FORM APPROVED LHD recommendation to follow Secretarial Order 2 Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C HAL055009 B WING 08/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 440 SALEM CHURCH ROAD THE ADDISON OF LINCOLNTON LINCOLNTON, NC 28092 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CORRECTIVE ACTION SHOULD BE CROSS-TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Tag338 10A NCAC 13F .0909 D 000 Initial Comments D 000 The recommendation from the Lincoln The Adult Care Licensure Section conducted a State involved complaint investigation and a County Health Department on 8/27/2020 COVID-19 Infection Control Survey with an onsite was to test all current previously negative visit on 08/25/20, a desk review survey on 08/26/20 - 08/28/20 and a telephone exit on residents and staff weekly until there were 08/31/20. no new positive cases within 14 days of the most recent positive case. D 338 10A NCAC 13F .0909 Resident Rights D 338 On 8/27/2020 per the direction of Lincoln 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of County Health Dep. the Facility does not all residents guaranteed under G.S. 131D-21, need to retest asymptomatic staff and Declaration of Residents' Rights, are maintained residents that have been tested positive in and may be exercised without hindrance. the past three months prior to the most This Rule is not met as evidenced by: recent round of testing. Current Residents TYPE A1 VIOLATION and staff who met the criteria for testing 9/01/2020 Based on record reviews, and interviews, the were tested between 8/28/2020 and facility failed to ensure recommendations and 9/01/2020. Results of these tests were guidance established by the Centers for Disease negative. COVID-19 test results are Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and available for review. directives from the local health department (LHD) were implemented and maintained to provide Current Residents and staff who met the 9/04/2020 protection of the residents during the global criteria for testing were again tested coronavirus (COVID-19) pandemic as related to rapidly taking action to test staff and all residents between 9/03/2020 and 9/04/2020 and all and retesting staff and residents that were results were negative. Current residents negative for COVID-19, weekly after an outbreak and staff who met the criteria for testing dated 06/29/20 to reduce risk of transmission and infection. were again tested on 9/10/2020 and all results were negative. All COVID-19 test The findings are: 9/10/2020 results are available for review. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term care (LTC) facilities dated 06/20/20 revealed: Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Executive Director

STATE FORM

Reviewed and accepted by Diana Spalding RN, BSN on 10/13/20.



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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE S	
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D 338	Continued From page	1	D 338	Lincoln County Health Dept.		
	-Testing asymptomatic	c residents with known or		recommended on 9/15/2020 that t	:he	
	suspected exposure to	o an individual infected with		community follow NCDHHS Secreta	arial	
	SARS-CoV-2 (COVID	-19), including close and		Order #2 from 8/07/2020 (see atta	ched	
	the facility).	.g., there is an outbreak in		order), which directs testing for all		
	-Perform expanded viral testing of all residents in			staff who have a direct and indirect		,
the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any Health Care Personnel (HCP) or any nursing home-onset SARS-CoV-2 infection in a resident). -A single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2			exposure to patients and infectious			
			materials at least every other week			
			at least every strict week			
			Current Staff who met this criteria	were	9/24/2020	
			tested between 9/22/2020 and 9/2	4/2020.		
	infection in a resident should be considered an outbreak.			results are all negative. (COVID-19	500	
	-Performing viral testir	ng of all residents as soon		results are available for review.)		
	as there is a new conf	irmed case in the facility will		a a a a a a a a a a a a a a a a a a a		
		ents quickly, in order to name		Current Staff who met this criteria	were	10/1/2020
	rapid implementation	of IPC interventions (e.g.,		tested again between 9/29/2020 ar	nd	
		se of personal protective		10/01/2020, all staff except one we		
	equipment) to prevent	SARS-CoV-2		negative. The staff member (worke		,
	transmission.	y is limited, CDC suggests		Memory Care the day before) who		
		residents who are close		positive is in self quarantine for at I		
	contacts (e.g., on the	same unit or floor of a new		days. The community tested the M		
		ed for by infected HCP). ordination with the Health		Care residents on 10/2/2020 per di		
	Department.	ordination with the Health		of the Lincoln County Health Depar		
	-After initially performi	ng viral testing of all		The state of the s	tment,	
	residents in response			all residents results were negative.		
	recommends repeat to	esting to ensure there are ong residents and HCP and		The community will continue routin	16	
	that transmission has			COVID-19 testing of current staff ba		9/21/2020
	described below.			the NCDHHS Secretarial order #4 da		,
		be coordinated with the				
	local, territorial, or stat	e nealth department. testing of all asymptomatic		9/21/2020 related to Positivity rate		
	previously negative res	sidents and staff,		Lincoln County per www.data.cms.g	-	
	approximately every 3	days to 7 days, until the		(See Attached order). The commun		
	testing identifies no ne	w cases of SARS-CoV-2		continue implementing these testin	g	

