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D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with onsite visits on 12/21/20 and 12/29/20 and a desk review survey from 12/22/20-12/23/20 and on 12/30/20 with a telephone exit on 12/30/20.	D 000		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention & Control Program (Emer) 10A NCAC 13F .1801 Infection Prevention and Control Program (Emergency Rules) (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 A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North	D 601		

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D 601	Continued From page 1 Carolina Department of Health and Human Services (NC DHHS), the local county health department (LHD), and the facility's COVID-19 infection control policy during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding the facility's failure to social distance at least six feet during communal dining, cleaning and sanitizing high-touch areas, staff not changing gloves between resident rooms, positive COVID-19 staff working with negative COVID-19 residents, failure to observe quarantine precautions for two residents who were admitted from a hospital setting, staff failing to perform COVID-19 screenings when entering the facility, and staff not trained on infection control specific to COVID-19. The findings are: Review of a resident COVID-19 testing spreadsheet dated 12/11/20 revealed: -There current census was 41. -There were 6 residents who tested negative. -There was 1 resident whose test results were inconclusive. -There were 34 residents who tested positive. Review of a resident COVID-19 testing spreadsheet dated 12/14/20 revealed: -There current census was 41. -There were 5 residents who tested negative; the resident whose test was inconclusive on 12/11/20, also tested negative. -There were 34 residents who tested positive; including a resident who tested negative on 12/11/20, also tested postive. -There were 2 residents who were listed as at the hospital.	D 601		

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-A resident who tested positive on 12/11/20, tested negative on 12/14/20.

Review of a resident COVID-19 testing spreadsheet dated 12/22/20 revealed:
-The four residents who tested negative on 12/14/20 tested negative.
-There was one resident who had a negative test on 12/14/20 who was not retested.

Interview with the Director on 12/21/20 at 10:10am revealed:
-Today, 12/21/20, was the first day the residents were out of quarantine.
-The residents had been quarantined for 10-days.
-The first positive test for COVID-19 was on 12/11/20, which included 37 residents and 2 staff.
-There were 3 additional staff who tested positive on 12/14/20.
-A resident who tested positive on 12/11/20, tested negative on 12/14/20 and would be considered a false negative and would not be retested for 28-days per recommendation from the local health department (LHD).
-All staff were asymptomatic at the time of testing, but one staff did develop symptoms after being quarantined at home for a couple of days.
-Two staff who tested positive for COVID-19 and were asymptomatic were allowed to quarantine in the facility due to staffing needs.
-The two staff who tested positive for COVID-19 were a medication aide (MA) and a personal care aide (PCA) who always worked together and the third PCA who was negative worked away from the other two staff.

Interview with the Facility Manager on 12/21/20 at 11:07am revealed:
-He had received notification from the hospital a

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resident had a positive COVID-19 test on 12/10/20 and they began preparing before the resident came back to the facility.
-When the resident came back to the facility on 12/10/20 the resident was isolated.
-The resident was sent back to the hospital on 12/11/20 for increased shortness of breath; the resident died at the hospital. (He did not know the exact date of death).
-All guardians, power of attorneys and responsible parties, and anyone on the visitor list was notified of the COVID-19 positive case.
-All residents and staff were tested for COVID-19 on 12/11/20 and the results came back on 12/13/20 for 37 COVID-19 positive residents and 2 COVID-19 positive staff.
-He thought the COVID-19 test results were false positive because so many were positive, so the COVID-19 test was done again on 12/14/20 and 36 residents tested positive for COVID-19 and 2 additional staff tested positive for COVID-19 for a total of 4 staff who had positive tests.
-One resident who tested positive for COVID-19 on 12/11/20 tested negative on 12/14/20.
-They did not isolate any residents when the test results came back positive for 37 residents on 12/13/20 because he thought the test results were a "false" positive.
-As soon as the COVID-19 test results came back positive the second time, 12/15/20, they began a facility quarantine and communal dining was stopped.
-On 12/15/20, if a resident was tested negative for COVID-19 and the roommate tested positive for COVID-19, the resident who tested negative for COVID-19 was moved to a room with another resident who had tested negative for COVID-19.
-All but "about" seven of the residents who tested positive for COVID-19 were asymptomatic.

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Second interview with the Facility Manager on 12/21/20 at 12:32pm
-All residents and staff who tested negative for COVID-19 on 12/14/20 were being retested today, 12/21/20.
-The resident who was sent to the hospital on 12/11/20 for shortness of breath died at the hospital but he did not know the date.
-A second resident was sent to the hospital on 12/12/20 for shortness of breath.
-Two residents were sent to the hospital on 12/17/20 for shortness of breath.
-A fifth resident was sent to the hospital on 12/20/20 for shortness of breath.

Interview with the Facility Manager on 12/29/20 at 10:38am revealed:
-Another resident was sent to the hospital for shortness of breath on 12/26/20; the resident died on 12/27/20 of COVID-19.
-The resident had been in quarantine.
-The resident had tested positive on both 12/11/20 and 12/14/20.

Telephone interview with the Facility Manager on 12/30/20 at 12:17pm revealed a total of three of the residents who were sent to the hospital had died from complications related to COVID-19.

1. Review of the North Carolina Department of Health and Human Services recommendations for adult care homes (ACH) dated 09/28/20;
-Ensure 6 feet of space between each individual and each table.
-Stagger meal times.
-Reduce or eliminate condiments and shared items on tables and serve individual packets.

