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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation survey onsite on July 1, 2020 with a desk review survey on July 2-9, 2020 and a telephone exit on July 9, 2020.	D 000		
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 A2 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 directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors and staff, appropriate use of personal protective equipment (PPE) by staff, and infection control procedures including practicing basic hand hygiene and safety precautions to reduce the risk of transmission and infection. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in long term care (LTC) facilities revealed: -Personnel should always wear a face mask in	D 338		

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the facility.
-Face masks should not be worn under the nose or mouth.
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.
-Residents should be screened daily for fever and symptoms of COVID-19.
-Personnel should be practicing social distancing (remain six feet apart) when in common areas.
-Social distancing should be implemented among the residents.
-If COVID-19 is identified in the facility, restrict all residents to their rooms.
-Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including eye protection, gloves, gown, and a N95 respirator face mask.
-A surgical mask can be used if a N95 mask is not available.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed:
-Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19.
-All facility staff should wear a face mask while in the facility.
-Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom.
-Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared

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for by a consistent group of designated facility staff.

Review of the facility's Infection Control Policy revealed:
-All employees must wash hands prior to shift, before caring for each resident, before feeding, or before getting clean linen.
-Hands should be washed before and after each glove use.
-Wear a new pair of gloves before caring for each resident.
-Change gloves between residents, even when using blood testing devices and single use auto disabling fingerstick devices.

Telephone interview with a Registered Nurse (RN) from the local health department (LHD) on 07/07/2020 at 10:05am revealed:
-The LHD was notified by the Administrator on 06/19/20 that a facility staff had a confirmed positive test result for COVID-19.
-A nurse from the LHD emailed and called the facility regarding basic infection control guidelines, including all staff wearing masks and isolating any COVID-19 positive residents.
-She and another RN from the LHD entered the facility on 06/23/20 and tested all residents and staff (113 tests).
-She was not screened or had her temperature checked when she entered the facility on 06/23/20.
-There were 24 of 29 residents in the Special Care Unit (SCU) and 8 of 36 residents in assisted living who tested positive for COVID-19.
-There were 15 staff who tested positive for COVID-19.
-She returned to the facility on 06/29/20 and observed facility staff wearing the same PPE throughout the facility among COVID-19 positive

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and COVID-19 negative residents.
-She observed staff wearing their mask down around their chin.
-There was used PPE laying on the handrail in the hallway.
-Residents were walking down the hall and in public areas without wearing masks.
-The facility staff was not following the guidelines related to PPE.
-She did not see any PPE (masks, gowns, or face shields) in the facility that was made available to the staff until a visit to retest all negative residents and staff on 07/02/20.
-The LHD will continue to test all negative staff and residents in the facility until there are two weeks of no positive COVID-19 test results.

Interview with the Resident Care Coordinator (RCC) on 07/01/20 at 3:55 pm revealed the Administrator was sick and was not in the facility.

Discussion on 7/2/2020 at 1:31pm with the facilty Owner revealed:
- A member of the management team "is there today, holding up her head."
- The management team member had a temperature of "101" and "she has COVID, too."

1. Observation upon entrance into the facility on 07/01/20 at 2:45pm revealed:
-There was a staff member standing at the front entryway holding a thermometer, who wrote each surveyors name and temperature on a paper attached to a clipboard, but no screening questions for the virus were asked upon entry.
-The staff member standing at the front entryway was wearing a mask covering her nose and mouth but was not wearing any other PPE.
-There were boxes of PPE on the floor, including gowns, gloves, and face shields.

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-A box of masks was located on a metal cart located by the front door.
-There were 3 staff members applying PPE, including mask, gown, face shield.
-The staff members had their temperature checked upon entry into the facility but were not asked any additional questions related to COVID-19

Telephone interview with a housekeeper on 07/09/20 at 10:45am revealed staff had taken her temperature but no screening questions for the virus had been asked.

Interview on 07/01/20 at 10:15am with the Adult Home Specialist (AHS) revealed:
-Her last visit to the facility was on 06/09/20.
-Staff had taken her temperature when she entered the facility but failed to ask her any questions related to COVID-19.

Interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS) revealed:
-Her last visit to the facility was on 06/15/20.
-Staff had taken her temperature upon entering the facility.
-She could not be sure if staff asked her any screening questions.

