made a note in the comment section of the 2 staff members he observed not wearing their mask appropriately.

Review of the Inspection Report from the local County Division of Public Health dated 10/23/20 revealed the following comment: "Saw 2 employees not wearing masks while working/talking with patients. Make sure to follow your policy's (sic) and procedures for mask wearing as well as the CDC guidelines."

Telephone interview with the Registered Nurse (RN) from the LHD on 11/12/20 at 8:30am revealed:
-The LHD was notified from the "acting" Resident Care Coordinator (RCC) on 10/27/20 of six residents who had tested positive for the COVID-19 virus.
-She instructed the RCC to test all the residents, which resulted in additional positive results for a

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total of seventeen residents.
-She informed the RCC she would come to the facility on 10/28/20 and retest all the residents who had tested negative.
-On 10/28/20 she went to the facility and retested all the residents who had tested negative and identified three additional residents who were positive for the COVID-19 virus for a total of 20 residents.
-She offered to test staff while she was at the facility on 10/28/20 but the RCC declined and informed her that she was performing the rapid tests on staff herself.
-The RCC was observed with her face mask below her nose or around her neck while she was testing staff for the COVID-19 virus.
-She also observed other staff members on 10/28/20 wearing their face masks incorrectly, with several staff noted to have their face mask pulled down below their nose.
-She also observed staff wearing gowns into the rooms and then when exiting the room they would hang the dirty gown on the outside of the door to the room facing the hallway.
-She informed staff that residents and staff were walking around and could brush up against the soiled gowns and they needed to remove them and that all staff needed to be wearing face masks appropriately which was covering their mouth and nose.
-She observed that staff did remove the gowns from the doors and placed trash bags tied to the handrail in the hallway outside each resident room and staff would remove their gown and place it in the trash bag when exiting the room.
-She did not return to the facility after 10/28/20, but spoke with the RCC several times by phone and e-mail and gave her guidance about staffing and essential employees, restricting visitors, how to request emergency staffing from the state, long

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term care face mask use, long term care infection, prevention, education and resources and to follow the guidelines set by the CDC and the NCDHHS, which included the proper use of face masks and gowns.

Telephone interview with a PCA on 11/17/20 at 10:38am revealed:
-Before the outbreak at the end of October 2020, he wore a mask and goggles the whole time he was in the facility.
-Since the outbreak, he was screened at the beginning of his shift, he wore a mask, gown and goggles and he washed his hands between residents.
-He changed the mask when it became soiled, he sanitized his goggles and changed gowns between each resident.
-Gowns were available outside each resident room door and there was a trash bag hanging outside the door to dispose of gowns after he exited the resident room.
-He saw other staff wear their PPE as instructed.
-The RCC and the Administrator kept staff informed of changes as they happened by having meetings at shift exchange.

Telephone interview with another PCA on 11/17/20 at 10:45am revealed:
-Before the outbreak, masks, gloves and goggles were worn and changed when they became soiled.
-Since the outbreak, she wore a mask and changed it when it became soiled but she now also wore a gown when she entered a resident's room and threw the worn gown away in a trash bag that was outside the door.
-Changes were communicated at shift exchange.
-Facility staff wore their PPE as they had been instructed.

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-The last time she received infection control training was on 10/28/20 by the facility's regional nurse.
-PPE training was done sometime before the infection control training.

Telephone interviews with the local Emergency Medical Services (EMS) Director on 11/12-16/20 revealed:
-The last time he personally was at the facility was three weeks ago but his staff had been called to the facility 13 times from 11/1/20 through 11/11/20.
-EMS staff had reported to him that facility staff did not wear any type of PPE except for a surgical mask.
-Staff at the facility "always" wore a surgical mask but "sometimes" it was below the nose.

Telephone interview with an EMS staff on 11/16/20 at 2:03pm revealed:
-EMS staff had been called to the facility on 11/11/20 because a resident needed to be transported to the local hospital.
-A staff member told her that the resident had thrown up on her.
-The facility staff had a wet spot of vomit on the thigh area of her pants leg.
-The facility staff was not wearing any PPE.
-The facility staff told her that she did not know if the resident had COVID-19 because the test was pending but EMS found out at the hospital that the resident was COVID-19 positive.
-Staff at the facility "usually" had on a surgical mask and gloves but she has never seen a gown on a staff member.
-Masks were "usually" worn properly when she saw them on staff at the facility.