Review of the facility's COVID-19 specific infection prevention and control policy regarding

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communal dining dated 10/23/20 revealed:
-Residents who have tested positive for a communicable disease will be served meals in their room.
-All other residents will be encouraged to have meals in their rooms.
-Residents who are not able to to have meals served to their rooms will be served in the dining room in a manner that allows 6 feet distance between them, which may include multiple seating for each meal.

Observation of the resident dining area on 12/21/20 at 12:20pm revealed:
-There were three dining areas designated as resident dining rooms.
-There was one dining area with two tables that had four seats and one table that had six seats.
-There was a second dining area with three tables and four seats at each table.
-There was a third large dining area with five tables that had four seats at each table.
-There were metal trays on the tables that had a vase with silk flowers, a condiment bottle, salt and pepper shakers and packets of dry nondairy creamer setting on each tray.
-The tables and chairs were not set so the residents would be seated six feet apart during meal service.

Interview with a resident on 12/21/20 at 11:00am revealed:
-He had been eating in his room for the last two weeks but before that everyone ate in the dining room.
-There was no social distancing in the dining room during meals.

Interview with a second resident on 12/29/20 at 10:48am revealed:

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-He had eaten in his room for about three weeks.
-Residents ate in the dining rooms before they were tested positive.
-There were bottles of ketchup and hot sauce on the table that he used when he ate.
-The residents did not sit six feet apart when they ate in the dining room.

Interview with the cook on 12/29/20 at 11:36pm revealed:
-He used a mixture of bleach and water to clean the tables in the resident dining rooms between meals.
-He began serving residents their meals in their rooms about 2 or 3 weeks ago; when the COVID-19 outbreak began.
-Before the outbreak the residents ate all at one time in the small and big dining rooms.
-He wiped the condiment bottles and salt and pepper shakers off once a day with the bleach and water mixture.

Interview with the Facility Manager on 12/21/20 at 12:20pm revealed:
-He never stopped communal dining because he thought the socialization the residents received while dining was "too beneficial".
-He only began in room dining two weeks prior, when the residents were tested and received positive results.
-He planned to return to communal dining that day because the residents were out of the 10-day window for testing positive; he had not set the dining rooms up for the residents to be socially distant.
-He did not think about removing the condiments from the table or sanitizing them between use.
-The tables were sanitized after every meal.
-He thought the COVID-19 virus was spread through the communal dining setting because so

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many residents had tested positive at the same time.

Telephone interview with the local health department (LHD) communicable disease nurse and prevention support team coordinator on 12/23/20 at 4:13pm revealed:
-The LHD did not recommend communal dining during a COVID-19 outbreak.
-Prior to a COVID-19 outbreak, the LHD recommended residents dine 6 feet apart, to have multiple dining sessions per meal and to disinfect surfaces between meals.
-The LHD did not observe a resident meal service during their visit on November 2020 but they did observe staff taking their breaks in the resident dining areas.

Telephone interview with the Administrator on 12/30/20 at 10:39am revealed:
-He had not given the Facility Manager any guidance on communal dining.
-He would have limited the number of residents at a table, spread the tables out to separate and have multiple meal times.
-He knew the Facility Manager had served the residents their meals in their rooms once they tested positive for COVID-19.

2. Review of the Centers for Disease Control (CDC) recommendations for cleaning and disinfection during the global pandemic (COVID-19) dated 05/29/20 revealed:
-Clean surfaces using soap and water to reduce the number of germs, dirt and impurities on the surface. Then use of a disinfectant to kill the germs on the surfaces.
-Practice routine cleaning of high touched surfaces; more frequent cleaning and disinfection may be required based on level of use.

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D 601	Continued From page 8 -High touch surfaces include: tables, doorknobs, light switches, countertops, handles, desks, telephones, keyboards, toilets, faucets, sinks, etc. Review of the facility's COVID-19 specific infection prevention and control policy regarding care of the environment dated 10/23/20 revealed: -Surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the resident (e.g., bed rails, bedside tables) and frequently-touched surfaces in the resident care environment (e.g.door knobs, surfaces in and surrounding toilets in resident's rooms) will be cleaned and disinfected on a more frequent schedule compared to that for other surfaces. Observation of the housekeeping cart on 12/21/20 at 10:40am revealed there were two spray bottles of cleaning product on the cart; one was labeled as a disinfectant, and one was not labeled. Observation on 12/21/20 at 11:18am revealed: -There was a telephone sitting on a shelf and a chair sitting next to the shelf in the hallway behind a set of double fire doors. -There was a positive COVID-19 resident using the telephone while seated in the chair; the resident did not have a mask on. -The resident could not be seen through the windows of the fire doors. -There was nothing available for the resident to sanitize the telephone after he completed his call. -No one sanitized the phone after the resident hung up and walked away. Interview with a resident on 12/21/20 at 11:08am revealed: -The housekeeper came into his room while he	D 601		

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was there and cleaned the room once a day.
-The housekeeper would dust the furniture and sweep and mop the floor every day but nothing else.
-He would see the housekeeper clean the doorknobs from "time to time" about "every other day or so".

Interview with a second resident on 12/21/20 at 11:20am revealed:
-He used the telephone located in the hallway one to two times a day.
-He did not wear his mask while on the phone because the person he called could not hear him.
-He did not know if the telephone was cleaned after he used it.

Interview with a third resident on 12/21/20 at 11:30am revealed:
-She was always in her room even before there were residents who tested positive for COVID-19.
-The housekeeper cleaned in her room once a day.
-There was a sink in her room and the housekeeper would clean that with a spray and a paper towel.
-The housekeeper never cleaned the bedside table, the door handles or the light switches.
-She thought her room should be cleaned "better with this thing [COVID-19] going around".

