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RIVERSTONE	104 EFIRD BOULEVARD NEW BERN, NC 28562

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and follow-up survey with an onsite visit on 02/02/21 and 02/03/21 and a desk review survey on 02/04/21 through 02/05/21 with a telephone exit on 02/05/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#1) was evaluated medically for 12 days after suffering a fall that resulted in a head injury and bruising. Review of the current FL-2 for Resident #1 dated 11/17/20 revealed: -Diagnoses included unspecified dementia, unsteadiness of feet, nutritional anemia and urinary tract infection. -She was intermittently disoriented. Review of the Resident Register for Resident #1 with admission date of 11/18/19 revealed that there was an adult protective services order for guardianship pending for the local department of social services. Review of an accident and injury report for Resident #1 dated 01/23/21 at 12:30pm revealed: -Resident #1 fell while attempting to get in her wheelchair.	D 273		

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D 273	Continued From page 1 -It was documented Resident #1 had a bump on the side of her forehead (which side of the head was not specified). -There was no documentation of vital signs on the injury report that was signed by the Administrator. Observation of Resident #1 on 02/02/21 at 11:20am revealed: -She had dark purple bruising over her right eye that extended under the right eye and down her right cheek. -She had a ping pong ball sized raised area at her right temple. Interview with the Administrator on 02/02/21 at 3:15pm revealed: -Resident #1 had fallen but she was unable to remember the date. -The Administrator had completed the injury report when Resident #1 fell. Second interview with the Administrator on 02/03/21 at 12:55pm revealed: -The primary care provider (PCP) for Resident #1 had not been notified of the fall. -She did not call emergency medical services (EMS) when Resident #1 fell. -EMS was not called because Resident #1 refused medical attention despite having a guardian. -The incident report had not been sent to the PCP office. Second interview with the Administrator on 02/03/21 at 4:00pm revealed: -There was no fall policy for staff to refer to for the facility. -She had called the office of the PCP for resident #1 but had not received a call back from them to report the fall.	D 273		

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D 273	Continued From page 2 -She did not know when she had attempted to call the PCP. -She did not know how many times she had attempted to contact the PCP for Resident #1. -Calls to Resident #1's PCP were not documented. -She should have documented that she attempted to call the PCP. Telephone interview with the Administrator on 02/04/21 at 9:00am revealed: -She spoke with the PCP's office on 02/03/21 and they would not be able to see Resident #1 until 02/09/21. -She was planning to send the resident to an urgent care office. Second telephone interview with the Administrator on 02/04/21 at 4:00pm revealed: -She was the staff member on duty who found Resident #1 after the fall. -The fall was not witnessed and Resident #1 was already in the wheelchair when she was found. -She called the nurse's line at the PCP's office for Resident #1 and asked them to call her back following the fall. -She did not leave any information regarding the fall or the injury when she left a message at the PCP's office. -Resident #1 was taken to an urgent care office on 02/04/21 between 12:30pm and 1:30pm. Telephone interview with the Administrator on 02/05/21 at 8:50am revealed: -Resident #1 was taken the emergency department of the local hospital on 02/04/21 because the wait was too long at the urgent care office. -Resident #1 remained at the hospital overnight for observation of elevated blood pressure.	D 273		

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-She did not know if Resident #1 had been admitted to the hospital.

Telephone interview with the information release staff at the local hospital on 02/05/21 at 1:50pm revealed that Resident #1 had been admitted to the hospital on 02/04/21 with an expected stay of two nights.

Telephone interview with the Program Manager at the local department of social services (DSS) on 02/04/21 revealed:
-The DSS was the legal guardian for Resident #1.
-The Administrator had reported the fall to the on-call staff at the time of the fall.
-EMS should have been called for Resident #1 at the time of the fall.
-Resident #1
should have been seen by a medical professional for follow-up.
-She had spoken with the Administrator of the facility and, due to a long wait at the urgent care office and was told that Resident #1 was taken to the emergency department at the local hospital.
-If she had been aware of the bruising, the continued knot on the head and the Administrator not hearing back from the PCP office, she would have used the personal cell number to contact the office and ensure the resident was seen by a provider.

Telephone interview with the business office manager at the PCP's office for Resident #1 on 02/04/21 at 12:35 revealed:
-The facility reported on 02/03/21 that Resident #1 had fallen.
-There had been no call from the facility regarding Resident #1 prior to 02/03/21.

