STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	08/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with an onsite visit on August 11, 2020 and a desk review survey on August 11, 2020 to August 13, 2020 and a telephone exit on August 13, 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 (NC DHHS) 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 screening of staff and visitors for symptoms of COVID-19. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed: -Facilities should limit access points and ensure that all accessible entrances have a screening station. -Personnel should always wear a face mask in	D 338		

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the facility.
-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.

Telephone interview with the local county Health Services Family Nurse Practitioner (FNP) on 08/14/20 at 10:33am revealed:
-Best practice would be to screen every visitor that entered the facility.
-There was a toolkit available to long-term care facilities for guidance on screening.
-Telephone calls to the facility were conducted weekly, checking to determine if the facility had enough PPE and staff were following CDC guidelines, wearing PPE and social distancing of residents.

Review of the facility's undated Coronavirus Policy revealed:
-Temperatures are to be taken prior to entering the facility.
-If a temperature is over 100 degrees Fahrenheit, staff are not to be allowed entrance into the facility.
-Hands should be washed prior to conducting any job-related activities.

Observations at the facility on 08/11/20 at 9:15am revealed:
-There were three residents on the front porch, two with a face mask covering their mouth and nose and another with a face shield and no mask.
-There was a sign posted next to the front door of the facility that read "Due to Coronavirus, if you have any of the following symptoms, please do not enter our facility. Fever, cough, sore throat,

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flu-like symptoms, or shortness of breath."
-The front door was unlocked.
-Upon entering the facility, staff did not ask to check temperatures or ask screening questions related to symptoms and exposure to COVID-19.
-There was no hand sanitizer or screening station near the front entrance.
-After several minutes in the front office area and prompting of staff, a medication aide (MA) conducted temperature checks and instructions for completing a screening questionnaire.
-Once prompted, facility staff initiated screening process by conducting temperature check and logging information into a log book.

Interview with the MA on 08/11/20 at 9:24am revealed:
-They screened staff, visitors and residents for COVID-19 symptoms and exposure.
-Screenings for visitors and staff was documented and kept in binders at the front desk.
-She did not have a response for why screening had not been initiated upon surveyor entering the facility.

1. Telephone interview with an outside provider on 08/12/20 at 3:25pm revealed:
-She had been at the facility for two weeks working with residents.
-The last time she visited the facility was last week.
-The door was not locked during her visit at the facility.
-No one at the facility checked her temperature and she did not answer any screening questions related to COVID-19 symptoms and exposure.
-She went room to room visiting residents at facility.

Review of "Affirmation of Infection Control

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Precautions" screening tool sheets dated 04/08/20 through 08/10/20 revealed there were no temperature log sign in forms for the provider between 07/27/20 and 08/10/20.

Telephone interview with a second outside provider on 08/13/20 at 8:42am revealed:
-He visited the facility at least weekly and was there on the afternoon of 08/10/20.
-No one at the facility checked his temperature and he did not answer any screening questions related to COVID-19 symptoms and exposure.

Review of "Affirmation of Infection Control Precautions" screening tool sheets dated 04/08/20 through 08/10/20 revealed no temperature log sign in form for the second provider on 08/10/20.

Telephone interview with a third outside provider on 08/13/20 at 11:30am revealed:
-She visited the facility once during the last 3 months.
She did not have her temperature checked upon entering the facility and was not asked to complete a COVID-19 screening and exposure questionnaire.
-She was not screened during a prn (as needed) visit to the facility.

Telephone interview with a fourth outside provider on 08/13/20 at 1:34pm revealed:
-She was last at the facility about one month ago (mid-July 2020).
-She did not have her temperature checked upon entering the facility and was not asked to complete a COVID-19 screening and exposure questionnaire.

Telephone interview with a PCA (Personal Care

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Aide) on 08/12/20 at 3:48pm revealed:
-All visitors were supposed to wait outside for the Administrator to let them in the facility.
-There was a binder at the front desk for visitors to complete a COVID-19 screening questionnaire and temperature check.

Telephone interview with the Resident Care Coordinator (RCC) on 08/13/20 at 10:13am revealed:
-The facility's front door was kept locked and visitors had to call to get into the facility.
-It was hard to keep the front door locked due to residents going outside.
-Residents were encouraged to use the back door and patio to go outside.
-If staff and/or supervisors were down the hall taking care of residents, it was hard to continuously monitor the front door.
-Visitors were expected to check in and be screened upon entering the facility.
-She and Business Office Manager (BOM) were always up front to monitor check in.
-She was working the afternoon of 08/10/20 but could not say if a COVID-19 screening questionnaire and temperature check was done for the second provider.
-Staff were expected to initiate screening and temperature checks for all visitors upon entering the facility.
-Screening would include any outside providers.
-Screening was important to prevent the spread of COVID-19.
-Residents who had pre-existing medical conditions were at a much higher risk to get COVID-19.

Telephone interview with the BOM on 08/13/20 at 10:48am revealed:
-Outside providers completed their screenings

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through their hiring agencies before starting their work day.
-Outside providers were medical professionals who were responsible for monitoring for possible symptoms and not coming into facility's if they were sick.
-There were no outside providers coming into the facility until the last few weeks (07/27/20).
-Usually she, the Office Manager (OM) and/or the RCC were responsible for screening visitors.
-The purpose of the screening is to make sure no one who entered the facility is exhibiting signs of COVID-19.

2. Review of the staff schedule dated 09/01/20 through 09/15/20 reveled:
-There were 4 columns labeled name, Sunday 9th, Monday 10th and Tuesday 11th.
-There was documentation a kitchen staff worked on the 9th and 11th.
-There was documentation a second shift personal care aide (PCA) worked on the 10th and 11th.
-There was documentation a third shift PCA worked on the 9th and 11th.