Interview with a housekeeper on 12/21/20 at 10:43am revealed:
-The unlabeled spray bottle contained a bleach and water mixture she made herself every morning.
-No one showed her how to mix the bleach and water mixture she just made it herself; she used a "capful" of bleach and poured it into the bottle with water.

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-She used the bleach mixture to sanitize the commode, the sink and faucets in the residents' bathrooms.
-She sprayed the bleach mixture onto a "rag" and then used the "rag" to wipe the surfaces in the bathroom.
-She used the labeled disinfectant to clean surfaces in the residents' rooms and common areas.
-She sprayed the disinfectant onto a paper towel and then wiped the surfaces in the residents' rooms.
-She wiped the beds and bed rails, dresser, and window seals in the resident's rooms as needed with the disinfectant.
-She used the disinfectant to wipe the handrails and door handles in the hallway once a day.
-She used the disinfectant once a day to wipe the telephone located in the hallway for residents' use.
-She had not increased the amount of cleaning or the frequency of cleaning that she did since the residents tested positive for COVID-19.
-No one had instructed her to increase cleaning of frequently touched surfaces; she had not had any additional training or instructions specific to COVID-19.
-The Facility Manager usually did the training for staff for infection control.

Interview with a second housekeeper on 12/21/20 at 11:16am revealed:
-She wiped down the handrails once a day usually right before she went home for the day.
-She used the disinfectant spray and a paper towel to wipe down the handrails in the hallway and bathrooms.
-She had not changed any of her cleaning routines since the beginning of the pandemic or since residents in the facility had tested positive

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for COVID-19 because she had not been told to change.
-The medication aide (MA) would tell her if there was something extra that needed cleaning.
-Before residents tested positive for COVID-19, the "night shift" cleaned the residents' common areas because that was when the residents were sleeping and in their rooms.

Interview with the MA on 12/29/20 at 2:04pm revealed:
-She knew to wipe down everything she touched and everything the residents touched with disinfecting wipes; no one told her to, she just knew.
-She cleaned anything she could at least once a shift once the residents had the virus.
-She cleaned door knobs, light switches, rails and doors.

Interview with the Resident Care Coordinator (RCC) on 12/29/20 at 1:48pm revealed:
-She did not have a cleaning schedule for the staff; she just knew what to clean like the door knobs.
-She told the staff anything they touched a resident could touch also and should be disinfected on each shift.
-She used disinfecting wipes to wipe down surfaces; the Facility Manager provided the disinfecting wipes and they had not run out.
-The Facility Manager told the staff to clean when they had "free time".
-Once COVID-19 was identified in the facility, staff started clean on all three shifts and to clean the residents' bathrooms every half an hour.
-She used the disinfectant wipes on the telephone after every use; she watched the residents when they used the telephone by the Director's office.

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-She could not see the telephone down the hallway and did not know how often that telephone was cleaned.

Interview with the Director on 12/21/20 at 10:10am revealed:
-All staff cleaned daily.
-If the staff were not doing anything, they should be cleaning.
-Staff on the second shift cleaned doorknobs, light switches, handrails, doors, telephone, and the time clock.
-After the residents and staff tested positive for COVID-19, they had a meeting and talked about sanitizing and cleaning.
-Staff were told, "if you touch it, you clean it."
-Staff were told to clean and sanitize everything, every time they touched it, such as thermometers, pulse oximeters, and handrails.

Interview with the Facility Manager on 12/21/20 at 12:51pm revealed:
-The housekeepers cleaned high touch areas once a day and all other staff cleaned when they had "down time".
-All the staff had a key to the cleaning storage room and could access the cleaning supplies.
-High touch surfaces were handrails, door knobs, bathroom surfaces and light switches.
-He told the staff to make sure the telephones were wiped clean at least once a day and after each use.
-He did not have disinfectant or disinfectant wipes sitting at the telephone station because he did not want the residents to have access to the cleaners.
-He did not think about the telephone behind the fire doors; he knew the staff could not see when the phone was used by a resident.
-The residents were not required to inform the

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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 staff when they used the telephone and were free to use the phones when they wanted. Telephone interview with the Administrator on 12/30/20 at 10:08am revealed: -He was not familiar with the terms "high touch or frequently touched surfaces". -The housekeepers should be cleaning the common areas daily and the residents' bed rails, dressers and night stands should be cleaned daily. -The frequency of cleaning surfaces should have been increased with the diagnosis of positive cases 3. Review of the Centers for Disease Control (CDC) recommendations for extended use of isolation gowns during the global pandemic (COVID-19) dated 10/09/20 revealed: -Consideration can be made to extend the use of isolation gowns (disposable or reusable) such that the same gown is worn by the same HCP when interacting with more than one patient housed in the same location and known to be infected with the same infectious disease (i.e., COVID-19 patients residing in an isolation cohort). -However, this can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as Clostridioides difficile, Candida auris) among patients. If the gown becomes visibly soiled, it must be removed and discarded or changed as per usual practices. Review of the facility's COVID-19 specific infection prevention and control policy regarding personal protection equipment (PPE) dated 10/23/20 revealed: -Before leaving the resident's room or cubicle, remove and discard PPE.	D 601		

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-Wear disposable medical examination gloves or reusable utility gloves for cleaning the environment or medical equipment.
-Remove gloves after contact with a resident and /or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one resident.
-Do not wear gowns even, for the repeated contacts with the same resident.

