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PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 01/05/21 and a desk review survey on 01/06/21 - 01/08/21 and a telephone exit on 01/08/21.	D 000		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure the facility was free of hazards as evidence by reports of live bed bugs in resident rooms #14 and #20 and not following mixing instructions on an insecticide. The findings are: Review of documentation dated 01/02/21 titled "1st shift notes" revealed: -At 11:00am live bed bugs were seen in a (named) resident's bed. -There was no documentation of the live bed bugs being reported to other staff, management, or a pest control service. -The documentation was not signed. Interview with the housekeeper/maintenance on 01/05/21 at 11:13am revealed:	D 080		

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-He saw bed bugs crawling on the wall in room #14 about 1 week ago.
-He sprayed an insecticide around the ceiling and baseboards of room #14.
-The insecticide label indicated it would treat bed bugs.
-He reported the live bed bug activity to the owner the same day.
-The named resident in the 01/02/21 documentation resided in room #20.

Review of a manufacturers label on a container identified by the housekeeper/maintenance as used for spraying the facility for bed bugs revealed:
-The insecticide was an indoor/outdoor insect concentrate.
-The insecticide was approved for control of the listed pests and mites indoors and outdoors.
-Bed bugs were not listed as pests controlled using the insecticide.
-The main ingredient was Bifenthrin 7.9%.
-Mix 1 ounce (oz) of insecticide with 1 gallon (gal) of water.
-Move person to fresh air if inhaled. Call 911 if not breathing.
-If on skin or clothing, remove contaminated clothing and rinse skin immediately with water for 15 - 20 minutes. Call a poison control center or doctor for treatment advice.

Interview with the Manager on 01/05/21 at 11:36am:
-He did not know bed bugs were seen in room #20's bed on 01/02/21.
-He did not know who documented the 01/02/21 note regarding bed bugs in the bed of room #20.
-He did not know there were live bed bugs seen on the walls of room #14.
-He did not remember being told about bed bug

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activity in the facility.
-He may have been told about bed bug activity in the facility and it "slipped his mind".
-He expected staff to tell him when bed bugs were seen so he could spray the rooms.
-The facility did not have a pest control contract.
-"I am the exterminator."
-He would spray bed frames, mattresses, furniture, base boards and walls in rooms where bed bug activity had been seen.
-He could not remember the last time he sprayed.
-He would use the same insecticide as the housekeeper/maintenance.

Interview with a medication aide/supervisor (MA/S) on 01/5/21 at 2:30pm revealed:
-She had not seen bed bugs in the facility in about 6 months to 1 year.
-She would report bed bugs to the Manager.

Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed:
-The facility last had bed bugs about 1 year ago.
-The bed bugs were treated at that time by an exterminator.
-There had not been any bed bugs in the facility since that time.
-Any staff who saw bed bugs were to tell him immediately so he could call an exterminator to treat the facility.
-He saw the Manager at the facility last night, 01/05/21.
-The Manager did not tell him about bed bugs in the facility.
-He expected the Manager to have told him last night, 01/05/21, about the bed bugs in the facility.
-It was not acceptable to treat the bed bugs with an over the counter insecticide because staff were not licensed pest controllers.
-Staff should not use an over the counter

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insecticide to treat bed bugs because it was not known what effects the chemical could have on the residents.
-It was not acceptable to not have scheduled an exterminator to evaluate and treat the facility for bed bugs.

Telephone interview on 01/07/21 at 11:15am with a nurse for the National Pesticide Information Center revealed:
-The active ingredient in the name brand chemical used by the facility to treat bed bugs was "Biferin".
-BIferin was a pyrethical pesticide.
-Droplets could suspend in air if no adequate ventilation when sprayed.
-The pesticide was an irritant to skin causing tingling and numbness if in contact.
-If inhaled it could cause respiratory track and nasal irritation. The irritation was not specified.
-The facility should follow label directions as it was a federal law and risk for exposure to not follow the label.

Telephone interview with the housekeeper/maintenance on 01/07/21 at 11:28am revealed:
-He would mix 3 oz of the insect spray with 1 gal of water.
-He liked to make it "extra strong" to be certain it would kill the bugs because stronger meant it was more effective.
-He would have the residents leave the rooms, open the windows for ventilation, and spray the rooms.
-The residents would return to their rooms about 2 hours later.

Based on observations and interviews, it was determined the resident in room #14 was not

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D 080	Continued From page 4 interviewable. Based on observation, interviews, and record reviews, it was determined the resident in room #20 was not interviewable.	D 080		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 3 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) in accordance with G.S. 131 E-256 upon hire. The findings are: Review of Staff A's personnel record revealed: -There was handwritten documentation of a 09/11/20 hire date. -There was no documentation of a HCPR check being completed upon hire. -There was documentation a HCPR check was completed on 01/07/21 with no substantiated findings. Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed: -It was his responsibility to verify findings on the	D 137		

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D 137	Continued From page 5 HCPR. -HCPR was to be verified prior to hire. A second telephone interview with the Administrator on 01/08/21 at 12:30pm revealed: -Staff A's HCPR was verified on 01/07/21. -Not verifying Staff A's HCPR before her start date was an oversight on his part.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of documents from Staff A's personnel record reveled: -Staff A was hired on 09/11/20. -There was documentation of a statewide criminal background check completed on 01/07/21. Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed: -It was his responsibility to complete a criminal background check prior to Staff A's start date. -A criminal background check was to be completed prior to hire.	D 139		

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D 139	Continued From page 6 A second telephone interview with the Administrator on 01/08/21 at 12:30pm revealed: -Staff A's criminal background check was completed on 01/07/21. -Not verifying Staff A's criminal background check before her start date was an oversight on his part.	D 139		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility	D 176		

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were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to resident rights, infection prevention and control program, and report and notification of a suspected or confirmed communicable disease outbreak.

The findings are:

Interview with a medication aide/supervisor (MA/S) on 01/05/21 at 10:37am revealed the Administrator was not in the building he was at his other facility.

A second interview with the MA/S on 01/05/21 at 11:31am revealed:
-She was unable to contact the Administrator.
-She left a message for the Administrator at another facility.

Interview with the Manager on 01/05/21 at 1:40pm revealed:
-He told the Administrator today, 01/05/21, of the current survey.
-The Administrator would not be coming to the facility today, 01/05/21.

A second interview with the Manager on 01/05/21 at 3:55pm revealed:
-The Administrator would come to the facility when needed, such as staffing shortage.
-The Administrator was last at the facility last week, "He just popped in.".

Telephone interview with a MA/S on 01/06/21 at 12:52pm revealed:
-The Administrator visited the facility 1 to 2 times

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per week.
-The Administrator would stay 30 minutes to 1 hour when he visited the facility.
-The Manager or Owner were responsible for the overall operation of the facility when the Administrator was not in the facility.
-When the Manager was not in the facility, the MA/S was responsible for overall operation of the facility.
-She never called the Administrator if she had a problem in the facility.
-She always called the Manager or the Owner if she had a problem in the facility.
-She talked to the Manager and the Owner every day.