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION PROVIDER/SUPPLIER/CLIA COMPLETED A. BUILDING: IDENTIFICATION NUMBER C B WING 08/31/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 440 SALEM CHURCH ROAD THE ADDISON OF LINCOLNTON LINCOLNTON, NC SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX CORRECTIVE ACTION SHOULD BE CROSS-PREFI COMPLETE TAG REGULATORY OR LSC IDENTIFYING REFERENCED TO THE APPROPRIATE X TAG DATE INFORMATION) DEFICIENCY) Continued From page 2 protocols until NCDHHS issues revised D 338 orders, or as otherwise directed by the infection among residents and HCP for a period of at least 14 days since the most recent Lincoln County Health Department. In the positive result. event that test availability is limited, the -This follow-up viral testing can assist in the clinical management of infected residents and in community will communicate with County the implementation of infection control Health Department for further directives. interventions to prevent SARS-CoV-2 9/10/2020 transmission. The current staff were educated by the Executive director and the Memory care Review of the Guidance from NC DHHS dated 04/15/20 revealed: Director on 8/28/2020 through 9/10/2020 -It was recommended after one patient with a on the companies' COVID-19 screening positive COVID-19 test result to test all policy, the COVID-19 visitor and third party residents and staff regardless of symptoms, when testing capacity permits. screening tool, Employee screening policy -If testing capacity is limited, priority should be and log, COVID-19 Third Party Provider and given to testing residents and staff with Vendor Visitation Acknowledgement policy. symptoms or those who had close contact with a case. -Testing of asymptomatic persons in an LTC Current Resident screenings continue each facilities should be done in consultation with the shift with temperatures obtained each shift local and state public health. and staff screenings continue at the Telephone interview with the Health Director (HD) beginning of the shift and temperatures from the Local Health Department (LHD) and oxygen saturation at the beginning. Communicable Disease Division on 08/31/20 at 10:30am revealed they supplied all facilities in middle and end of each shift per company Lincoln county with the LTC facilities Guidance guidelines. dated 04/02/20, "Facilities should refer to CDC's guidance on COVID-19". Health and Wellness Director, Executive Director or designee will monitor current Review of the COVID-19 LTC Facility Guidance dated 04/02/20 revealed: staff, residents and visitor screenings daily -State and local health departments should work as part of management meeting and together with long-term care facilities in their monitor testing as needed. Results will be communities to determine and help address 9/28/2020 long-term care facility needs for PPE and/or discussed during the Quality Assurance COVID-19 tests. review monthly for ongoing compliance for -Facilities should also refer to CDC's guidance to

Division of Health Service Regulation

long-term care facilities on COVID-19.

three months and then quarterly

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED
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D 338	Continued From page	e 3	D 338	thereafter. The First Quality Assur	ance
D 338	Telephone interview of Disease (CD) Nurse for 8:06am revealed they Considerations for Me Long Term Care (LTC) to the Health and We attachment in an ema 07/02/20. Review of the CDC C Care Units (MCU) in It Facilities dated 05/12 considerations at the with COVID-19 asymptominection has been idepersonnel on the MCD exposed or infected, a be needed. Review of the facility's Community Leaders." Divisional Health and revealed: -For the employees we resident who tested primpacted employee in Begin taking temperate beginning, middle and off the employee show contracted agency to incident and they will attreatment. If the physician sends and says that they con COVID-19, they were symptom free for 72 holf the physician tests test results are received.	with the Communicable from the LHD on 08/28/20 at a provided the CDC permory Care Units (MCU) in C) Facilities dated 05/12/20 Ilness Director (HWD) as an ail, by the LHD CD Nurse on considerations for Memory Long Term Care (LTC) /20 revealed one of the time was, when a resident ptomatic SARS-CoV-2 pentified, other residents and J may have already been and additional testing may as COVID-19 "Guidance for dated 05/29/20 from the Wellness Director (DHWD) who work directly with a positive, speak with the mediately. Setures of employees at the dend of shift. The symptoms, contact their triage and report the send to a clinic for medical so them home without a test inclusively do not have on quarantine until nours. Them, stay at home until the ed.	D 338	thereafter. The First Quality Assurreview as held on 9/28/2020. If there is a positive COVID-19 result the community for either a current member or resident, the Executive or Designee will contact Lincoln Collealth Department for further directly also follow the current company pure of the event of an outbreak the Executive of Director or Designee will community the state and county officials and focurrent recommendations to ensurrecommendations and protocols at the community has identified and implementing resources from NCD COVID-19 Outbreak toolkit for Long Settings that will be utilized as an omnitoring tool to maintain complementations and protocols and monitoring tool to maintain complementations.	ult within t staff e Director ounty ective and olicies. ecutive icate with follow the re re in place 9/30/2020 are OHHS g term ongoing
ivision of Use	-In State required test follow the guidance fro lth Service Regulation	ing for employees, always om the LHD.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SU	
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D 338	-This was guidance for guidance for testing of Review of the New C Congregate Living Se 07/08/20 at 5:00pm re-There were 34 total a-There were 3 lab corresidentsThere were 0 lab corresidentsThere were 0 hospita at the facility. Telephone interview of Specialist (AHS) on 0 on 07/13/20 she rece (email) from the Busing which stated the LHD COVID-19 outbreak, that time were to test including staff and quiresidents in the MCU Review of the email for Director (AHD) from the Disease Division to the 1-On 06/17/20 at 3:56 pm ("LTCF COVID-19 Prowith instructions to rest the most up-to-date reinfection prevention pron 07/23/20 at 12:40 ("CDC Guidance", and Responding to COVID-19 Outbreak of Strategies to Mitigate Staffing Shortages and Emergency-Resource the email was the cur	or staff and did not address or retesting residents. OVID-19 Outbreaks in settings Report dated evealed: residents at the facility. Infirmed COVID-19 positive of the staff. Selized and 0 deaths reported everyone in the facility arantine the positive of the severyone in the facility arantine the positive of the cand recommendations at everyone in the facility arantine the positive of the cand recommendations at everyone in the facility arantine the positive of the cand recommendations at everyone in the facility arantine the positive of the CDC guidance for the cand recommendations about a cedures dated 06/16/20 fer to the CDC guidance for the commendations about the cand recommendations are cand recommendations.	D 338	The Health and Wellness Director, Executive Director or designee will staff on the North Carolina Depart Health and Human Services COVID Outbreak Toolkit for Long-Term Ca Settings to include: LTC Infection Cassessment Tool, LTC Infection Pre Staffing Worksheet, LTC Infection Prevention Education Resources, a Emergency Staffing and Resource F Training will be ongoing.	l educate ment of 1-19 are Control evention	10/5/2020

