Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER: WELLINGTON PARK

STREET ADDRESS, CITY, STATE, ZIP CODE: 329 COOPER STREET, KENANSVILLE, NC 28349

RECEIVED
JUL 28 2020
ADULT CARE LICENSURE SECTION

(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 Complaint Investigation survey onsite on May 23, 2020 with Desk Review survey on May 28 - 29, 2020, June 1- 5, 2020, June 8- 12, 2020 and June 15- 16, 2020.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a hazard free environment by impeding the walkway in halls and common areas with trash cans, a trash bag, a rolling cart, spilled food, and other items that were trip and/or fall hazards. The findings are: Review of the facility's undated Policy and Procedure for Infection Control revealed: -Universal precautions were to be used by all staff of the facility. -Housekeeping surfaces such as the floors and walls would be kept visibly clean on a regular basis. -Spills would be cleaned promptly. Observations of the common hallways during a facility tour on 05/23/20 at 8:55am revealed:	D 079	The following steps have been taken by the facility to correct the deficient area of practice sited for 10A NCAC 13F .0306a) (a) (5) Housekeeping and Furnishings during the June 16, 2020 survey. ▪ Staff were instructed to clear and clean all hallways immediately. They were instructed to remove any items from the floor and to reframe from leaving carts in the hallways. They were also instructed to check throughout each shift to assure hallways remain clear, clean and free of any potential hazard. ▪ All staff were required to participate in a review of the facility's COVID 19 Policies and Procedures for Infection control. Completed immediately by the director and formally by Vidant Home Health on June 10, 2020, and June 18, 2020. ▪ All staff were retrained on Infection Control, Cleaning and Sanitizing, Fall Hazards- Maintaining Hazard Free Environment. A review was conducted immediately on June 16, 2020 by director and followed by formal training on June 18, 2020 by Vidant Home Health	

Jamesia Niemgua Director 7/21/2020
Nich Nalle Director 7/21/20
POC reviewed/accepted 7/30/20

			Director, Frances Wilson, RN (License #140583).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Director / Director

(X6) DATE 7/21/2020 / 7/21/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 079	Continued From page 1 -The floors in the hallways were dirty with debris and were sticky when walked upon, creating a fall hazard. -On the men's hallway, there was spilled cereal and spilled milk outside of a resident's room and one black plastic trash bag on the floor blocking areas of the floor, creating a slip and fall hazard. -On the men's hall, there was roller-type metal cart with boxes and some linen on it, blocking areas of the hallway floor creating a fall hazard. -There were multiple polystyrene disposable food serving boxes and small trash cans sitting on the floor outside of numerous residents' rooms down the length of the hallways, creating trip and/or fall hazards. -There were multiple residents ambulating in the hall, including at least one resident with a rollator walker. Interview with a housekeeper on 05/23/20 at 9:06am revealed: -He was scheduled to work from 7:00am - 7:00pm today (05/23/20). -He had just arrived at work. -He mopped the floors if they were dirty. Observations of the common area at the end of the women's hall and looking down the C hall from the common area on 05/23/20 at 9:15am revealed: -There was a pile of clothing laying on the floor in the common area located directly across from entrance to C hall, creating a fall hazard. -There were two personal care aides (PCAs) on the main hall who had visualization of the clothing on the floor; neither PCA acknowledged or addressed the clothing on the floor in the common area. Observations on 05/23/20 at 9:32am revealed;	D 079	To prevent reoccurrence of deficiency sited for 10A NCAC 13F .0306a) (a) (5) Housekeeping and Furnishings during the June 16, 2020 survey, the following measures have been implemented. ▪ The facility has developed a checklist for monitoring housekeeping services which includes (a) monitoring of hallways to assure they are maintained clean, free of spills and equipment or anything else that would be a hazard for residents or staff. ▪ A regular schedule for mopping hallways has been given to house keeping and supervising staff. ▪ All staff have been instructed to support the housekeeping staff by cleaning any spills identified immediately and removing any hazards noted in hallway or common areas. ▪ Housekeeping staff have received special training on cleaning precautions and care related to COVID 19 including use of PPE, labeling special use trash receptacles on C hall. ▪ A staff member that cleans up an identified spill will notify the housekeeping staff so that housekeeping staff can follow with a more detailed clean-up if needed. ▪ The director should be notified anytime a cart, tray or any other hazard is found and removed from hallway or common areas. The director will then make an effort to identify who is responsible for the hazard found. Employee found to be responsible will receive instruction and a reprimand with consequence that may include loss of job for repeated incidents. - The supervisor-in-charge on shift is responsible for monitoring hallways for cleanliness and hazard ▪ The facility director is responsible for completing the monitoring checklist for housekeeping services and environmental hazards at least daily to assure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 079	Continued From page 2 -Two residents from the C hall walked past a PCA into the common area located directly across from C hall. -The laundry was still lying on the floor in the common area. Telephone interview with the Director on 06/15/20 at 2:00pm revealed: -The disposable food trays should not have been on the floor in the hallways. -Staff were expected to stay on their assigned hall to ensure nothing was on the floor. -Staff should ensure there was nothing blocking the hallways. -Staff should ensure there were no hazards on the floors or in the hallways such as slip and fall hazards.	D 079	This portion of the plan of correction was completed on June 18, 2020.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure physician notification for 3 of 3 sampled diabetic residents (#1, #2, #5) with finger stick blood sugars (FSBS) greater than 400 at the time of the FSBS result. The findings are: 1. Review of copies of documentation dated from March 2020-May 2020 picked up from the facility	D 273	The following steps have been taken by the facility to correct the deficient area sited resulting in a Type A2 Violation sited for 10A NCAC 13F .0902(b) Health Care during the June 16, 2020 survey. Staff have been instructed to assure that all physician order request are dated by the physician at the time the request is made or a verbal order is received and dated at the time of request. Staff are instructed that verbal orders received are to be documented immediately, read back to the physician issuing the order and faxed to the office for the physician's signature. Verbal orders not signed, dated and returned to the facility signed and dated within 15 days will be reported to the facility's director. The director will make daily contact with the physician's office, documenting each contact until the signed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 3 on 06/11/20 for 3 of 3 sampled residents (#1, #2, #5) with a diagnosis of diabetes revealed notifications to the primary care provider (PCP) for elevated finger stick blood sugar (FSBS) results, FSBS check refusals, and insulin administration refusals were documented on Physician Order Request forms for 3 of 3 sampled residents (#1, #2, #5). a. Review of Resident #1's current FL-2 dated 5/15/20 revealed diagnoses included coronary artery disease (CAD), diabetes mellitus type II and resolved COVID 19. Review of Residents #1's Physician Order Request forms revealed: -There were fifteen Physician Order Request forms provided and reviewed dated in the month of March 2020. -There were twenty-one Physician Order Request forms provided and reviewed dated in the month of April 2020. -Each of the forms had a section for physician orders, physician signature and date. -Fifteen of fifteen Physician Order Request forms reviewed dated in March of 2020 had the physician signature written exactly the same and in the same position on each separate form. -Twenty-one of twenty-one of Physician Order Request forms reviewed dated in April of 2020 had the physician signature written exactly the same and in the same position on each separate form. -The PCP signature on each of Resident #1's Physician Order Request forms matched the primary care provider (PCP) on Resident #2's Physician Order Request forms and Resident #5's Physician Order Request forms. Examples of the forty-six Physician Order	D 273	and dated order is returned to the facility. The signed and dated order will be placed in the facility record. ▪ Facility notified the Primary Care Physician of all out of range readings. ▪ Medication Aides and Supervisors have been instructed to assure that all residents requiring blood glucose monitors are given written parameters for when the physician should be notified for both high and low blood glucose readings. ▪ Diabetic orders were updated and signed by the physician which included parameters for physician notification. This was completed on June 18, 2020 and June 25, 2020. ▪ The medication Aides and SIC have been instructed to assure that notification of readings outside of the physician's written parameters are made to the physician following the medication pass except in instances where resident is symptomatic and immediate notification is required. ▪ The facility has developed a form to assist with proper documentation of readings outside of the physician written parameters and notification of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 4 Request forms provided for Resident #1 related to PCP notification for elevated FSBS included: Review of an undated Physician Order Request form for Resident #1 revealed: -Resident #1's FSBS was 446 on 03/26/20 at 11:00am and 432 at 5:00pm, "MD was notified." -The assistant to the director signed as completing the form. -In the order section of the form there was documentation which read "noted." -It was signed by Resident #1's PCP and dated 03/26/20. Review of a second undated Physician Order Request form for Resident #1 revealed: -Resident #1's FSBS was 479 on 03/28/20 at 11:00am and 543 at 5:00pm, "MD was notified." -The assistant to the director signed as completing the form. -In the order section of the form there was documentation which read "noted." -The form was signed by Resident #1's PCP and dated 03/28/20. Review of a third undated Physician Order Request form for Resident #1 revealed: -The single form had documentation of multiple FSBS results for multiple dates ranging from 04/01/20-04/09/20. -Resident #1's FSBS was 368 on 04/01/20 (no time documented), gave 5 units. -The FSBS was 502 on 04/03/20, gave 5 units contacted PCP and gave plenty of water. -The FSBS was 456 at 8:00am, notified Physician's Assistant (PA). -The FSBS was 551 on 04/01/20 (no time documented); notified PA. -The FSBS was 417 (no time documented), gave 5 units and "notified MD."	D 273	order. Staff have also been instructed to document all efforts made to implement physician instruction and to recheck the blood glucose and document in the resident record. ▪ Staff have been instructed to assure that each notification to the physician regarding blood glucose readings outside the physician written parameters are made on separate forms and reported following each reading that fall outside the parameters regardless of the numbers of readings taken within the same day. ▪ Staff have been instructed to assure all notifications are filed in the resident's record. physician. Staff have been instructed to assure that all areas of the form is complete including notification including the blood glucose reading, the time the reading was taken, and any treatment given prior to notification. ▪ Following notification, staff have been instructed to follow any instructions given by the physician and document in the resident's record. Staff have been instructed to treat the physician instruction as a verbal order.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

D 273 – Summary Statement of Deficiencies:

Continued From page 5

-The FSBS was 481 on 04/03/20 at 11:00am, gave 5 units.
-The FSBS was 463 on 04/04/20 at 11:00am, "notified MD."
-The FSBS was 519 on 04/06/20 at 11:00am, "notify MD."
-The FSBS was 433 on 04/07/20 at 11:00am, "notify MD by DW."
-The FSBS was 426 on 04/08/20 at 11:00am ..."notify MD."
-The FSBS was 431 on 04/09/20 at 11:00am, the MD was notified.
-The FSBS was 403 on 04/01/20 at 5:00pm, gave 5 units, "notify MD by DW."
-Resident #1 refused FSBS check on 04/02/20 (no time documented).
-In the order section of the form there was documentation which read "continue to follow sugars"
-The form was signed by Resident #1's PCP but there was no date beside the signature.

Review of a fourth undated Physician Order Request form for Resident #1 revealed:
-Resident #1's FSBS was 502 on 04/03/20 at 8:00am and 481 at 11:00am, "MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #1's PCP and dated 04/03/20.

Review of a fifth undated Physician Order Request form for Resident #1 revealed:
-Resident #1's FSBS was 456 on 04/06/20 at 8:00am and 519 at 11:00am, 5 units were given both times and "MD was notified." -The assistant to the director signed as completing the form.