Telephone interview with the Manager on 01/06/21 at 1:24pm revealed:
-The Administrator did not have a set schedule when he visited the facility.
-The Administrator came to the facility 2 to 3 times per week.
-The Administrator would spend an entire shift and/or work through the night at the facility.
-The Administrator would work on paperwork, speak with residents' families, or work on the floor if the facility was short staffed.
-When the Administrator was not in the building, he oversaw the overall operation of the facility.
-If he was not in the facility the MA/S oversaw the overall operation of the facility.
-When he needed help in the facility, he would call the Administrator.
-If the Administrator was not available, he would call the Owner.
-The Manager worked as the MA/S on third shift 11:00pm to 7:00am, Sunday through Saturday.
-The Manager worked as the cook Sunday through Saturday from 4:00pm - 6:00pm.
-The Manager transported residents to

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appointments 3 times per week from 10:00am to 12:00pm.
-The Manager would start management duties at 7:00am daily.
-His management duties included checking with staff to make sure they had what they needed for their shift, checked residents in the facility, and checked resident rooms.
-The Administrator was aware of the duties that he performed daily in the facility.
-The Manager did not have a process in place prior to 01/05/21 to ensure staff were doing what was he expected of them in infection control and resident care and services.
-"I just check on the residents."

Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed:
-He visited the facility 3 times a week for 1 - 2 hours depending on what needed to be done when there.
-He was at the facility the morning of 01/05/21 to drop off mail and the evening of 01/05/21.
-Prior to 01/05/21, he was last at the facility on 12/29/20 to pick up documents.
-He was on leave from 12/30/20 - 01/03/21.
-When at the facility he would tour the building, check on residents to see what they were doing, and look in the dining room and kitchen to see what meals were being prepared compared to the menu.
-It was a shared responsibility between the Owner and the Administrator to ensure residents with a COVID-19 diagnosis were isolated.
-He never inspected rooms to ensure residents with a COVID-19 diagnosis were isolated.
-He was concerned about the spread of COVID-19 in the facility because there had been residents who had tested positive and he "tried to stay away" from the facility when residents began

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D 176	Continued From page 10 being diagnosed with COVID-19 because he did not want to contract COVID-19. -He did not have a process in place to ensure residents with COVID-19 were isolated. -He had never provided or arranged a formal in-service trainings for staff on COVID-19. -He did not look at the CDC or NCDHHS websites for COVID-19 updates. -He did not make sure staff were following his guidance for COVID-19 and overall expectations to ensure resident care and services was being performed as he expected. -He relied on the Manager and Owner to ensure staff were doing what was expected. -It was a "lack of responsibility" on his part to ensure staff were doing what was expected. -"I dropped the ball." -He knew to educate staff to wash hands, wear face masks, and social distance by information seen on television, bulletins posted in provider offices, common sense and a conference he attended in October 2020. -He did not have a process in place for COVID-19 testing prior to 01/05/21. -There was no reason why a process for testing staff and residents was not in place prior to 01/05/21. -He did not know COVID-19 screening questions should be included in the screening process. -Staff could contact him 24 hours a day if needed. -He did not know the hours the Manager worked at the facility. -The Manager was at the facility "the majority of the day on first shift". -The Manager "over saw the operations of the building" when he was not there. -The Manager would transport residents to and from provider appointments, fill in for the cook and help out in the kitchen if there was a call out, and staff as a MA.	D 176		

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-He did not know how many times a week the Manager would provide resident transportation, fill in for the cook, or staff as a MA.
-He did not know the Manager cooked resident dinners every day.
-He did not know the Manager staffed as a MA/S third shift 7 days a week.

Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed:
-She did not know if she had ever seen the Administrator at the facility during her facility visits.
-She would often see the Manager during her facility visits.

Non-compliance was identified at violation level in the following rule areas:

1. Based on observations and interviews the facility failed to ensure 2 out of 2 residents sampled were treated with respect, consideration and dignity related to personal care. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation).]

2. Based on observations, record reviews, and interviews, 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 (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to implementing all guidance and training of staff regarding that guidance; screening of visitors, staff, and residents; facility wide testing and retesting during an outbreak; isolation and cohorting of residents with confirmed or

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D 176	Continued From page 12 suspected COVID-19 diagnosis; and inappropriate use of facemasks by staff. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A1 Violation)]. 3. Based on interviews and record reviews the facility failed to report COVID-19 diagnoses to the local health department (LHD) when one resident and one staff member tested positive for COVID-19 and failed to report suspected COVID-19 for one resident to the LHD. [Refer to Tag D618, 10A NCAC 13F .1802(A) Reporting and Notification of a suspected or confirmed communicable disease outbreak (Type A2 Violation)]. _____ The Administrator failed to review and ensure implementation and maintenance of the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) for COVID-19 and failed to have a system for oversight of the overall operations of the facility resulting in the COVID-19 outbreak in the facility not being reported to LHD; mass testing for staff and residents being delayed until prompting during the survey; a resident with a confirmed COVID-19 diagnosis not being isolated from other residents; staff, visitors and residents not being screened for signs and symptoms of COVID-19; and residents not being provided with the services necessary to maintain their health and safety related to testing during the COVID-19 pandemic. The Administrator's failure resulted in serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in	D 176		

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D 176	Continued From page 13 accordance with G.S. 131D-34 on 01/08/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2021.	D 176		
D 327	10A NCAC 13F .0906 (f-3) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services Visting (3) A signout register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; This Rule is not met as evidenced by: Based on observations, record review's and interviews, the facility failed to have a sign out register that indicated the departure time, expected time of return for residents as evidenced by a resident (#1) who was out of the facility during the onsite survey and failed to sign out when he left the premises. The findings are: Resident of Resident #1's current FL-2 dated 12/29/20 revealed diagnoses of schizoaffective disorder, Vitamin D deficiency, and nail fungus. Review of Resident #1's Resident Register	D 327		

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revealed an admission date of 09/14/16.

Review of Resident #1's Letter of Appointment General Guardian dated 09/08/16 revealed Resident #1 was documented as an incompetent person and was appointed a Power of Attonery (POA).

Observations during the facility on 01/05/21 from 10:37am to 1:16pm revealed:
-Resident #1 was not present in the facility.
-The sign out log was not at the nurses' station.

Interview with a personal care aide (PCA) on 01/05/21 at 12:40pm revealed:
-Resident #1 had left the facility after breakfast.
-Resident #1 left the facility daily.

Interview with Resident #1 on 01/05/21 at 1:16am revealed:
-He had left the facility after he ate breakfast in the facility on 01/05/21 at 9:30am.
-He did not sign out when he left the facility after he ate breakfast.
-He would sign out if the sign out register was available at the nurse's station.
-The medication aide/supervisor (MA/S) allowed him to leave if he returned before it was dark outside.
-He walked to a local grocery store and hung out at the store.
-He walked to a local fast food restaurant to eat lunch, after he left the grocery store.

Review of the sign out register revealed there were no entries documented for 01/05/21.

Review of the daily resident hourly checklist dated 01/05/21 revealed:
-Resident #1 was checked as "in the facility" from

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8:00am to 9:00am, 9:00am to 10:00am, and 10:00am to 11:00am.
-Resident #1 was not checked as "in the facility" from 11:00am to 12:00pm and 12:00pm to 1:00pm.