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
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D 338	Continued From page	5	D 338	The Health and Wellness Director a	and/or	
	were no new positive	cases within 14 days of the		Designee shall conduct-a weekly in	nventory	
	most recent positive of	case.		of the current PPE inventory and w	/ill	
		am, the email subject was,		provide a PPE report to the Execut	tive	
		sting and staffing". A link rence to the press release.		Director on a weekly basis to verify	that an	
	The press release had	d information for testing with		adequate amount of PPE are availa		
		sources for requesting		staff use . If it is identified that the		
	additional staffing and Personal Protective Equipment (PPE).			community does not have an adeq	uate	
	zquipinoni (i i z).			supply of PPE the Executive Director		
	Resident's test results	s Monitoring Grid and the s revealed 19 residents		order to meet the needs of the cor		
	tested positive for CO	VID-19 and 16 residents DVID-19.		PPE Tracker Results will be discussed using the Quality Assurance revised		
	After review of the fac	cility's Monitoring Grid and		during the Quality Assurance revie		
	the resident's negative	e COVID-19 test results it		monthly for ongoing compliancy for		
	was determined 9 of t negative for COVID-1	he 16 residents who tested 9, were not retested.		months and then quarterly thereaf First Quality Assurance review was		
	Congregate Living Se	OVID-19 Outbreaks in ttings Report dated evealed there were 40 total		9/28/2020 This process is ongoing		
	staff at the facility.	vocaled there were to total				
	Staff's test results rev	s Monitoring Grid and the ealed only 19 total staff sted positive for COVID-19, e for COVID-19 and 1				
	the Staff's negative C	cility's Monitoring Grid and OVID-19 test results it was staff who tested negative ot retested.				
	08/27/20 at 1:51pm re	vith the facility physician on evealed: s in the facility on a weekly				

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		HAL055009	B. WING		08/31/2020
NAME OF P	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE	
THE ADD	ISON OF LINCOLNTON		EM CHURCH ROAL)	
(VA) ID	CHMMADYCT		NTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (CORRECTIVE ACTION S REFERENCED TO TH DEFICIE	SHOULD BE CROSS- COMPLETE HE APPROPRIATE DATE
D 338	Continued From page	7	D 338		
	before his test results	were back.			
		e first to show symptoms			
	and tested positive fo	r COVID-19 on 06/29/20.			
	-The resident was on	quarantine when admitted			
	but he had dementia	and it was hard to keep him			
	in his room.		-		
		in the hall without a mask			
	several times.				
	-She developed a feve	er of 103 degrees			
	was told to go get too	first week of July 2020 and			
	-There was no facility	ted by the Administrator. wide testing when the			
	COVID-19 outbreak o				
	-The Memory Care Di				
	Administrator told the	staff they should go and get			
	tested by their physici				
	symptoms.				
	-She went to an urger	it care and was tested			
	about 3-4 days after s	he had the temperature of			
	103 degrees Fahrenh				
	-She tested positive fo	or COVID-19 and the			
	Administrator told her	to stay home for 10 days.			
	residents were tested	acility including staff and			
		the MCU that displayed			
		d on 07/09/20 and only			
	some of the residents	in AL.			
	-The only retesting per	rformed was of the			
	residents who tested p	ositive for COVID-19.			
	-The retesting was to be	pe done on the COVID-19			
	positive residents in or	der to get 2 negative			
	COVID-19 test results	in order to come off			
	isolation.				
	Interview with a secon	d PCA on 08/25/20 at			
	10:30am revealed:				
	-She worked on the Mo				
	-She started working a	t the facility around the end			
	of July 2020.	dministrator there was a			
rision of Hoo	Ith Service Regulation	difficient there was a			

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
		HALOSSOO	B. WING		С
		HAL055009	B. WING		08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE	
		440 SAL	EM CHURCH ROAD)	
THE ADDI	SON OF LINCOLNTON		NTON, NC 28092		
(V4) ID	SHIMMADVST	ATEMENT OF DEFICIENCIES			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (CORRECTIVE ACTION S REFERENCED TO TH DEFICIE!	SHOULD BE CROSS- COMPLETE BE APPROPRIATE DATE
D 338	Continued From page	e 9	D 338		
	residents and staff wi	hich included symptoms,			
	testing and deaths.				
	-The Administrator in:	structed the staff who			
		to go to their physician's			
	office and get tested.				
		d not report to work because			
	she developed a feve	er, chills and loss of smell.			
		nptoms to the Administrator			
	on 07/08/20.				
	-She was tested on 0	7/09/20 at the lab as	A. C.		
	directed by her physic				
-There were 2 or 3 other staff directed by the		14.			
		rt to their physician and be			
	tested because they				
		formed her the residents			
	who tested positive for	or COVID-19 would be			
		d 2 negatives so they could			
	come off isolation.				
	-She was out of work	from 07/09/20 to 07/20/20,			
	because she tested p	ositive for COVID-19.			
	-The health departme	ent informed her she could			
	return to work on 07/2	20/20 if she was out 10 days			
	and 72 hours without	symptoms.			
	Interview with the Adr	ministrator on 08/25/20 at			
	12:20am and 3:35pm				
	-She did not test all re	esidents and staff on			
	07/09/20.		-6		
	-On 07/09/20 she had	some of the residents who			
	were symptomatic in	the facility tested for			
	COVID-19.				
	-She kept track of the	residents and staff on the			
	facility monitoring grid				
		was where she recorded			
		ults, onset date and time of			
		s or remedies, date and			
	time the community w	as notified the date they			
	were placed on the lis	st.			
	-She kept all test resu	ılts for the residents and			
	staff.				
iriaian af IIa	olth Convice Degulation				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

