PRINT	ED: 0	B/11/20	20
FO	RMA	PPROV	E

SIALEMEN	of Health Service Reg					PRINTED: 08/11 FORM APPR
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL061008		B. WING_		
NAME OF P	PROVIDER OR SUPPLIER	QTD	FET AD		0.74.74	07/31/2020
B&LFAN	MILY CARE HOME	842	CANE	CREEK RO	STATE, ZIP CODE	
		BAH	ERS	ILLE, NC 2	8705	
(X4) ID PREFIX	SUMMARY ST (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		ID		
TAG	TEOGRATORY OR	LSC IDENTIFYING INFORMATION)		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	10111000
C 000	Initial Comments			C 000		
	The Adult Care Licens	sure Section conducted a	100			Aug I
	COVID-19 focused In	fection Control our investigation				
ĺ	all offsite visit on July	29, 2020 and a desk review 20 to July 31, 2020 and a			ALL CONCERNS	
	telephone exit on July	31, 2020.	147		SURVEYORS WE	RE
C 311	10A NCAC 13G .0909	Residents' Rights		C 311	CORRECTED IMMEDIA	ATELY
	10A NCAC 13G .0909	Posidont Di-Li			FOLLOWING THE C	MPLETTON
1 1	A family care home shi	all assure that the rights at			OF THE SURVEY	1
1.5	an residents guarantee	ed under G.S. 131D 21				
1.	Declaration of Residen	its' Rights are maintained				ļ
	and may be exercised	without hindrance.				
-	This Rule is not met as TYPE A2 VIOLATION	s evidenced by:				
	Based on observations	manual				
111	nierviews, the facility fa	ailed to ensure				
re	ecommendations and	Ouidance established by				
U	ne Centers for Disease	Control (CDC) the Next				
0	Carolina Department of Services (NCDHHS), ar	nd directives from the				
10	cal nealth department	(LHD) were implemented			The Administrates	
and maintained to provide protection of tresidents during the global coronavirus		de protection of the			The Administrator is resp	onsible for
10	esidents during the glo	bal coronavirus as related to appropriate			monitoring the facility dai following gidelines are be	iy to make sure t
30	creening of visitors and	Staff lise of perconal	1		staff and residents. 8/27/	and rollowed by t
hi	rotective equipment (P	PE) by staff and			201001113. 0/2//	PH
re	esidents following socia	distancing guidelines.				,91
Th	he findings are:				EFFECTIVE IMMEDIA	a TTT N 4
Re	eview of the Center for	Disease Control (CDC)			LITECTIVE IMMEDIA	י לישות
1 90	delines for the preven	tion and spread of the				
00	ionavirus in long term	care (LTC) facilities			MASKS ARE WORN	
16	vealed:				WHEN STAFF IS IN	
i -ri	ersonnei should alway e facility.	s wear a face mask in			CLOSE PROXIMITY TO	i i
	Service Regulation			1	LANGE CONTRACTOR OF THE PROPERTY OF THE PROPER	