Telephone interview with Resident #1's Power of Attorney (POA) on 01/07/212 at 8:24am revealed:
-He was aware that Resident #1 left the facility daily and walked into town.
-Resident #1 would become irritable if he was not able to leave the facility.

Telephone interview with Resident #1's social worker at his Primary Care Provider's office on 01/06/21 at 11:13am revealed:
-She was aware that Resident #1 was leaving the facility daily.
-She expected Resident #1 to notify staff and sign out on the sign out register when he left the facility.

Interview with the Manager on 01/05/21 at 11:50am revealed:
-Resident #1 left the facility every day.
-Resident #1 refused to sign out every time he left the facility.
-Resident #1 would become upset if he was asked to sign out or asked to not leave the facility.
-The sign out register should have been available for residents to use at the nurse's station.
-He had not reviewed the sign out register and did not remember the last time he reviewed it.

Telephone interview with the Administrator on 01/06/21 at 4:09 revealed:
-Resident #1 left the facility whenever he wanted to.
-Resident #1 was supposed to sign out of the

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D 327	Continued From page 16 facility on the sign out register. -Resident #1 was supposed to notify a staff member when he left the facility. -He was not aware that Resident #1 had not signed out of the facility on the sign out register. -He had not reviewed the sign out register and did not remember the last time he reviewed it.	D 327		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure 2 out of 2 residents sampled were treated with respect, consideration and dignity related to personal care. The findings are: 1. Observations of a resident's room on 01/05/21 at 1:20pm revealed: -There was a male resident with upper and lower extremity contractions lying in bed. -The resident was not wearing clothing and his genitals and buttocks were exposed. -The resident's room door was open. -There was no staff in the room. -The medication aide/supervisor (MA/S) walked into the resident's room with bed linen in her arms. Interview with the MA/S on 01/05/21 at 2:25pm	D 338		

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revealed:
-Resident room doors should be closed during personal care for "dignity and respect" of the resident.
-She removed the resident's clothing and adult incontinent brief to perform incontinent care and change the linens.
-She did not have bed linens to place on the bed.
-She left the room to retrieve bed linens.
-She did not close the resident's room door during personal care because she was so focused on the resident.
-She had been previously trained to close the resident doors when performing personal care by the facility's contracted Registered Nurse (RN).
-She did not know when she was trained and could not associate the training to a specific holiday or time of year.
-She did not know why she left the resident's door open to retrieve bed linens.

Attempted interview with the male resident in the room that was observed on 01/05/21 at 3:55pm was unsuccessful.

Refer to interview with the Manager on 01/05/21 at 1:40pm.

Refer to interview with the Administrator on 01/06/21 at 3:13pm.

2. Observations of another resident room on 01/05/21 at 1:35pm revealed:
-There was a female resident lying in bed in the room.
-The room was located across from the nurses' station.
-The resident's room door was completely open.
-The personal care aide (PCA) was performing incontinent care for the resident.

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-The PCA rolled the resident from her back to her right side and began to wipe the resident's buttocks.
-The resident's buttocks was exposed and visible from the hall and nurses' station.
-The manager was sitting in the nurses' station.
-There were 3 other residents siting in chairs in the hallway parallel and to the right of the nurses' station.
-The resident receiving personal care was visible by at the least one of the residents in the hall.
-The Manager was prompted regarding the resident being exposed and the door open during personal care.
-The Manager sighed, stood from the chair, walked to the room, and closed the door.

Interview with the PCA on 01/05/21 at 2:20pm revealed:
-She did not pay attention the resident's door not being closed when provided personal care for the resident whose buttocks were exposed.
-Normally she would close resident doors when performing personal care.

Attempted interview with the female resident on 01/05/21 at 3:25pm was unsuccessful.

Refer to interview with the Manager on 01/05/21 at 1:40pm.

Refer to interview with the Administrator on 01/06/21 at 3:13pm.

_____

Interview with the Manager on 01/05/21 at 1:40pm revealed:
-Closing the resident's door with personal care "must have slipped the PCA and MA/S mind".
-He expected resident room doors to be "cracked" open when staff performed personal

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D 338	Continued From page 19 care. -Staff had been trained to keep resident room doors "cracked" open when they performed personal care. -The doors should be "cracked" open when staffed performed personal care in case the resident fell from bed and staff needed to "call" out for help. Interview with the Administrator on 01/05/21 at 3:13pm revealed: -Leaving resident doors open when providing personal care would expose the resident to other residents and staff in the facility. -Staff were expected to close resident doors when providing personal care to respect the resident's privacy. -Staff had been trained to close resident doors when they performed personal care. The facility failed to ensure two residents were treated with dignity and respect. The facility's failure resulted in a male resident whose clothing and adult incontinent brief had been removed having his buttocks and genitals exposed when the room door was open while the MA/S stepped out of the room to retrieve bed linen; and a female resident whose buttocks was exposed when the room door as left open during adult incontinent brief change that was visible from the nurses' station and hall. The facility's failure was detrimental to the welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/07/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY	D 338		

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D 338	Continued From page 20 22, 2021.	D 338		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. 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) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to implementing all guidance and training of staff regarding that guidance; screening of visitors, staff, and residents; facility wide testing and retesting during an outbreak; isolation and cohorting of residents with confirmed or suspected COVID-19 diagnosis; and	D 612		

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D 612	Continued From page 21 inappropriate use of facemasks by staff. The findings are: Review of the CDC guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed: -All essential visitors and personnel should be screened for the presence of fever and symptoms of the virus when entering the facility. -Personnel should wear a facemask and residents should be encouraged to wear a facemask when out of their rooms and when leaving the facility. -A single new case of COVID-19 should be considered an outbreak. -Perform viral testing of all residents as soon as there is a new confirmed case. -Testing identifies infected residents quickly to assist in their clinical management and allow rapid implementation of infection prevention and control interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent transmission. -After initially performing viral testing of all residents in response to an outbreak, the CDC recommends repeat testing to ensure there are no new infections among residents and staff and that transmission has been terminated. -Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days since the most recent positive result. -If COVID-19 is suspected or identified in a resident immediately isolate the resident in their room and notify the health department. The resident should be prioritized for testing. -Encourage all other residents to self-isolate, if	D 612		

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not already doing so, while awaiting assessment.
-Persons with COVID-19 and experiencing symptoms should not be around others for 10 days since symptoms first appeared, 24 hours with no fever without the use of fever reducing medications and other symptoms of COVID-19 are improving.
-Persons with COVID-19 and not experiencing symptoms should not be around others until 10 days after a positive test for COVID-19.

Review of the NC DHHS guidelines for the prevention and spread of COVID-19 in long term care facilities revealed:
-Staff should be screened for fever and respiratory symptoms prior to starting their shift.
-Residents should be actively screened for fever and respiratory symptoms at least daily.
-Follow current CDC guidance for testing of residents in long term care settings.
-Consult with your local health department (LHD) regarding placement of residents testing positive for COVID-19.
-Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff.

The facilities infection control prevention policy and COVID-19 policies and procedures were requested on 01/05/21 but were not provided prior to survey exit.

Review of the census provided on 01/05/21 revealed there were a total of 29 residents in the facility.