Telephone interview with the Business Office Manager (BOM) on 08/12/20 at 8:45am revealed:
-The staff schedule dated 09/01/20 through 09/15/20 was the August 2020 staff schedule.
-She had started the September 2020 schedule and forgot to change the heading before providing the schedule for review.
-The laundry staff was not on the schedule; the laundry staff worked Monday through Friday from 8:00am to 1:00pm and was responsible for managing the laundry.
-The kitchen staff worked from 5:30am to 5:30pm and PCAs worked 8 hours shifts.

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a. Review of the laundry staff's temperature logs dated August 2020 revealed there were no temperature results documented from 08/06/20 through 08/11/20.

Review of the laundry staff's time card dated 08/01/20 through 08/13/20 revealed there was documentation the laundry staff worked 08/03/20 through 08/05/20 and 08/08/20 through 08/10/20.

Telephone interview with the laundry staff on 08/12/20 at 1:35pm revealed:
-She worked Monday through Friday and was off weekends unless she was called in to work on the weekend.
-She worked each day except 08/10/20 and 08/11/20 for the month of August 2020.
-She forgot to write down her temperature for those days and it must have slipped her mind.
-There was a temperature log book up front at the nurse's station.
-Staff were responsible for checking their temperatures, documenting the result and initialing the log book upon entry to the facility.

b. Review of the third shift PCA's temperature logs dated August 2020 revealed there were no temperatures documented on 08/01/20 and 08/07/20.

Review of the third shift PCA's time card dated 08/01/20 through 08/13/20 revealed there was documentation the third shift PCA worked 08/03/20 through 08/06/20, 08/08/20, 08/09/20 and 08/11/20.

Telephone interview with the third shift PCA on 08/12/20 at 3:48pm revealed:
-She worked third shift as a PCA and worked six to seven days a week.

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-Staff were supposed to check their temperature every day before starting their shift.
-There was a log book to document temperature checks located at the front desk.
-The facility used a tympanic ear thermometer or mouth thermometer with a cover to check temperatures.
-She worked 08/01/20, 08/03/20, 08/04/20, 08/05/20, 08/07/20, 08/09/20, and 08/11/20 for the month of August 2020.

Telephone interview with the BOM on 08/13/20 at 2:46pm revealed:
-The third shift PCA may have worked on 08/01/20 and 08/07/20 as she reported and did not punch in on her time card.
-If the third shift PCA worked without punching in, there would not have been a time card record of her working.

c. Review of the kitchen staff's temperature logs dated August 2020 revealed there were no temperatures documented from 08/06/20 through 08/11/20.

Review of the kitchen staff's time card dated 08/01/20 through 08/13/20 revealed there was documentation the kitchen staff worked on 08/08/20 and 08/09/20.

Attempted telephone interview with the kitchen staff on 08/13/20 at 3:12pm was unsuccessful.

Telephone interview with the BOM on 08/13/20 at 10:48am revealed the kitchen staff worked from 5:30am until 5:30pm; the kitchen staff worked on 08/09/20 but did not work on 08/11/20.

d. Review of the second shift PCA's temperature logs dated August 2020 received on 08/11/20

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revealed there were no temperatures documented from 08/05/20 through 08/11/20.

Upon request on 08/12/20, the time card dated 08/01/20 through 08/13/20 for the second shift PCA was not provided for review.

Attempted telephone interview with the second shift PCA on 08/12/20 at 3:45pm was unsuccessful.

Telephone interview with the BOM on 08/13/20 at 10:48am revealed the second shift PCA worked on 08/10/20 and 08/11/20.

Telephone interview with the Office Manager (OM) on 08/12/20 at 2:03pm revealed:
-The front door should have been locked, and visitors should be let in the facility.
-There was a thermometer at the desk and a log book to document staff and visitor temperatures.
-All visitors completed a screening form for symptoms and exposure to COVID-19; the forms were kept in the binder at the front desk.
-The Resident Care Coordinator (RCC) sat at the front desk to monitor screening for staff and visitors.
-Staff were expected to check their temperatures at the front desk upon entering the facility and document the result in the binder.
-She, the BOM and the RCC would glance through the staff log book to review temperature logs.
-She had not reviewed the staff temperature logs since 08/06/20.

Telephone interview with RCC on 08/13/20 at 10:13am revealed:
-All staff were expected to check their temperatures and document in the log book at

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the front desk at the start of their shift every day.
-She encouraged and reminded staff to check and document their temperatures and document every day.
-She, the OM and MA/Supervisor were responsible for reviewing the staff temperature log book.
-She reviewed the staff temperature log book every other day.

Telephone interview with the BOM on 08/13/20 at 10:48am revealed:
-The purpose of the screening is to make sure no one who enters the facility is exhibiting signs of COVID.
-MA, RCC, and herself are responsible for monitoring the temperature log book.
-The temperature log book was monitored every other day.

_____

The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic. The facility failed to implement and maintain a process to ensure screening for symptoms and exposure to COVID-19 was implemented for all visitors and staff prior to entering the facility. The facility's failure to consistently screen all visitors and staff placed all residents at substantial risk for infection and transmission of the deadly COVID-19 virus and constitutes a Type A2 violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/20 for this violation.

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D 338	Continued From page 10 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2020.	D 338		
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 received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to residents' rights. The findings are: 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 (NC DHHS) 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 screening of staff and visitors for symptoms of COVID-19 [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights Type A2 Violation].	D914		