D 273 – Provider's Plan of Correction:

- Qualified Medication Aide (QMA) and other staff received training on Caring for residents with diabetes on June 17, 2020. Training was conducted by Brenda L. Gwynn, RN. The training included documentation, follow-up, referral, responding to blood glucose readings outside of parameters given by the physician, blood glucose monitoring, sliding scale insulin administration and other basic information regarding caring for residents who have diabetes.
- The staff also received training of Documentation, Notification of physician, Implementation of out of Range Form. This training was conducted by the Director of Vidant Home Health and Hospice. On June 18, 2020.
- Staff have been instructed to notify physician each time an insulin dependent resident refuses his insulin administration. The staff is instructed to document each notification and physician instruction in the resident record and follow the physician's instruction. Any time the diabetic resident is symptomatic and appears to need additional care beyond the facility's capabilities (i.e. profuse sweating, refusing meals, vomiting, unusual incoherence), the resident should be immediately transported to the hospital. (Staff should Call 911.)
- QMA have been notified that reading consistently above the physician perimeters should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 6 -In the order section of the form there was documentation which read "noted." -The form was signed by Resident #1's PCP and dated 04/06/20. Review of a sixth undated Physician Order Request form for Resident #1 revealed: -The single form had documentation of FSBS results for three dates, 04/07/20-04/09/20. -The FSBS was 412 on 04/07/20 at 5:00pm, gave 5 units and "notified MD." - The FSBS was 484 on 04/08/20 at 5:00pm, gave 5 units and "notified MD." - The FSBS was 449 on 04/09/20 at 5:00pm, gave 5 units and "notified MD." -In the order section of the form there was documentation which read "noted." -The form was signed by Resident #1's PCP and dated 04/09/20. Telephone interview with the Director on 06/16/20 at 10:27am revealed: -Resident #1's Physician Order Request forms with the multiple dates and FSBS results meant the PCP was contacted each time at the time of each result. -When given the example of the third Physician Order Request form reviewed above, she acknowledged it meant the PCP had been notified thirteen different times by phone, at the time of each FSBS result. -She could not answer if she had any other documentation of the PCP being notified for over 60 FSBS results greater than 400 for Resident #1 from March 2020-May 2020. -She could go through the Resident Care Coordinator's (RCC) call log to look for additonal documentation. Refer to the telephone interview with a medication	D 273	▪ reported individually to the physician as aforementioned but also reported as consistent elevations and instructions requested. This is also to be brought to the attention of the facility director. ▪ Supervisory staff have been instructed to notify the resident's guardian or responsible person when there is a significant change in the resident's condition (i.e. new diagnosis or changes in resident condition requiring physician evaluation or hospitalization) ▪ Follow-up and Referral policy as well as when and who notifies the physician was thoroughly reviewed with all staff on June 16, 2020 and June 17, 2020 by the director and by the director of Vidant Home Health on June 18, 2020. <u>The following measures have been implemented to prevent reoccurrence</u> of the deficient area sited resulting in a Type A2 Violation sited for 10A NCAC 13F .0902(b) Health Care during the June 16, 2020 survey. (a) Staff training in caring for resident with diabetes required at least annually.(b) monitoring of resident records for blood glucose readings,notification, follow-up and referrals. Monitoring will be completed by the facility director at least weekly to assure continued compliance and adherence to the facility's policies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 7 aide (MA) on 06/11/20 at 12:11pm. Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am. Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm. Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:22 pm. Refer to the telephone interview with the Director on 06/16/20 at 10:27am. b. Review of Resident #5's current FL-2 dated 01/21/20 revealed diagnoses included diabetes mellitus type two, chronic back pain, anxiety, and major depressive disorder. Review of Residents #5's Physician Order Request forms revealed: -There were fourteen Physician Order Request forms provided and reviewed dated in the month of March 2020. -There were fourteen Physician Order Request forms provided and reviewed dated in the month of April 2020. -There were four Physician Order Request forms provided and reviewed dated in the month of May 2020. -Each of the forms had a section for physician orders, physician signature and date. -Fourteen of fourteen Physician Order Request forms reviewed dated in March of 2020 had the physician signature written exactly the same and in the same position on each separate form. -Fourteen of fourteen of Physician Order Request forms reviewed dated in April of 2020 had the physician signature written exactly the same and in the same position on each separate form.	D 273	on notification, follow-up and referrals. This portion of the plan of correction was completed on June 22, 2020 and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL031006		C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 8	D 273		

-Four of four of Physician Order Request forms reviewed dated in May of 2020 had the physician signature written exactly the same and in the same position on each separate form
-The PCP signature on each of Resident #5's Physician Order Request forms matched the PCP on Resident #1's Physician Order Request forms and Resident #2's Physician Order Request forms.

Examples of the thirty-two Physician Order Request forms provided for Resident #5 related to PCP notification for elevated FSBS included:

Review of a Resident #5's undated Physician Order Request forms revealed:
-Resident #5's FSBS was 471 on 03/06/20 at 5:00pm and 574 at 8:00pm, 12 units were given.
-"MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #5's PCP and dated 03/06/20

Review of a second undated Physician Order Request form for Resident #5 revealed:
-Resident ##5's FSBS was 457 on 04/02/20 at 5:00pm and 588 at 8:00pm, 12 units were given both times and "MD was notified." -The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #5's PCP and dated 04/02/20.

Review of a third undated Physician Order Request form for Resident #5 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER: WELLINGTON PARK
STREET ADDRESS, CITY, STATE, ZIP CODE: 329 COOPER STREET, KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 9

-Resident #5's FSBS was 429 on 05/13/20 at 11:00am and 426 at 8:00pm, 12 units were given both times.
-"MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #5's PCP and dated 05/13/20.

Telephone interview with the Director on 06/16/20 at 10:27am revealed:
-She could not answer if she had any other documentation of the PCP being notified for at least 40 FSBS results greater than 400 for Resident #5 from March 2020-May 2020.
-She could go through the Resident Care Coordinator's (RCC) call log to look for additonal documentation.

Refer to the telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm.

Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am.

Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm.

Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:32 pm.

Refer to the telephone interview with the Director on 06/16/20 at 10:27am.

c. Review of Resident #2's current FL-2 dated 06/01/20 revealed diagnoses included COVID-19, diabetes type II, hypertension, bipolar disorder, seizure disorder, acute renal failure and anoxic

(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 273	Continued From page 10	D 273		

brain damage.

Review of Residents #2's Physician Order Request forms revealed:
-There were eight Physician Order Request forms provided and reviewed dated in the month of March 2020.
-There were nine Physician Order Request forms provided and reviewed dated in the month of April 2020.
-There were four Physician Order Request forms provided and reviewed dated in the month of May 2020.
-Each of the forms had a section for physician orders, physician signature and date.
-Eight of eight Physician Order Request forms reviewed dated in March of 2020 had the physician signature written exactly the same and in the same position on each separate form. -Nine of Nine of Physician Order Request forms reviewed dated in April of 2020 had the physician signature written exactly the same and in the same position on each separate form.
-Four of four of Physician Order Request forms reviewed dated in May of 2020 had the physician signature written exactly the same and in the same position on each separate form.
-The PCP signature on each of Resident #2's Physician Order Request forms matched the PCP signature on Resident #1's Physician Order Request forms and Resident #5's Physician Order Request forms.

Examples of the twenty-one Physician Order Request forms provided for Resident #2 related to PCP notification for elevated FSBS and insulin refusals included:

Review of a Resident #2's undated Physician Order Request forms revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 11

-Resident #2's FSBS was 464 on 03/09/20 at 11:00am, "MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #2's PCP and dated 03/09/20

Review of a second undated Physician Order Request form for Resident #2 revealed:
-Resident #2's FSBS was 546 on 04/20/20 at 7:00am, "MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #2's PCP and dated 04/20/20.

Review of a third undated Physician Order Request form for Resident #2 revealed: - Resident #1's FSBS was 406 on 05/09/20 at 7:00am and 419 at 11:00am.
-"MD was notified."
-The assistant to the director signed as completing the form.
-In the order section of the form there was documentation which read "noted."
-It was signed by Resident #2's PCP and dated 05/09/20.

Telephone interview with the assistant to the Director on 06/15/20 at 11:43am revealed: - She could not verify that Resident #2's primary care provider (PCP) had been notified of his FSBS which were outside of the ordered parameters for any of the 13 Physician Order Request forms completed and signed by her for April 2020 and May 2020.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 12	D 273		

-She had reviewed Resident #2's electronic medication administration records (eMARs) and saw the FSBS was over the parameter so she completed the Physician Order Request form.
-When she documented "MD was notified" on the Physician Order Request form, it meant the medication aide (MA) had notified the PCP -She did not verify with the MA that the PCP was notified; she only assumed the MA had contacted the PCP.

Refer to the telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm.

Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am.

Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm.

Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:22 pm.

Refer to the telephone interview with the Director on 06/16/20 at 10:27am.

2. Review of Resident #1's current FL-2 dated 5/15/20 revealed
-There was a medication order for Novolog Flexpen (a rapid acting insulin used to lower blood sugar), give subcutaneously (SQ) times daily with meals according to the following sliding scale for finger stick blood sugar (FSBS) result of 100 - 200 = 1 unit; for FSBS result of 201-250 = 2 units; for FSBS result of 251-300 = 3 units; for FSBS result of 301- 350 = 4 units; for FSBS greater than 350 = 5 units.
-There were no FSBS parameters for when the the primary care provider (PCP) should be notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 13

Review of Resident #1's previous medication orders dated 01/02/20 revealed:
-There was a medication order for Novolog Flexpen (a rapid acting insulin used to lower blood sugar), give SQ times daily with meals according to the following sliding scale for finger stick blood sugar (FSBS) result of 100 - 200 = 1 unit; for FSBS result of 201-250 = 2 units; for FSBS result of 251-300 = 3 units; for FSBS result of 301- 350 = 4 units; for FSBS greater than 350 = 5 units.
-There were no FSBS parameters for when the primary care provider (PCP) should be notified.

Telephone interview with a medication aide (MA) on 06/11/20 at 12:11 pm revealed:
-She administrated insulin to diabetic residents after she performed their FSBS checks.
-If Resident #1's FSBS was greater than 400, she notified his PCP.

Telephone interview with the assistant to the Director on 06/12/20 at 2:35 pm revealed the facility's policy and procedure for FSBS results that were less than 60 or greater than 400 without parameters was to administer insulin according to the resident's sliding scale, if the resident had a sliding scale, then call and notify the doctor.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed the PCP was supposed to be called for FSBS results of greater than 400 or less than 60 or whatever the parameter range was ordered.

Review of Resident #1's Vitals Report dated March 1, 2020 to May 31, 2020 revealed:
-From 03/01/20 through 03/31/20, Resident #1's FSBS was documented at 400 or greater than

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 14 400 on eighteen occasions. -From 03/01/20-03/31/20, the FSBS results greater than 400 ranged from 401-597. -For example: on 03/07/20 at 11:45am the FSBS result was 521; on 03/09/20 at 12:12pm, the FSBS result 552; was on 03/10/20 at 8:00am, the FSBS result was 597; on 03/28/20 at 6:46pm, the FSBS result was 543. -From 04/01/20 through 04/30/20, Resident #1's FSBS was documented at 400 or greater than 400 on twenty-seven occasions. -From 04/01/20-04/30/20, the FSBS results equal to or greater than 400 ranged from 400-551. -For example: on 04/01/20 at 12:04pm, the FSBS result was 551; on 04/03//20 at 8:00am the FSBS result was 502; on 04/06/20 at 12:11pm, the FSBS result was 519; on 04/4/15/20 at 11:00am the FSBS result was 458. -From 05/01/20-05/21/20, the FSBS result was greater than 400 on only one date, 05/19/20 at 8:00am with a result of 492. Review of Resident #1's March 2020 electronic medication administration records (eMAR): -There was an entry for Novolog SSI use a directed on the sliding scale three times daily with meals "100- 200 = 1 unit, 201-250 = 2 units, 251-300 = 3, 301 - 350 =" (the rest of the sliding scale was not on the eMAR entry) with administration times of 8:00am, 11:00am and 5:30pm with documentation of administration from 03/01/20- 03/31/20. -There were no FSBS parameters for when the PCP should be notified. Review of Resident #1's April 2020 eMAR revealed: -There was an entry for Novolog SSI use a directed on the sliding scale three times daily with meals "100- 200 = 1 unit, 201-250 = 2 units,	D 273		

D 273 | D 273

Continued From page 15

251-300 = 3, 301 - 350 =" (the rest of the sliding scale was not on the eMAR entry) with administration times of 8:00am, 11:00am and 5:30pm. Novolog was documented as administered per the SSI orders from 04/01/20-04/10/20 at 11:00am.
-There was a second entry for Novolog SSI use a directed on the sliding scale three times daily with meals "100- 200 = 1 unit, 201-250 = 2 units, 251-300 = 3, 301 - 350 =" (the rest of the sliding scale was not on the eMAR entry) with administration times of 8:00am, 11:00am and 5:30pm. Novolog was documented as administered on the second Novolog SSI entry from 04/13/20 at 8:00am-04/30/20.
-There were no FSBS parameters for when the PCP should be notified.