Review of Resident #1's medical records from the

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D 273	Continued From page 4 Emergency Department (ED) at local hospital with the admission date of 02/04/21 revealed: -Resident #1 was seen for an unwitnessed fall and had a large hematoma on the right side of her head. -A head CT scan without contract was done on 02/04/21 at 7:31pm. -There was a CT of the cervical spine without contrast done on 02/04/21 at 7:38pm that showed no fracture. _____ The facility failed to seek medical evaluation for Resident #1 following a fall with a head injury for 12 days. The facility's failure resulted in substantial risk of neglect and physical harm to the resident which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 5, 2021 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 7, 2021.	D 273		
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	D 612		

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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 B 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 Carolina Department of Health and Human Services (NCDHHS), and Local Health Department (LHD) 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 screening of staff for signs and symptoms of COVID-19 and at least one staff who failed to isolate and continued working after testing positive for COVID-19.

The findings are:

Review of the CDC Return to Work Criteria for Healthcare Personnel dated 08/10/20 revealed healthcare personnel who are asymptomatic throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test.

Review of the CDC Duration of Isolation and Precautions for Adults with COVID-19 dated 10/19/20 revealed:
-For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days after symptom onset and

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resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms.
-For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days after the date of their first positive test for COVID-19.

Review of the NC DHHS guidance dated 09/04/20 revealed:
-Consult with the LHD and CDC guidance on management of COVID-19 positive staff.
-Staff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolation.

Review of the CDC Infection Control guidance updated 12/14/20 revealed screen everyone entering a healthcare facility for signs and symptoms of COVID-19.

1. Review of the facility's COVID-19 test results for December 2020 revealed one staff tested positive for COVID-19 on 12/18/20 and no residents tested positive for COVID-19 in December 2020.

Interview with the Administrator on 02/02/21 at 2:50pm revealed staff and residents were tested for COVID-19 about once a month and sooner if any staff or residents exhibited symptoms of COVID-19 according to guidance from the local health department.

Review of the facility's COVID-19 test results for January 2021 revealed:
-Forty-seven residents were tested in-house by rapid COVID-19 testing on 01/14/21 and all residents tested negative.
-There was no documentation of any testing for

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D 612	Continued From page 7 COVID-19 for staff on 01/14/21. -One staff tested positive for COVID-19 on 01/15/21. -A second staff tested positive for COVID-19 on 01/16/21. -A third staff tested positive for COVID-19 on 01/17/21 and one resident tested positive for COVID-19 on 01/17/21 while hospitalized. -A fourth staff and 41 residents tested positive for COVID-19 on 01/19/21 during facility-wide testing. -Another resident tested positive for COVID-19 on 01/26/21. Review of email notification from the county communicable disease nurse dated 01/15/21 at 4:28pm revealed: -The facility had 2 positive COVID-19 cases within 28 days and was determined to be in outbreak status. -Guidance was provided that all negative residents and employees needed to be tested every 7 days for 28 days and do not re-test residents or employees who had already tested positive for COVID-19. Interview with the Administrator on 02/02/21 at 2:50pm revealed: -The facility reached outbreak status for COVID-19 on 01/15/21 when the second staff tested positive for COVID-19 and she notified the local health department. -She was given guidance to begin COVID-19 testing all negative staff and employees every 7 days for 28 days. -She could not arrange for facility-wide COVID-19 testing until 01/19/21 due to availability of their facility's COVID-19 testing team. -No staff or residents had tested positive for COVID-19 between 12/18/20 and 01/15/21.	D 612		

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D 612	Continued From page 8 Review of the facility's staff COVID-19 Screening Log forms revealed: -Screening logs included documentation of staff temperature checks. -Staff were screened for and documented if they had "no symptoms, fever (100.4 F or >), cough, sore throat, shortness of breath, or other symptoms" of COVID-19. -Staff were screened if they had "been in contact with a person with a laboratory confirmed infection?". -Staff were screened if they had "traveled internationally with the last 14 days?" Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 12/18/20, there were 7 out of 14 staff clocked in for duty with no documentation of any COVID-19 screenings. Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 12/19/20, there were 8 out of 14 staff clocked in for duty with no documentation of any COVID-19 screenings. Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 12/20/20, there were 2 out of 12 staff clocked in for duty with no documentation of any COVID-19 screenings. Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 12/21/20, there were 4 out of 15 staff clocked in for duty with no documentation of any COVID-19 screenings. Review of the facility's time cards for facility staff	D 612		

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compared with the facility's staff COVID-19 Screening Log revealed on 12/22/20:
-There were 3 out of 15 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There were 5 out of 15 staff clocked in for duty were not screened for symptoms related to COVID-19.
-There were 2 out of 15 clocked in for duty who were screened for their temperatures only.

Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 01/23/21:
-There were 2 out of 8 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There was 1 out of 8 staff clocked in for duty who was not screened for symptoms related to COVID-19.

Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 01/24/21:
-There was 1 out of 8 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There were 2 out of 8 staff clocked in for duty were not screened for symptoms related to COVID-19.

Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 01/25/21:
-There were 5 out of 16 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There were 3 out of 16 staff clocked in for duty were not screened for symptoms related to COVID-19.
-There was 1 out of 16 clocked in for duty who

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was screened for their temperatures only.
-There was 1 out of 16 clocked in for duty who was not screened regarding international travel or contact with a confirmed laboratory infection.

Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 01/26/21:
-There was 5 out of 11 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There were 4 out of 11 staff clocked in for duty were not screened for symptoms related to COVID-19.

Review of the facility's time cards for facility staff compared with the facility's staff COVID-19 Screening Log revealed on 01/27/21:
-There were 6 out of 12 staff clocked in for duty with no documentation of any COVID-19 screenings.
-There was 1 out of 12 staff clocked in for duty was not screened for symptoms related to COVID-19.
-There were 2 out of 12 clocked in for duty who were screened for their temperatures only.

Interview with a medication aide (MA) on 02/03/21 at 10:31am revealed:
-Staff screened themselves for COVID-19 before the start of their shifts.
-Staff had to check their temperatures and answer the COVID screening questions for symptoms.
-She sometimes forgot to do her COVID-19 screenings when she was late for work or she did not document her COVID-19 screenings if there was no ink pen at the screening station.

Interview with a personal care aide (PCA) on

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02/03/21 at 11:06am revealed:
-He normally checked his own temperature and answered the screening questions each morning before starting his shift for COVID-19 screenings.
-He was not sure why sometimes he did not document when he screened for COVID-19 when he entered the facility.
-"There was no reason for not answering the COVID-19 screening questions or doing the temperatures" prior to the start of his shift.

Interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:56am revealed:
-He screened himself prior to starting each shift for COVID-19 and documented on the facility COVID-19 screening logs. .
-Staff were expected to take their own temperature and answer the screening questions for themselves when they did their COVID-19 screenings before the start of their shifts.
-The Administrator was responsible for ensuring staff completed the documentation of COVID-19 screenings at the start of each shift.

Telephone interview with the RCC on 02/05/21 at 12:41pm revealed:
-Staff were expected to complete COVID-19 screenings and document on the facility's COVID-19 screening log each time they entered the building, including when staff returned from a lunch break if they left the facility.
-He "assumed" the re-screening for COVID-19 only included the temperature portion.

Interview with the Administrator on 02/03/21 at 12:55pm revealed:
-She expected staff to screen themselves when entering the facility.
-Staff were expected to document their temperature and answer the screening questions

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on the COVID-19 screening log provided.
-She checked the staff screening logs weekly and was not aware staff were not completing the screening question portion on the logs.
-She was concerned that staff with symptoms coming into the facility could spread infection.

2. Review of the facility's COVID-19 staff test results revealed the Business Office Manager (BOM) tested positive for COVID-19 on 01/19/21 and results were reported on 01/20/20.

Review of the facility's time records for the BOM revealed:
-The BOM worked in the facility on 01/21/21 from 11:15am to 11:15pm.
-The BOM worked in the facility on 01/22/21 from 8:00am to 2:00pm.
-The BOM worked in the facility on 01/25/21 from 9:00am to 2:15pm.
-The BOM worked in the facility on 01/26/21 from 8:15am to 1:45pm.
-The BOM worked in the facility on 01/27/21 from 9:30am to 4:00pm.
-The BOM worked in the facility on 01/28/21 from 10:15am to 5:15pm.
-The BOM worked in the facility on 01/29/21 from 8:45am to 5:00pm.

Review of the facility's COVID-19 company policy revealed:
-This COVID-19 policy applies to all our employees who physically work in our office(s).
-If a staff had positive COVID-19 diagnosis, staff could return to the office only after had fully recovered with a physician's note confirming recovery.

Telephone interview with the county communicable disease nurse from the local

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health department (LHD) on 02/03/21 at 4:30pm revealed:
-She did not remember if she spoke directly to the Administrator about isolation regarding staff who tested positive for COVID-19.
-She provided the Administrator an email of isolation guidance when the facility went into outbreak status on 01/15/21.
-She never told the Administrator that staff did not need to isolate when they tested positive for COVID-19.
-Staff who were asymptomatic should remain on isolation for 10 days from the date they tested positive before they returned to work.
-Staff who were symptomatic should remain at home on isolation for 10 days from the onset of their symptoms and 24 hours of being symptom free before returning to work.
-The BOM should have isolated for at least 10 days after her positive COVID-19 test date.
-She never told the Administrator that BOM did not need to isolate when the BOM tested positive for COVID-19.
-The BOM should not have been in the facility during her 10-day isolation period.