Observation of the entryway at the front of the building on 07/01/20 between 3:30pm to 7:15pm revealed no staff member stationed at the front door to screen staff or visitors to the facility.

Refer to the telephone interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS).

Refer to the telephone interview with the facility's

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D 338	Continued From page 5 contracted Home Health nurse on 07/06/20 at 2:05pm. Refer to the telephone interview with the physician's Nurse Practitioner (NP) on 07/06/20 at 11:17am. Refer to the telephone interview with the Special Care Coordinator (SCC) on 07/08/20 at 11:23am. Refer to the telephone interview with the Resident Care Coordinator (RCC) on 07/07/20 at 11:15am. Refer to the telephone interview with the Vice-President/Owner on 07/07/20 at 10:30am. 2. Observation of the Resident Care Coordinator (RCC) and another staff member on 07/01/20 at 2:57pm enter the 200 hallway from the Special Care Unit (SCU) and exit the 200 hallway into the main hallway without changing any PPE prior to leaving the 200 hall (SCU and the 200 hallway had COVID-19 positive residents). Observation of a PCA on 07/01/20 at 3:04pm revealed: -She entered a resident's room wearing a face shield, mask, gown and gloves. -The resident in the bed by the window asked for ice water. -The PCA took the resident's personal cup, exited the resident's room, walked down the 200 hallway and proceeded to the main dining room. -Upon entering the dining room, the PCA proceeded to put ice into the resident's cup from a cooler containing ice and returned with the cup in hand to the resident on the 200 hallway. -The PCA then proceeded back to the entrance of the 200 hallway to the small round table where she changed her gloves.	D 338		

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D 338	Continued From page 6 Observation of a personal care aide (PCA) on the SCU on 07/01/20 at 3:07pm revealed: -He entered a residents room with a sign posted on the door that had printed on it "Attention after leaving room all PPE must be removed/disposed, new PPE put on in place of old, PPE located at the front door"and exited the room approximately 3 minutes later. -He removed his gown and gloves, rolled them up, and carried them in his hands as he walked down the hallway. Interview with a PCA on 07/01/20 at 3:15pm revealed: -The signs posted on some of the resident room doors were for residents that tested positive for COVID-19. -He did not know if the signs meant the residents were tested positive or negative for COVID-19. -He had removed his gown and gloves after exiting the resident room that had tested positive for COVID-19 and disposed of the gown and gloves in the trash in the dining area. -He was instructed to discard his used PPE in the trashcan under the sink in the dining area. -He had completed infection control training during his new hire orientation. Observation of a second PCA in the SCU dining area on 07/01/20 at 3:50pm revealed: -She removed her gown, rolled it up with her hands touching all parts outside of the gown, and discarded it into the trashcan under the sink. -She used her unwashed hands to pull her uniform top in a downward motion. -She used her left hand to push a folded piece of paper down into her left pocket of her uniform top. -She walked over to the sink and washed her	D 338		

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hands with soap and water.

Observation of a third PCA on the SCU on 07/01/20 at 3:50pm revealed:
-She was standing in the dining area wearing a gown, mask and face shield.
-She used her ungloved hands to remove her gown and rolled it up, touching all parts of the outside of the gown, and pushed it into the trashcan located under the sink.
-She used her unwashed hands to touch her t-shirt and pull it in an outward motion.
-She walked over to the sink and washed her hands with soap and water.

Observation of the SCU dining room on 07/01/20 at 4:50pm revealed:
-There was a counter with a sink that staff were using to wash their hands after removing their dirty PPE.
-Under the sink was a trashcan for used PPE disposal.
-There were clean plastic cups on the counter near the sink.
-There was a beverage cart containing pitchers of tea and milk next to the counter near the sink.

Interview with a PCA on the SCU on 07/01/20 at 4:55pm revealed:
-Staff had "always" used the sink to wash their hands since the virus first started in the facility.
-She was not aware the clean cups and beverage cart should not be near the sink where the staff washed their hands.

Observation of a PCA on the SCU on 07/01/20 at 5:22pm revealed:
-The PCA was in a room providing personal care to a resident that had tested positive for COVID-19.