1. Implementation and training of CDC and NCDHHS recommendations and guidance.

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D 612	Continued From page 23 Interview with the medication aide/supervisor (MA/S) on 01/05/21 at 10:45am revealed: -There were no residents in the facility who were diagnosed with COVID-19. -There was one resident currently in the hospital with COVID-19. Interview with the maintenance staff/housekeeper on 01/05/21 at 11:06am revealed he did not remember if he received any COVID-19 training at the facility. Interview with the Manager on 01/05/21 at 11:14am revealed: -The facility had policies related to COVID-19 and Infection Control, but he could not find them. -He educated staff monthly about COVID-19 updates that he received from the adult home specialist (AHS) from the local Department of Social Services (DSS). -He last educated facility staff in December 2020 about screening for COVID-19 symptoms and the proper way to wear a facemask. A second interview with the MA/S on 01/05/21 at 11:31am revealed: -She had not received any COVID-19 training by the facility. -Everything she learned about preventing the transmission of COVID-19 was learned when she went to the hospital related to COVID-19 in November 2020. A second interview with the Manager on 01/05/21 at 12:01pm revealed: -The last in-service for COVID-19 provided by the Administrator was March or April 2020. -He thought the local health department (LHD) sent CDC updates via email.	D 612		

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D 612	Continued From page 24 -He would review with staff if COVID-19 updates or guidelines were received by the LHD via email. -If he received any COVID-19 updates via email from the LHD he would keep the updates in his email folder. -He could not provide the COVID-19 updates received via email from the LHD. -He educated staff in December 2020 to perform COVID-19 screening questions for staff before clocking in to work. -He educated staff in December 2020 to perform COVID-19 screening questions for before entering the facility. -He educated staff in December 2020 to wear their facemasks over their nose and under their chin. -He knew what education to provide the staff regarding COVID-19 by reading information from NC DHHS received via email. -There was no documentation of staff education for COVID-19. -He last received email from NC DHHS one month ago about the COVID-19 vaccine. -He did not know where the email from NC DHHS was. -The Administrator would know where the email from NC DHHS was located. -The LHD and adult home specialist (AHS) with the local DSS would call weekly to check in with the facility regarding COVID-19. -Sometimes the LHD and AHS would provide verbal COVID-19 updates during their weekly calls. -The last verbal updated received from the LHD was 2 weeks ago regarding the COVID-19 contamination period. -Staff were educated at that time regarding the COVID-19 contamination period. -He tried to verbally educate facility staff weekly with COVID-19 updates if received during the	D 612		

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weekly phone calls from the LHD and AHS.

A third interview with the Manager on 01/05/21 at 12:24pm revealed:
-He did not check the CDC or NC DHHS guidelines for guidance and recommendations on COVID-19.
-If he had questions, he would contact the AHS or LHD.
-The Administrator received emailed updates from the NC DHHS.
-The Administrator called him with any updates that he received from NC DHHS.
-He was last updated by the Administrator in December 2020.
-He verbally told staff the updated COVID-19 information that he received from the Administrator in December 2020.
-He turned on the television for residents and staff to watch and receive updated COVID-19 updated information.

Interview with the cook on 01/05/21 at 12:36pm revealed:
-He had not received any COVID-19 education from the facility.
-He knew how to correctly wear a facemask by watching the news and "using common sense".

Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed:
-He never looked at the CDC website for updated COVID-19 guidance.
-He never looked at the NC DHHS website for update COVID-19 guidance.
-He would look at emails received from NC DHHS.
-The last NC DHHS email he looked at was about 2 weeks ago regarding visitation and dining.
-He had not provided staff any in-services on

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D 612	Continued From page 26 COVID-19. -He attended a virtual healthcare association conference in October 2020 where he learned information about COVID-19. -He had trained facility staff in October 2020 about the proper use of wearing a facemask and hand hygiene from information obtained during the October 2020 virtual conference. -Prior to October 2020 he would provide staff education on COVID-19 from information he had learned through the television, bulletins posted at provider offices, and common sense. -He received updated information on guidelines from the long-term care association through email. -He verbally provided any updated information he received about COVID-19 to the Manager. -Facility staff had never had an official COVID-19 in-service taught by trained personnel. -He had not reached out to the LHD or pharmacy to train the facility staff on COVID-19. Documentation of COVID-19 updates the facility received via email from the LHD were requested on 01/05/21 but was not provided by survey exit on 01/08/21. 2. Screening of staff, residents, and visitors for signs and symptoms of COVID-19. Observation during the facility tour on 01/05/21 from 10:37am - 11:04am revealed: -Surveyors were permitted entrance into the facility by a resident and waited in hallway in the front entrance. -The resident walked down the hall and informed the MA/S of visitors in the facility. -The medication aide/supervisor (MA/S) was observed putting on a mask as she walked to the front entrance door.	D 612		

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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 612	Continued From page 27 -The MA/S did not have a thermometer or screening questions in her hand as she walked down the hall. -After prompting, the MA/S took the temperatures of the surveyors 30 minutes after entering the building. -The MA/S did not document surveyor temperatures. -The MA/S did not ask COVID-19 screening questions. Interview with a medication aide/supervisor (MA/S) on 01/05/21 at 11:04am revealed: -She could not find the visitor log to document surveyor temperatures. -There were currently no residents who were diagnosed with COVID-19 in the facility. -There was one resident currently in the hospital who had tested positive for COVID-19 2 weeks ago during a hospital admission. -Residents' temperatures were checked once a day by the MA/S and personal care aides (PCA) and documented in a resident log book. -The MA/S checked the temperatures of staff who entered the facility and documented the temperature in a staff log book. -The facility had not allowed visitors to enter the facility, except healthcare personnel. -There were residents in the facility who were currently receiving home health services. -Visitors' temperatures were taken at the front entrance before they could enter the building. -The MA/S on duty was to take the temperature of the visitor and document the temperature in the visitor log book. -Staff members', residents', and visitors' hands must be sanitized once they entered the building. -She did not ask any staff members, residents, or visitors any screening questions before entrance into the facility.	D 612		

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D 612	Continued From page 28 -She was not told by the facility Manager to ask any staff members, residents, or visitors screening questions. Review of the facility's visitor log on 01/05/20 at 11:38am revealed: -There were 12 visitors documented from 03/01/20 - 03/10/20 -There were 3 visitors after 03/10/20 with no date documented. -There was no documentation of visitors from 03/11/20 - 01/05/21. -There were no temperatures documented. -There were no COVID-19 screening questions documented. Interview with the Manager on 01/05/21 at 11:50am revealed: -Residents were not supposed to leave the facility during the COVID-19 pandemic. -One resident did not follow the facility policy and left the facility daily. -The MA/S on duty was expected to take the temperature of oncoming staff members and visitors. -The MA/S on duty was expected to ask the oncoming staff members if they had any symptoms of COVID-19. -If the staff member had an elevated temperature or had any COVID-19 symptoms the staff member would not be allowed to enter the facility. -Staff temperatures and COVID-19 symptoms should have been documented in a staff log book by the MA/S. -Staff temperatures and COVID-19 screening questions had not been documented since 12/31/20 because he was trying to develop a spreadsheet for documentation. -He could not find the 2020 COVID-19 staff screening and temperature log book.	D 612		