Review of Resident #1's May 2020 eMAR revealed:
-There was an entry for Novolog SSI use a directed on the sliding scale three times daily with meals 100- 200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301 -350 = 4 units, greater than 350=5 units with administration times of 8:00am, 11:00am and 5:30pm.
-Novolog was documented as administered from 05/01/20- 05/11/20 and 05/16/20 at 8:00am-05/21/20 at 5:30pm.
-Novolog was not administered from 05/11/20 at 8:00am -05/15/120 at 5:30pm because the resident was in the hospital.

Review of hospital discharge summary for Resident #1 dated 05/15/20 revealed: -The resident was brought to the emergency department on 05/11/20 with fever and confusion. -The resident was admitted for inpatient stay and discharged 05/15/20.
-Diagnoses included diabetes mellitus, coronary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 16 artery disease (CAD), and COVID-19 (resolved).

Review of a laboratory (lab) result for Resident #1 from a local hospital dated 05/11/20 revealed: -Resident #1's Hemoglobin A1C result was 12.1 (Hemoglobin A1C is a blood test that provides the average blood sugar over a two to three- month time frame).
-The normal reference range was documented as less than 6.5.

Review of a previous lab result for Resident #1 dated 02/10/20 revealed a Hemoglobin A1C result of 9.6.

According to the American Diabetes Association a Hemoglobin A1C target result of less than 7% is recommended for adults with a diagnosis of diabetes. The higher the level of A1C increases the risk of developing diabetes complications. Complications include neuropathy (nerve damage), kidney disease, and diabetic ketoacidosis. (Diabetic ketoacidosis is a serious complication which can lead to coma and death).

Review of Resident #1's Resident Notes dated from 01/21/20-05/22/20 revealed:
-There was no documentation the PCP was notified for any FSBS results greater than 400. -On 05/21/20 (no time documented), there was an entry by the Home Health provider that Resident #1's FSBS was 298 "this morning". Encouraged staff to check four times a day and make sure he eats.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed the expectation was to notify the PCP at the time of the FSBS result. The PCP notification policy was requested on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 17	D 273		

Continued From page 17

06/15/20 at 2:00pm and 06/16/20 at 10:27am but was not provided prior to survey exit.

Additional documentation of PCP notification for Resident #1 was not provided prior to survey exit.

Refer to the telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm.

Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am.

Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm.

Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:22 pm.

Refer to the telephone interview with the Director on 06/16/20 at 10:27am.

3. Review of Resident #2's current FL-2 dated 06/01/20 revealed:
-Diagnoses included COVID-19, diabetes type II, hypertension, bipolar disorder, seizure disorder, acute renal failure and anoxic brain damage.
-The resident was semi-ambulatory and oriented.
-There was an order for Novolog 100 units Flexpen, inject 10 units subcutaneously with meals (used for the treatment of diabetes). -There was an order for Lantus Solostar 30 units every evening (used for the treatment of diabetes).

Review of Resident #2's physician's order dated 04/27/20 revealed:
-A physician's order dated 04/27/20 for Novolog 100 units/ml, Flexpen, use sliding scale and inject subcutaneously before meals: 0-150 =0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 18	D 273		

units, 301-350 = 8 units, 351-400 =10 units, 401-450 =12 units.
-There were no parameter ranges for when to notify the Primary Care Provider (PCP).

Telephone interview with the assistant to the Director on 06/12/20 at 2:35pm revealed the facility's policy and procedure for FSBS results that were less than 60 or greater than 400 without parameters was to administer insulin according to the resident's sliding scale, if the resident had a sliding scale, then call and notify the doctor.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed the PCP was supposed to be called for FSBS results of greater than 400 or less than 60 or whatever the parameter range was ordered.

Review of the April 2020 and May 2020 electronic medication administration records (eMAR) Medication Notes for Resident #2 revealed: -On 04/02/20 at 7:00am, patient refused Novolog (medication to treat diabetes).
-On 04/07/20 at 5:00pm, patient refused Novolog.
-On 05/09/20 at 5:00pm, patient refused Novolog.
-On 05/12/20 at 7:30am, patient refused Novolog.
-On 05/13/20. at 3:00pm, patient refused Novolog.
-On 05/13/20 at 5:00pm, patient refused Novolog. -On 05/16/20 at 3:30pm, patient unable to take medications.
-On 05/17/20 at 7:00am, patient unable to take medications.
-On 05/17/20 at 4:30pm, patient unable to take medications.
-On 05/18/20 at 8:00am, patient refused all meds due to upset.

Review of the April 2020 Vitals Report log

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 19

revealed 9 times Resident #2's finger stick blood sugar readings (FSBS) were above 400: -On 04/08/20, the 7:00am FSBS reading was 453.
-On 04/09/20, the 7:00am FSBS reading was 402.
-On 04/15/20, the 11:00am FSBS reading was 402.
-On 04/17/20, the 7:00am FSBS reading was 435.
-On 04/17/20 the 11:00am FSBS reading was 437.
-On 04/20/20, the 7:00am FSBS reading was 546;
-On 04/20/20 the 11:00am FSBS reading was 529.
-On 04/28/20, the 7:30am FSBS reading was 424.
-On 04/29/20, the 7:00am FSBS reading was 465.

Review of the May 2020 Vitals Report log revealed 9 times Resident #2's finger stick blood sugar readings (FSBS) were above 400: -On 05/09/20, the 8:55am FSBS reading was 406.
-On 05/09/20, the 10:33am FSBS reading was 419.
-On 05/18/20, the 10:53am FSBS reading was 400.

Review of Resident #2's Physician Order Request dated 05/18/20 revealed "Resident's blood sugar was high and was vomiting on 05/18/20, resident was sent to ER, MD was notified."

Review of Progress Notes for Resident #2 dated 05/18/20 revealed:
-(Resident #2) was sent to the local hospital per physician request after being informed of his

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 20

blood sugar level and vomiting all morning.
-The blood sugar reading was high.
-(Resident #2) was admitted to the hospital for further evaluation.

Telephone interview with a personal care aide (PCA) on 06/15/20 at 2:40pm revealed:
-Two or three days before Resident #2 went to the hospital (05/15/20 to 05/17/20), she observed him eating breakfast and he threw it up.
-After the observation, she told the Co-Resident Care Coordinator (Co-RCC) Resident #2 threw up his breakfast.

Review of a local laboratory COVID-19 test report for Resident #2 dated 05/10/20, revealed the results were "Detected Critical".

Review of the hospital Emergency Department records for Resident #2 dated 05/18/20 revealed: -On 05/18/20 at 10:48am Resident #2 presented to the ED complaining of nausea and vomiting blood.
-"He had significant emesis with coffee-ground looking material, clearly there was blood in it, the patient was hypotensive (low blood pressure)." -Resident #2 was treated aggressively to get his blood glucose down.
-Resident #2 was admitted to the Intensive Care Unit (ICU).

Review of a hospital discharge summary for Resident #2 dated 05/23/20 revealed:
-The resident presented to the hospital emergency department on 05/18/20 with nausea and vomiting.
-The resident's FSBS result was 787 on admission.
-Diagnoses included hyperosmolar syndrome, gastroenteritis due to COVID-19, and acute renal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 21 failure. (Hyperosmolar syndrome is a complication of diabetes caused by extremely high blood sugar). -The resident was discharged 05/23/20. Review of a laboratory (lab) result for Resident #2 from a local hospital dated 05/20/20 revealed: -Resident #1's Hemoglobin A1C result was 9.6. (Hemoglobin A1C is a blood test that provides the average blood sugar over a two to three- month time frame). -The documented reference range for Hemoglobin A1C was less than 6.5%. Review of a previous lab result for Resident #2 dated 02/24/20 revealed Resident #2's Hemoglobin A1C result was 10.2 (Hemoglobin A1C is a blood test that provides the average blood sugar over a two to three- month time frame). According to the American Diabetes Association a Hemoglobin A1C target result of less than 7% is recommended for adults with a diagnosis of diabetes. The higher the level of A1C increases the risk of developing diabetes complications. Complications include neuropathy (nerve damage), kidney disease, and diabetic ketoacidosis. (Diabetic ketoacidosis is a serious complication which can lead to coma and death). Review of a second hospital discharge summary for Resident #2 dated 06/02/20 revealed: -The resident was admitted on 05/29/20 and discharged on 06/02/20. -Diagnoses included type 2 diabetes with diabetic ketoacidosis without coma, acute kidney injury, and COVID-19. Telephone interview with a Medication Aide (MA)	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273		D 273		

Continued From page 22

on 06/12/20 at 4:00pm revealed:
-Resident #2 tested positive for COVID-19 (on 05/10/20) and resided on the "C" Hall (designated for COVID-19 residents) before he was sent to the hospital on 06/18/20.
-The MA administered medications, including insulin, to Resident #2.
-Resident #2 did not usually refuse his medications when she administered them.
-She was not sure what the eMAR documentation of "patient not able to take medication" meant. -Resident #2 was sometimes nauseated and not able to take his medications.
-There should be documentation of Resident #2 having nausea in the Progress Notes..
-The facility's practice for contacting the PCP was if Resident #2's FSBS was greater than 400 or less than 60, call the PCP for instructions and document in the Progress Notes.

Telephone interview with the Co-Resident Care Coordinator on 06/12/20 at 2:35pm revealed: -Resident #2 had diabetes and physician orders for Lantus (long acting insulin), scheduled Novolog and Novolog using a sliding scale for meals (short acting insulin).
-There was no physician ordered blood sugar parameter ranges indicating when to contact the PCP for Resident #2, but the facility practice was if a residents' FSBS level was greater than 400, call the PCP; if the FSBS level was less than 60, do not administer insulin and call the PCP. -Communications with the PCP regarding Resident #2 should be documented in the Progress Notes.
-Resident #2 always had nausea problems, had vomited emesis looking like coffee grounds, but could not recall the date.
-Resident #2 would refuse to take insulin when he was having nausea problems but could not recall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 23 the dates -Resident #2 had already been diagnosed with COVID-19. -Resident #2 was sent to the hospital on 05/18/20 for nausea, vomiting and high FSBS (did not give reading). Telephone interview on 06/16/20 at 2:15pm with the Resident Care Coordinator (RCC) revealed: -She kept a call log and a note pad to document communications with the PCP. -"Sometimes she would write (about communications) and sometimes she did not always document." -She was not aware if calls were made by staff to Resident #2's PCP. -If she had communications regarding Resident #2 having high finger stick blood sugars, she would have to go back and look (in her notes); there should be notes for each of the times Resident #2 had high finger stick blood sugars. -Resident #2 ate snacks often; he ate gummy candies, chocolate and drank soft drinks he bought in from the vending machines or brought by the family. -Resident #2 had nausea, vomiting and his FSBS was high (no number given) on 05/18/20 and was sent to the hospital for treatment. -She did not know if the PCP saw Resident #2 for nausea, vomiting and FSBS levels before he was sent to the hospital. Review of Resident #2's Progress Notes revealed: -There was no documentation between 04/29/20 to 05/18/20 of Resident #2's FSBS readings. -There was no documentation of communications to the PCP regarding Resident #2's FSBS readings. PCP Progress Notes requested on 06/10/20 and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 24 06/11/20 were not submitted to the survey team for Resident #2 by the end of the survey. Telephone interview on 06/16/20 at 11:05am with the PCP's Office Manager revealed: -On 02/27/20 Resident #2 was established as a patient and a plan was made to manage his diabetes medication. -On 04/20/20 the facility staff called to report Resident #2's blood sugar was 546. -On 05/01/20 facility staff called to report Resident #2's blood sugar was 45. -On 05/18/20 a note was received from the Co-RCC that "Resident #2 had been up all-night vomiting, his FSBS was high, he was sweating and panting and was sent to the ED". -There were no notifications of Resident #2 having nausea and vomiting prior to going to the hospital. -There was no notification from the facility of the 05/10/20 lab report for Resident #2 testing positive for COVID-19. -There were no notes or calls to the PCP except on 04/20/20, 05/01/20, and 05/18/20 in Resident #2's records. Telephone interview with Resident #2's Guardian on 06/14/20 at 5:35pm revealed: -She had not been able to go into the facility to see Resident #2 because of the visiting restrictions in place for COVID-19. -She was not notified when Resident #2 was diagnosed with the virus. -She did not know when Resident #2 started vomiting at the facility; she was not notified of any details of his condition before the facility sent him to the hospital on 05/18/20. -She was notified by the ED physician that Resident #2 had been throwing up blood in the ED and his finger stick blood sugar was very	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 25	D 273		

high.