STATE FORM

Division	of Health Service Regi	ulation			PRINTED: 08/11/2
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			FORM APPROV
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY
			A BUILDIN	IG:	COMPLETED
	375 A W	1	1		
		FCL061008	B. MNG		l
NAME OF	PROVIDER OR SUPPLIER	STREET	T ADDDESS		07/31/2020
BRIFA	MILY CARE HOME	240	ET ADDRESS, CITY,	STATE, ZIP GODE	
DULIA	MILT CARE HOME	842 0	ANE CREEK RO	AD	
(X4) ID	SHAMADVET	BAKE	RSVILLE, NC 28	3705	
PREFIX	(CAGO DEPICIENT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID .	PROVIDER'S PLAN OF CO	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	CONCH CORRECTIVE ACTIO	M CHOULD DO
		,	TAG	CROSS-REFERENCED TO THE	APPROPRIATE DATE
C 311	Continued From page	1		DEFICIENCY)	
	177 50705	The state of the s	C 311		
	-Face masks should n	ot be wom under the nose	1	*	
	or mouth.				nous
	-All essential visitors s	hould be screened for the	- 1		AUG.
	presence of rever and	Symptoms of the vinus		DZIDIZ	
	when enrelled me phil	ding		RESIDENTS HAD	NO VISITIONS
	-Personnel should be s	screened for fever and		WITH THE GOVERN	Ø e
ĺ	symptoms of COVID-1	9 before starting each			
	Start.			IMPLEMENTED PAGE	2 -
	-Residents should be s	creened daily for fever and			
	Symptoms of COVID-1	9.	Ì	ONLY ONE RESIL	Palt
1	-Personnel should be p	practicing social distancing	1		
	(icitiali) six leet apart) (when in common areas	ł	HAD A VISTOR-	HER
	the residents.	ild be implemented among	1	DAUGHTER- WHO	
1	the residents.	-		1 .	0.000
	Posion of the At a -	_		BEEN ISOLATING	AND
	Review of the North Ca	rolina Department of			
	Health and Human Sen	vices (NCDHHS) for		HAD NOT BEEN B	u
	facilities revealed:	of the coronavirus in LTC		OF THE COUNTY	. 1
			1	OF THE COUNTY	
1	the facility.	vear a face mask while in			1
				PERM	
١,	signs and symptoms of	ould be screened daily for		RESIDENTS ARE S	CRETATES
1 -	All essential visitors sho	COVID-19.		DAUL OF	T-COS C.S
s	signs and symptoms of (COVID 40		DAILY AS 15 571	FF (2)
6	intering the building.	COVID-19 before	-	TEMPERATURES AR	
-	Social distancing should	be implemented among		ICMVERDIURES PP	E
t	he residents to include of	Communal dining	1	CHECKED EACH A	
1			1 1	EACH A	ORNING AUD
R	leview of the facility's In	fection Control Police		HOGGED .	- THE
110	sceived on 07/30/20 rev	ealed:	1	FACILITY HAS CL	Act CTB
-	Staff and residents shou	d be screened daily to		TO MAS CA	SED
	isule they are tree of si	mptoms related to		TO ANY VISITORS -	_
0	OVID-19.			11025	
T-	he facility should be foll	lowing all established			
1 3	Machines.			RESIDENTS HAVE L	REDAL
-A	Il activities and commun	nal dining are canceled.		Choose of the C	JEDIN
1~	ocial distancing should	be enforced		GIVEN MASKS; A	5 HAS
-1	ace masks should be di	istributed to all staff and		STAFF-	69587
10	Siderius.		1		
of Health	Service Regulation			JO ACTIVITIES HAVE	E BEEN
FORM			RADO	SCHEDULED DOLL	200
	f		411	KIII DEFINITION OF THE DE	If continuation sheet 2 of 8
				DISTRICTANCE (4)	CF STYLM
				DISTANCING AT A DURING THE DAY	
				DUDINK THE	EALS AND
	Doubles			DAY	4
	reviewed and	Accepted 08/		,	

Reviewed and Accepted 08/

PRINTED: 08/11/2020

Division	of Health Service Reg				PRINTED: 08/11/ FORM APPRO
AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
			*	A. BUILDING:	COMPLETED
		FGL061008		B, WING	
NAME OF F	PROVIDER OR SUPPLIER	STREE	ETADDO	ESS. CITY, STATE, ZIP CODE	07/31/2020
B& LFA	MILY CARE HOME			REEK ROAD	
		BAKE	RSVIL	LE, NC 28705	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	1		
TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO	THE APPROPRIATE COMPLETE
C 311	Continued From page	2	-+	C 311	ICY)
					"
	Observation upon ent	rance into the facility on		HAUF SHOWN	¥
	07729720 at 10:45am	'evealed:		- MARCH	1. RESIDER
	-The Administrator me	et the surveyors at the front		11005	MAND
	door of the facility.			THUE SHOULD I	VO SIENS
	-She was not wearing	a face mask.		00	-141.5
I	-She did not check the	surveyors temperature.		OR SYMPTOMS	DE Chillia so
	symptoms of COVID-1	E SUrveyors for singe and		1	-1 6010 19-
	-There was no PPE ne	ear the front door.		Sugar	
		1		SURVEYORS WER	E THE
1	10:50am revealed:	ng room on 07/29/20 at		ONLY PEOPLE TO	enter
	-There were two reside	ents sitting across from		FACILITY	
	each other at a table.	i e		FACILITY SINCE	JULY 4
	 The residents were 3 tweeting face masks. 	feet apart and were not		WHEN I RESIDER	T HAD
	Interview with one resid	dent on 07/20/20 -+		GONE TO HER.	DAMGATTORE
- 1	10:57am revealed:			Posining	כמשוחיייי
	A family member had o	come into the facility on	1	RESIDENCE - THE	RE WERE
1	11/21/20 to take the res	ident on an outing		4 Dag 01 -	
-	The family member wa	s not screened for signs		4 PEOPLE TOTAL	- INCLUDING
-	and symptoms of COVI	U-19:	1	RESIDENT AND NO	TAGE HAN
t	o screen for signs and	esident's temperature daily symptoms of COVID-19.		Borns	ערות כ-יי
	The resident had not se	en staff wearing face		BEEN OUT OF	THE COUNTY
1.11	dSKS.	*.		AND ALL HOD BEE	Vel Kni nanth
-	Staff had not offered the	e resident a face mask.		The Letter	DOLATING.
_	ine resident ate all me with the other residents.	als at the kitchen table	1	RESIDENT HAD BE	
	Staff had not offered to	CODIO manini ii		REIDENT HAD BE	EEN PROVIDED
re	esident's room in order	to socially distance.		A MAST BY HET	R DAUKUMER
0	bservation of the kitche	20 00 07/20/20 -+			GUAIGIC
12	2:45pm revealed there	were four residents			
se	eated 2 feet from each	other eating their lunch.			
In	terview with a second r	esident on 07/29/20 at			į
11	:00am revealed: Service Regulation				