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-The PCA was wearing a mask, face shield, gown, and gloves.
-The PCA finished providing care, removed her gloves and used hand sanitizer.
-The PCA did not remove her gown.
-She walked across the hall and entered another resident room.

Interview with the PCA assigned to the SCU on 07/01/20 at 5:26pm revealed:
-She had been trained to wash her hands and change her gown and gloves after providing care only for resident's that were positive for the virus.
-She "thought" the resident she just provided care for had been negative for COVID-19.
-She did not know who was negative or positive for COVID-19.

Interview with a second PCA on the SCU on 07/01/20 at 5:29pm revealed:
-There were not enough gowns in the SCU.
-The staff would have to call the staff on the Assisted Living side to bring more gowns.
-Sometimes it took too long for staff to bring more PPE to the SCU.

Observation of the meal service on the SCU on 07/01/20 at 5:39pm revealed:
-Meal trays were served with disposable plates, cups, and silverware and delivered to resident rooms by the PCAs.
-One PCA exited a resident room who had tested positive for COVID-19 after providing personal care, had not changed her gown, took a meal tray from the cart, and delivered it to another residents room.

Interview with the PCA on 07/01/20 at 5:39pm revealed she did not have any clean gowns on the SCU to change into and had to deliver the

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D 338	Continued From page 9 meal trays to the residents. Observation of a PCA on 07/01/20 at 6:15pm revealed: -She exited the assited living (AL) dining room and was wearing a gown, mask, gloves, and face shield. -She carried a can of disinfectant spray and sprayed her pant legs and gown. -She sat the spray can of disinfectant down on a water fountain and entered the laundry room. Interview on 07/01/20 at 4:07pm with the PCA assigned to the 200 hallway revealed: -She was newly employed with the facility. -PPE supplies were kept in boxes at the front entrance and she was responsible for keeping the supplies on the small round table on the 200 hall. -She had been instructed to remove her PPE after she had left a resident's room. -The face shields were sprayed with disinfectant and left out in the sun to dry for about 5 minutes then they were ready to be used again. -If she needed more PPE she would ask the RCC. -Residents could keep disinfectant spray in their rooms. -The signs on the door were for residents that had COVID-19. -She treated all the residents as if they were all sick. Interview with a PCA assigned to the 100 hallway on 07/01/20 at 5:21pm revealed: -She was expected to change her gown and gloves between working with each resident. -She had to change her gown and gloves and spray herself with disinfectant spray when she moved from one hallway to another and between the assisted living hallways and SCU.	D 338		

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-She used a cart to collect the soiled linens and trash.
-She rolled the cart down the hallway to collect the linens and trash.
-She had to get a biohazard bag out of the medication room if she had linens soiled with blood.

Interview on 07/01/20 at 10:15am with the Adult Home Specialist (AHS) revealed:
-Her last visit to the facility was on 06/09/20.
-She had observed some staff wearing face masks, some staff wearing a face mask over their mouth but leaving their nose exposed and some staff wearing their mask under their chin not covering their mouth or nose.
-She observed some staff with gloves on and some staff not wearing gloves.
-She discussed her concerns with the RCC on 06/09/20.
-She was informed by the RCC that the staff were to be wearing mask, gowns, gloves and goggles.
-She did not observe all the staff wearing all the appropriate PPE on her visit on 06/09/20.

Refer to the telephone interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS).

Refer to the telephone interview with the facility's contracted Home Health nurse on 07/06/20 at 2:05pm.

Refer to the telephone interview with the physician's Nurse Practitioner (NP) on 07/06/20 at 11:17am.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 07/08/20 at 11:23am.

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Refer to the telephone interview with the RCC on 07/07/20 at 11:15am.

Refer to the telephone interview with the Vice-President/Owner on 07/07/20 at 10:30am.

3. Observation of the Special Care Unit (SCU) on 07/01/20 at 3:05pm revealed there was no hand sanitizer available for use.

Interview with a Personal Care Aide (PCA) on the SCU on 07/01/20 at 3:06pm revealed:
-There was no hand sanitizer available in the SCU.
-There had been a bottle of hand sanitizer at 10:00am on the counter in the dining room.
-She did not know where the hand sanitizer was at.
-They were instructed to call the MA if they required more hand sanitizer because it was locked in the medication room.
-She had not called the MA for more hand sanitizer.

