| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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<br><br>The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with an onsite visit on July 15, 2020 and a desk review survey July 15, 2020 to July 16, 2020 and a telephone exit on July 16, 2020. | D 000 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>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.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure all residents were free from neglect related to infection control during a global, viral pandemic.<br><br>The findings are:<br><br>Observation at the main entrance of the facility on 07/15/20 at 9:05am revealed:<br>-There was a sign posted on the door notifying visitors of current visitation restrictions.<br>-A Personal Care Aide (PCA) opened the door.<br>-The PCA was not wearing a mask.<br>-The PCA did not request temperature checks nor inquire about the presence of COVID-19 symptoms.<br>-The PCA left the front entrance room to inform the Administrator of the survey teams' arrival.<br>-The PCA returned, still unmasked, and directed the survey team to the Administrator's office.<br><br>Observation at the main entrance of the facility on | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 1<br><br>07/15/20 at 9:07am revealed:<br>-A Medication Aide (MA) came to the entrance at the request of the PCA who had answered the door.<br>-The MA was not wearing a mask.<br><br>Observation of the Administrator and the Administrator In Charge (AIC) on 07/15/20 at 9:08am revealed:<br>-The Administrator was not wearing a mask when she opened the office door and greeted the surveyors.<br>-The AIC was not wearing a mask initially but put one on upon the surveyors entry into the office.<br>-The Administrator nor the AIC requested temperature checks or inquired about the presence of COVID-19 symptoms for the survey team.<br><br>Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the COVID-19 in long term care facilities revealed:<br>-Personnel should wear a face mask at all times while in the facility.<br>-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.<br>-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.<br>-Residents should be screened daily for fever and symptoms of COVID-19.<br>-All personnel should practice social distancing (remain at least six feet apart) when in common areas.<br>-Implement social distancing among residents.<br><br>Review of the North Carolina Department of Health and Human Services (NCDHHS) guidance for the prevention and spread of COVID-19 in | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 2 | D 338 | | |

long term care facilities revealed all staff should wear a face covering while in the facility, and those face coverings must be surgical masks, as long as surgical mask supplies are available.

Review of facility documentation related to infection control training and COVID-19 training revealed:
-Nine employees received the state approved infection control training by the home health nurse on 05/21/20.
-Nine employees received the state approved infection control training by the home health nurse on 05/28/20.
-Two employees had completed the state required COVID-19 webinar training.

Observation on the hallway leading to the Administrator's office on 07/15/20 at 9:30am revealed there was an opened box of gloves placed on a handrail at the start of the hallway for staff use.

Observations in the living room on 07/15/20 at 9:13am revealed:
-There were three residents watching television.
-There was a PCA seated in the living room.
-The PCA was not wearing a mask.
-Two residents sat in chairs side by side and were not socially distanced at least 6 ft. apart.
-The third resident was sitting socially distanced with at least 6 ft. from the other residents and PCA.
-None of the residents were wearing masks.

Observation of a PCA exiting a resident room on 07/15/20 at 9:12am revealed the PCA was not wearing a mask.