4/K111

Mani 35r 63/15/2020

Division	of Health Service Re	egulation	9			100	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION			
	ta ta	- STATE OF THE PROPERTY	A. BUILDING:		COMPLETE	D	
•		FCL061008	B. WING				
EMME OF P	ROUDER OR OUTFLIEF				07/31/20	020	
	140		CAME OFFICE DOLL				
O L PAN	MILY CARE HOME		CANE CREEK ROAI ERSVILLE, NC 287				
(X4) ID PREFIX	SUMMERY	STATEMENT OF SECICIENCIES	10	PROVIDER'S PLAN OF CORRE			
TAG	REGULATORY C	NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION OF	שמווות פר	(X5) OVPLET	
			IAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE	
C 311	Continued From pa	ige 3	C 311				
	-He was going to th	e dining room to eat meals			į		
	with the other resid	ents.					
i	-He preferred to ca	this meals inside his room			2		
ĺ	from the other resid	t able to be socially distance lents when he went to the		THIS RESIDENT A	PREFER		
!	dinning room.	lents when he went to the		1621 11.00	PETERS		
i	-He was not getting	his temperature checked		TO ISOLAME IN ALS	ROOM		
1	daily.			BELAUSE OF HIS HE	75,-77.1		
	once when he had t	e mask by the facility staff		1	1		
	once when he had to leave the facility for a doctor's appointment.			DISABILITIES - THE	ONLY		
İ	Interview with a third	d resident on 07/29/20 at		CONTROT HE HAS WI	ITH		
	11:05am revealed:				1		
1	-Sometimes a family	member will visit with the facility on the porch.		THE WITH WHERE 3	RESIDENT		
1.	-Staff had not offere	d the resident a face mask.	2	HAS BEEN AT MEAL	711175		
1.	 Staff did not wear fa 	ace masks.		- JULY HI FIEHL	IMES.		
17	The resident had re	ceived a face mask from the		RESIDENTS PLE SOCIA	****		
	family member.	e resident's temperature to					
, 5	screen for signs and	symptoms of COVID-19	1 1	DISTANCING AND EM			
- 1	Staff had not offered	to serve meals in the	1 2				
ľ	resident's room in order to socially distance.		ľ	N 2 SHIFTS -			
1	Telephone interview	with a resident's family		RESIDENTS AME BEEN			
- [member on 07/30/20 at 4:55pm revealed: -The family member had not been into the facility since the virus (COVID-19) started in March 2020When the family member would bring items to			THE DEEN	GIVEN		
s			Į į	MASKS -	ĺ		
2			-	Gu (a)			
-\				STAFF (2) HAD NOT	WORK		
a	ne resident she wou to inside the facility.	ld ring the doorbell and not	- I	YASIS BELLUSE WE	400		
-	The staff that came t	to the door were not wearing					
fa	ace masks.		<u> </u>	NOT BEEN IN CHEE	PROXIMITY		
0	bservation of the ou	itside of the facility from	17	TO LES IDENTS - MASI	KS ARE		
11	1:30am to 1:00pm re	evealed:	1	WORN WHEN STAFF I	MUST BO OF	IT	
-7	The Assistant Admin	istrator got in a vehicle in		D BUY GRACERES A	וון עש ממ	0	
of Health	Service Regulation	cility as a passenger without		MEDICATIONS .	THE W		
FORM	os rice negulation		nan-	100			
th of Health	ne driveway of the fa Service Regulation	cility as a passenger without	BMDG	MEDICATIONS.	ND PKH		