Observation of a staff on 12/21/20 at 10:53am revealed:
-She came out of a positive COVID-19 resident room without changing her gloves and then went into a second positive COVID-19 resident room with the same gloves on.
-She then left the second room and went into a third positive COVID-19 resident's room with the same pair of gloves she wore while in the first two rooms.

Observation of a housekeeper on 12/29/20 at 10:49am revealed:
-She went into a positive COVID-19 resident's room with gloves on and performed cleaning task; including mopping and emptying trash.
-She then came out of the room and went into a second resident's room without changing her gloves and performed the same cleaning task.

Observation of a personal care aide (PCA) on 12/29/20 at 10:56am revealed:
-She went into one positive COVID-19 resident room with gloves on and then went into a second positive COVID-19 resident room with the same gloves on.
-She left the second resident room with her gloves on and went into a third resident room

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without changing her gloved.
-She dialed a telephone number on the hallway telephone for a resident and then handed the telephone to the resident.
-Shee did not change her gloves between any of these tasks.

Interview with a PCA on 12/21/20 at 10:19am and 1:29pm revealed:
-She knew from experience as a PCA at another facility how to put on a gown, and a facemask.
-She was told to wear a gown and a facemask but was told she did not need to wear a face shield because she wore glasses.
-She was told to dispose of the gown at the end of her shift or when she went into a room with a resident with a negative diagnosis of COVID-19.
-There was nothing to identify the positive COVID-19 residents rooms so she did not know which residents were positive COVID-19 residents.

Interview with a second PCA on 12/21/20 at 12:54pm revealed:
-She had not been told when to change her gown; she was told to by another PCA to "keep her gown on at all times".
-She wore the same gown while doing personal care for residents that were negative and residents that were positive for CIVID-19; she changed her gloves between resident care.
-She did not know which residents had tested positive for COVID-19 were and she did not know who the residents were who had tested negative were.
-She was told to change her gloves between doing resident care; for example, changing incontinence briefs.

Interview with a housekeeper on 12/29/20 at

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D 601	Continued From page 16 11:13am revealed: -She knew to change her gloves after "awhile"; she would change them every 10 minutes or so. -She changed her gloves when they were visibly dirty; she did not change her gloves between cleaning resident rooms. -She had not been trained or told when to change her gloves. Telephone interview with the local health department (LHD) prevention support team coordinator and infection control nurse on 12/23/20 revealed: -The LHD recommended full PPE for staff when there were positive cases of COVID-19 in the facility. -She was concerned if staff were not changing gloves between resident rooms, because there would be an infection control issue, related to cross contamination. -Staff should have changed between resident rooms; anytime any staff went into a resident's environment the gloves were considered contaminated even if nothing was touched. -Housekeepers should have changed their gloves after cleaning each resident's room to prevent the spread of infection. -If any staff touched an infected resident or anything in the infected resident's environment and then failed to change gloves and went into a second resident's room then the second resident and their environment were then susceptible to contamination. -The LHD would have provided guidance for PPE usage if they were contacted by the Facility Manager or Administrator. Interview with the Director on 12/29/20 at 2:25pm revealed: -She had told the staff to keep gloves in their	D 601		

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pockets so they would always have clean gloves available and they would not have to walk all the way back to the cart every time they needed to change gloves.
-She instructed staff to change gloves after doing any direct resident care, any hands-on contact with a resident and cleaning like emptying the garbage.
-She expected gloves to be changed often.
-She had told staff not to wear the gloves from resident to resident and to change their gloves from room to room.
-She began to monitor the housekeepers' use of gloves since residents tested positive for COVID-19.
-She did not conduct formal training but did instruction with staff; she taught them as they worked.

Interview with the Facility Manager on 12/29/20 at 1:17pm revealed:
-He did infection control training on 01/03/20 for all staff; the training was not specific to COVID-19 infection and preventions.
-The training on 01/03/20 included training on proper mask and glove usage.
-He expected staff to change gloves between residents' rooms.
-He was concerned staff would cause cross contamination between residents if they failed to change gloves and gowns.
-He had told the staff to put on a clean gown before going into the room of a COVID-19 negative resident; they could continue to wear the same gown if they went into a positive room after the negative room.
-He and the Director verbally told the staff who the COVID-19 negative residents were.
-He told staff they could wear the same gown between residents if the residents they were

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caring for were positive; they only need to change the gown when it became soiled.

Telephone interview with the Administrator on 12/30/20 at 10:08am revealed:
-The facility staff had always used gloves and had been trained on proper use; the facemask began being worn in February 2020 and the gowns began being worn once there were residents that were positive for COVID-19.
-The staff should have been trained by the Facility Manager to remove gloves when coming out of the residents' rooms and disposed of.
-He had conversations with the Facility Manager about training of the staff and the LHD did onsite training with the staff.
-The Facility Manager had done a training for PPE usage with all staff in February 2020; including cooks, housekeepers, maintenance, PCAs and MAs.
-Even without a global pandemic the staff should know when to change gloves.

4. Review of the CDC guidelines for the prevention and spread of the coronavirus disease in LTC facilities last updated 11/20/20 revealed:
-For a resident returning for readmission to the facility, a provision may include the resident being placed in a single-person room or in a separate observation area, so the resident can be monitored for evidence of COVID-19.
-Staff should wear a N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
-Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after

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their admission.