D 338 Continued From page 10 The staff were only tested if they were symptomatic and they were told to go get tested by their own physicians if they displayed symptoms for COVID-19. On 07/09/20, the facility's contracted lab gave them COVID-19 tests for the facility physician, home health and the MCD to perform testing on the residents were positive for COVID-19 and required 2 negative test results to be removed from isolation. The DHWD instructed her to only test the residents on 07/09/20 and there would be retesting of all residents who tested positive for COVID-19 until they had 2 negative COVID-19 tests in order to come off isolation. There was not a contract with a lab to have the staff tested. She tested positive for COVID-19 on 07/06/20 and was one of the "first' ones positive at the facility. She could not get a test completed until 07/06/20. On 07/02/20, she began having symptoms of a fever, aches and pains and a sore throat. She was not at work and stayed home until 07/20/20, after she was out for 10 day with 72 hours of symptom free as directed by the DHWD. All resident testing was based on a physician's order. She, the Health and HWD and the DHWD were	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			(X3) DATE SURVEY COMPLETED	
THE ADDISON OF LINCOLNTON 440 SALEM CHURCH ROAD LINCOLNTON, NC 28092 (A4) ID SUMMARY STATEMENT OF DEPICIPACIOES (EACH DEPICIPACY CAN STATEMENT OF DEPICIPACIOES (EACH DEPICIPACY CAN STATEMENT OF THE PROPRIATE DEPICACY CAN STATEMENT OF THE PROPRIATE DEPICACY CONTROL OF THE PROPRIATE DEPICACY OF TH	· ·		HAL055009	B. WING		08	
Add Salem Church Road Lincolnton Add Salem Church Road Lincolnton, No. 28992	NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE		
D 338 Continued From page 10 -The staff were only tested if they were symptomatic and the MCDUD-19 estitor for COVID-19. -On 07/09/20, the facility's contracted lab gave them COVID-19 and required 2 negative test residents who were symptomatic or if the residents who were symptomatic or if the residents who tested positive for COVID-19 and required 2 negative test who they have could be retesting of all residents who tested positive for COVID-19 tests for COVID-19 and required 2 negative test results to be removed from isolation. -The DHWD instructed her to only test the residents who tested positive for COVID-19 tests in order to come off isolation. -There was not a contract with a lab to have the staff tested. -She tested positive for COVID-19 on 07/06/20 and was one of the "first" ones positive at the facility. -She could not get a test completed until 07/06/20. -On 07/07/20, she began having symptoms of a fever, aches and pains and a sore throat. -She was not at work and stayed home until 07/20/20, after she was out for 10 day with 72 hours of symptom free as directed by the DHWD. -All resident testing was based on a physician's order. -She, the Health and HWD and the DHWD were	THE ADDI	SON OF LINCOLNTON					
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-The staff were only tested if they were symptomatic and they were told to go get tested by their own physicians if they displayed symptoms for COVID-19. -On 07/09/20, the facility's contracted lab gave them COVID-19 tests for the facility physician, home health and the MCD to perform testing on the residents who were symptomatic or if the residents were positive for COVID-19 and required 2 negative test results to be removed from isolation. -The DHWD instructed her to only test the residents on 07/09/20 and there would be retesting of all residents who tested positive for COVID-19 until they had 2 negative COVID-19 tests in order to come off isolation. -There was not a contract with a lab to have the staff tested. -She tested positive for COVID-19 on 07/06/20 and was one of the "first' ones positive at the facility. -She could not get a test completed until 07/06/20, on 07/02/20, she began having symptoms of a fever, aches and pains and a sore throat. -She was not at work and stayed home until 07/20/20, after she was out for 10 day with 72 hours of symptom free as directed by the DHWD. -All resident testing was based on a physician's order. -She, the Health and HWD and the DHWD were	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION SHO REFERENCED TO THE A	OULD BE CROSS- APPROPRIATE	COMPLETE
symptomatic and they were told to go get tested by their own physicians if they displayed symptoms for COVID-19. -On 07/09/20, the facility's contracted lab gave them COVID-19 tests for the facility physician, home health and the MCD to perform testing on the residents who were symptomatic or if the residents were positive for COVID-19 and required 2 negative test results to be removed from isolation. -The DHWD instructed her to only test the residents on 07/09/20 and there would be retesting of all residents who tested positive for COVID-19 until they had 2 negative COVID-19 tests in order to come off isolation. -There was not a contract with a lab to have the staff tested. -She tested positive for COVID-19 on 07/06/20 and was one of the "first' ones positive at the facility. -She could not get a test completed until 07/06/20. -On 07/02/20, she began having symptoms of a fever, aches and pains and a sore throat. -She was not at work and stayed home until 07/20/20, after she was out for 10 day with 72 hours of symptom free as directed by the DHWD. -All resident testing was based on a physician's order. -She, the Health and HWD and the DHWD were	D 338	Continued From page	10	D 338			
responsible for the reporting the COVID-19 outbreak to the LHD, and following the recommended guidance given from the LHDThe BOM and the HWD spoke with the LHD and received recommendations and reported those to the DHWDShe did not receive the recommendations from the LHD but the BOM and HWD did and reported those to the DHWD and she followed what the		-The staff were only to symptomatic and they by their own physiciar symptoms for COVID-On 07/09/20, the facithem COVID-19 tests home health and the I the residents who wer residents were positiv required 2 negative te from isolation. -The DHWD instructed residents on 07/09/20 retesting of all resident COVID-19 until they he tests in order to come -There was not a cont staff tested. -She tested positive for and was one of the "finite facility. -She could not get a te 07/06/20. -On 07/02/20, she beging fever, aches and pains -She was not at work and the work of symptom free -All resident testing was order. -She, the Health and he responsible for the repoutbreak to the LHD, a recommended guidant -The BOM and the HV received recommendate the DHWD. -She did not receive the the LHD but the BOM.	ested if they were were told to go get tested as if they displayed -19. lity's contracted lab gave for the facility physician, MCD to perform testing on e symptomatic or if the e for COVID-19 and st results to be removed d her to only test the and there would be ats who tested positive for ad 2 negative COVID-19 off isolation. ract with a lab to have the or COVID-19 on 07/06/20 rst' ones positive at the est completed until gan having symptoms of a s and a sore throat. and stayed home until as out for 10 day with 72 e as directed by the DHWD. as based on a physician's HWD and the DHWD were corting the COVID-19 and following the ce given from the LHD. WD spoke with the LHD and ations and reported the recommendations from and HWD did and reported				