Review of email notification from the county communicable disease nurse dated 01/15/21 at 4:28pm revealed:
-The facility had 2 positive COVID-19 cases within 28 days and was determined to be in outbreak status.
-Guidance was provided regarding healthcare workers duration of isolation and precautions, through the link provided: https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html.

Interview with the Administrator on 02/03/21 at 12:55pm revealed:

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	HAL025026	A. BUILDING: _____ B. WING _____	R 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSTONE	104 EFIRD BOULEVARD NEW BERN, NC 28562

(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 14 -If staff tested positive for COVID-19, staff were supposed to be out of work for isolation for 10 days from their test date and she reported the positive staff results to the county health department. -She would check her email to see if she had received any guidance from the county health department regarding when staff should return to work after they tested positive for COVID-19. -The BOM did not isolate when she tested positive for COVID-19, but the BOM only went in to COVID-19 positive residents' rooms in the facility when she worked. -Other staff did not go into the office where the BOM was working. -The BOM wore gown, gloves, masks, face shield, and booties when she left her office to go into the positive residents' rooms to get them to complete needed paperwork. Telephone interview with a personal care aide (PCA) on 02/05/21 at 3:26pm revealed: -The facility had an outbreak of COVID-19 around 01/19/20 with both residents and employees. -There were no designated halls for COVID-19 residents; only designated rooms for COVID-19 positive residents because there were so many residents who tested positive for COVID-19. -He saw the BOM in the hallways by the residents' rooms "every day that she worked during the outbreak". -He did not see the BOM go into any residents' rooms because he "was busy with resident care". -He did not know what the BOM was doing the hallways where the residents' rooms were. Telephone interview with the BOM on 02/04/21 at 10:29am revealed: -She had been the BOM since 2018 at the facility. -She tested positive for COVID-19 on 01/19/21	D 612		

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D 612	Continued From page 15	D 612		

and she was notified she was positive for COVID-19 late one night on either 01/21/21 or 01/22/21 when the Administrator called her with the results of her COVID-19.
-The Administrator did not tell her that she should not come to work and needed to isolate for 10 days.
-She was asymptomatic for COVID-19 and no one from the health department called her regarding the need to isolate after she tested positive for COVID-19.
-She still came to work and used the same entrance door and time clock as the other employees.
-She came to work already donning her gown, gloves, mask, and face shield because she knew she was COVID-19 positive.
-She worked from the business office during her entire work day after she tested positive for COVID-19.
-She did not leave the business office.
-She did paperwork for the residents and left the paperwork on the Administrator's desk in the business office so the Administrator could get the needed residents' signatures.

Telephone interview with Administrator on 02/04/21 at 4:10pm revealed:
-She notified the BOM by phone on either 01/21/21 or 01/22/21 that the BOM was positive for COVID-19.
-She was not sure of the date of notification and she did not document when she notified the BOM of the positive COVID-19 results.
-She did not tell the BOM that she could return to work or that the BOM should isolate for 10-days because of the positive COVID-19 results.
-She "was under the assumption that positive staff could work with positive residents" and the BOM wanted to work.

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D 612	Continued From page 16 -The BOM never isolated after she tested positive for COVID-19 on 01/19/21 and the BOM worked as she was scheduled. -She nor any other staff went in the business office when the BOM was the facility. -There were no designated halls for COVID-19 residents; only designated rooms for residents who tested positive for COVID-19. -The BOM went into residents' rooms after she tested positive for COVID-19. -She could not verify which residents' rooms the BOM went into because she "was too busy working as a medication aide on the medication cart". -The BOM wore gown, gloves, masks, face shield, and booties when she left her office to go into the isolated residents' rooms to get them to complete needed paperwork. -If the BOM needed paperwork completed by residents who tested negative for COVID-19, the BOM emailed the paperwork to the her and the Administrator had the paperwork completed by the negative residents. -She did not see the BOM use any of the staff bathrooms or other shared staff areas when the BOM worked after she tested positive for COVID-19. The facility failed to maintain the recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) for the screening of staff for COVID-19 and failed to ensure staff isolated for at least ten days after testing positive for COVID-19 which placed the residents at risk for increased transmission of COVID-19. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 612		

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D 612	Continued From page 17 The facility provided a plan of protection in accordance with G.S. 131D-34 on February 5, 2021. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 22, 2021	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and infection prevention and control program. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#1) was evaluated medically for 12 days after suffering a fall that resulted in a head injury and bruising. [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure	D912		

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D912	Continued From page 18 recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and Local Health Department (LHD) 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 screening of staff for signs and symptoms of COVID-19 and at least one staff who failed to isolate and continued working after testing positive for COVID-19. [Refer to Tag D0612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)].	D912		