Observation of a PCA on the SCU on 07/01/20 at 3:07pm revealed:
-The PCA assisted a resident who had tested positive for COVID-19 into bed.
-The PCA wore a mask, face shield, and a gown.
-The PCA was not wearing gloves.
-The PCA left the resident's room and pushed a wheelchair from the room into the bathroom across the hall.
-The PCA did not use hand sanitizer or wash her hands with soap and water.

Interview with the PCA on the SCU on 07/01/20 at 3:10pm revealed:
-She had taken the wheelchair into the bathroom to disinfect it.

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-She had been trained to wear gloves and wash her hands or use hand sanitizer after assisting residents.
-She had forgotten to wash her hands.

Observation of a second PCA on the SCU on 07/01/20 at 3:20pm revealed:
-She exited a residents room, did not remove any PPE, walked down the hallway, and entered another residents room.
-She exited the second residents room, walked to the dining area, removed her gloves and discarded them into the trash.
-She did not wash her hands or use hand sanitizer before she applied new gloves.
-She walked to the far side of the dining room, picked up linens from a rolling cart, walked down the hall and entered another residents room.

Interview with the second PCA on the SCU on 07/01/20 at 3:30pm revealed:
-When asked how often staff changed their gloves or washed their hands she said, "We are supposed to when going from room to room, but sometimes we can't" and they are "too busy".
-She "tried" to wash her hands as often as possible.
-She washed her hands after exiting a resident room before entering another resident room "most of the time".
-She did not wash her hands or change gloves when she exited the first residents room and entered the second residents room because she was "in a hurry".

Observation of a third PCA on the SCU on 07/01/20 at 3:30pm revealed:
-The PCA assisted a resident who had tested positive for COVID-19 into her room.
-The PCA had touched the resident's shoulders

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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
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and arms when escorting her to her room.
-The PCA was wearing a mask, face shield, gown, and gloves.
-The PCA exited the resident's room and walked into the dining room.
-The PCA, without removing her gloves, opened a new box of face masks and attempted to remove a face mask.

Interview with the PCA on the SCU on 07/01/20 at 3:41pm revealed:
-She had forgotten to remove her gloves and wash her hands before opening the box of masks.
-She had received training after the outbreak of COVID-19 in the facility about "one month ago".
-The RCC and the Administrator had given the training.
-She had been taught to do frequent hand washing, wear a mask, face shield, gown, and gloves.
-She had been taught to change her gloves and gown between residents.

Observation of the Resident Care Coordinator (RCC) passing medications on the 100 hallway on 07/01/20 at 4:45pm revealed:
-The RCC did not change gloves between residents while checking fingerstick blood sugars (FSBS).
-Several gloves were available on the medication cart in the storage unit attached to the side of the cart.
-She rolled the same medication cart from the 100 hallway through the entryway and through the double doors separating the 200 hallway from the entryway.
-She did not clean the medication cart before moving throughout the facility
-She did not change her gown, mask, or gloves

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D 338	Continued From page 14 before moving throughout the facility. Interview with the RCC on 07/01/20 at 4:51pm revealed: -She knew she was supposed to change gloves between residents when checking their FSBS. -She had put on a new pair of gloves in the medication room before coming to administer medications and check FSBS. -She did not change her gloves because the gloves available on the cart did not fit. -She needed to get a different size of gloves and put them on the cart. -She "always changes gloves" when entering a different hallway of the facility. Refer to the telephone interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS). Refer to the telephone interview with the facility's contracted Home Health nurse on 07/06/20 at 2:05pm. Refer to the telephone interview with the physician's Nurse Practitioner (NP) on 07/06/20 at 11:17am. Refer to the telephone interview with the Special Care Coordinator (SCC) on 07/08/20 at 11:23am. Refer to the telephone interview with the RCC on 07/07/20 at 11:15am. Refer to the telephone interview with the Vice-President/Owner on 07/07/20 at 10:30am. 4. Observation of the Special Care Unit (SCU) on 07/01/20 between 3:00pm to 5:30pm revealed there were no staff cleaning.	D 338		