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(V2) DATE CLIDVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
			7. BOILDING.		
		HALOSSOO	B. WING		С
		HAL055009	B. WING		08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE	
THE ADDI	SON OF LINCOLNTON	440 SAL	EM CHURCH ROAD		
The state of the s			NTON, NC 28092		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N/EACH
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IAG	REGULATORTORT	LSC IDENTIFYING INFORMATION)	TAG	REFERENCED TO THE APPROPRI	IATE DATE
				DEFICIENCY)	
D 338	Continued From page	e 11	D 338		
	DHWD instructed.				
		onal training/updates were			
	handled by the HWD	, and the HWD reported to			
	the DHWD for guidan	re			
	-Any information she				
	COVID-19 was discu	ssed with the DHWD and			
	she followed the DHV	VD quidance			
		d her the recommendations			
	from the LHD were only guidelines and they would use their corporate guidelines instead, so they only tested symptomatic residents on				
	07/09/20, staff that we	ere symptomatic were			
	instructed to notify the	eir physician for testing and			
	there was no re-testin	g of all residents and staff			
	who tested negative for	or COVID-19, weekly for 14			
	days from the latest C	OVID-19 positive case to			
	make sure there were	no new COVID-19 cases			
	as recommended by t	he LHD.			
	-There were 9 resider	nts and 1 staff member that			
	passed away from CC	VID-19 in the facility.			
	Telephone interview w	rith the AHD of the LHD on			
	08/26/20 at 9:15am re				
		ords, on 07/02/20, their CD			
	Nurse spoke with the				
	reported case of COV				
		e to test all residents and			
		then retest all residents			
	and staff weekly for 14	4 days or until there were no			
	new positive cases of COVID-19 in the facility. -The last communication with the facility staff was on 07/17/20. -On 07/21/20, she emailed the Administrator with				
-	the current recommen	dations to test all staff and			
		t all COVID-19 negatives			
	weekly until there were	e no new COVID-19			
	positives within 14 day	s of the most recent			
	COVID-19 positive cas	se.			
	-On 07/23/20, she em	ailed the Administrator with			
	the current recommen	dations, again, as			
vision of Hea	Ith Service Regulation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE		
		1141.055000	B. WING		C	C	
		HAL055009	B. WING		08/3	1/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
THE ADDI	201 07 1111001 11701	440 SAL	EM CHURCH ROA	D			
THE ADDI	SON OF LINCOLNTON		NTON, NC 28092				
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	COPPECTION (EACH	2.1-1	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION		(X5) COMPLETE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	REFERENCED TO T		DATE	
				DEFICIE	ENCY)		
D 338	Continued From page	e 12	D 338				
	mentioned in the 07/	21/20 email and a link to use					
	as a testing resource						
	additional staff.	and now to request					
		17/20, there were multiple					
	emails and phone cal						
		for the facility to return the					
		t on voice mail messages,					
		il for updates on the facility's					
		no return communication					
	from the facility staff.	no return communication					
	-The lack of response from the facility caused alarm for herWith the outbreak already started, not following the CDC/LHD recommendations for testing and						
		ase the risk of the spread of					
	COVID-19 in the facil						
		0-19 cases could turn to					
		ases and if they were not					
		ative COVID-19 cases could					
	_	e spread of COVID-19 in					
	the facility.						
		ncreased risk of death in					
	this population of elde	erly residents to be very					
	high.	•					
						-	
	Telephone interview v	vith the BOM on 08/26/20 at					
	3:00pm revealed:						
		arge while the Administrator					
	was out of the facility						
		dence regarding guidance					
		e LHD, was given to the					
	HWD and Administra						
	-The HWD was responsible for communicating						
		he Administrator about the					
	LHD recommendation						
		ceived all guidance from the					
		e testing and retesting of the				- 1	
	residents.						
		Administrator COVID-19					
	testing required an or	der which was easier with					

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED	
		1141 055000	B. WING			C	
		HAL055009	D. WING		08/	31/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
THE ADDI	CON OF LINCOLNTON	440 SAL	EM CHURCH ROAD				
THE AUDI	SON OF LINCOLNTON	LINCOL	NTON, NC 28092				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PDECTION (EACH		
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION SHO		(X5) COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	REFERENCED TO THE	APPROPRIATE	DATE	
				DEFICIENC	;Y)		
D 338	Continued From page	e 13	D 338				
		the staff, and that's why all					
		sting guidance by their					
	physician.						
		aintained communication					
		d the DHWD during the					
	COVID-19 outbreak in					*	
		as responsible for handling					
		break testing and retesting.					
		nd residents in the MCU					
		layed symptoms and after					
		's order to have a COVID-19					
	test performed.						
		formed the staff they did not					
		the lab to test them and if					
		oms, to go get tested on					
	their own.						
	Tolophono intoniowy	with a third MA on 08/26/20					
	at 6:30pm revealed:	With a third WA off 06/20/20					
		second shift in the MCII					
		second shift in the MCU. sidents in the MCU who					
		who tested positive for 20 and the facility was					
	considered in an outb						
		e MCU residents were					
	tested as directed by						
		out testing on the Al side					
		rked the MCU and was not					
	allowed to cross over						
		g of the staff unless they					
		d then staff were directed to					
	see their own physicia						
	-There was no retesti						
	negative residents or						
	-There was testing of						
		get two negative test results					
	so they could come o						
	,						
	Telephone interview v	with the DHWD on 08/28/20					
	at 4:47pm revealed:						
	•						