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D 612	Continued From page 29 -The only visitors allowed into the facility were healthcare providers. -Healthcare providers were expected to ring the doorbell at the front entrance of the building before they entered. -A resident or any staff member working at the facility was expected to answer the doorbell. -If a resident answered the door, the resident was expected to immediately notify a staff member that there was a visitor at the front entrance. -If a staff member answered the doorbell, that staff member was expected to have taken the visitor's temperature before they entered the facility. -The staff member was expected to document the visitor's temperature in the visitor log book. -The staff member was expected to ask the visitor did they have a fever or cough after their temperature was taken. -He threw away the visitors' temperature and COVID-19 screening question log book on 01/01/21 because a beverage had spilled on the log book. -Visitors' temperatures and COVID-19 screening questions had not been documented since 01/01/21 because he had not started a new log book. -He had not started a new visitor log book because he was occupied with facility wide COVID-19 vaccines on 01/04/21. Interview with a resident on 01/05/21 at 1:16pm revealed: -He left the facility daily after he ate breakfast. -He left the facility after eating breakfast this morning, 01/08/21. -He walked to a local grocery store and a fast food restaurant to eat lunch. -He wore his mask whenever he left the facility. -Staff did not take his temperature when he	D 612		

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D 612	Continued From page 30 returned to the facility. Observations of the same resident on 01/05/21 at 1:31pm revealed: -The resident entered the facility through the front entrance. -His facemask was pulled down around his chin, not covering his nose. -He walked into the facility and walked past the MA/S and PCA. -The MA/S and PCA did not check his temperature or ask him any COVID-19 screening questions. -The resident walked down the hallway and into his room that he shared with 2 other residents. Telephone interview with the communicable disease nurse at the Local Health Department (LHD) on 01/05/21 at 2:29pm revealed: -Visitors should be screened at the front entrance by facility staff prior to entry. -Visitors should have their temperature taken and asked the signs and symptoms of COVID-19 to decrease possible transmission and exposure. -The staff member that screened the visitor should be documenting all temperatures and screening questions for visitors in a log book. -Staff should be stationed close by the front entrance of the building to screen anyone coming into facility. -Visitors should not have to prompt staff to screen or check their temperatures. -Residents should be screened and have their temperature taken before re-entering the facility, after they had left the facility. Telephone interview with a MA/S on 01/06/20 at 12:52pm revealed: -When a resident left and returned to the facility, the PCA or MA/S were supposed to check the	D 612		

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resident's temperature when they returned to the facility.
-The MA/S and PCA were supposed to make sure the resident sanitized their hands upon reentry into the facility.

Telephone interview with the Manager on 01/06/21 at 1:15pm revealed:
-He expected residents that left the facility and returned to the facility to have on a mask.
-He expected residents to be screened and have their temperature taken when they left and returned to the facility.
-He was responsible for ensuring residents were screened and had their temperature taken when they left and returned to the facility.
-If he was unavailable the MA/S would be responsible for screening and taking temperatures when residents left and returned to the facility.
-The MA/S would be responsible if he were unavailable because they would be the next in charge at the facility.
-If the Manager and MA/S were unavailable, the PCA would be responsible for screening and taking residents' temperature when they left and returned to the facility.

Telephone interview with the Administrator on 01/06/21 at 3:33pm revealed:
-He did not require the facility staff to ask COVID-19 screening questions to staff, residents, or visitors.
-He was not aware that it was CDC and NC DHHS guidelines to ask screening questions to staff, residents, or visitors because he did not review the CDC and NC DHHS website for guidance.
-He did not have a process in place for screening residents for COVID-19.

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D 612	Continued From page 32 -He did not check to make sure residents, visitors, and staff were screened for signs and symptoms of COVID-19. -He did not know if the Manager checked that staff, residents, and visitors were being screened. -The MA/S was responsible for checking the residents' temperature every day, every shift. -He was aware that there was resident that left the facility daily and walked half a mile to a local grocery store. -He expected residents who left the facility to have their temperature taken by the MA/S upon their return to the facility. Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed: -Staff temperature checks should be performed prior to the beginning of each shift. -Visitors temperatures were to be assessed prior to entering the facility. -Residents' temperatures were to be assessed daily. -She expected the facility to follow CDC guidelines regarding the COVID-19 screening questions for staff, residents, and visitors. -Not following CDC guidelines for COVID-19 screening could place residents at risk for contracting COVID-19. -If a resident left the campus, the resident's temperature was to be assessed on each return to the facility. -Residents who left the campus could be a reservoir for COVID-19 placing other residents at risk for contracting COVID-19 if they were not screened on each return to the facility. -A resident who previously had COVID-19 should still be screened each time they left and returned to the campus because they could still be a carrier of COVID-19 and transmit to others.	D 612		

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D 612	Continued From page 33 Documentation was requested on 01/05/21 of daily resident screenings but was not provided prior to survey exit on 01/08/21. Documentation was requested on 01/05/21 of daily staff screenings but was not provided prior to survey exit on 01/08/21. 3. Facility wide testing and retesting during an outbreak. Interview with a mediation aide/supervisor (MA/S) on 01/05/21 at 10:45am revealed: -There had never been facility wide COVID-19 testing for residents and/or staff. -She tested positive for COVID-19 on 11/22/20 or 11/23/20 while off duty. -A resident tested positive for COVID-19 when admitted to a local hospital on either 11/22/20 or 11/23/20. -An additional resident was admitted to the hospital about 2 weeks ago and tested positive for COVID-19 on admission. Interview with the Manager on 01/05/21 at 11:41am revealed: -There were 29 residents currently in the facility. -Four residents in the facility had tested positive for COVID-19 during hospitalizations since November 2020 to December 2020. -Two residents in the facility were tested for COVID-19 on 12/03/20 by their Primary Care Physician (PCP), because each of their roommates had tested positive during a hospitalization. -One of the residents that was tested for COVID-19 on 12/03/20 tested negative for COVID-19. -The resident that tested negative for COVID-19	D 612		

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on 12/03/20 was not re-tested for COVID-19.
-The other resident that was tested for COVID-19 on 12/03/20 resulted positive on 12/06/20.
-If a resident had symptoms of COVID-19 they would be sent out to the emergency room.
-In December 2020, during a call to the facility by the LHD to inquire about COVID-19 outbreak status, he asked the communicable disease nurse to provide facility testing for COVID-19.
-He was told by the communicable disease nurse at the LHD that she did not have enough staff available to send to the facility to test all facility staff and residents.
-He did not take steps to initiate facility wide testing for COVID-19 after the December 2020 conversation with the LHD communicable disease nurse.

Telephone interview with a communicable disease nurse at the Local Health Department (LHD) on 01/05/21 at 2:13pm revealed:
-She called the Manager on 12/15/20 and told him to report all resident COVID-19 positive test results to the LHD.
-She had advised the Manager to call and fax the COVID-19 test results to the LHD when he had a resident that tested positive for COVID-19 in the facility.
-The facility did not have to report to the LHD residents that test positive for COVID-19 while hospitalized; the hospital reported positive COVID-19 test to the LHD.
-She instructed the facility Manager to do facility wide testing or retesting of residents who had tested negative for COVID-19 when she spoke to him on 12/15/20.