Telephone interview with the local county health department (LHD) prevention support team coordinator on 12/23/20 at 3:36pm revealed:
-She had made an on-site visit to the facility on 11/09/20 for an infection control assessment.
-She knew the facility was taking new admissions, but there were no new admissions at the time of her visit.
-New admissions should have a negative COVID-19 test prior to admission.
-New admissions should be quarantined for 14-days.
-Even if a new resident had a negative COVID-19 test, the new resident should be quarantined because the COVID-19 test could be inaccurate.
-If a new admission was interacting with other residents there was the potential for infecting other residents.
-New admissions should be quarantined until COVID-19 could be ruled out.

a. Review of Resident #1's current FL-2 dated 11/20/20 revealed diagnoses included cervicalgia, left intertrochanteric femur fracture, and major neurocognitive disorder.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 11/20/20 from a hospital.

Review of Resident #1's laboratory test results for COVID-19 revealed negative test results dated 11/18/20 meant the patient was unlikely to have been infected with COVID-19 unless they had a recent exposure to a COVID-19 positive person since the sample was collected.

Interview with Resident #1 on 12/29/20 at

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D 601	Continued From page 20 10:40am revealed: -He had been in the hospital a long time before being admitted to the facility "about a month ago." -He moved into a room with another resident. -He went to meals with other residents in the dining room every day since admission to the facility. -No one ever told him he needed to stay in his room. -He never had a private room. Interview with a personal care aide (PCA) on 12/29/20 at 11:01am revealed: -Resident #1 did not have a private room when he moved in. -Resident #1 had a roommate before COVID-19, but then he was moved into his current room with a different roommate. -She was not told to do anything different when working with new admissions; she wore a mask and gloves. Interview with a medication aide (MA) on 12/29/20 at 12:25pm revealed: -Resident #1 was not placed in isolation when he was admitted. -Resident #1 had a roommate when he was admitted to the facility. Interview with the Facility Manager on 12/29/20 at 12:49pm revealed: -He did not quarantine Resident #1 at admission. -He assigned Resident #1 to a room with a roommate because it was the only male bed. -When COVID-19 first began all new admissions were required to have a negative COVID-19 test and were quarantined for 14-days. -They stopped quarantining new admissions in October 2020. -New admissions coming from the hospital and	D 601		

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then having to quarantine for 14-days did not "sit well" with new residents.
-He did not think it was right to quarantine new residents because the resident already did not want to move into the facility, and it "made it hard" for the resident to quarantine.
-"In the beginning, they would quarantine" new admissions because if someone was asymptomatic and positive for COVID-19 it would not spread in the building, but it was frustrating for the new resident.
-He did not recall if the LHD provided guidance on new admissions.
-He could not restrain new residents and make them stay in their rooms.
-If a new admission had a negative COVID-19 test he did not instruct staff to do anything different regarding the use of personal protective equipment (PPE); staff wore a mask and used gloves.
-He did not use the C-hall rooms for new admissions because those rooms were going to be used for COVID-19 positive residents.
-New admissions did not want to be on that side of the building; they wanted to be where everyone else was.

Telephone interview with the Administrator on 12/30/20 at 9:50am revealed:
-New residents were required to have a COVID-19 negative test prior to admission.
-He was not aware of any recommendations related to new admissions and quarantining the resident.
-Residents had rights and could not be made to stay in their rooms.

b. Review of Resident #2's current FL-2 dated 12/09/20 revealed diagnoses included closed fracture of the left lateral malleolus and closed

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displaced fracture of the left malleolus with malunion widening.

Review of Resident #1's Resident Register revealed Resident #2 was admitted to the facility on 12/09/20 from a hospital.

Review of Resident #2's laboratory test results for COVID-19 revealed:
-COVID-19 was not detected.
-Negative results were presumptive and should not be used as the sole basis for treatment or other patient management decisions.

Interview with Resident #2 on 12/29/20 at 10:50am revealed:
-He had been at the facility for about 2-3 weeks after a hospitalization.
-He moved into a room with another resident.
-He went to meals with other residents until they stopped meals when the "virus" was going around.
-He was not told he needed to stay in his room when he moved in.
-He never had a private room.

Interview with a personal care aide (PCA) on 12/29/20 at 11:01am revealed:
-Resident #2 did not have a private room when he moved in.
-Resident #2 had a roommate before COVID-19, but then was moved into his current room with a different roommate.
-She was not told to do anything different when working with new admissions, she wore a mask and gloves.

Interview with a medication aide (MA) on 12/29/20 at 12:25pm revealed:
-Resident #2 was not placed in isolation when he

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was admitted.
-Resident #2 had a roommate when he was admitted to the facility.

Interview with the Facility Manager on 12/29/20 at 12:49pm revealed:
-He did not quarantine Resident #2 at admission.
-He assigned Resident #2 to a room with a roommate because it was the only male bed.
-When COVID-19 first started all new admissions were required to have a negative COVID-19 test and were quarantined for 14-days.
-They stopped quarantining new admissions in October 2020.
-New admissions coming from the hospital and then having to quarantine for 14-days did not "sit well" with new residents.
-He did not think it was right to quarantine new residents because the resident already did not want to move into the facility, and it "made it hard" for the resident to quarantine.
-"In the beginning, they would quarantine new admissions" because if someone was asymptomatic and positive for COVID-19 it would not spread in the building, but it was frustrating for the new resident.
-He did not recall if the LHD provided guidance on new admissions.
-He could not restrain new residents and make them stay in their rooms.
-If a new admission had a negative COVID-19 test he did not instruct staff to do anything different regarding the use of personal protective equipment (PPE); staff wore a mask and used gloves.
-He did not use the C-hall rooms for new admissions because those rooms were going to be used for COVID-19 positive residents.
-New admissions did not want to be on that side of the building; they wanted to be where everyone

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else was.