Telephone interview with the Director on 06/16/20 at 10:27am revealed:
-She acknowledged Resident #2 had been to the hospital recently for vomiting and diabetic ketoacidosis.
-She was not working when Resident #2 was sent to the hospital on 05/18/20.
-She was told by the Supervisor started vomiting and was sent out to the hospital the same day for evaluation.
-She would not expect any delay in the resident being sent to the hospital and the PCP being notified.
-She only knew what the Supervisor had told her about it.
-"Most of the time" the Supervisor would document on a resident's status, PCP notification, and need to go to the hospital; the Supervisor did not say if he documented Resident #2's 05/18/20 hospital visit or PCP notification.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed the expectation was to notify the PCP at the time of the FSBS result.

The PCP notification policy was requested on 06/15/20 at 2:00pm and 06/16/20 at 10:27am but was not provided prior to survey exit.

Refer to the telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm.

Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm.

Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:22 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 26	D 273		

Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am.

Refer to the telephone interview with the Director on 06/16/20 at 10:27am.

4. Review of Resident #5's current FL-2 dated 01/21/20 revealed:
-Diagnoses included diabetes mellitus type two, chronic back pain, anxiety, and major depressive disorder.
-There was an order for blood sugar checks before meals and at bedtime.

Review of Resident #5's physician's orders dated 03/05/20 revealed:
-There was an order for finger stick blood sugars (FSBS) scheduled for three times a day before meals and once a day at bedtime.
-There was an order for sliding scale insulin (SSI) with parameters for a FSBS reading of 401 or greater administer 12 units of Novolog (a rapid acting insulin used to control blood sugar levels) and contact the physician.

Review of Resident #5's eMAR for March 2020 revealed:
-The eMAR provided for March 2020 was incomplete and did not include all pages and medication ordered.
-There was an entry for Novolog 100 units scheduled at 7:00am, 11:00am, 6:00pm and 8:00pm; parameters for FSBS greater than 401 administer 12 units of Novolog and call the physician.
-There was documentation of FSBS of 401 or above 21 of 124 times.
-There was no documentation on the eMAR that the physician was notified for FSBS greater than 401.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 27 Review of Resident #5's vitals report for FSBS dated March 2020 revealed: -Resident #5's FSBS readings were documented as 401 or above 21 of 124 times for March 2020 with examples as follows: -There was documentation on 03/06/20 of FSBS readings of 471 at 4:44pm and 574 at 8:21pm. -There was documentation on 03/24/20 of FSBS readings of 450 at 11:00am, 507 at 5:00pm and 557 at 8:06pm. Review of Resident #5's physician order request dated 03/06/20 revealed: -Resident #5's FSBS was documented as 471 at 5:00pm and 574 at 8:00pm. -Twelve units [Novolog] were documented as "given" and the physician was notified. -The physician signed and dated the document once on 03/06/20; the remark on the order section of the document was "Noted". -The physician was not notified each time the FSBS was outside of parameters on 03/06/20, she was only notified once on that date. Review of Resident #5's physician order request dated 03/24/20 revealed: -Resident #5's FSBS readings were documented as 450 at 11:00am, 507 at 5:00pm and 557 at 8:00pm. -Twelve units [Novolog] were documented as "given" and the physician was notified. -The physician signed and dated the document once on 03/24/20; the remark on the order section of the document was "Noted". -The physician was not notified each time the FSBS was outside of parameters on 03/24/20, she was only notified once on that date. Resident #5's April 2020 and May 2020 electronic	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: _____ B. WING _____	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 28	D 273		

Medication Administration Records (eMARs) were requested on 06/01/20 and were not available for review by the end of the survey.

Review of Resident #5's vitals report for FSBS dated April 2020 revealed:
-Resident #5 had documented FSBS readings of 401 or above 23 of 120 times for April 2020 with examples as follows:
-There was documentation on 04/01/20 of FSBS readings of 551 at 4:20pm and 469 at 7:23pm. -There was documentation on 04/02/20 of FSBS readings of 457 at 5:00pm and 588 at 8:30pm.

Review of Resident #5's physician order request dated 04/02/20 revealed:
-Resident #5's FSBS was documented as 457 at 5:00pm and 588 at 8:00pm.
-Twelve units [Novolog] were "given" and the physician was notified.
-The physician signed and dated the document once on 03/24/20; the remark on the order section of the document was "Noted".
-The physician was not notified each time the FSBS was outside of parameters on 04/02/20, she was only notified once on that date.

Review of Resident #5's vitals report for FSBS dated 05/01/20 through 05/15/20 revealed: -Resident #5 had documented FSBS readings of 401 or above 5 of 60 times for 05/01/20 through 05/15/20 with example as follows:
-There was documentation on 05/13/20 of FSBS readings of 429 at 12:28pm and 426 at 8:30pm.

Review of Resident #5's physician order request dated 04/01/20 revealed:
-Resident #5's FSBS was documented as 551 at 5:00pm and 469 at 8:00pm.
-Twelve units [Novolog] were "given" and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER: WELLINGTON PARK

STREET ADDRESS, CITY, STATE, ZIP CODE: 329 COOPER STREET, KENANSVILLE, NC 28349

(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 273	Continued From page 29	D 273		

Continued From page 29

physician was notified.
-The physician signed and dated the document once on 03/24/20; the remark on the order section of the document was "Noted".
-The physician was not notified each time the FSBS was outside of parameters on 04/01/20, she was only notified once on that date.

Review of Resident #5's progress notes for the dates of March 2020, April 2020 and May 2020 revealed there was no documentation of FSBS readings outside of parameters or contacting Resident #5's primary care physician (PCP).

Review of Resident #5's lab results dated 02/10/20 revealed a Hemoglobin A1C result of 10.7. (Hemoglobin A1C a blood test used to measure an average blood glucose level over a two to three-month period).

Review of a second lab result for Resident #5's dated 03/18/20 revealed a Hemoglobin A1C result of 10.5.

According to the American Diabetes Association a Hemoglobin A1C target result of less than 7% is recommended for adults with a diagnosis of diabetes. The higher the level of A1C increases the risk of developing diabetes complications. Complications include neuropathy (nerve damage), kidney disease, and diabetic ketoacidosis. (Diabetic ketoacidosis is a serious complication which can lead to coma and death).

Telephone interview with a representative from the contracted pharmacy on 06/12/20 at 3:22pm revealed:
-Resident #5 most recent order for Novolog 100 units was dated 03/05/20.
-The order was for FSBS scheduled before meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 30 at 7:00am, 11:00am, 6:00pm and bedtime at 8:00pm. -For FSBS greater than 401 administer 12 units and call the physician. Telephone interview with the Co-Resident Care Coordinator (Co-RCC) on 06/12/20 at 3:00pm revealed: -There was a facility wide policy for FSBS; if greater than 400 the primary care physician (PCP) was supposed to be notified. -He contacted the PCP by phone; it would depend on how severe the FSBS reading was as to when he would call the PCP. -If the resident "was not sweating or cranky" he would wait until after he finished administering medication to the remaining residents and then call the PCP to report the FSBS. -He had a two-hour window for contacting the PCP; an hour before and an hour after the scheduled medication administration time. -He always gave the required 12 units of insulin before he called the PCP. -The PCP would either instruct him to send the resident to the hospital or to do a second FSBS or a recheck within an hour. -Once the PCP was notified of the FSBS the MA would document the contact in the "nurses' notes", it was not documented anywhere else. -He could not recall any of Resident #5's FSBS results or her medication orders; he could not recall if he had ever contacted Resident #5's PCP due to FSBS results. -The physician's order request form was used to document a resident's return from the hospital or a change in an order. -The PCP would document the change for an order in the comment section and sign the physician's order request form when she came into the facility.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 31	D 273		

Continued From page 31

Telephone interview with a Medication Aide (MA) on 06/12/20 at 3:38pm revealed:
-She called the PCP when a resident's FSBS was outside of the parameters.
-When the PCP gave a verbal order for a recheck for high FSBS she would document the PCP's orders in the progress notes.
-The Resident Care Coordinator (RCC) or the Co-RCC would send a fax to the PCP after verbal orders were given so there would be a "paper trail".
-She had not called Resident #5's PCP because Resident #5's FSBS were "always good" and not high.

Telephone interview with the office manager at Resident #5's PCP office on 06/16/20 at 10:55pm revealed:
-The facility had the PCP's cell phone number and could call, text or email her via the cell phone.
-The PCP made note of the contact from the facility and the office kept the note in the resident's record.
-The facility could fax a request to the office and the office would call the PCP to relay the information.
-There were no documented calls or faxes from the facility to the PCP on file in the office for March 2020, April 2020, or May 2020.

Telephone interview with the RCC on 06/16/20 at 2:07pm revealed:
-MAs were required to report all FSBS out of parameters without delay to the PCP by phone; if she was working, she would contact the PCP for the MA.
-The call to the PCP was documented on a physician's order request by the RCC the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 32	D 273		

following work day and placed into the resident's record after the PCP signed off.
-There should be a separate sheet for each time Resident #5's FSBS was outside of parameters; there should not be multiple parameters on one sheet.
-She was in the process of training the facility's office manager to fill out the physician's order request; the office manager must have documented the parameters incorrectly. -She kept a note pad that she would try to document calls or text messages to the PCP, but she admitted she did not document every call due to the lack of time.
-She documented the time and the reason for the call, but she did not document the date of the call or the PCP's response on the note pad.
-She knew Resident #5 had multiple FSBS that were high and outside of the parameters, but Resident #5 ate a lot of "junk food" and snacks brought in by the family and she purchased out of the vending machine.
-The PCP was aware of Resident #5's high FSBS and was constantly monitoring her and had adjusted the resident's insulin.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed the expectation was to notify the PCP at the time of the FSBS result.

The PCP notification policy was requested on 06/15/20 at 2:00pm and 06/16/20 at 10:27am but was not provided prior to survey exit.

Refer to the telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm.

Refer to the telephone interview with the Resident Care Coordinator on 06/15/20 at 12:25pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	see below	D 273		

Continued From page 33

Refer to the telephone interview with the facility's PCP on 06/15/20 at 1:22 pm.

Refer to the telephone interview with the assistant to the Director on 06/15/20 at 11:43am.

Refer to the telephone interview with the Director on 06/16/20 at 10:27am.

____

Telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm revealed:
-The FSBS results were documented in the computer and showed on the residents' eMARs. -When a resident's FSBS result was outside of the ordered parameters, she notified the Resident Care Coordinator (RCC).
-The RCC notified the PCP by phone.
-The MAs and RCC documented in the resident records when the PCP was notified.
-If the RCC was not there, the MAs called the PCP and documented the notification in the residents' notes.
-The PCP was supposed to be notified at the time of the FSBS result and the documentation was supposed to be done at the time of the notification.
-For a FSBS result greater than the ordered parameters, the RCC or MA would notify the PCP by phone and document the notification in the progress notes.