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D 338	Continued From page 15 Observation of the SCU on 07/01/20 at 3:06pm revealed: -There was a sign on the door of one resident room. -Printed on the sign was "Attention after leaving room all PPE (personal protective equipment) must be removed/disposed, new PPE put on in place of old, PPE located at the front door". Interview with a PCA on the SCU on 07/01/20 at 3:14pm revealed: -The signs had been on the doors of rooms with residents that were positive for COVID-19. -The signs had been taken down by management on 06/30/20 and put on the doors of rooms with residents that did not have the virus. -She did not know why the signs had been changed. -It was confusing to know if the residents were positive or negative for COVID-19. Interview with a second PCA on the SCU on 07/01/20 at 3:15pm revealed the signs were on the doors of resident rooms that were positive for the virus. Interview with the Resident Care Coordinator (RCC) on 07/01/20 at 3:17pm revealed: -The signs should be on the door of rooms with residents that were negative for the virus. -She had changed the signs on 06/30/20 because the owner had instructed her to. Observation on 07/01/20 at at 3:17pm of the front entryway connecting the 100 hallway to the 200 hallway and the dining area revealed: -A resident in a wheelchair came through the closed double doors from the 200 hallway (where COVID-19 positive residents were located) and	D 338		

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entered the dining room wearing a mask down below his chin with his nose and mouth exposed.
-Another resident followed the first resident out of the same doorway from the dining room with no mask and continued down the 100 hallway (COVID-19 negative only residents).

Observation on 07/01/20 at 4:29pm of the front entryway connecting the 100 hallway to the 200 hallway and the dining area revealed another resident entered the entryway from the 200 hallway and continued through the dining room to the smoking area without wearing a face mask.

Interview with the Activities Director on 07/01/20 at 3:23pm revealed:
-All the residents smoke in the same area.
-The smoking area should be sprayed with disinfectant after each resident.
-The residents from the 100 hallway were not allowed on other hallways in the facility where there were COVID-19 positive residents.

Interview with a PCA assigned to the 100 hallway on 07/01/20 at 3:40pm revealed:
-The smoking area used by the residents was located through the dining room.
-The facility only had one smoking area for the residents to use.
-Residents that were COVID-19 positive and negative used the same smoking area.
-The residents had to be separated by at least 6 feet in the smoking area.
-She was responsible for monitoring the smoking area to make sure no more than three residents were in the smoking area at one time.
-All residents should be wearing a mask when walking to and from the smoking area.

Observation on 07/01/20 at 5:28pm of a resident

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coming out of his room revealed:
-He had a mask on and went to the main hallway water fountain to get a drink of water.
-The resident took his mask off to drink water from the fountain.
-The resident did not place the mask back on after he finished drinking water.
-A staff member standing nearby in the dinning room yelled out for him to put his mask back on.
-The resident did not put his mask back on and returned to his room.
-There was no observation of staff cleaning the water fountain after the resident used it.

Interview on 07/01/20 at 5:39pm with a PCA revealed:
-Anyone in the facility could use the water fountain if they wanted something to drink.
-She was not responsible for cleaning the water fountain.
-She did not know who was responsible for cleaning the water fountain.

Telephone interview with a representative from the facility's contracted cleaning company on 07/08/20 at 10:01am revealed:
-The facility had contacted them to do a deep cleaning treatment on 05/12/20, 06/18/20, 06/21/20, and 06/24/20.
-They were told to enter the facility through the back door.
-A staff member checked the temperature of the technician, but she did not know if any screening questions were asked to the technician.
-The technician used an electrostatic sprayer to spray cleaning disinfectant in all resident rooms, bathrooms, hallways, kitchen, door knobs, hand rails, and water fountains.
-The cleaning disinfectant used killed bacteria and viruses.

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-They gave the facility four-gallon sized buckets and 12 packets of disinfectant to mix with water that would make 12 gallons of disinfectant.
-The disinfectant provided to the facility had to be mixed as needed because it had a 14-day shelf life.

Refer to the telephone interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS).

Refer to the telephone interview with the facility's contracted Home Health nurse on 07/06/20 at 2:05pm.

Refer to the telephone interview with the physician's Nurse Practitioner (NP) on 07/06/20 at 11:17am.