Telephone interview with a second communicable disease nurse at the LHD on 01/06/21 at 9:00am revealed:

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-On 12/15/20 during a call to the facility, the Manager asked for guidance regarding testing residents for COVID-19.
-On 12/15/20 she referred the facility to the NC DHHS communicable disease nurse because the facility was unable to handle a COVID-19 outbreak.
-The Manager did not have a plan in place for an COVID -19 outbreak, testing, or reporting of residents who had tested positive for COVID-19.

Telephone interview with the Manager on 01/06/20 at 1:15pm revealed:
-The LHD did not give him any guidance on getting the residents and staff tested for COVID-19.
-There was an infectious disease provider for the LHD who attempt to contact him by telephone, but he was unable to speak with the provider because of missed phone calls from 12/15/20 - 12/17/20.
-He did not follow up with the LHD provider.

Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed:
-It was the facility's responsibility to provide facility wide testing for COVID-19.
-She made a routine visit to the facility on 12/03/20 and the Manager asked her to test a resident for COVID-19 because the resident's family member had been worried the resident would get sick.
-This resident was tested for COVID-19 on 12/03/20 and the result was positive.
-She did not know this same resident's roommate had previously tested positive for COVID-19.
-She did not know there were other residents at the facility who had tested positive for COVID-19.
-On 12/03/20, she emailed the Manager to

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contact a lab to schedule facility wide testing for COVID-19.
-In the email were instructions on how to set up the facility with the lab for COVID-19 testing.
-She expected the facility to have contacted the lab upon receipt of her email to schedule facility wide testing for COVID-19.
-She expected to have been notified when the first resident had a diagnosis of COVID-19 in November 2020.
-If notified, she would have tried to have facility wide COVID-19 testing completed in November 2020 to decrease the risk of exposure and spread of COVID-19.
-If notified the resident's roommate had tested positive for COVID-19, she would have tried to have performed facility wide testing instead of only testing two residents on 12/03/20 to decrease the risk of exposure and spread of COVID-19.
-She expected to have been told when any resident tested positive for COVID-19.
-She was not notified how many residents were diagnosed with COVID-19 during her 12/31/20 visit or at any time.

Telephone interview with the Manager on 01/07/21 at 1:30pm revealed:
-He received an email from the facility's PCP on 12/03/20 with instructions on how to contact the lab to schedule facility wide testing for COVID-19.
-He did not follow up with the email he received on 12/03/20 from the facility PCP.
-The email must have "slipped" his mind.

Telephone interview with the Administrator on 01/06/21 at 3:33pm revealed:
-He did not have a process in place for facility wide testing for COVID-19 prior to 01/05/21.
-He was not aware the PCP gave the directive to

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the Manager to have all residents and staff tested for COVID-19.
-He knew residents and staff needed to be tested for COVID-19 because there were residents who had tested positive for COVID-19
-The residents and staff needed to be tested because he wanted to prevent the spread of COVID-19 in the facility.
-Approximately 1 month ago he responded to a solicitation email regarding scheduling COVID-19 testing for residents and staff.
-He did not receive a response to his email.
-He did not follow back up with the COVID-19 testing provider.
-He did not receive guidance from the LHD regarding COVID-19 testing for residents and staff.

A second telephone interview with the Manager on 01/07/21 at 4:15pm revealed:
-A contracted lab was in the facility to set up COVID-19 testing for all residents and staff today, 01/07/21.
-Both he and the Administrator would be performing the COVID-19 testing today, 01/07/21, once trained by the contracted lab representative currently onsite.

Telephone interview with the contracted lab sales manager on 01/07/21 at 4:16pm revealed:
-He was there to show the Manager how to navigate the electronic portal to enter requisitions and receive COVID-19 test results.
-COVID-19 testing of staff and residents would begin today, 01/07/21, or tomorrow, 01/08/21.

Review of COVID-19 test results dated 01/08/21 and received 01/11/21 for 22 residents of the facility revealed:
-There were 2 out of 22 residents tested who

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were positive for COVID-19.
-There was 1 of 22 residents whose test was "Inconclusive" (Levels of the virus were present but not enough required to interpret as positive. Repeat testing was recommended).

4. Isolating/cohorting of residents with confirmed or suspected COVID-19 diagnosis.

Interview with a medication aide/supervisor MA/S on 01/05/21 at 11:15am revealed:
-There was no designated COVID-19 hall.
-There was no designated COVID-19 staff.
-Residents who returned from the hospital with a COVID-19 diagnosis would be isolated in their room for 14 days.
-Residents who returned from the hospital without a COVID-19 diagnosis would be isolated in their room for 7 days.
-Residents who were exposed to another resident diagnosed with COVID-19 would be on isolated to their room for 7 days.
-The residents on isolation would be served meals in their rooms and provided with a bed side commode.
-Staff would put on a gown, facemask, and gloves before entering the isolated resident's room.

Interview with the Manager on 01/05/21 at 12:03am revealed:
-There were no rooms or hall designated for residents who tested positive for COVID-19.
-There was not enough space in the facility to have a designated COVID-19 hall.
-He did not have any empty rooms in the facility to isolate residents who tested positive for COVID-19.
-The resident who tested positive for COVID-19 stayed in his room with his roommate that was COVID-19 negative.

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D 612	Continued From page 39 -There was no designated staff to care for residents with COVID-19. -The facility did not have enough staff available to have separate staff assigned to work with just COVID-19 positive residents. -The residents who had a diagnosis of COVID-19 were not cohorted or isolated together. -Residents who were diagnosed with COVID-19 ate their breakfast, lunch and dinner meals in their room. -At times, he allowed residents diagnosed with COVID-19 to eat in the facility dining room when no other residents were present because the resident wanted to eat in the dining room. -He was not concerned that a resident diagnosed with COVID-19 ate in the community dining room because the resident would wear a facemask and there were no other residents in the dining room. Telephone interview with the communicable disease nurse at the Local Health Department (LHD) on 01/05/21 at 2:13pm revealed: -She spoke with the Manager on 12/15/20 and 12/20/20 about keeping residents diagnosed with COVID-19 separated from residents without COVID-19. -The Manager told her that he did not have enough space in the facility to separate residents who had COVID-19 from residents who did not have COVID-19. -She told the Manager that if a resident tested positive for COVID-19 that the resident needed to be isolated from any residents that were COVID-19 negative. Telephone interview with a medication aide/supervisor (MA/S) on 01/06/21 at 1:00pm revealed: -There was a resident that tested positive for COVID-19 in the facility on 12/03/20.	D 612		