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
				7 1000		
			D MANO			С
		HAL055009	B. WING		08	/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE.	ZIP CODE		
			EM CHURCH ROAD			
THE ADDI	SON OF LINCOLNTON		NTON, NC 28092	,		
0(0.15	CUMMARYOT		410N, NC 20092			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SH		(X5)
TAG		LSC IDENTIFYING INFORMATION)	TAG	REFERENCED TO THE		COMPLETE DATE
				DEFICIEN	CY)	
D 338	Continued From page	a 14	D 338			
			D 330			
	-On 05/29/20, she se	nt the updated version of				- 2.3
		for Community Leaders to				
	the HWD.					
		reated by herself and other				
		tion and updated as needed.				
		OC guidance for employees				
		or COVID-19 and it did not				
	include residents who	tested positive for				
	COVID-19.					
		o follow the LHD first and if				
		ce from the LHD then follow				
	the test-based strate					
		as notified by the HWD two				
	residents tested posit					
		outbreak after the second				
	person tested positive					
		oke with the Health Director				l l
		was given the most recent				
		idations and guidelines.				
		mandated by the CDC/LHD				
		orate guidance to test only				
		aff if they showed symptoms, eir physician and to retest all				
		sulted in two negatives.				
		symptomatic the staff were				
		act their physician and get				
	tested.	dot their physician and get				
	-The upper managen	nent met and discussed the				
		ne decision to test all the				
	residents on the MCL	J because they were "fragile"				
	and where it started,					
	Assisted Living (AL).					
	-On 07/07/20, there v	vas COVID-19 testing				
		MCU residents and some of				
	the AL the residents.					
	-There were no conve	ersations with upper				
	management regardi					
	COVID-19 negative r	esidents.				
		e remaining residents on the				
	AL side that were not	tested on 07/07/20 and				
Divinian of He	alth Service Population					

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMP	SURVEY
	HAL055009	B. WING			C /31/2020
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
THE ADDISON OF LINCOLNTON	Y .	LEM CHURCH ROAD NTON, NC 28092)		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO CORRECTIVE ACTION SH REFERENCED TO THE DEFICIENCE	OULD BE CROSS- APPROPRIATE	(X5) COMPLETE DATE
positiveSporadically, 7 day for the residents on they performed add residents and the re residents was com 07/26/20 and 07/28 -The HWD was res activities related to Administrator was o 07/20/20On 07/06/20, the A in touch with the HV -On 07/10/20, the A for the activities rel help of the HWD by -On 07/20/20, the A facilityThe HWD cut off o according their reco 08/20/20. Telephone interview 5:45pm was unsuc Review of the elect Communicable Dis Local Health Depai Division to the HWI -On 07/02/20 at 4:2 HWD, the subject w Attachments includ LCTF dated May 12 -On 07/31/20 at 11 the Business Office was, guidance regathe email included;	ys after the results came back the MCU tested on 07/07/20, ditional testing of the AL etesting of the positive MCU pleted on 07/09/20, 07/11/20, 3/20. Sponsible for directing all the outbreak because the out of the facility 07/02/20 - Administrator was out and kept WD and her while at home. HWD was out of the facility. Administrator was responsible lated to the outbreak, with the y telephone communication. Administrator returned to the communication with her and ords, his last day was W with the HWD on 08/28/20 at cessful. It cronic mail from the ease (CD) Nurse from the rease (CD) Nurse from the rease (CD) Nurse from the rease (CD) and the BOM revealed: 24pm, an email was sent to the was, "more guidance", led; Considerations for MCU in	D 338	SET IGEN		

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL055009	B. WING		C 08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE,	ZIP CODE	
T::= ADD!			EM CHURCH ROAD		
THE AUDI	ISON OF LINCOLNTON		NTON, NC 28092		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (E	FACH (Y5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	OSS- COMPLETE
D 338	Continued From page	: 16	D 338		
D 338	negative residents and continuing to test weed days without a case? -On 08/17/20 at 4:47p HWD, subject was CE included; Responding Homes dated 06/11/20 in Nursing Homes dated 06/11/20 in Nur	d staff and was the facility ekly until they have gone 14 om, an email was sent to the DC Guidance, attachments into COVID-19 in Nursing 0, Preparing for COVID-19 red 07/02/20. with the CD Nurse from the co6am revealed: oke with the HWD at the COVID-19 case and testing policy for staff to be work after being g positive for COVID-19. ailed the HWD CDC's currently of the MCU was an emphasis on testing and er one resident or staff we for COVID-19, there were exceed but asymptomatic for the recommendation to test and to re-test all negative 14 days after the most 0-19 case was important. Oke with the DHWD ecommendation to do 9 testing which included d retest all COVID-19-19 I there were no new within 14 days of the most 0-19 case.	D 338		
	information with recom- On 07/31/20 at 11:31: the BOM, with a quest completed testing on a	am, she sent an email to			

Division of Health Service Regulation

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL055009	B. WING	C 08/31/2020