Refer to the telephone interview with the Special Care Coordinator (SCC) on 07/08/20 at 11:23am.

Refer to the telephone interview with the Resident Care Coordinator (RCC) on 07/07/20 at 11:15am.

Refer to the telephone interview with the Vice-President/Owner on 07/07/20 at 10:30am.

_____

Telephone interview on 07/08/20 at 2:16pm with the Licensed Health Professional Support Nurse (LHPS) revealed:
-Her last visit to the facility was on 06/15/20.
-The Administrator was responsible for letting her know when the facility needed a training.
-On 6/22/20, the Administrator called her and informed her not to come to the facility as they had 2 confirmed cases of COVID-19.
-She had no concerns about staff wearing their PPE during her 06/15/20 visit.
-She was responsible for teaching the annual

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infection control and PCA training.
-She used the infection control information in the certified nursing assistant book, from the local college, to teach the facility staff.
-She had not provided an infection control in-service this year.
-She had received a telephone call from the owner on 07/02/20 or 07/03/20 about providing a PPE and infection control in-service but later informed the in-service would be provided by the local health department.
-There were no plans currently for her to provide any trainings or assessments.

Telephone interview with the facility's contracted Home Health nurse on 07/06/20 at 2:05pm revealed:
-She provided care to some of the residents at the facility every Monday, Wednesday, and Friday.
-She last visited the facility on 07/06/20.
-The facility checked her temperature and asked her a couple of screening questions upon entry.
-Staff wore PPE but "I know they aren't changing PPE for every room".
-She had provided education to a PCA previously when she saw the PCA not change her gloves between personal care of residents during the quarantine.
-She had noticed "in the last week or so, everyone started changing PPE pretty regularly".
-The facility had placed signs on the doors of resident rooms to distinguish who had tested positive or negative for the COVID-19.

Telephone interview with the physician's Nurse Practitioner (NP) on 07/06/20 at 11:17am revealed:
-The facility had not been allowing visitors since the outbreak.

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D 338	Continued From page 20 -She had not been in the facility since the outbreak and her telehealth visits were in the process of being setup. -The staff were wearing masks and gowns before the outbreak of COVID-19. -Staff were now wearing N95 masks, gowns, face shields, and gloves. -There were 90% of the residents in the facility who were positive for COVID-19 but were without symptoms. -Staff should be following the CDC guidelines which would decrease the risk of the virus spreading to other residents. Telephone interview with the Special Care Coordinator (SCC) on 07/08/20 at 11:23am revealed: -The residents on the SCU were quarantined to their rooms after the facility's first case of COVID-19. -The facility had attempted to separate residents that were negative and positive that shared a room, but the residents did not want to move. -The Administrator had given training to staff after the first case of COVID-19 at the facility. -The staff were to change all their PPE after leaving a resident's room. -Housekeeping staff cleaned the SCU daily and the care staff was to clean on the second and third shifts. -The dirty PPE should have been disposed of in a cart which the staff left outside of the resident room. -When the supply of PPE was low on the SCU staff was instructed to call staff on the AL for more. -When the supply of hand sanitizer was low, staff were instructed to call the MA. -The signs on the resident room doors meant a resident was positive for the virus.	D 338		

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D 338	Continued From page 21 -Staff should not have used the sink in the dining room to wash their hands. -Staff should have been using the sinks in the bathrooms. -Residents in the SCU did not use the water fountain. -The water fountain had been cleaned daily. Telephone interview with the Resident Care Coordinator (RCC) on 07/07/20 at 11:15am revealed: -She had received additional infection control training from the Administrator since the pandemic started. -The additional infection control training included how to put on and take off PPE correctly, when to put on and take off PPE, and when to wash hands. -PPE did not have to be changed when going from a room that tested positive for COVID-19 to another room that had tested positive for COVID-19. -PPE was to be changed when going from a virus positive room to a virus negative room. -The facility had designated the laundry room to remove old PPE and new PPE was to be applied in the break room on the SCU or the locker room on the AL side. -She and the MAs monitored staff and made sure they followed guidelines regarding wearing and changing PPE appropriately. -The facility had "plenty" of PPE supplies. -She or the Owner delivered PPE supplies to the SCU and made sure "they have plenty of it". -Staff had a new system in place to open clean PPE supplies and had been trained to remove gloves, wash or sanitize hands, apply clean gloves, and then open new PPE supplies so they were not contaminated. -The Administrator had previously trained	D 338		