Interview with one PCA on 07/15/20 at 9:26am

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 3<br>revealed:<br>-Her job responsibilities included providing personal care assistance to residents.<br>-She did not receive temperature checks at the start of each shift.<br>-She was not asked COVID-19 screening questions at the start of each shift.<br>-Gloves were readily accessible for her use.<br>- "As far as I know" the facility had a supply of masks available.<br>-She had received training on the use of personal protective equipment.<br>-Residents continued to receive their meals in the dining room seated 6 ft. apart from other residents.<br>-To accommodate all the residents, they had two separate meal times to ensure social distancing in the dining room.<br><br>Interview with a second PCA on 07/15/20 at 9:35am revealed:<br>-Her job responsibilities included providing personal care assistance to residents.<br>-She was being checked "some" for symptoms of COVID-19 when she came to work.<br>-She also self-monitored for symptoms of COVID-19.<br>-The facility had masks, gloves, and gowns available for staff use.<br>-Handwashing, using hand sanitizer, and wearing masks were ways to prevent the spread of infection in the facility.<br>-The facility was currently restricting visitation to the facility.<br>-Currently outside health care providers who still made in-person visits in the facility included a Home Health Nurse (HHN), a Physical Therapist (PT), a podiatrist, and a Nurse Practitioner (NP) who was the primary care provider for most of the residents. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 4<br>-For meals, residents were seated in the dining room, two residents per table, to ensure social distancing.<br>-All staff wore gloves to serve meals and to provide healthcare to residents.<br>-Residents were quarantined upon return to the facility for 14 days if they had to go out of the facility for any reason.<br>-Residents were not asked to wear masks unless they had to go out of the facility.<br><br>Observations in the dining room on 07/15/20 at 9:15am revealed:<br>-The Activity Director (AD) was leading a Bible study.<br>-The AD was not wearing a mask.<br>-There were six residents who participated.<br>-None of the residents were wearing masks.<br>-The AD was seated at a 4 ft. by 4 ft. table with only the table width separating her from the resident who sat across from her.<br>-There were two additional 4 ft. by 4 ft. tables with two residents seated per table separated in distance by the width of the table.<br><br>Observations in the facility kitchen on 07/15/20 from 9:44am to 9:50am revealed:<br>-The Cook was in the kitchen preparing lunch.<br>-She was not wearing a mask.<br><br>Interview with the Cook on 07/15/20 at 9:45am revealed:<br>-She did not receive temperature checks at the start of each shift.<br>-She was not asked COVID-19 screening questions at the start of each shift.<br>-Staff were not required to wear masks.<br>-Residents were not required to wear masks.<br>-She had received infection control training "a month or two ago." | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 5<br>-Residents were seated two residents per table now for meals instead of four residents per table for meals.<br>-There were now two meal times for residents to ensure social distancing.<br><br>Observations of a MA on 07/15/2020 at 9:23am revealed:<br>-She was in the Administrator's office and was not wearing a mask.<br>-The Administrator asked her to put on a mask if she was going to speak with a surveyor.<br>-The MA and the AIC walked down the hall to a locked closet to retrieve a mask for her to wear.<br><br>Interview with a MA on 07/15/20 at 9:25am revealed:<br>-All staff were trained in infection control once a year, but MA's received it twice a year.<br>-The facility had a limited supply of Personal Protective Equipment (PPE) in March 2020 but they had enough "now".<br>-All staff had been instructed to do the state mandated COVID-19 training and she had already completed it.<br>-She did not wear a mask when she was in the medication room by herself, but she wore one whenever she left the room.<br>-Staff had their temperature checked and were screened for COVID-19 at the beginning of their shift.<br>-She was not sure which staff member was responsible for screening staff when they reported for their shift, because she reported to work later than the other staff.<br>-Outside medical personnel had been limited to the NP, HHN, hospice and PT.<br>-All outside medical personnel were screened and had temperature checks when they visited, before they saw residents. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 6<br>-All outside medical personnel came to this facility as their first visit of the day to reduce any risk of infection and they wore a mask when they were with residents.<br>-Residents were not routinely screened for COVID-19.<br>-She did not screen residents because she knew the residents "so well" and could tell when they were sick by a change in mood, skin coloring or the development of a new cough.<br>-Residents only recently started going to outside medical appointments and when they did they had to wear a mask.<br>-No visitors were allowed, and all family talked with residents through the window in an effort to reduce the risk of infection.<br>-Meals were served in 2 shifts and residents were limited to 2 to a table, opposite each other.<br>-Activities were conducted in such a way that residents were limited to 2 at a table and spaced far apart.<br>-No staff had gone home sick since the start of the pandemic, but if they had the staff would be required to get tested and residents would be quarantined until test results were known.<br>-The home health nurse had recently conducted infection control training with all the staff.<br><br>Observation of the Activity Director in the dining room on 07/15/20 at 10:09am revealed she was not wearing a mask.<br><br>Interview with the Activity Director on 07/15/20 at 10:10am revealed:<br>-She did not receive temperature checks at the start of each shift.<br>-She was not asked COVID-19 screening questions at the start of each shift.<br>-Staff were not required to wear masks. | D 338 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 7 | D 338 | | |

Interview with a resident on 07/15/20 at 9:10am revealed:
-Some staff wore a mask, and some did not.
-Residents did not have to wear a mask unless they left the facility.
-Her temperature was taken about 2 times per month.
-Residents ate in 2 different shifts and there were only 2 residents at each table.

Interview with a second resident on 07/15/20 at 9:14am revealed:
-He was only required to wear a mask if he left the building.
-His temperature was taken monthly.
-He had not seen a mask on any staff.
-Meals were served and activities were conducted with 2 residents at each table.

Interview with a third resident on 07/15/20 at 9:18am revealed:
-Her temperature was taken monthly.
-Meals were served and activities were conducted with 2 residents at each table.
-Staff wore masks occasionally.

Interview with a fourth resident on 07/15/20 at 9:20am revealed:
-Staff were not routinely wearing masks.
- "Nobody's been sick here yet. We've been lucky."

Interview with a fifth resident on 07/15/20 at 9:57am revealed:
-The resident was not being screened for symptoms of COVID-19 or having their temperature checked.
-A HHN came in recently to draw blood for labs and did not wear a mask.
-Residents were required to wear masks when

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 8 | D 338 | | |

they went outside the facility for any reason.