		STREET ADDRESS, CITY, STATE				
THE ADDISON OF LINCOLNTON		440 SALEM CHURCH ROAD LINCOLNTON, NC 28092				
(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) COMPLET DATE		
D 338	Continued From page 17	D 338				
	until they have gone 14 days without a case. There was no reply to that questionIt was not until 08/27/20 the Administrator contacted her requesting guidance.					
	Telephone interview with the HD from the Loca Health Department Communicable Disease Division on 08/31/20 at 10:30am revealed: -When new guidance came out from Centers for Medicare and Medicaid Services (CMS), a mass email was sent out to all facilities in Lincoln County by his departmentHis CD Nurse sent out guidelines and recommendations to test all staff and residents and to retest all COVID-19 negatives weekly urthere were no new COVID-19 positives within 1 days of the most recent positive COVID-19 cas on 07/02/20 after they were notified of the breakoutHe received only "minimal reports" from the facility, lacking the information such as how ma residents and staff were tested, how may positives and negatives from the testing and when the negatives were to be tested again as recommendedThere was no request for a consultation or	or ess				
	resources needed, just "silence". -His biggest concern was the lack of communication and no follow-up with a minimal response from the facility. -When the death reports from the state started to come in, he was unsure if the facility was					
	following their guidanceThe facility should have tested all the staff and residents when the outbreak began on 07/02/20-When he spoke with the HWD, there was an issue with testing staff and the resources were provided to help with testing. There was no repl from the facility in relation to the need for assistance with testing.	0.				

PRINTED: 09/22/2020 FORM APPROVED

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL055009	B. WING		C 08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STATE	ZIR CODE	00/31/2020
			M CHURCH ROAL		
THE ADDI	SON OF LINCOLNTON		TON, NC 28092	D.	
(X4) ID	SUMMARYSTA	ATEMENT OF DEFICIENCIES		DD0/47-7-15	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIAT DEFICIENCY)	DSS- COMPLETE
D 338	Continued From page	18	D 338		
	-The AHD of the LHD				
	guidance/resources fo	or testing and staffing to the			
	HWD on 07/21/20 and				
	-He expected the facil	ity to contact them if they			
	staff as that he sould a	th testing the residents and			
- 9		accommodate their needs.			
	of all staff and resider	ve a plan in place for testing nts during an outbreak and if			
- 1	the plan was not work	ting, then the LHD was to be			
	called and assistance	could be given			
	-He was not aware of	an issue with the testing of			
	all residents and staff	at the facility.			
	-He expected the facili	ity to follow the guidance			
	and recommendations	set forth by the LHD and			
	to test all staff and res	idents and to retest all staff			
	and residents weekly i	until there were no new			
		4 days of the most recent			
	positive case.	retest residents and staff			
	fully could increase the	risk of exposure to			
	COVID-19 because the	ere would be no way to			
	know who to quarantin	e or isolate to prevent			
	further spread.				
	-The facility did not foll	ow the CDC/LHD			
	recommendations and	guidelines provided which			
	led to loss of life.	f positive cases, which also			
	-He had strong concer	ns related to the facility not			
	following the CDC/LHD	recommendations.			
	Review of the Death C	ertificates revealed:			
	-On 07/20/20, a reside				
	Pneumonia.				
	-On 07/21/20, a reside				
	Obstructive Pulmonary COVID-19 infection.	Disease resulting from			
	-On 07/22/20, a resider	nt died of Phoumonia			
	secondary to COVID-1	птанеа от Епециопіа 9			
	-On 07/31/20, a resider				
	respiratory failure.				
	th Service Regulation	4		7	

Division of Health Service Regulation

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE Co	ONSTRUCTION	(V2) DATE OUD) (E) (
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		HAL055009	B. WING		C
NAME OF F	DOWNER OF CLIPPLIED				08/31/2020
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		
THE ADD	ISON OF LINCOLNTON		EM CHURCH ROAD	0	
			NTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (CORRECTIVE ACTION SHOULD BE CR REFERENCED TO THE APPROPRIA' DEFICIENCY)	OSS- COMPLETE
	resulting from presunting from presunting from presunting of Alzheimer's Diseast -On 08/03/20, a residual cardiomyopathy secont presumptive COVID-On 08/03/20, a staff COVID-19 Pneumoniton 08/09/20, a residual con 08/09/20	Brain with complications ned of COVID-19. lent died from complications se. lent died from Ischemic and Ischemic sof 19 infection. member died from Ischemic and Ischemic Bowel. lent died of COVID-19			
	-A total of 9 residents documented as a cau -One of the 10 deaths negative for COVID-1 LHD recommendation	and Atrial Fibrillation. ent died from COVID-19. had COVID-19 use of death. s was a resident who tested 9, was not retested per the ns, died from ischemic ndary to complications of			
	and guidance establis Disease Control (CDC (LHD), and the North Health and Human Se implemented and mai protection to the resid coronavirus (COVID-1 the risk of transmissic COVID-19 related to a testing from 06/29/20 residents and staff an residents and staff the COVID-19, weekly aft reduce risk of transmilack of testing in acco	lents during the global 19) pandemic for reducing on and infection of a delay of facility wide to 07/09/20, not testing all d not re-testing the at tested negative for ter an outbreak in efforts to ssion and infection. The rdance with the guidance to determine who may have			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL055009	B. WING		C 08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	00/31/2020
THE ADDI	SON OF LINCOLNTON	440 SAL	EM CHURCH ROAD		
			NTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS- COMPLETE
D 338	Continued From page	20	D 338		
	failures resulted in se death constitutes a Ty				
	The facility provided a accordance with G.S. on 08/25/20.	a plan of protection in 131D-34 for this violation			
	CORRECTION DATE VIOLATION SHALL N 30, 2020.	FOR THE TYPE A1 IOT EXCEED SEPTEMBER			
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914		
	Every resident shall h	ration of Residents' Rights ave the following rights: al and physical abuse, ion.			
	observation, interview	as evidenced by: Based on v, and record review, the e all residents were free from sident Rights.			
	The findings are:				
	and guidance establis Disease Control (CDC (LHD), and the North Health and Human Se implemented and mai protection to the resid coronavirus (COVID- the risk of transmissio COVID-19 related to a	lents during the global 19) pandemic for reducing on and infection of a delay of facility wide to 07/09/20, not testing all			