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employees how to open new PPE supplies.
-She did not know why a PCA on the SCU did not change her gloves and contaminated a new box of face mask she opened after she had touched a resident who tested positive for COVID-19.
-All residents were provided a mask to wear by the facility.
-Residents are being monitored every shift for temperature, pulse, oxygen and blood pressure who had tested negative for the COVID-19.
-Staff were monitored by completing a questionnaire upon arrival for their shift and temperature was checked and recorded on a log.
-Residents who had tested positive were isolated from residents who tested negative.
-The facility encouraged residents to stay in their room with the door closed, but some residents opened the doors.
-Signs were posted on the doors of residents that had tested positive for COVID-19.
-She worked as the second shift MA on 07/01/20 and knew she was supposed to change gloves between residents when she checked finger stick blood sugars (FSBS) "but I didn't".
-The facility's policy was for the MA to change gloves between residents when FSBS were checked.
-The facility had contracted a cleaning company who performed several deep cleaning treatments at the facility.

Telephone interview with the Vice-President/Owner on 07/07/20 at 10:30am revealed:
-The Administrator was not available for an interview.
-He was currently the "acting Administrator" for the facility.
-All facility staff completed infection control training upon hire which was completed by a

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D 338	Continued From page 23 Nurse Consultant. -He conducted a staff wide meeting after the pandemic had started to educate the staff on the signs and symptoms of COVID-19 and discussed what they could expect in the facility. -Also, he met with the residents and discussed the same information. -He was not sure if the Administrator had completed any additional training after the facility had an outbreak. -The facility had kept a good supply of PPE since the beginning of the pandemic, including gown, gloves, masks, and face shields. -The PPE was stored in the Administrator's office and he and the RCC were responsible for making sure it was available to the staff and residents. -The staff should be wearing masks appropriately the entire time they are in the facility. -He had distributed masks to the residents after the first COVID-19 positive case was identified. -The staff did not have to change any of their PPE when moving from a COVID-19 positive resident's room to another COVID-19 positive resident's room. -He was not sure where the staff were supposed to dispose of soiled PPE. -They were sanitizing and reusing the face shields. -The facility staff should be entering the facility through the front door and having their temperatures checked. -A staff member should be monitoring the front door to screen all staff and visitors. -The screening questions included asking if the staff or visitor had any symptoms of COVID-19, traveled in the last 14 days, and had contact with a COVID-19 positive individual. -The LHD had recommended isolating the residents that were COVID-19 positive but some residents had refused to move.	D 338		

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D 338	Continued From page 24 -The staff were asking the COVID-19 positive residents to keep their doors shut and to stay in their rooms but they could not make the residents do either of these. -The facility had one medication cart for the assisted living and one medication cart for the SCU but they only had one cart that was used to check fingerstick blood sugars (FSBS). -The cart used to check FSBS was stored in the SCU and used throughout the facility. -He had not realized he needed to monitor the use of the water fountain in the common areas. -The housekeepers were responsible for sanitizing and cleaning the facility, including washing handrails daily and emptying the trash. -He had an outside cleaning company come and spray the facility. -The cleaning company had sprayed and sanitized the water fountain. -The RCC and the SCU Coordinator were responsible for making sure the staff was wearing the PPE correctly. _____ The facility failed to ensure staff were following infection control guidelines during a viral pandemic related to the screening of visitors and staff, appropriate use of personal protective equipment (PPE) by staff, and infection control procedures including practicing basic hand hygiene and safety precautions to reduce the risk of transmission and infection which placed the residents at risk of contracting a serious viral illness constitutes a Type A2 violation. _____ The facility was given a directed plan of protection on 07/02/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 8,	D 338		

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D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided the necessary care and services to maintain their physical health as related to resident rights. Based on observations, 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 directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors and staff, appropriate use of personal protective equipment (PPE) by staff, and infection control procedures including practicing basic hand hygiene and safety precautions to reduce the risk of transmission and infection[Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D914		