Interview with a sixth resident on 07/15/20 at 10:40am revealed:
-He had blood drawn recently by a Home Health Nurse.
-The nurse had not worn a mask.

Interview with a seventh resident on 07/15/20 at 10:40am revealed:
-She had physical therapy twice a week.
-The physical therapist did not wear a mask.
-She had bloodwork, oxygen levels and blood pressure taken by the home health nurse 2 weeks ago.
-The home health nurse did not wear a mask.

Interview with the Administrator and the AIC on 07/15/20 at 9:43am revealed:
-PPE was difficult to obtain initially but they had access to it now.
-Staff were not required to wear a mask.
-The facility did not have a policy related to infection control because they did not know what would need to be put in a policy for infection control.
-The HHN, who was a registered nurse, had conducted infection control training for all staff, using the infection control manual as a guide.
-If a resident had to leave the facility for some reason, when they returned, they were quarantined for 5 days and they had temperature checks twice a day.
-Staff were not screened when they reported to work because they self-monitored and knew not come to work if they were sick.
-Staff are "all like one big family and know not to go anywhere when they leave here".
-She did not have documentation of the screenings conducted on the healthcare visitors

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 9 | D 338 | | |

that came to the facility.
-No resident had contracted COVID-19, but if they did, the facility would contact the county health department and the facility's NP and follow their instructions.
-All dining was done in 2 shifts, with 2 residents to a table.
-No outsiders could participate in any activities.

Observation of the facility's mask supply in a locked hall closet on 07/15/20 at 10:29am revealed:
-There were two boxes of 50 disposable masks.
-There was one bag of 30 disposable masks.
-There was one box of 20 N95 masks.

Interview with the AIC on 07/15/20 at 10:29 am revealed:
-She kept "plenty" of PPE available and ordered it on an as needed basis when she saw supply was getting low.
-The facility had a box of supplies in an out-building that contained all the PPE they received from the National Guard.
-The National Guard supplied the facility with face shields, shoe coverings, mask, gloves and gowns.

Telephone interview with a Housekeeper on 07/15/20 at 3:48pm revealed:
-She had worked at the facility as a housekeeper since December 2019.
-They had not been checking her temperature or asking her questions to screen for COVID-19 until "today."
-Staff had not been required to wear masks before "today."

Telephone interview with the facility's NP on 07/15/20 at 4:09pm revealed:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 10 | D 338 | | |

-She went to the facility every Monday.
-The facility did not do any type of screening on her upon entry into the facility.
-The number of residents she saw each week varied based on the needs of the facility.
-She saw residents in their room.
-She wore a mask while in the facility.
-She saw some staff wear masks about half the time.
-Residents did not wear masks.

Telephone interview with a HHN on 07/16/20 at 8:02am revealed:
-She went to the facility 3 to 4 times a week.
-She always went to the facility first thing in the morning.
-She recently conducted infection control training related to COVID-19 with staff.
-Staff screened her for COVID-19 symptoms and took her temperature when she entered the facility.
-She wore a mask when she was in the facility.
-She had not seen staff or residents wear a mask when she was at the facility.
-Staff started keeping a screening log and wearing a mask as of today (07/16/2020).

Telephone interview with a PT on 07/16/20 at 8:10am revealed:
-He went to the facility 2 times a week.
-Staff screened him for COVID-19 symptoms and took his temperature when he entered the facility.
-He wore a mask when he was in the facility.
-Staff wore a mask "most of the time".
-He required residents wear a mask during treatment.

Telephone interview with a hospice nurse on 07/16/20 at 9:20am revealed:
-She went to the facility once a week, either late

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 338 | Continued From page 11<br>morning or right after lunch.<br>-The facility did not do any type of screening on her upon entry into the facility.<br>-She wore a mask when she was in the facility.<br>-Masks were worn by staff but not by residents.<br><br>_____<br>The facility failed to ensure staff were following infection control guidelines during a global, viral pandemic including wearing facial masks, screening visitors for the presence of illness or symptoms, and following social distancing in the facility with 26 residents which placed the residents at risk of contracting a serious viral illness. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a plan of protection on 07/15/20 in accordance with G.S. 131D-34 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020. | D 338 | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure residents received care and services which were adequate, and in compliance with relevant federal and state laws and rules and | D914 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL014015 | A. BUILDING: _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRANDVIEW VILLA ASSISTED LIVING | 2544 GRANDVIEW CIRCLE SW LENOIR, NC 28645 |

| (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 12<br>regulations related to Resident Rights.<br><br>The findings are:<br><br>Based on observations and interviews, the facility failed to ensure all residents were free from neglect related to infection control during a global, viral pandemic. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. | D914 | | |