Telephone interview with the Administrator on 12/30/20 at 9:50am revealed:
-New residents were required to have a COVID-19 negative test prior to admission.
-He was not aware of any recommendations related to new admissions related to quarantining the resident.
-Residents had rights and could not be made to stay in their rooms.

5. Review of the CDC guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities last updated 11/20/20 revealed:
-All health care personnel should be screened at the beginning of their shift by actively checking their temperatures for fever and screening for other symptoms of COVID-19; and document the absence of those symptoms.
-Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 before starting each shift/when they enter the building.

Review of the NC DHHS guidelines for the core principles of COVID-19 infection prevention for larger residential settings, with seven or more beds, last updated on 10/16/20 revealed the facility should screen all staff daily for temperature checks, presence of symptoms, and known exposure to COVID-19.

Telephone interview with the LHD prevention support team coordinator on 12/23/20 at 3:36pm revealed:
-She made an on-site visit to the facility on

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11/09/20 for an infection control assessment.
-She recommended the loss of taste and smell be added to the screening questions.
-Staff should be screened every day even if someone had to be hired to be responsible for screening staff.
-If the staff stayed overnight, they should be screened at least daily.
-If the staff were not screened, the facility would not know if the staff were infected or not.

Review of the facility's Staff Screening and Restrictions from Working Policy revealed:
-The policy was dated 10/23/20.
-All staff will be screened for fever and respiratory symptoms at the start of each shift.
-Staff temperatures will be taken and the absence of shortness of breath, new or change in cough, and sore throat will be documented.

Review of the facility's staff screening forms revealed:
-The form included the date and time, the name of the staff, and phone number.
-There were three COVID-19 screening questions, including close contact with someone known to have COVID-19, traveled to an area with widespread concern for COVID-19 and symptoms of a fever, cough, shortness of breath, flu, cold, or pneumonia like symptoms.
-There was a section for the staff's temperature to be recorded.

Review of the facility's staff screening forms and punch cards dated 11/25/20 revealed there were 4 staff who had punched into work but had not completed a screening.

Review of the facility's staff screening forms and punch cards dated 11/26/20 revealed there were

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D 601	Continued From page 26 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 11/27/20 revealed there was 1 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/04/20 revealed there was 1 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/05/20 revealed there were 5 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/06/20 revealed there were 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/07/20 revealed there were 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/08/20 revealed there were 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/09/20 revealed there were 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/18/20 revealed there were	D 601		

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D 601	Continued From page 27 3 staff who had punched into work but had not completed a screening. Review of the facility's staff screening forms and punch cards dated 12/19/20 revealed there was 1 staff who had punched into work but had not completed a screening. Interview with a personal care aide (PCA) on 12/29/20 at 11:26am revealed: -She screened herself when she came through the door every day. -She knew she had to screen herself before clocking into work. -She did not know why she had missed screening herself on 11/26/20, she must have been in a hurry that day. Interview with the Maintenance Director on 12/29/20 at 12:08pm revealed: -He had screened himself before he clocked in. -If he had not completed a screening on 11/26/20 and 12/07/20 it was because he "forgot." Interview with the cook on 12/29/20 at 12:19pm revealed: -He would ring the bell, enter the front door, sanitize his hands, and complete the screening questions and temperature check before he went to work. -He had the medication aide verify the temperatures every time. -Sometimes he would be so cold when he came in the thermometer did not work and he "meant to go back and recheck it" but he would get busy and forgot to. -If his name was not on the screening, he "just forgot." Interview with a medication aide (MA) on	D 601		

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D 601	Continued From page 28 12/29/20 at 12:25pm revealed: -Staff screened themselves. -If she was at the screening area and someone needed assistance, she would help them, but she did not see any sense in it because the staff knew what to do. -She had not checked the temperature for the cook because the cook knew how to check his own temperature. -She had not screened any staff, but she had fixed the thermometer for a staff when someone had changed the mode on the thermometer. Interview with the Resident Care Coordinator on 12/29/20 at 1:43pm revealed: -She was responsible for making sure all staff screened and signed in daily. -She thought the staff screened themselves and must have forgotten to write it down. -If she did not see someone who had not screened in, she must have missed it. Interview with the Director on 12/29/20 at 2:08pm revealed: -Another staff checked her temperature when she was screened in. -Staff were not supposed to screen themselves. -Whoever opened the door would check the temperature and write it down, and then they would answer the screening questions themselves. -If someone had not screened in, she would have thought it was because they were talking and forgot to write it down. -They were initialing to show who had checked the temperature, but she had noticed they were no longer doing this. -She thought the Facility Manager was making sure all the staff screened in.	D 601		

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D 601	Continued From page 29 Interview with the Facility Manager on 12/29/20 at 12:49pm revealed: -He looked at the screening sheets every day he worked but may have missed someone. -He calculated the number of staff who should have screened in based on number of staff scheduled. -At the beginning of COVID-19 everyone was "really good about screening in but over the last month, and a half staff had become slack." -Some staff had been coming in through the backdoor, clocking in, and going to work without screening. -He was concerned staff were working without screening in. -He expected all staff to screen in daily. -If staff were asymptomatic, they could have brought COVID-19 into the building. -He expected all staff to screen in before working daily. Telephone interview with the Administrator on 12/30/20 at 9:50am revealed: -Staff should be screened before each shift. -The staff were using screening logs. -The staff were checking their temperatures. -He knew the staff was screening in but they did not have any checks or balances. -If the staff were not screening it would make contact tracing more difficult. -The purpose of the screening was preemptive, if identified an early symptom the staff might be contagious so you would send them home. 6. Review of the CDC Return to Work Criteria for Health Care Personnel (HCP) with SARS-CoV-2 Infection date 08/10/20 revealed: -If HCP were tested and found to be infected with SARS-CoV-2, they should be excluded from work until they meet all Return to Work Criteria. HCP	D 601		