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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 612	Continued From page 40 -The resident diagnosed with COVID-19 remained in his room with another resident who was not diagnosed with COVID-19 for 10 days. -The resident was isolated to his room for 10 days. Telephone interview with the Manager on 01/06/21 at 1:34pm revealed: -When the resident was diagnosed with COVID-19 in the facility on 12/06/20 he was not symptomatic. -He allowed the resident diagnosed with COVID-19 to eat alone in the dining room during meal times. -The dining room would be cleaned and disinfected before and after the resident ate his meals. -The resident would take his shower in the middle of the night. -The shower room would be cleaned and disinfected before and after the resident finished his shower. Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed: -He was not aware that a resident diagnosed with COVID-19 remained in the same room as a resident without COVID-19. -He should have been notified immediately by the Manager or MA/S. -He expected staff to isolate residents diagnosed with COVID-19 away from residents without COVID-19. -Staff had not been trained to isolate residents diagnosed with COVID-19 from residents without COVID-19. -There should have been empty rooms available in the facility to isolate residents diagnosed with COVID-19 from residents without COVID-19. -He did not know how many empty rooms there	D 612		

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D 612	Continued From page 41 were in the facility. -The resident diagnosed with COVID-19 should not have been allowed out of his room to eat in the dining room during meal times. -Residents diagnosed with COVID-19 should have been moved to an empty room away from residents without COVID-19 to prevent the spread of COVID-19 in the facility. -It was the responsibility of the Manager, the Owner, and the Administrator to make sure residents diagnosed with COVID-19 were isolated from residents without COVID-19. -He had educated staff on isolating residents diagnosed with COVID-19 from residents without COVID-19 in the past (no date provided). Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed: -On 12/06/20 she called and gave the Manager orders to isolate a resident in his room for at least 14 days because the resident had tested positive for COVID-19. -The Manager agreed to isolate the resident in his room for 14 days. -She did not know a resident diagnosed with COVID-19 was sharing a room with a resident without COVID-19. -When residents diagnosed with COVID-19 shared a room with a resident without COVID-19 placed the resident without COVID-19 at increased risk for contracting COVID-19. -Cohorting residents who were diagnosed with COVID-19 with residents without COVID-19 was unacceptable because it increased the risk for COVID-19 transmission for all residents at the facility. -A resident with COVID-19 should not eat in the dining room even if eating alone due to the risk of transmission of COVID-19.	D 612		

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D 612	Continued From page 42 5. Inappropriate use of personal protective equipment (PPE). a. Observations on 01/05/21 at 11:07am - 11:25am revealed: -There was a nurses' station located on the entrance of two hallways. -There were two residents sitting beside each other along one of the hallways across from the nurses' station. -The two residents wore their facemasks below their noses. -There was one resident sitting along the second hallway across from the nurses' station. -The resident wore their facemask below their nose. -The three residents were visible from the nurses' station. -There was a medication aide/supervisor (MA/S) walking around in the nurses' station. -The MA/S did not prompt the three residents to reposition their facemasks. -A personal care aide (PCA) approached one of the residents and repositioned the resident in the chair. -The PCA did not prompt the resident to reposition the facemask. -The PCA did not prompt the other two residents to reposition their facemasks. -The MA/S repositioned clothing of one resident without prompting the resident to reposition their facemask. -The MA/S walked past the other two residents without prompting them to reposition their facemasks. -The MA/S pulled down her facemask below her mouth to talk with visitors. -The MA/S took a breath and repositioned her facemask to cover her nose and mouth.	D 612		

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D 612	Continued From page 43 Interview with the MA/S on 01/05/21 at 11:25am revealed: -She would pull her facemask below her mouth about 2 times every two hours during her shift because it was difficult to breath wearing the facemask. -She lowered the facemask below her mouth because she had to take a breath of air. -Residents were supposed to wear their facemasks over their noses and below their chins. -She did not notice the three residents wearing their facemasks below their noses. -She should have paid attention to how the residents wore their facemasks. -She should have prompted the residents to reposition their facemasks. Observations on 01/05/21 at 11:57am revealed: -The cook walked from the kitchen through the dining room, down the hall the past the nurses' station to the bathroom and back to the kitchen. -The cook wore a facemask below his nose. -The Manager was at the nurses' station. -The Manager did not prompt the cook to reposition his facemask to cover his nose. Interview with the Manager on 01/05/21 at 12:01pm revealed: -He did not notice the cook's facemask below his nose. -He expected residents and staff to wear their facemask over their nose and under their chin. -Every month he would educate staff to wear facemasks over their nose and under their chin. Observations of the cook on 01/05/21 at 12:36pm revealed: -He was in the kitchen wearing a facemask below	D 612		

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D 612	Continued From page 44	D 612		

his nose.
-He was prepping residents' meal plates for dinner.
-The cook required prompting by surveyor to reposition his facemask over the nose and below the chin.

Interview with the cook on 01/05/21 at 12:36pm revealed:
-He was supposed to wear the facemask over his nose and under his chin.
-He would sometimes pull the facemask below his nose because it became hard to breath.

Observation of the facility on 01/05/21 at 1:00pm revealed:
-There were two residents sitting in the hall to the right of the nurses' station.
-The Manager was standing in the hallway with surveyors.
-The MA/S walked down the hall past one resident, the Manager and surveyors.
-The MA/S wore her mask below her chin not covering her nose or mouth.
-The Manager was prompted regarding the MA/S not wearing her facemask over her nose and under her chin.
-The Manager prompted the MA to reposition her facemask.

A second interview with the Manager on 01/05/21 at 1:00pm revealed:
-It was difficult to constantly prompt residents to wear their facemasks over their nose and under their chin.
-He expected staff to prompt residents to wear their mask over their nose and under their chin.

Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed:

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-He expected staff to always wear facemasks over the nose and under the chin while in the facility.
-He expected any staff who was not wearing their facemask over the nose and under their chin to be prompted by other staff to wear their facemask correctly.
-Facemasks were to be worn correctly to prevent COVID-19 transmission and contraction because someone may have COVID-19 and not know until it was diagnosed.
-He expected staff to prompt residents to wear facemasks over their nose and under their chin to prevent the spread and contraction of COVID-19.

Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed:
-She expected staff and residents to always wear masks over their nose and under their chin while in the facility to aide in infection control.
-She expected staff to prompt residents to wear facemasks over their noses and under their chins to decrease transmission of infection.

b. Observation of a personal care aide (PCA) on 01/05/21 from 12:45pm revealed:
-She entered the laundry room wearing gloves and carrying a bib.
-She placed the bib in the dirty laundry basket.
-She exited the laundry room without removing her gloves.
-She did not touch the doorknob when she exited the laundry room.
-She removed a bib from another resident sitting in the hallway beside the laundry room wearing the same gloves.
-She entered the laundry room and placed the bib in the dirty laundry basket.
-The PCA required prompting to remove gloves

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D 612	Continued From page 46 and perform hand hygiene. Interview with the PCA on 01/05/21 at 12:50pm revealed: -She had removed a bib from a resident and placed the bib in the dirty laundry. -She exited the laundry room wearing the contaminated gloves. -She removed a bib from another resident wearing the same contaminated gloves. -She did not change gloves between resident care because the resident was finished eating. -She was only going to remove the resident's bib and not "actually" touch the second resident. -She knew she should change gloves and perform hand hygiene between resident care. -She had a shirt pocket full of gloves. Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed: -He expected gloves to be discarded and hand hygiene performed after each resident care before providing care to another resident. -It was not acceptable that the PCA did not discard gloves, perform hand hygiene and apply new gloves prior to removing the bib from the second resident because it was placing residents at risk for increase of transmission of infection. Telephone interview with the facility's Primary Care Provider (PCP) on 01/07/21 at 11:31am revealed she expected gloves to be changed and hand hygiene performed between resident care to decrease the risk of cross contamination. _____ The facility failed to follow the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) guidelines and recommendations for coronavirus (COVID-19) during the global	D 612		