Telephone interview with the assistant to the Director on 06/15/20 at 11:43am revealed: -She was hired as a personal care aide (PCA) and worked as the Director's assistant.
-She completed the "paperwork" for FSBS results by documenting the FSBS result and the PCP had been notified on a Physician Order Request form.
-She got the residents' FSBS results by reviewing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 34 the electronic medication records (eMARs). -There was generally a box on the eMARs that would say to call the PCP if the FSBS was above a specified parameter. -She went by whatever the eMARs said; different residents had different parameters of when to notify the PCP. -The MAs had been trained to notify the PCP if the FSBS result was above a certain number and it was the MAs responsibility to notify the PCP. -She did not check FSBS or notify the PCP. -It was not her responsibility to notify the PCP of FSBS results outside of ordered parameters. -It was the MAs responsibility to check the FSBS and to notify the PCP. -When she was completing the Physician Order Request forms for FSBS results, she was "assuming" the PCP had been notified by the MA. -She had not verified with the MA that the PCP was notified. -There was no communication between her and the MAs on whether the MA notified the PCP for a FSBS outside of ordered parameters. -When she was completing the Physician Order Request forms for FSBS results, she had not verified with the MA that the PCP was notified. -She was unsure why the PCP signature was the same of all the Physician Order Request forms. -The facility did not have a stamp of the PCP's signature or forms that were already signed by the PCP. -The PCP signed and dated the Physician Order Request forms for the residents when she was at the facility. -When she completed the Physician Order Request forms, the forms did not have the PCP's signature on them. Telephone interview with the Resident Care Coordinator (RCC) on 06/15/20 at 12:25pm	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 35 revealed: -When a resident had a FSBS result outside of the ordered parameters, the MA was supposed to call the PCP and wait for a return call. -After calling the PCP, the MA completed a Physician Order Request form with the FSBS result. -The Physician Order Request form was not always filled out at the same time of the FSBS result; sometimes the MAs were busy and completing the form was delayed. -The expectation was for the MA to stop what they were doing and notify the PCP at the time the FSBS was outside of the parameters. -She acknowledged the assistant to the Director completed the Physician Order Request forms sometimes after she (RCC) or a MA communicated to the assistant to the Director the FSBS results. -When the assistant to the Director wrote "MD was notified" on a Physician Order Request form, it meant the RCC or MA had notified the PCP by telephone of the FSBS and told the assistant to the Director that the PCP had been called. -There would not be any documentation in the residents' notes on the residents' status unless the resident was sent out to the hospital and there would not be a way to verify the PCP was called for FSBS results except the Physician Order Request form that the PCP signed and dated. -The PCP signed the form and dated the forms when she was onsite at the facility. -The date beside of the PCP's signature on the Physician Order Request forms was the date the PCP was onsite and signed the form. -The PCP's signature was hand signed when the PCP was onsite "most of the time." -She was not there when the PCP signed the Physician Order Request forms.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 36 -She did not know why the PCP's signature was exactly the same on all of the Physician Order Request forms for Resident #1, Resident #2, and Resident #5. -The facility did not have Physician Order Request forms that were blank at the top and already signed by the PCP at the bottom. Telephone interview with the facility's PCP on 06/15/20 at 1:22 pm revealed: -She would expect for the facility's staff to notify her if a resident's finger stick blood sugars were "greater than 450 or greater than 500". -The facility would call her or call her office and leave a message and she would either contact the facility or gave her office instructions to tell the facility what to do. -She was not sure what the facility's notification process was. -Everyone at the facility notified her in different ways such as some would notify her by calling her directly, others would notify her through her office via a faxed form or phone call. -For the most part she signed the Physician Order Request forms at the facility, because she was at the facility every week. -She always signed paperwork when she went to the facility and sometimes the date would be filled in next to where she signed, which was okay with her as long as they did notify her. -The word "noted" meant she read the notification and she was not going to do anything about changing to the medication. Telephone interview with the Director on 06/16/20 at 10:27am revealed: -For FSBS results outside of the ordered parameters, staff would continue with the medication pass and recheck the FSBS in 30 minutes per the facility's policy.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 37	D 273		

-She expected staff to go ahead and notify the PCP by phone when a FSBS result was outside of the ordered parameters.
-The residents' FSBS orders were written to have MAs call her or the RCC and they would tell staff to give the resident some water and recheck the FSBS.
-The assistant to the Director documented the Physician Order Request forms after the RCC had already called the PCP about the FSBS and then told her (the assistant to the director) to complete the form.
-If it was not documented in each resident's notes, the facility could not verify the PCP was notified each time a FSBS result was outside of the ordered parameters.
-The facility could look at the RCC's phone records or "basically" just confirm with the PCP she was called.
-She did not know why the PCP's signature was the same on all of the multiple Physician Order Request forms.
-She had not seen the PCP use a stamp to sign the forms.
-The word "noted" was written by the PCP in the order section of the Physician Order Request forms to document she reviewed it and did not have any new orders.
-The PCP signed the forms when she was onsite. -The dates beside of the PCP's signature was the date the PCP signed each form.

____

The facility failed to notify the Primary Care Provider (PCP) of multiple finger stick blood sugars (FSBS) results greater than 400 for 3 of 3 diabetic residents with orders for FSBS from March 2020 to May 2020 at the time of the actual FSBS result. All 3 residents had Hemoglobin A1C (Hgb A1C) laboratory (lab) results greater than 7% which is the target result recommended by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 273	Continued From page 38 the American Diabetes Association for adults diagnosed with diabetes. (Hgb A1C is a blood test that determines the average blood sugar for a period of two to three months). Resident #1's Hgb A1C result was 9.6 on 02/11/20 and 12.1 on 05/11/20. Resident #2's Hgb A1C result was 9.6 on 05/20/20. Resident #5's Hgb A1C result was 10.5 on 03/18/20. According to the American Diabetes Association, the higher the level of A1C increases the risk of developing diabetes complications which include neuropathy (nerve damage), kidney disease, and diabetic ketoacidosis (also known as DKA which is a serious complication that can result in coma and death).The facility's failure resulted in delays in PCP notification for all 3 residents and Resident #2 experiencing hyperglycemia requiring two hospitalizations due to complications of diabetes (diabetic ketoacidosis and hyperosmolar syndrome) and placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. ______________ The facility provided a Plan of Protection in accordance with G.S.-34 on June 16, 2020. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 31, 2020.	D 273		
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:	D 338	The following steps have been taken by the facility to correct the deficient area of practice resulting in Type A1 violation sited for 10A NCAC 13F .0909 Resident Rights during the June 16, 2020 survey. The facility has implemented a checklist to monitor building including COVID Hall at least twice a day for deficiency noted and other CDC/NC, DHHS, and LHD requirements in place during the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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		D 338		

Continued From page 39

TYPE A1 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 visitors, staff, and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolating residents in their assigned rooms; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and safety precautions to reduce the risk of transmission and infection.

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:
-Personnel should always wear a face mask in 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.
-Screen residents daily for fever and symptoms of COVID-19.
-All personnel should practice social distancing

COVID pandemic. At least one of the twice a day monitoring checklist will be completed by the facility director.

- All staff are required to wear face masks at work. Staff have been instructed to assure that their face masks covers their nose and mouth.
- Staff have been instructed that anyone seeking entrance into the building (including monitoring agents) must undergo COVID screening including temperature checks, answering questions regards symptoms and contacts.
- A notebook dedicated to recording temperature of staff, visitors, and residents has been placed at the nursing station and in the director office. Each temperature check is logged into the notebook at the time of the check. QMA/SIC are responsible for logging temperature checks and they have been instructed to be very careful to log accurately on the correct sheet at the time of the temperature check. Staff have been instructed to reframe from the use of note pads, etc. to record temperature checks. Employees who violate this possible will be issued a reprimand with appropriate consequence.
- Staff have been informed that they cannot clock-in to start their shift until their temperature has been checked and other COVID screening completed and logged. This is without exception.
-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 40 (remain at least six feet apart) when in common areas. -Implement social distancing among 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 PPE including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available. Review of notification from the North Carolina Department of Public Health dated 05/07/20 revealed: -Two of 59 residents residing in the facility had tested positive for COVID-19. -No staff had tested positive for COVID-19. - The date of first symptom onset was documented as 04/29/2020. -Contact Tracing was being conducted by the LHD and the LHD would continue to monitor. - Discussion was in progress regarding the testing of all residents and staff of the facility. Review of a copy of a letter addressed to the facility's Director dated 05/07/20 from the LHD revealed: -The LHD documented in the letter of notification on 04/29/20 that a resident residing in the facility had tested positive for COVID-19 and over the next "several days" other residents had also tested positive for COVID-19. -Timely and transparent communication with residents, employees, and families is necessary along with strict attention to basic infection prevention measures are critical to successfully manage the ongoing COVID-19 outbreak situation. -The letter provided directives for the facility to create a written plan that focused on	D 338	▪ Staff has a more than sufficient supply of PPE on hand that is accessible for staff use. The PPE supply includes, N95 mask, surgical mask, face shields, gloves, gowns, eye googles, shoe covers. There is also a sufficient supply of hand sanitizer. ▪ All staff have been instructed to don and remove PPE according to facility policy including washing hands and changing gloves after entering any resident's room, ▪ Hand sanitizer is available at each entrance to the building, on medication carts, in offices, and the smoking area. ▪ Staff have been instructed to assure social distance of at least 6 foot. ▪ Staff have been instructed to monitor residents for appropriate placement of mask. Any residents found to have mask removed and is outside of their room or within six feet of another person will be encouraged to replace the mask. The resident will be reminded of the importance of keeping the mask in place. They will be encouraged to do so. Any residents found to be outside of their room or within six feet of another person and have mask not properly place (i.e. below the nose) will be assisted to properly place the mask. The resident will be reminded of how to properly place mask and the importance of keeping the mask properly place. They will be encouraged to do so. ▪ Residents and staff have been instructed to keep social	

Division of Health Service Regulation

PRINTED: 07/02/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 41 "temperature and symptom screening," wearing appropriate personal protective equipment (PPE), social distancing, "cough etiquette," and "proper disinfection" which described actions the facility would take to protect residents and employees. -Restrict all visitors except for compassionate care situations. -Restrict all residents to their rooms. -The letter provided directives for the facility to implement specific precautions to reduce further risk of COVID-19 transmission to include but not limited to the following: ensure all residents wear a cloth face covering, ensure all residents that used the smoking area were at least 6 feet apart, and ensure all staff wore appropriate PPE. -The letter provided a list of COVID-19 resources to include multiple links to CDC guidelines and recommendations for infection prevention, LTC facilities, COVID-19 testing, and a COVID-19 preparedness checklist for LTC facilities. -The letter was signed by the following: the LHD Health Director and dated 05/07/20; the facility's Director and dated 05/07/20; and two witnesses' signatures and dated 05/07/20. Telephone interview with the local county Health Services Registered Nurse (RN) on 06/16/20 at 3:10pm revealed: -She made telephone calls to the facility's Director weekly, checking to determine if the facility had enough PPE and staff were following CDC guidelines, wearing PPE and distancing residents. -COVID-19 testing was done for residents on 05/08/20, 05/21/20 and 06/04/20; COVID-19 testing was currently being done weekly. -Several weeks ago (did not remember the date), she received a complaint the facility staff were not wearing face masks when on duty and caring for the residents.	D 338	▪ distancing of at least six feet including outside the facility in the smoking area. Staff and residents are instructed to wear mask over mouth and nose when in the smoking area and not smoking. ▪ Staff have been instructed to limit the number of residents and staff in the smoking area at the same time in order to allow for appropriate social distancing. ▪ Staff have been instructed to always wear a face mask while in the facility or in the smoking area when not smoking. They are instructed to wear the mask per facility policy. ▪ The facility has developed creative ways to encourage reluctant residents to wear mask and stay off halls, using incentives and praise. ▪ Staff have been instructed to be observant and diligent in instructing and redirecting residents in handwashing, wearing mask, and social distance. ▪ Staff monitor halls, and resident's on COVID hall have been instructed not to leave the C hall. Any resident leaving C hall is to be redirected to their room. ▪ Staff working on C hall have been instructed to place any used PPE into appropriate labeled disposal containers on the C hall. They have been instructed that any PPE that must be reused, must be treated according to policy, spray with appropriate disinfectant solution, and placed in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER: WELLINGTON PARK