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with suspected SARS-CoV-2 infection should be prioritized for testing, as testing results will impact when they may return to work and for which patients they might be permitted to provide care.
-Developing criteria to determine which HCP with suspected or confirmed SARS-CoV-2 infection (who are well enough and willing to work) could return to work in a healthcare setting before meeting all Return to Work Criteria-if staff shortages continue despite other mitigation strategies. Implementing this is a crisis strategy and should be implemented only as a last resort when other options have been exhausted.

Review of the CDC guidelines for the prevention and spread of the coronavirus disease in Long Term Care (LTC) facilities last updated 12/10/20 revealed identify health care personnel who will be assigned to work only with residents on the COVID-19 care unit.

Review of the NCDHHS guidelines for prevention and spread of the coronavirus in LTC facilities revealed the facility should have cohort residents that tested positive with dedicated staff in one area and COVID-19 negative residents with dedicated staff in a separate area.

Telephone interview with the LHD prevention support team coordinator on 12/23/20 at 3:36pm revealed:
-The LHD Communicable Disease Nurse had talked to the facility manager via telephone on 12/14/20; the facility Manager was encouraged to quarantine staff who tested positive for COVID-19 at home.
-If the staff who tested positive for COVID-19 had to work because of a staffing shortage, they would expect that staff to work only in the area where residents who had tested positive for

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D 601	Continued From page 31 COVID-19 were isolated and not in the main part of the facility interacting with other staff and residents. -Staff could not work with residents who had tested positive for COVID-19 and residents who had tested negative for COVID-19. -The facility should have set staff for residents who had tested positive for COVID-19 and set staff for residents who had tested negative for COVID-19. Review of the facility's Staffing During a Communicable Disease Outbreak Policy revealed: -The policy was dated 10/23/20. -Supervisors would be trained and assigned to other duties including, but not limited to, resident care activities. -Develop plans to allow asymptomatic staff who have had an unprotected exposure to the virus that causes COVID-19 but are not known to continue to work. -If shortages continue despite other mitigation strategies, consider implementing criteria to allow health care personnel with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all return to work criteria, to work. Review of a resident's December 2020 electronic medication administration record (eMAR) revealed: -The resident had tested negative for COVID-19 on 12/11/20 and 12/14/20. -There was documentation of medication administration for 8:00am and 8:00pm medications. -On 12/13/20-12/16/20 and 12/18/20 a medication aide (MA) who had tested positive for COVID-19 on 12/11/20 documented the	D 601		

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administration of medication at 8:00am and on 12/14/20-12/15/20 and 12/17/20-12/19/20 at 8:00pm.

Interview with the medication aide (MA) who had tested positive for COVID-19 on 12/29/20 at 1:43pm revealed:
-She was quarantined in the facility after testing positive for COVID-19.
-She was the only MA on the days she was scheduled to work.
-She did not go into the rooms of residents who had tested negative for COVID-19.
-There was a personal care aide (PCA) who was also a MA who would administer medications to the residents who had tested negative for COVID-19.
-She would "pull" the resident's medication and ask another MA to administer the medication to the residents who had tested negative for COVID-19; she knew the medication had been administered so she documented it on the eMAR.
-If there was no other MA in the facility, she would wait for the Director to come in and administer the medication to the residents who had tested negative for COVID-10.

Interview with a resident on 12/29/20 at 1:54pm revealed:
-He had tested negative for COVID-19 "a lot of times."
-If the named MA was working, she administered his medication; no one had administered his medication for the named MA.

Interview with a PCA on 12/29/20 at 1:58pm revealed:
-She worked as a PCA when she was not scheduled as the MA.
-If the MA took a break, she would ask her to hold

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the medication cart keys.
-If the MA needed her to do something she would, but when the MA was on the schedule as the MA, she was the only MA."

Second interview with the PCA on 12/29/20 at 2:01pm revealed:
-She administered medication to the residents who had tested negative for COVID-19.
-She did not document administering the medication because the MA was "standing right there with her."

Interview with the Director on 12/29/20 at 2:24pm revealed:
-Whoever documented on the eMAR would have been the MA who administered the medication.
-She did not think about the MA who had tested positive being the only MA in the building.
-The MA who tested positive for COVID-19 had not asked her to administer medication to the residents who had tested negative for COVID-19.
-She had made sure a personal care aide (PCA) who had tested positive for COVID-19 did not work with a resident who had tested negative for COVID-19.
-She had not given any direction for the MA on what to do for medication administration.

Interview with the Facility Manager on 12/29/20 at 2:54pm revealed:
-COVID-19 positive staff did not work with negative residents.
-There was only one COVID-19 positive MA and that MA did not administer medications to COVID-19 negative residents.
-When he was in the facility the MA would pull the medication and ask him to administer it to the COVID-19 negative residents.
-He did not initial the eMAR; he knew whoever

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administered the medication should initial the eMAR.
-The Director would also administer medications to COVID-19 negative residents for the MA.
-He did not administer medications to Resident #1 or Resident #2.
-If the positive MA administered medication to a negative resident, it was concerning because she could have caused cross-contamination.
-The LHD had instructed him not to allow positive staff to work with negative residents.