Telephone interview with another EMS staff on

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D 601	Continued From page 9 11/16/20 at 2:25pm revealed: -EMS staff had been called to the facility on 11/11/20 because a resident needed to be transported to the hospital. -When she went into the resident's room, the resident was "laid over on the staff because the resident was weak". -The staff told her that the resident had thrown up on her. -The staff had "no PPE what-so-ever on; nothing". -There was a wet spot where vomit was on her pants leg. -Staff "usually say I don't know" when asked by EMS if the resident had COVID-19. -Residents did not "usually" wear a mask. -"Sometimes" staff wore the surgical mask under their nose. Telephone interview with a hospice nurse on 11/12/20 at 1:11pm revealed: -She observed a staff member wear their mask down below their chin. -Sometimes the staff was not wearing goggles or face shields. -She was in the facility on 11/11/20 and had not observed the staff wearing gowns. -She had asked three different staff members to assist her with three different residents. -Each of the residents were identified as testing positive for COVID-19. -Each staff member that helped her with the residents did not put a gown on before entering the resident's room. -She did not think all staff were taking the infection control guidelines seriously. Telephone interview with the "acting" RCC on 11/17/20 at 10:19am revealed: -Staff had not been instructed to stop wearing	D 601		

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gowns with residents who did not have COVID-19.
-She had instructed staff to continue wearing PPE as they had been doing all along since the beginning of the outbreak.

Telephone interview with the newly hired RCC on 11/16/20 at 2:15pm revealed:
-She started working at the facility on 11/11/20.
-She had assisted a hospice nurse in the facility on 11/11/20 to change the bed linens for a resident.
-She did not put on a gown before entering the COVID-19 postivie resident's room.
-She had on an N95 mask with a surgical mask over it, face sheild and gloves.
-She did not know why she did not put on a gown on before she went into the resident's room.

Telephone interview with the acting RCC on 11/16/20 at 1:44pm revealed:
-When the pandemic began back in March 2020, the staff had a hard time wearing the masks.
-She bought everyone goggles with her own money several weeks ago.
-All facility staff were supposed to be wearing a surgical mask and goggles or face shields since the recent outbreak had started.
-The facility was following guidance from the LHD.
-The LHD had instructed them to not reuse gowns after providing care to residents who tested positive for COVID-19.
-The facility had immediately put trash bags outside every resident's door for staff to removed and disposed of contaminated gowns and other PPE.
-Gowns were available in a storage room on each hallway and should be placed in the hand rail outside each resident room for easy accessibility

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by the staff.
-She helped the Hospice Nurse assist a resident who tested positive for COVID-19 on 11/11/20 without putting on a gown.
-She had gone into the resident's room without a gown because it was an emergency and she was focused on helping the resident.

Telephone interview with the facility's Nurse Practitioner (NP) on 11/12/20 at 1:49pm revealed:
-She had last visited the facility on 10/20/20 before the outbreak of COVID-19.
-She had been doing porch visits with some residents, telephone calls, telehealth, and looking through windows of some residents since residents tested positive for COVID-19.
-The Corporate office had a policy that if she went inside a COVID-19 positive facility she would not be able to go into another facility for 14 days and she had residents residing at 5 other facilities.
-The RCC called her daily to update her on residents conditions and concerns.
-The facility tried to separate the COVID-19 positive and negative cases initially, but the virus spread rapidly throughout the facilty.
-Staff were always wearing their PPE and wearing it correctly when she visited the facility.
-The staff did the "best they could" to get residents to wear mask and socially distance but it was "impossible" being a memory care unit.

Telephone interview with the Administrator on 11/17/20 at 10:56am revealed:
-The facility had been following infection control guidelines from the CDC, NCDHHS and the LHD related to COVID-19 since the beginning of the pandemic.
-The staff were wearing masks and face shields or goggles the entire time they were in the facility.
-Since the outbreak, the facility had continued to

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D 601	Continued From page 12 follow guidelines from the CDC, NCDHHS, and the LHD. -The facility had plenty of PPE available for their staff and the PPE was available for the staff to use while in the building. -The LHD had advised the facility to begin wearing gowns when providing direct care activities to the residents who tested positive for COVID-19 once the facility had their first positive COVID-19 resident. -The LHD had advised the facility staff to put on a new gown before providing care for each COVID-19 positive resident and remove the gown immediately when they had finished providing care. -He completed rounds daily in the facility to make sure all the staff were wearing the PPE according to the guidelines. -If he was not in the building, the Supervisor that was working the shift was responsible for making sure the staff were wearing the PPE correctly. _____ 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 local health department (LHD) for infection prevention and transmission during the COVID-19 pandemic related to staff wearing mask inappropriately, residents not wearing a mask while moving around the facility, and staff not wearing a gown when providing direct care to residents who had tested positive for COVID-19. The facility's failure to follow the guidance related to infection prevention for COVID-19 increased the opportunity for the virus to spread in the facility, resulting in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____	D 601		

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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
D 601	Continued From page 13 The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 19, 2020.	D 601		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided the necessary care and services to maintain their physical health as related to resident rights. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection to the residents in the facility during the global Coronavirus (COVID-19) pandemic related to the accessibility and use of personal protective equipment (PPE) by staff and residents. [Refer to Tag 601, 10A NCAC 13F .1801(c)1(E) Infection Prevention and Control (Type A2 Violation)].	D914		