STREET ADDRESS, CITY, STATE, ZIP CODE: 329 COOPER STREET, KENANSVILLE, NC 28349

(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 42 -The RN immediately called the facility, checking on the availability of PPE, and determined PPE was available to wear, but staff were not wearing the face masks at work. -She instructed the Director on the importance of staff wearing masks at work and it was the Director's responsibility to assure the facility was following CDC guidelines for COVID-19 management. Review of the facility's undated Policy and Procedure for Infection Control revealed: -Universal precautions were to be used by all staff of the facility. -Gloves were to be worn routinely. -Staff were to clean hands and change gloves between each patient contact. -Staff were not to touch anything with dirty gloves that anyone may touch without gloves, like a doorknob. -Staff would use appropriate PPE. -The facility would follow the most updated guidance from NC DHHS and CDC for COVID-19 for care of all residents with confirmed or suspected COVID-19. -Staff would be monitored for appropriate and consistent use of PPE per COVID-19 guidance. -Residents would be screened for COVID-19 with temperature checks and checking for respiratory symptoms. -All staff would be screened for COVID-19 before starting each shift for fever and respiratory symptoms. -All visitors would be screened for COVID-19 for fever and questioning related to respiratory and other symptoms. -All residents and staff would practice social distancing of at least 6 feet in all situations in which it was possible. -Environmental surfaces, including bathroom	D 338	▪ appropriate area, never left on the hall or in common area. ▪ Staff have been instructed to change gloves between residents and when leaving C hall to change all PPE. ▪ A PPE room is set up on the C hall and staff have been instructed to assure the room is continuously stocked with sufficient PPE supplies for use on the C hall. ▪ This portion of the corrective action plan was completed on June 18, 2020 and on-going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 43 surfaces, surfaces frequently touched by hands and all food preparation areas would be cleaned and disinfected more than other areas. Confidential telephone interview with a provider revealed: -The provider contacted facility staff and provided infection control practice recommendations for the facility to implement to prevent the transmission of COVID-19. -Recommendations included residents should have had daily temperatures taken to identify residents with elevated temperatures. -Recommendations included staff should have worn surgical masks in the facility and when near residents. -Recommendations included staff should have worn gloves when providing personal care to residents. -The facilty staff responded resident temperatures were taken daily. -Prior to 04/30/20 staff were not observed wearing gowns, gloves, face shields, goggles or face masks. -Staff were observed wearing N-95 or surgical masks, gloves and gowns for the first time on 04/30/20. 1. Observations of the outside of the facility on 05/23/20 at 8:48am revealed: -There was a sign posted on the window to the left of the front door that the facility was not accepting visitors "at this time." -There was a second sign posted on the window to the left of the front door which read "If you or someone you know have had close contact with has been sick with any type of contagious illness within the last 48 hours, please, please reconsider visiting with our residents until you have been free of symptoms for 7 days. Please	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 44 adhere to the following respiratory hygiene/cough etiquette: cover nose/mouth when coughing or sneezing into the insides of your elbow instead of your hands. Use tissues to contain respiratory secretions and dispose of them in nearest waste receptacle after use. Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials." -The front door was locked, and staff did not respond to answer a knock to the door. -In the side yard to the left of the front door/entrance, there was one female individual wearing blue colored scrubs, gloves, a hairnet, and an N-95 respirator mask and one male individual wearing blue jeans, a t-shirt, baseball type cap, and blue medical type masks that did not cover his nose. -The female identified herself as "kitchen" staff and started walking towards a second door located behind the yard area on the left side of the front door. -Upon reaching the side door entrance, the kitchen staff opened the side entrance door and was prompted on whether screening was required prior to entrance into the facility. -The side door had a sign posted that the facility was not accepting visitors at this time and another sign posted with instructions for coughing etiquette. Interview with the kitchen staff on 05/23/20 at 8:49am revealed: -The front door was locked. - "Come in the side door." -When asked if screening was necessary, she responded "No, come on in. You need to see the boss." Observation upon entrance into the facility on 05/23/20 at 8:50am revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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	See below	D 338		

Continued From page 45

-There was a medication aide (MA) standing in the right hall at a medication cart administering medications.
-The kitchen staff told the MA the [named staff] whom she had identified as the boss was needed.
-The MA told the kitchen staff "He's probably asleep."

Interview with the MA on 05/23/20 at 8:51am revealed:
-The [named staff] was needed to discuss when screening was required.
-There were three staff currently on duty: herself and two personal care aides (PCAs).
-There were currently five residents in the facility with a diagnosis of COVID-19.
-The residents with a COVID-19 diagnosis were "down that hall, past the door." (The hall was later identified by staff as C hall).

Interview with the Co-Resident Care Coordinator on 05/23/20 at 9:20am revealed:
-Staff were screened at the start of their shift by checking their temperature.
-A [named] staff who was the assistant to the facility's Director was responsible for screening staff and documenting the staffs' temperatures. -Residents were screened by having their temperatures checked three times daily at 8:00am, 2:00pm, and 8:00pm by the same staff person, him, or a MA.
-The residents' temperatures were documented in a log book by whichever staff checked them.

Review of a log book identified by the Co-Resident Care Coordinator as the log book for residents' temperatures on 05/23/20 at 9:21am revealed:
-There were sheets on a monthly log dated May

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 46 2020 with "COVID-19" and the residents name at the top. -Three of three residents' temperature logs reviewed last had temperatures documented on 05/17/20. -There was no documentation in the log book of staff temperature screenings for review. A second interview with the Co-Resident Care Coordinator on 05/23/20 at 9:22am revealed he could not find documentation of the staff temperature screenings right now. A third interview with the Co-Resident Care Coordinator on 05/23/20 at 9:45am revealed: -Precautions implemented in the facility since the COVID-19 pandemic to prevent infection and transmission included restricting visitor's except for emergency medical services (EMS), and health care providers; screening visitors and staff by taking their temperature and asking for symptoms of infection upon entry; and screening residents three times daily with temperature checks and symptoms. -Anyone with a temperature of 99 degrees Fahrenheit (F) or above was not allowed to enter the facility. -Staff who had a fever or any symptoms of infection were not supposed to come in to work. - Staff were screened before their shift by the assistant to the director. -The assistant to the director worked Monday - Friday; when she was not on duty, he screened the staff by taking their temperature. -He had not checked staff temperatures today (05/23/20) because he had "slept in" this morning because he had worked all night. Confidential staff interview revealed: -There had been times when staff had purchased	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 47 their own PPE but there was plenty of PPE available now. -Staff were supposed to have their temperature checked when they arrived at work. -The staff's temperature had not been checked today (date withheld to maintain confidentiality) upon arrival. -There had been "many days" when the staff's temperature was not checked prior to starting their shift. -The staff did not know if there were other staff that did not have their temperature checked upon arrival to work. Review of the staff temperature logs dated May 2020 received on 06/11/20 revealed: -The confidential staff's temperature was documented on the log for the date the staff reported it was not checked (date withheld to maintain confidentiality). -The Director's temperature was documented on the following dates when the Director was out of the facility due to COVID-19 diagnosis: 97.2 degrees F on 05/18/20; 97.8 degrees F and 05/19/20; 97.2 degrees on 05/20/20; and 97.4 degrees F on 05/21/20 and 05/22/20. Telephone interview with the Director on 06/15/20 at 2:00pm revealed: -She acknowledged she was not at the facility from 05/18/20 - 05/22/20. -Someone else's temperature's must have been documented on her designated temperature log form from 05/18/20 - 05/23/20. -The temperatures for the residents were not documented on the log on 05/23/20 because a lot of times the temperatures were checked and documented on a blank sheet of paper then transferred to the log book to prevent contamination.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 48 -The residents' temperatures had been checked but had not been transcribed to the log. -Either she, her assistant, or the Resident Care Coordinator (RCC) were responsible for transcribing the temperatures from the blank sheets to the logs. -She expected all staff to be screened with temperature checks before the start of each shift. -The medication aides (MAs) or Co-Resident Care Coordinators were responsible for ensuring staff were screened and for checking and documenting temperatures. 2. Observations on 05/23/20 at 8:50am revealed: -There was a medication aide (MA) standing in the right hall at a medication cart administering medications. -The MA had on a blue medical type mask that was not covering her nose. -There were two residents with the MA; none were practicing social distancing by standing closer than 6 feet of each other. -One resident did not have on a mask; the second resident had on a mask. -There was a third resident down the hall that had on a mask that did not cover her nose. Observations during the initial facility tour on the men's hall on 05/23/20 at 8:55am revealed: -There were several residents in the hall with their masks below their noses -At the end of the men's hallway, there was a resident common area in which two residents were sitting at a distance of greater than 6 feet apart. Neither resident was wearing a mask/facial covering. -There was a third resident walking in the common area; the resident pulled a cloth covering on his neck up so that it covered his nose and mouth.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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		D 338		

Continued From page 49

-There were no staff available to prompt or re-direct residents back into their rooms or prompt on the correct positioning of the facial masks.

Interview with a resident on 05/23/20 at 8:55am revealed the staff on duty were outside in the smoking area.

Observations of the outside smoking area on 05/23/20 at 8:56am revealed:
-There were nine residents and two staff members in the smoking area; some residents had on masks and some did not have on masks. -The two staff had on masks placed below their noses
-Four of the nine residents in the smoking area were not maintaining 6 feet of social distancing.

Interview with two personal care aides (PCAs) on 05/23/20 at 8:56am revealed:
-They were the only two direct care staff on duty at the time; there was currently one MA on duty.
-They were "on break."
-The facility census was "about 65."
-The PCAs acknowledged they were supposed to wear masks.
-"That is really it unless we go down the contaminated hall."
-The contaminated hall was C hall.
-When they went to C hall, they "suited up" in jumpsuits and wore gloves and masks. -There were no staff designated to care specifically for the residents on C hall.
-The staff wore the blue hospital type masks like they were wearing. The staff did not wear N-95 masks when on C hall.
-The residents were all supposed to be wearing masks at all times.
-All residents had been given a cloth mask.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 50	D 338		

-"Most" residents did not like wearing a mask. -The staff could not make the residents wear masks.
-The residents were not supposed to be in the halls and were supposed to stay in their rooms; staff could not make residents stay in their rooms.

Observations on 05/23/20 from 9:00am-9:02am revealed:
-The two PCAs left the outside smoking area and entered the building; leaving the residents outside in the smoking area.
-The PCAs passed two residents in the hall who were not wearing a mask or facial covering. -The PCAs did not prompt or re-direct the residents back into their rooms or the requirement to use masks.

Second interview with a resident on 05/23/20 at 09:03am revealed:
-Residents were supposed to wear masks when they came out of their rooms because some residents had COVID-19.
-He forgot to wear his mask sometimes.

Observations of the main hall near the office on 05/23/20 at 9:05am revealed:
-The [named] Co-Resident Care Coordinator and a housekeeper was standing in the hall near the office.
-There were two residents in the hall.
-One resident was wearing a mask below her nose.
-The Co-Resident Care Coordinator or housekeeper did not prompt the residents to return to their rooms.
-The Co-Resident Care Coordinator or housekeeper did not prompt the resident to place the mask over their nose.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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		D 338		

Continued From page 51

Interview with the Co-Resident Care Coordinator on 05/23/20 at 9:05am revealed:
-He was not available earlier because he had been asleep; he had worked until about 5:00am.
-The facility census was 59.
-There was one MA currently on duty and two PCAs currently on duty.
-There was supposed to be a third PCA on duty, but the PCA was not there and he did not know where that PCA was.

Interview with two PCAs on 05/23/20 at 9:15am revealed:
-The PCAs wore "suits" when they went on C hall. -They also wore gloves and the blue hospital type masks on C hall.
-They did not wear goggles or face shields when on C hall.
-There were six residents currently on C hall; all were male residents.
-"Five have COVID."
-The facility's stock of PPE was kept locked up in the office.
-They changed their gloves "whenever we need to."
-They changed their masks every day.

Observations of the common area at the end of the women's hall and looking down the C hall from the common area on 05/23/20 at 9:15am revealed:
-There was one resident walking in the hall on C hall. The resident pulled his mask up over his nose and kept walking in the hall.
-There were two PCAs in the women's hall who could directly visualize C hall.
-The two PCAs did not re-direct or prompt the resident on the C hall to go back into his room. -One PCA picked up the blue jumpsuit cover off the wood table, held it up for visualization, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 52	D 338		

then placed it back on the wood table at the beginning of C hall.
-As the PCAs walked back down the women's hall toward the office area, they passed by the MA and two residents in the hall; one resident did not have on a mask.
-The residents were not prompted by either of the three staff to go back into their room and the resident without a mask was not prompted on the requirement of a mask.
-As the PCA passed by the MA, the MA said that she changed masks several times a day and changed her gloves between residents. -The MA then stated, "we are supposed to change PPE after going on the infected hall," but she did not know if everyone did that.

Observations in the facility's office with the Co-Resident Care Coordinator on 05/23/20 at 9:20am revealed:
-The Co-Resident Care Coordinator was not wearing a mask or other PPE and was not practicing social distancing.
-The Co-Resident Care Coordinator provided access to the facility's current PPE stock.
-The PPE on hand included 1 box of face shields, three boxes of goggles, 58 gowns, and 10 jumpsuit type clothing covers, and numerous boxes of gloves.
-There were no N-95 masks observed. -There was one pump spray bottle of an environmental cleaning disinfectant which the Co-Resident Care Coordinator identified as the disinfectant used by staff to spray down the blue PPE jumpsuits.