Telephone interview with the Administrator on 12/30/20 at 9:50am revealed:
-He would not allow staff who had tested positive for COVID-19 to work with residents who had tested negative for COVID-19 unless there was absolutely no other choice.
-If there were staff who had tested positive for COVID-19 they should have been sent home.
-He was not aware staff who had tested positive for COVID-19 staff had quarantined in the building and were working.
-If there was not enough staff, he would make sure the staff who tested positive for COVID-19 only worked with residents who had tested positive for COVID-19.

7. Review of the Center for Disease Control and Prevention (CDC) guidelines for Preparing for COVID-19 in Nursing Homes last updated 11/20/20 revealed:
-Educate Residents, Health Care Personnel (HCP), and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves.
-Regularly review CDC's Infection Control Guidance for Healthcare Professionals about COVID-19 for current information and ensure staff and residents are updated when this

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guidance changes.
-Reinforce adherence to standard infection prevention and control measures including hand hygiene and selection and correct use of personal protective equipment (PPE).
-Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
-CDC has created training modules for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
-Educate HCP about any new policies or procedures.

Review of the facility's Infection Prevention and Control Program Policy revealed:
-The policy was not dated.
-The Administrator will assure all staff are trained within 30-days of hire and annually on the policies and procedures regarding standard precautions, transmission-based precautions, reporting of communicable diseases and conditions, suspected or confirmed communicable disease, staff screening and restriction, visitor screening and restriction.
-The training on hand-hygiene and personal protective equipment (PPE), included in the standard precautions, will include hands-on demonstration by a trained instructor and return demonstration by the staff person.

Interview with a housekeeper on 12/21/20 at 10:43am revealed she had not had any additional training related to cleaning specific to COVID-19.

Interview with a second housekeeper on 12/29/20 at 11:13am revealed she had not received any COVID-19 focused training; she just cleaned more now because there were residents that

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were positive for COVID-19 in the facility.

Interview with a personal care aide (PCA) 12/21/20 at 10:29am revealed she had not received any training specific to COVID-19.

Interview with a second PCA on 12/21/20 at 12:54pm revealed she had not received any training specific to COVID-19.

Interview with a third PCA on 12/21/20 at 2:14pm revealed she had not had any training specific to COVID-19, "we learned as we went."

Interview with a PCA on 12/29/20 at 11:01am revealed she had not had COVID-19 training at the facility, she knew what to do from watching the television.

Interview with a medication aide (MA) on 12/21/20 at 1:56pm revealed:
-She had been trained by the Facility Manager to prescreen before coming to work, to wash hands, to wear personal protection equipment (PPE) including gowns, not to enter negative rooms with a dirty gown on.
-The Facility Manager had done the training when the pandemic first began in March 2020 and again when the residents received a positive test result.
-The training was given to everyone as a group and was mandatory; she was not required to sign in for training.

Interview with the Director on 12/21/20 at 10:10am revealed:
-She thought a nurse conducted an in-service on COVID-19 before she started working at the facility (November 2020).
-She thought the Facility Manager conducted

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D 601	Continued From page 37 training on COVID-19. Interview with the Facility Manager on 12/21/20 at 11:07am revealed: -He watched a video workshop/meeting related to the COVID-19 pandemic the LHD provided every month and would discuss the Webinar with the staff at the monthly meetings. -He had an agenda for the monthly meetings, but he did not keep the agenda. -He did not have a staff attendance sheet for the monthly meetings. -The LHD prevention support team coordinator was scheduled to do COVID-19 training with the staff, but it was canceled after the residents and staff tested positive for COVID-19. -The staff had infection control training in January 2020, but not specific to COVID-19. Telephone interview with the Administrator on 12/30/20 at 9:50am revealed: -He knew the Facility Manager had multiple training classes with the staff. -He did not check to make sure the staff had training so ultimately, he was responsible. The failure of the facility to adhere to the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), local health department (LHD) recommendations and guidance, and the facility's COVID-19 policy regarding residents not social distancing at least six feet apart while communal dining, not cleaning and sanitizing high-touch areas, staff not changing gloves between resident rooms, staff who tested positive for COVID-19 working with residents who had tested negative for COVID-19, failure to observe quarantine precautions for two residents who were admitted from a hospital setting, staff failing to perform	D 601		

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D 601	Continued From page 38 COVID-19 screenings when entering the facility, and staff not trained for infection control specific to COVID-19 which placed the residents at increased risk for transmission and infection from COVID-19. On December 11, 2020, thirty-seven residents tested positive for COVID-19, six of the residents were hospitalized and three residents died with COVID-19 as the cause of death. The facility's failure placed the residents at increased risk for transmission and infection from COVID-19, resulting in serious physical harm, and death which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/21/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 20, 2021.	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 free from neglect as related to infection prevention and control. The findings are: Based on observations, record reviews, and	D914		

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D914	Continued From page 39 interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS), the local county health department (LHD), and the facility's COVID-19 infection control policy during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding the facility's failure to social distance at least six feet during communal dining, cleaning and sanitizing high-touch areas, staff not changing gloves between resident rooms, positive COVID-19 staff working with negative COVID-19 residents, failure to observe quarantine precautions for two residents who were admitted from a hospital setting, staff failing to perform COVID-19 screenings when entering the facility, and staff not trained on infection control specific to COVID-19.[Refer to Tag D601 10A NCAC 13G .1801 Infection Prevention and Control Program (Type A1 Violation)].	D914		