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D 612	Continued From page 47 pandemic in which multiple residents were diagnosed with COVID-19. The facility did not implement guidance and train staff on current guidance; visitors, staff and residents were not screened for signs and symptoms of COVID-19 including a resident who was out in the community daily; a resident with a COVID-19 diagnosis was not isolated resulting in the resident having meals in the common dining area. The facility failed to conduct facility wide testing and retesting for COVID-19 at the time of an outbreak. The lack of testing and retesting resulted in the facility not knowing the COVID-19 status of each resident. Recommended facility wide COVID-19 testing conducted on 01/08/21 revealed 2 out of 22 residents were COVID-19 positive. The facility's failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/07/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2021.	D 612		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in	D 618		

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D 618	Continued From page 48 Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to report COVID-19 diagnoses to the local health department (LHD) when one resident and one staff member tested positive for COVID-19 and failed to report suspected COVID-19 for one resident to the LHD. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed: -The local health department (LHD) should be notified immediately if COVID-19 is suspected or confirmed among residents or facility personnel; if a resident developed a severe respiratory infection resulting in hospitalization; if 3 or more residents or facility personnel developed new-onset respiratory symptoms within 72 hours of each other. -Prompt notification of the health department about residents and personnel with suspected COVID-19 was critical. -The LHD helped ensure all recommended infection prevention and control measures were in place. -Rapid action to identify, isolate, and test others who might be infected was critical to prevent further spread. Review of the North Carolina Division Health and	D 618		

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D 618	Continued From page 49	D 618		

Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in long term care facilities revealed a confirmed or suspected case of COVID-19 in a resident or staff of a long-term care setting should be immediately reported to the LHD.

Interview with a mediation aide/supervisor (MA/S) on 01/05/21 at 10:45am revealed:
-She began to feel bad while off duty and she tested positive for COVID-19 on 11/22/20 or 11/23/20 at a local urgent care center.
-She reported her positive diagnosis of COVID-19 to the facility Manager.

Telephone interview with a medication aide/supervisor (MA/S) on 01/06/21 at 1:00pm revealed:
-There was a resident that tested positive for COVID-19 in the facility on 12/03/20.
-The resident remained in his room with another resident while he was positive for COVID-19 for 10 days.

Interview with the Manager on 01/05/21 at 11:47am revealed:
-He did not report the staff who tested positive for COVID-19 to the LHD.
-He did not know he needed to report the residents or staff who had tested positive for COVID-19 to the LHD.

A second interview with the Manager on 01/05/21 at 2:20pm revealed:
-There were 2 residents who were diagnosed with COVID-19 at the end of November 2020 and/or the first of December 2020 at the hospital.
-Each of the two residents diagnosed with COVID-19 had a roommate.
-He asked the facility's primary care provider

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D 618	Continued From page 50	D 618		

(PCP) to test the roommates for COVID-19 on 12/03/20.
-One of the two residents tested by the PCP on 12/03/20 tested positive for COVID-19.
-On 12/06/20, he was notified via fax that the resident was positive for COVID-19.
-He did not notify the LHD the resident had tested positive for COVID-19.
-He did not notify the LHD he suspected the second resident (roommate) may have had COVID-19 and had tested negative on 12/03/20.
-He did not know that he needed to report residents who were positive with COVID-19 to the LHD.

Telephone interview with the communicable disease nurse at the LHD on 01/05/21 at 2:00pm revealed:
-She called and told the Manager on 12/15/20 to notify the LHD of any residents and staff who tested positive for COVID-19 in the facility.
-The facility had not notified the LHD of any confirmed or suspected COVID-19 diagnoses for any staff or residents of the facility.
-She last spoke with the MA/S on 01/04/21 and there were no residents with a COVID-19 diagnosis reported on that date.

Telephone interview with a second communicable disease nurse at the LHD on 01/06/21 at 9:00am revealed the facility had not notified the LHD of any confirmed or suspected COVID-19 diagnoses for any staff or residents of the facility.

Review of the resident's lab report dated 12/06/20 revealed the resident was tested for COVID-19 on 12/03/20 and the results dated 12/06/20 were positive.

Review of the second resident's lab report dated

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D 618	Continued From page 51 12/06/20 revealed the second resident was tested for COVID-19 on 12/03/20 and the results dated 12/06/20 was negative. Telephone interview with the Administrator on 01/06/21 at 3:13pm revealed: -There were 4 residents who tested positive for COVID-19 "over a span of time". -He did not specify the timeframe those residents tested positive for COVID-19. -Each resident who tested positive for COVID-19 should have been reported to the Department of Social Services Adult Home Specialist. -He did not know all residents diagnosed with COVID-19 were to be reported to the LHD. -He expected the facility Manager to have reported the COVID-19 positive cases to the LHD per guidance of the LHD so the facility could have received guidance and/or assistance to help decrease the spread of COVID-19. _____ The facility failed to follow the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) guidelines for notification of the local health department (LHD) of staff and residents with confirmed COVID-19 diagnoses and a suspected COVID-19 diagnosis. The facility's failure resulted in the facility not receiving guidance from the LHD on measures for preventing and decreasing transmission and infection, and mass testing not being coordinated timely resulting in a delay in testing which placed the residents at increased risk for contracting COVID-19. The facility's failure resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 618		

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D 618	Continued From page 52 accordance with G.S. 131D-34 on 01/07/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2021.	D 618		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure residents were treated with respect and dignity. The findings are: Based on observations and interviews the facility failed to ensure 2 out of 2 residents sampled were treated with respect, consideration and dignity related to personal care. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		
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.	D914		

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D914	Continued From page 53	D914		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure residents were free from neglect related to reporting and notification of a suspected or confirmed communicable disease outbreak, infection prevention and control program and management of facilities.

The findings are:

1. Based on observations, record reviews, and interviews, 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 (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to implementing all guidance and training of staff regarding that guidance; screening of visitors, staff, and residents; facility wide testing and retesting during an outbreak; isolation and cohorting of residents with confirmed or suspected COVID-19 diagnosis; and inappropriate use of facemasks by staff. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A1 Violation)].

2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026048	A. BUILDING: _____ B. WING _____	C 01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VALLEY ADULT CARE HOME	3522 CAMDEN ROAD FAYETTEVILLE, NC 28306

(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
D914	Continued From page 54 resident rights, infection prevention and control program, and report and notification of a suspected or confirmed communicable disease outbreak. [Refer to Tag D176, 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation)]. 3. Based on interviews and record reviews the facility failed to report COVID-19 diagnoses to the local health department (LHD) when one resident and one staff member tested positive for COVID-19 and failed to report suspected COVID-19 for one resident to the LHD. [Refer to Tag D618, 10A NCAC 13F .1802(A) Reporting and Notification of a suspected or confirmed communicable disease outbreak (Type A2 Violation)].	D914		