Interview with the Co-Resident Care Coordinator on 05/23/20 at 9:20am revealed:
-Staff were supposed to wear gloves, suits, masks, and face shields when on C hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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		D 338		

Continued From page 53

-The facility had previously been low on gowns, but not lately.
-The staff re-used the "blue suits"; they sprayed them down after use with the "antiseptic" spray then let them dry a few minutes before reuse.

Interview with a kitchen staff on 05/23/20 at 9:25am revealed:
-The residents were supposed to be staying in their rooms.
-The dining rooms were closed.
-Residents' meals were taken to the residents' rooms and the residents ate meals in their rooms.

Observations on the women's hall on 05/23/20 at 9:26am revealed:
-The MA was at the medication cart with a resident that was not wearing a mask; the MA was wearing a mask.
-There was another resident walking in the hall with a rollator without practicing social distancing; the resident was wearing a cloth face mask. -The MA stepped inside the doorway of a resident room and administered insulin from an insulin pen in the right upper arm of the resident that was not wearing a mask.
-The MA did not prompt the resident with the rollator to return to her room, to practice social distancing, or prompt the other resident to wear a mask.

Interview with the MA on 05/23/10 at 9:26am revealed:
-She did not take the medication cart onto C hall when she administered medications to the residents on C hall.
-She "suited up" in PPE with a suit, gloves, and mask and took the medications to the residents on C hall.
-She changed her PPE after going onto C hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 54 Observations of C hall on 05/23/20 at 9:32am revealed; -A PCA was standing in the common hallway at the entrance to C hall; she already had on a blue surgical type mask and gloves and was donning a blue jumpsuit that had been laying on the wood table. -The PCA did not have on an eye shield or goggles. -There were 3 residents standing in the hall on C hall who were visible to the PCA and within voice reach. -Two of the three residents did not have on face masks or facial coverings. -One of the two residents without masks said without prompt or questioning "I better go get my mask," turned around, and went into a room. -The PCA did not prompt the residents to return to their rooms or to put on a mask. -The PCA knocked on the door to resident room #9 and went into the room, touching the resident, who was lying in bed, on the arm with her gloved hand. She asked the resident "You okay?" The resident did not respond verbally. -The PCA did not change her gloves after exiting resident room #9. -The PCA proceeded to resident room #8, opened the door by using the doorknob, entered room #8, opened a disposable polystyrene food container that was sitting on the bedside table and then closed the food container. She asked the resident, who was in the bed, "Are you okay," then left resident room #8 and was back in the hall. -The PCA did not change her gloves after exiting room #8. -The PCA proceeded to resident room #11. She knocked on the door, then entered the room. -She asked the resident "Do you need anything?"	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 55 The resident responded "No" verbally. The PCA exited room #11. -There were two residents in the hall; both were wearing masks. -The PCA was removing the blue suit when one of the two residents who was standing in the hall on C hall walked past her and into the common area of the women's hall which was directly across from C hall. -The PCA did not prompt or re-direct the resident back to C hall or to his room. -The PCA hung the blue suit on the wood rail in the common women's hall. She did not spray the suit with any type of disinfectant; the jumpsuit was left by the PCA on the wood rail. -The PCA removed her gloves, put the gloves in a trash can on the housekeeping cart that was parked on the women's hall, then cleaned her hands using hand sanitizer from the housekeeping cart. -The PCA did not change her mask and proceeded to walk back down the women's hall towards the office area. -There were two residents still standing in C hall and common area when the PCA left C hall; the PCA did not prompt or re-direct the residents back into their rooms. Observations of the MA on 05/23/20 at 9:35am revealed she was standing at the medication cart in the main hallway near the office, her facial mask was below her nose. Interview with the Co-Resident Care Coordinator on 05/23/20 at 9:45am revealed: -Precautions implemented in the facility since the COVID-19 pandemic to prevent infection and transmission included giving all residents cloth masks; isolating residents into their room and having them wear masks at all times; social	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 56 distancing; staff keeping residents' smoking materials and taking the residents out to smoke at specific times for staff to monitor social distancing. -Residents were supposed to be isolated to their rooms and to wear cloth masks at tall times. -Residents were supposed to be 6 feet apart when in the smoking area and staff were supposed to go out with the residents to the smoking area to watch for social distancing. -Staff reminded residents to stay in their rooms and should be reminded residents to wear their masks too by talking to them, encouraging them, and re-directing them. -Some resident said they did not like wearing their masks or they lost their mask; if they lost their mask, he gave them another mask. -Staff were supposed to be using masks and gloves at all times; when on C hall, staff were also supposed to wear gowns or jumpsuits, goggles, and booties on their shoes. -The facility had a supply of N-95 masks; staff were supposed to be wearing the N-95 masks on the COVID hall (C hall). -A named individual from the local health department (LHD) told the staff they could reuse the gowns and goggles as long as the items were sprayed with a 50/50 bleach solution or disinfectant and dried before re-use. -He had told staff he would rather they not reuse PPE. -Staff were "not reusing too much" PPE. -Staff were supposed to change their masks when going into each residents' room. -There was supposed to be a box with a red bag in it on C hall for trash. The boxes with red bags were picked up by the contracted pharmacy. -The box with the red bag for trash was not on C hall today (05/23/20) because he took it out last night.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ________ B. WING ________	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 57 Telephone interview with a medication aide (MA) on 06/11/20 at 12:11pm revealed: -For approximately 2 months (since March 2020), the facility had implemented the following in response to the COVID-19 pandemic: residents and staff were supposed to wear masks at all times; social distancing when in halls of 6 feet; having signs posted as reminders for staff and residents; and residents temperatures were checked three times a day at 8:00am, 2:00pm, and 8:00pm by a Co-Resident Care Coordinator. -The residents were supposed to wear cloth masks. -The staff wore the blue surgical type masks or the N-95 white masks. -Residents who had tested positive for COVID -19 were all isolated on the C hall. -There was always a PCA assigned to C hall on each shift. -When staff were on C hall, they wore full PPE which consisted of gown, gloves, apron, face mask, face shield, and shoe covers. -When staff left C hall, they removed all of their PPE at the end of C hall and placed it in a disposable box at the end of the hall. -There was a station at the end of C hall with hand sanitizer, clean gloves and clean masks. -Staff were not supposed to reuse any PPE when leaving C hall and were supposed to put on new PPE after leaving C hall. -If she saw a resident in the hall, not social distancing, or without a mask, she talked to them, reminded them, and re-directed them. -Only seven residents were allowed in the smoking area at one time and staff were out with them to make sure they were social distancing; staff disinfected the smoking area in between the residents going out to the smoking area.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 58 Telephone interview with the Administrator on 06/12/20 at 1:55pm revealed: -Residents had been directed to stay in their rooms and to wear masks but many residents did not do as directed. -He had been told staff were constantly re-directing the residents, but the residents could not be forced to stay in their rooms or to wear a mask. -He referred questioning to the facility's Director, Regional Director, and a named staff of the LHD regarding what was implemented and expected to be in place as COVID-19 precautions. Telephone interview with the Director on 06/15/20 at 2:00pm revealed: -The facility's infection control policy had always been in effect and was updated to include directives on COVID-19 around 03/10/20. -Staff had been trained on and signed the policy. -Staff were expected to wear appropriate personal protective equipment (PPE). -She expected the staff to follow the local health department (LHD), Centers for Disease Control (CDC) guidelines for COVID-19 and to follow the facility's infection control policy to reduce and prevent the spread of COVID-19 for residents and staff. -She "recommended" that the residents followed the infection control policy and CDC guidelines. -Residents were encouraged by staff to follow the policy and guidelines but residents could not be made to follow the policy or guidelines. -She expected staff to talk to, re-direct, and encourage residents to follow the policy and guidelines. Telephone interview with the Regional Director on 06/15/20 at 3:55pm revealed: -Staff were expected to follow the infection control	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 59	D 338		

policy and LHD & CDC guidelines related to COVID-19.
-All staff had been trained on the facility's infection control policy and had signed the policy.
-Staff were trained yearly on the policy and also trained at the beginning of the COVID-19 pandemic (no date provided).
-Staff were expected to wear appropriate PPE. -When on the COVID-19 hall (C hall), staff were expected to wear gowns, masks, gloves, and a face shield.
-Residents could not be forced to stay in their rooms or to wear a mask.
-Staff were expected to try to enforce the LHD and CDC guidelines related to COVID-19 with the residents.
-If staff observed a resident without a mask, the staff were expected to encourage the resident to wear a mask and to explain the risks of not wearing a mask to the resident.
-"Residents have the right to make poor decisions for themselves."

3. Observations of the main hall near the office area and entryway at the side door on 05/23/20 at 8:53 revealed:
-There was no hand sanitizer or PPE available on the table for use upon entrance.
-There were multiple signs posted on the office windows and adjacent walls related to infection control, coughing etiquette, social distancing, limiting visitation, and cessation of activities. -There was a telephone sitting on a ledge at the office door.
-There was no hand sanitizer or PPE available at the office area on main hall area for use by staff, visitors, or residents.

Observations during the initial facility tour on 05/23/20 at 8:55am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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	(see below)	D 338		

Continued From page 60

-The floors on the mens' hall were dirty with debris, spilled cereal and milk.
-Some areas of the floor felt sticky when walked upon.
-There were multiple polystyrene disposable food serving boxes sitting on the floor down the length of the hall.
-There was one black plastic trash bag on the floor.

Interview with two personal care sides (PCAs) on 05/23/20 at 8:56am revealed:
-There was currently no housekeeping staff on duty.
-Housekeeping staff worked 7:00am-3:00pm shifts 7 days per week; they did not know the last shift housekeeping had worked.

Observations on 05/23/20 from 9:00am-9:02am revealed:
-Two PCAs were sitting outside in the designated smoking area, left the outside smoking area and entered the building; leaving residents outside in the smoking area.
-The PCAs were not observed cleaning orsanitizing the smoking area before leaving.

Interview with a housekeeper on 05/23/20 at 9:06am revealed:
-He was scheduled to work from 7:00am - 7:00pm today (05/23/20).
-He had just arrived at work.
-He had not received any specific training on cleaning precautions for COVID-19.
-Since the outbreak of COVID-19, the way he performed cleaning of the facility was "pretty much the same thing" as he had always done (prior to COVID-19) except he was told by the Co-Resident Care Coordinator to spray the door knobs with disinfectant and wipe them down more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL031006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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		D 338		

Continued From page 61

often.
-His process for cleaning was to go up and down each hall and clean the floors, bathrooms, and resident rooms and take out the trash.
-He swept the floors.
-He mopped the floors if they were dirty. -His process for cleaning the C hall where residents resided who had COVID-19 was the same as the process as he used on all the other halls and he did "nothing extra" except he wore a suit, mask, and gloves when he cleaned the C hall.
-He did not wear a face shield or goggles on the C hall.

Observations of the common area at the end of the women's hall and looking down the C hall from the women's hall common area on 05/23/20 at 9:15am revealed:
-There was a pile of clothing laying on the floor in the common area at the end of the women's hall located directly across from entrance to C hall. -There were two blue colored jumpsuit style clothing covers at the beginning of C hall; one was hanging on the wooden rail and the second was laying on a wood table placed near the rail; both of which were readily accessible and could be inadvertently brushed or touched by anyone walking in the women's common hall. -There was no hand sanitizer available or accessible to staff or residents.
-There was no trash receptacle in place on C hall for disposal of trash and contaminated items such as PPE.
-There was no PPE station or designated area with clean PPE available.

-There was a clear trash bag laying on the floor on C hall behind the wooden table which contained trash to include soiled adult incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 62	D 338		

briefs.
-There were 2 plastic disposable type cups sitting on the wooden table beside the blue jumpsuit clothing cover.

Observations in the facility's office with the Co-Resident Care Coordinator on 05/23/20 at 9:20am revealed:
-There were numerous cans of an EPA approved spray disinfectant.
-There was one pump spray bottle of an EPA environmental cleaning disinfectant which the Co-Resident Care Coordinator identified as the disinfectant used by staff to spray down the blue PPE jumpsuits.