Division of Health Service R	egulation	100		FORM APPROVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		· OKMAFFROVE
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
•	FCL061008	B. WING -		07/04/0000
NAME OF PROVIDER OR SUPPLIER	STRE	EET ADDRESS CITY, ST	ATE ZID CODE	07/31/2020
3 & L FAMILY CARE HOME		CANE CREEK ROA		ž.
	BAK	ERSVILLE, NC 287		
(X4) ID SUMMARY PREFIX (EACH DEFICIE	STATEMENT OF DESIGNATION			
TAG REGULATORY	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOLLDBE
C 311 Continued From pa	age 4	C 311		
wearing a mask an -The driver of the v mask. -The Assistant Adm facility within the ob- different vehicle. -He was not wearin facility. Telephone interview the Assistant Admin -He was a first resp facility on emergence -He wore a face ma facility into the comm -He did not wear a fi to the facility becaus residents "running a -Staff were taking th	d left the facility. The highest continuous and left the facility. The highest continuous and the continuous		BOTH THE DRIVER P PUT ON MASKS WHEN DUTERED THE VEHICLE ARE FIREMEN AND A IS KEPT IN THE VEH FOR MASK DISPOSAL. WAS NOT WEARING WHEN HE RETURNET WHE WAS AFONE IN	I SIC EI BOTH HILLE SIC A MASK DELPUSE
-The facility should be from the CDC and the COVID-19The staff should be facilityThe residents in the social distancing to the reduce the spread of the residents and stagetting COVID-19 if the guidelines.	re providers office on revealed: e following all guidelines e NCDHHS related to wearing a mask in the facility should be practicing to best of their shifts to	.307	MMEDIATELY WHEN IS IN RESIDENTS WHOKE ARE WORN - RESIDENTS PLACTICIA ISTANCING AND JO A NITEL ACT WITH ENC	AREA 14 SOCIAL 30 T

Division of Health Service Regulation			_ *	FORMAPPROVE		
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FCL061008	B. WING		07/	24/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE ZID CODE	1 011	31/2020
DRIEAT	MLY CARE HOME		II GRIEV POR			
Da LIA.	MET CALE HOME		SVILLE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LEG IDENTITY WHO THE DEMANDING	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION'S CROSS DEPLAYOED TO THE A DEFICIENCY)	HOLLDE	(X5) CCMPLETE DATE
C 311	Continued From page	e 5	C 311			
	-The Administrator ba	ed reached out to her at the				
	beginning of the pane	demic				
	-She reviewed basic		1			
!	Administrator related	to hand hygiene and the	1			
	importance of wearing	0 & face mask				
	-She reviewed the an	propriate signage that	1	41		
	should be posted insi	de the facility.				
{	Interview with the Adr	ministrator on 07/29/20 at				
	11:20am revealed:	51. 01.725/20 at	1			
1	-She was staying up I	to the date with the				
i	guidelines from the C	DC and the NCDHHS.				
	-She "shut down" the	facility when the pandemic				
	started.			4.5	6	
į	-She stopped all visito	ers from entering the facility		ADMINISTRATOR HA		
i	and stopped admitting	any new admissions.		DENIED ADMISSID	N TO	
	-She was not screening	ng any visitors because no	i			
	one was allowed in th	e facility.		ANYONE REQUESTI		
!	 She had plensy of did but was having a harr 	aning supplies in the facility I time gatting face masks		PLAKEMENT SING	E	
	until recently.	gotting rape masks		MARCH 2020 -		
1	-There was one reside	ent who had left the facility		The second		
	with a family member.					
-	-The family member w	ras "not going anywhere so resident leave the facilty.		THIS WAS A JU	F7 4	
1	 The Assistant Admini 	strator had taken the two		DUTING THAT OCC	ured	
i	male residents out of the facility for a hair cut.			AT RESIDENTS DA	HIGHTERS	
	-She had not been wo -She had not offered t	aring a mask in the facility. o give the residents a mask	1	AND DNLY 4 PEOI	01.12.	
-	to wear in the facility.	give the residents a mask :	1		, 1	
	-She had not offered to	o let the residents eat		INCLUDING RESIDE	,	l
	meals in their rooms.			WELL IN WITEN DA	HVCE.	- 1
-	-The residents stayed	in their rooms often and did		A PIENIC WAS HE	Nag	
. 11	not congregate. -The residents and sta			AN WISIDE PATT		
	others.	iii were isolated from			_	1
		were safe from COVID-19	1	FAMILY SCORL DIST	TNUED.	1
i	n the facility because	no residents were leaving				1
1	and no visitors were en	ntering the facility			-	
	She could not find her	infection control policy but		IFELTION CONTROL !	Doney	
on of Healt	h Service Regulation		1	WAS WONTER		

THE FOLLOWING DAY.