Interview with the Co-Resident Care Coordinator on 05/23/20 at 9:45am revealed:
-The facility currently had three housekeeping staff, but one would not come to work due to the COVID-19 pandemic.
-One [name] housekeeping staff came in every day.
-The housekeeper cleaned the bathrooms, resident rooms, and mopped the floors daily. -The carpet in the main foyer was not vacuumed every day.
-The floors were mopped with water and a named disinfectant cleaner; they could not use bleach in the mop water because of the odors from the bleach.
-The cleaning of the facility since the COVID-19 pandemic included just keeping everything as clean as possible and the housekeeper wiping the wooden rails in the halls and door knobs twice a day with a 50/50 bleach solution or "antiseptic" spray; the "aides" on third shift also cleaned the rails and door knobs again on third shift.
-The completion of cleaning was not documented anywhere.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 63 -The two housekeepers could probably use more help, but the third housekeeper could not work right now. -The contracted pharmacy came out in "probably" April 2020 and provided infection control training and one other training for "most" of the facility staff to include housekeeping staff, the Director, and RCC. -The housekeeping staff had not had any special classes or training on COVID-19 cleaning precautions; he had talked to the housekeepers and told them how long the virus could live on surfaces and what they could and could not spray around the residents. Telephone interview with a MA on 06/11/20 at 12:11pm revealed: -For approximately 2 months (since March 2020) all staff had been cleaning and disinfecting high touch surfaces such as rails, door knobs, tables, and chairs whenever they could. -Staff disinfected the smoking area in between the residents going out to the smoking area. Interview with the Director on 06/15/20 at 2:00pm revealed: -The facility had gone above and beyond with environmental cleanliness since the COVID-19 outbreak and were cleaning and sanitizing high touch areas every two hours. -She had personally cleaned throughout the facility "many times." -All staff had been assisting with the environmental cleaning and were expected to sanitize the hand rails, clean the bathrooms, and mop every 2 hours. -Staff were supposed to wipe down the surfaces and sanitize the smoking area in between use of six residents at a time. -Sanitizer was in place throughout the building.	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 66 management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to resident rights and health care which is the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure physician notification for 3 of 3 sampled diabetic residents (#1, #2, #5) with finger stick blood sugars (FSBS) greater than 400 at the time of the FSBS result. [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Type A2 Violation)].	D914	▪ This portion of the plan of correction was completed on June 25, 2020 and is ongoing.	
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 65	D914		
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 with the necessary care and services to maintain their physical health as related to resident rights, health care, and implementation. The findings are: 1. 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 visitors, staff, and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolating residents in their assigned rooms; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and safety precautions to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the	D914	The following steps have been taken by the facility to correct the deficient area of practice sited for G.S. 131D-21 Declaration of Residents' Rights during the June 16, 2020 survey. ▪ All staff have received updated training on the Resident's Bill of Rights and are aware that the importance of follow all rules and guidance provided by Department of Health Service Regulation, Local Health Department and they Duplin County Department of social services including emergency rules initiated during the COVID 19 pandemic. We will assure that regarding blood glucose monitoring and reporting, policy and procedures for infection control including COVID 10 policy are adhered to by all staff. ▪ Any staff found to violate the rules and guidelines will be reprimand with penalty which could include loss of employment if incident warrant this action. ▪ This will be monitored through day to day communication with residents by the Director and supervisory staff and monitoring checks of halls and record keeping according to the aforementioned schedule on a routine basis. ▪	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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 66 management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to resident rights and health care which is the responsibility of the Administrator. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure physician notification for 3 of 3 sampled diabetic residents (#1, #2, #5) with finger stick blood sugars (FSBS) greater than 400 at the time of the FSBS result. [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Type A2 Violation)].	D914	▪ This portion of the plan of correction was completed on June 25, 2020 and is ongoing.	
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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
D980	Continued From page 67 receive adequate and appropriate care and services and to be free of neglect as related to resident rights and health care. The findings are: Interview with the Co-Resident Care Coordinator (Co-RCC) on 05/23/20 at 9:45am revealed: -He had basically overseen the facility and had not left the facility for 3 weeks since the facility's Director and Resident Care Coordinator (RCC) had been out of work. -The Director and RCC would be returning to work on Tuesday (05/26/20). -The Director was not the actual Administrator of the facility. -The Administrator had not been to the facility in approximately one week. Telephone interview with the facility's Director on 06/01/20 at 9:54am revealed the Administrator had not been to the facility since she returned to work (date not provided) but was available by phone. Telephone interview with the Assistant Director in training on 06/15/20 at 11:43am revealed: -She was hired in March or April 2020. -Since being hired, she had not ever met the Administrator but knew he came to the facility one day when she was not there. -She was not sure of the date of the Administrator's last visit to the facility. -The Administrator called the facility at least once a week and she had spoken with the Administrator by phone (date not provided). A second telephone interview with the facility's Director on 06/15/20 at 2:00pm revealed: -The Administrator was "in and out" of the facility	D980	The following steps have been taken by the facility to correct the deficient area of practice sited for G. S. 131D-25 Implementation during the June 16, 2020 survey. The administrator will provide oversight, guidance and training to assure that the resident's receive adequate and appropriate care and services and that they remain free of neglect as related to the resident rights and health. ▪ The administrator and/or his designee will be in the facility at lease monthly to observe the provision of services and communicate with residents, as well as to provide guidance and training. ▪ When not in the facility, the administrator will continue to use camera surveillance to monitor services being provided. Any problem noted will be dealt with and corrected immediately. ▪ The administrator and/or his designee will also talk with the in-house director each business day to assure operation of the facility is sufficient, staff issues are minimal and resolved as soon as possible, and supplies are readily available. ▪ This portion of the plan of correction was complete on June 18, 2020 and is ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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
D980	Continued From page 68	D980		

monthly; he completed a walk through and provided notes of any concerns he had.
-The facility had a Regional Director who assisted with the oversight of the facility's operations. -The Regional Director completed monthly audits of the facility (specific details of the audits were not provided).
-She had been unable to work at the facility 0518/20-05/25/20; she returned to work on 05/26/20, but she had still been monitoring the facility while absent.
-While she was absent, she was still working and had maintained constant contact with the local health department, a named Co-RCC, the Regional Director, and the Resident Care Coordinator (RCC).
-The RCC had also been out of work during the same time frame that she had been out of work (dates not provided).
-During her absence, the Regional Director was handling the everyday operations of the facility. -During her absence, the Administrator had not been to the facility but had been monitoring the facility's video camera footage and was available by phone as needed.
-When asked if she had any concerns or had reported any concerns to the Administrator during her absence, she did not respond with an answer.

Telephone interview with the RCC on 06/15/20 at 12:25pm revealed:
-She had been out of work from 05/17/20-05/28/20; she returned to work on 05/29/20.
-During her absence, a Co-RCC had been responsible for completing her duties and she had maintained contact with the Co-RCC during her absence.
-Although she was not in the facility on those dates, she was still working by monitoring the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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
D980		D980		

Continued From page 69

facility's video camera footage and maintaining constant contact by phone or the computer with the Director, the Co-RCC, the Regional Director, and the Administrator.

Telephone interview with the Regional Director on 06/15/20 at 4:13pm revealed:
-She was responsible for assisting with oversight of the facility.
-Prior to COVID-19, she went to the facility about every two weeks.
-Since the COVID-19 pandemic (specific dates not provided), she was utilizing phone calls, conference calls, and telemonitoring for oversight.
-Telemonitoring involved reviewing the video camera footage in the common areas such as the common areas and smoking area.
-She was in contact with the Director, RCC, and Co-RCC multiple times a day when the Director and RCC were out.
-Her telemonitoring and calls were ongoing and involved ensuring staffing was "good", monitoring different residents and their care, and cleaning of the facility.
-During the time of the Director and RCC's absence, she did not have any concerns related to use of PPE or maintaining CDC guidelines related to COVID-19 within the facility.

Telephone interview with the Administrator on 06/12/20 at 1:55pm revealed:
-The facility's Director and RCC had not been able to work for a period of time in mid-May 2020.
-He thought the Director had been out of work for 8-10 days (dates not provided).
-During the time frame that the Director and RCC had been out, he was not able to go to the facility but there was a Regional Director that helped with oversight of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ___ B. WING ___	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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
D980	Continued From page 70	D980		

-During the time frame that the Director and RCC had been out, the Regional Director was not able to go to the facility.
-The Regional Director was managing the facility "from afar" during this time frame by looking at the cameras remotely.
-There was also a Co-RCC overseeing the facility during that time frame who was very knowledgeable and had been staying onsite in the building which had benefited the residents by the Co-RCC being there as an extra staff on duty and to supervise other staff.
-The facility's Director was also trying to oversee the facility during this time frame via video camera review as much as she could.
-He had been told and assumed the Director was in constant contact with the Co-RCC during her absence.
-He was "almost sure" the Director had been in contact with the LHD from the start of the notification of positive COVID-19 cases in the facility and had been following the LHD guidelines.
-When the Director and RCC had been out, (before 05/23/20), the facility had been doing the best they could in a new and changing situation with the Director and RCC out of the facility. -After 05/23/20, the facility developed and incorporated a daily checklist which he had approved.
-After the development of the checklist, it had been completed twice daily to ensure all concerns identified on 05/23/20 had been addressed. -He referred additonal questioning to the facility's Director, Regional Director, and a named staff of the LHD regarding what was implemented and expected to be in place regarding implementation of CDC guidelines and COVID-19 precautions. -"I am just not there, so I don't know."

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031006	A. BUILDING: ______ B. WING ______	C 06/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PARK	329 COOPER STREET KENANSVILLE, NC 28349

(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
D980	Continued From page 71 Non-compliance was identified at violation level in the following rule areas: 1. 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 visitors, staff, and residents; use of personal protective equipment (PPE) by staff and residents; practicing social distancing and isolating residents in their assigned rooms; practicing basic hand hygiene and infection control procedures and maintaining environmental cleanliness and safety precautions to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC 13F. 0909 Resident Rights (Type A1 Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure physician notification for 3 of 3 sampled diabetic residents (#1, #2, #5) with finger stick blood sugars (FSBS) greater than 400 at the time of the FSBS result. [Refer to Tag D273, 10A NCAC 13F. 0902(b) Health Care (Type A2 Violation)]. The Administrator failed to ensure the facility's infection control policy was maintained, and staff adhered to the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and the North Carolina Department of Health and Human Services (NC DHHS) to protect the residents from infection and transmission of Coronavirus	D980		

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Richard A. Cresenzo, Executive Officer
Wellington Park, Inc., Licensee
Wellington Park
2135 South Scales Street
Reidsville, NC 27320

9590 9402 5231 9122 6627 15

2. Article Number (Transfer from service label)

7019 0700 0000 1710 5231

PS Form 3811, July 2015 PSN 7530-02-000-9053

COMPLETE THIS SECTION ON DELIVERY

A. Signature
x Dorothy Fugua ☐ Agent ☐ Addressee

B. Received by (Printed Name) Dorothy Fugua

C. Date of Delivery 7/7/20

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

RECEIVED
JUL 14 2020
ADULT CARE LICENSURE SECTION
RALEIGH

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Insured Mail
☐ Insured Mail Restricted Delivery (over $500)
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery

Domestic Return Receipt

7019 0700 0000 1710 5231

U.S. Postal Service
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.

REIDSVILLE, NC 27320
OFFICIAL USE

Certified Mail Fee $3.55
$ $2.85
Extra Services & Fees (check box, add fee as appropriate)
☐ Return Receipt (hardcopy) $ $0.00
☐ Return Receipt (electronic) $ $0.00
☐ Certified Mail Restricted Delivery $ $0.00
☐ Adult Signature Required $ $0.00
☐ Adult Signature Restricted Delivery $

Postage $2.20

Total Postage and Fees $8.60

0171
19
Postmark Here
07/02/2020

Sent To
Street and Apt. No., or PO Box
City, State, ZIP+4®

Richard A. Cresenzo, Executive Officer
Wellington Park, Inc., Licensee
Wellington Park
2135 South Scales Street
Reidsville, NC 27320

PS Form 3800, April 2015 PSN 7530-02-000-9047 See Reverse for Instructions