If continuation sheet 6 of 8

Division	of Health Service Rec	ulation			FORM APPROVE
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	OF CORRECTION	IDENTIFICATION NUMBER:	AND DESCRIPTION OF THE PARTY OF	G;	(X3) DATE SURVEY COMPLETED
		FCL061008	B. WNG		
NAME OF P	ROVIDER OR SUPPLIER	STORM			07/31/2020
			ADDRESS, CITY, S		
B & L FAN	MILY CARE HOME		NE CREEK RO		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			
PREFIX TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERS TO THE APPROPRIES OF THE APPROPRIES O	II D BE
C 311	Continued From pag	le 6	C 311		
	would continue looki	na			
					ā
-	The facility failed to e	ensure staff were following		VISITORS HAVE NOT	RUEN
	intection control guid	elines during a viral	1	The state of the s	
	staff appropriate use	the screening of visitors and of personal protective		ALLOWED IN FACILITY	4
	equipment (PPE) by	staff, and following social		UNTIL PHASE 2 WAS	IMPLEMENTED
	distancing guidelines	related to communal dining transmission and infection		DAMY I RESIDENT H	
	which placed the resi	dents at risk of contracting a		DE ITA / 160 DOLLE	745
1	serious viral illness. This failure re substantial risk of serious physica	This failure resulted in		DISITOR (HER DANGHTER)	
		ious physical harm and		DOUGHTER HAD NOT &	EEN DUT
	riegiect and constituti	es a Type A2 violation.		OF THE COUNTY	
	The facility submitted	a plan of protection on		OF THE COUNTY	
	07/29/20 in accordan	ce with G.S. 131D-34 for			
İ	this violation.			NOWE OF THE RESIDE	ENTS OR
1	CORRECTION DATE	FOR THE TYPE A2		STAFF HAVE SHOWN A	
	VIOLATION SHALL N	OT EXCEED AUGUST 30,			
1	2020.			SIGNS OR SYMPTONS	5 OF
C 914 (G.S 131D-21(4) Decla	aration Of Resident's Rights	C 914	COVID M -	į
E	Every resident shall h	ave the following rights:		STAFF HAS ALWAYS EN	USURE#
r	neglect, and exploitati	al and physical abuse, on.		THAT RESIDENTS HOLE	1
T	This Rule is not met a	as evidenced by		SAFE AND HAVE NEVER	
E	Based on observation:	s, interviews, and record		AND THE RESERVE OF THE PERSON	
re	eviews, the facility fail	ed to ensure residents		ABUSED, NEELECTED OR	EXPLOITED .
W	vere provided the nec	essary care and services to		4	
re	naintain their physical esident rights.	nearn as related to	3.51	THERE ME NO REGU	LAR
В	ased on pheervations	s, record reviews, and		VISITURES IN THIS FACE	
ir	nterviews, the facility f	ailed to ensure			5)
jr€	ecommendations and	quidance established by		AND WITH ONLY 4 A	
th	ne Centers for Diseas	e Control (CDC), the North		EXPOSURE TO COULD HA	5 BEEN
	Service Regulation	A	1 1	VERY LIMITED - NO RE	

BEEN ILL WITH ANY 5/MPTOMS If continuation sheet 7 of 8

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DA	ORM APPRO
•					,	СО	MPLETED
JAME OF O	ROVIDER OR SUPPLIER	FCL061008	: '	B. WING		١,	7/24/2022
		STR	EET AD	DRESS, CITY, STATE	ZIP CODE	1 0	17/31/2020
3 & L FAN	HILY CARE HOME	842	CANE	CREEK ROAD			
(X4) ID PREFIX	SUMMARY ST	TEMENT OF DECIDE	EKSV	ILLE, NC 28705			_0_0
TAG	TESSONOR!	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX. TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CHOUNT	(X5) COMPLE DATE
C 914	Continued From page			C 914			
	and maintained to pro- residents during the gl (COVID-19) pandemic screening of visitors ar personal protective eg	and directives from the nt (LHD) were implemented wide protection of the obal coronavirus as related to appropriate as related to appropriate use of uipment (PPE) by staff, and ial distancing guidelines NCAC 136, oppo					
and the same of th							
			1		, p		
	. 8						
		2 .					İ
	3 a						