Division of Health Service Regulation

STATE FORM

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL055009	B. WING		C 08/31/2020
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE,	ZIP CODE	
THE ADDI	SON OF LINCOLNTON		EM CHURCH ROAD NTON, NC 28092)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPRO DEFICIENCY)	E CROSS- COMPLETE
D914	residents and staff the COVID-19, weekly af reduce risk of transm lack of testing in account led to to the inability to been asymptomatic a opportunity for disease failures resulted in sedeath constitutes a Type of the COVID resident sedeath sede	at tested negative for ter an outbreak in efforts to ission and infection. The ordance with the guidance o determine who may have	D914		

Division of Health Service Regulation

STATE FORM



STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER GOVERNOR

MANDY COHEN, MD, MPH SECRETARY

SECRETARIAL ORDER No. 2 **Mandatory Testing for Staff in Nursing Homes**

August 7, 2020

Nursing homes are at risk of experiencing outbreaks of SARS-CoV-2 ("COVID-19") and the residents of these facilities are often in a high-risk category for serious complications from COVID-19. Ensuring the health and safety of residents in nursing homes has been challenging and required tremendous work on the part of facility management and frontline staff. The Centers for Disease Control and Prevention ("CDC") recommends routine testing of staff at nursing homes without known or suspected exposure to COVID-19. Based upon the CDC guidance, I have determined that after initial testing of all residents and staff, testing must be required every other week for all staff at nursing homes who have the potential for direct or indirect exposure to patients or infectious materials. If resources allow, nursing homes are encouraged, but not required, to test staff more frequently than every other week.

Under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.31(b)(2), the Governor may impose prohibitions and restrictions on the operations of business establishments, along with other places at which people may congregate. Under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.30(b)(5), the Governor may impose prohibitions and restrictions on other activities or conditions which are reasonably necessary to control in order to protect lives during the state of emergency. Under N.C. Gen. Stat. § 166A-19.10(b)(3), the Governor may delegate this authority. In Section 2 of Executive Order No. 152, the Governor delegated to the undersigned the authority to prohibit and restrict activities and operations of long term care facilities, including nursing homes, under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.30(b)(2) and (5).

Based upon the foregoing and pursuant to the authority delegated to me by Governor Cooper in Executive Order No. 152, I find that the following restrictions for nursing homes, a subset of long term care facilities regulated by the Department of Health and Human Services ("DHHS"), are reasonably necessary to maintain order and protect lives during the State of Emergency and are required to slow the spread of COVID-19. Therefore, I order the following:

This Order applies only to nursing homes.

Section I. Mandatory Testing and Reporting.

After nursing homes have completed their initial testing of all residents and staff, the nursing homes shall continue to test all staff who have the potential for direct or indirect exposure to patients or infectious materials at least every other week. Facilities do not need to retest asymptomatic staff that have tested positive in the 3 months prior to the most recent round of testing. The nursing homes shall report their results to DHHS every two weeks in compliance with the DHHS reporting requirements. DHHS will provide nursing homes with additional guidance and instructions for completing the reports and the date to begin submitting the biweekly reports. If new positive cases for COVID-19 are identified, facilities shall immediately report cases to their local health department and follow guidance for additional testing and reporting when

> WWW.NCDHHS.GOV TEL 919-855-4800 • FAX 919-715-4645 LOCATION: 101 BLAIR DRIVE • ADAMS BUILDING • RALEIGH, NC 27603 MAILING ADDRESS: 2001 MAIL SERVICE CENTER • RALEIGH, NC 27699-2000 AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Section II. Funding.

DHHS will be providing CARES Act (P.L. 116-136) funding to nursing homes to pay for the required testing. Nursing homes that fail to substantially comply with these testing and reporting requirements will not be eligible for the payment and will be required to refund payments if testing is not performed in accordance with this Secretarial Order.

Section III. Distribution.

This Secretarial Order shall be: (1) distributed to the news media and other organizations calculated to bring its contents to the attention of the general public; and (2) distributed to nursing home administrators and to others as necessary to

Section IV. Effective Date.

This Secretarial Order is effective immediately. This Secretarial Order shall remain in effect until September 22, 2020, unless rescinded or replaced with a superseding Secretarial Order. An Executive Order rescinding the Declaration of the State of Emergency will automatically rescind this Secretarial Order.

Signed this the 7th day of August 2020.

Mandy K. Cohen, MD, MPH

Secretary

STATE OF NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER GOVERNOR

MANDY COHEN, MD, MPH SECRETARY

SECRETARIAL ORDER No. 4 Mandatory Testing for Staff in Nursing Homes

September 21, 2020

Nursing homes remain at risk of experiencing outbreaks of SARS-CoV-2 ("COVID-19") and the residents of these facilities are often in a high-risk category for serious complications from COVID-19. Ensuring the health and safety of residents in nursing homes has been challenging and has required tremendous work on the part of facility management and frontline staff. On August 7, 2020, I issued Secretarial Order No. 2, Mandatory Testing for Staff in Nursing Homes, which established testing and reporting requirements consistent with the Centers for Disease Control and Prevention (CDC) guidance.

Recognizing the correlation between community transmissions and facility outbreaks and in an effort to align with recently released federal requirements, I have determined that nursing homes, including nursing home beds in hospital facilities, must now test in accordance with the requirements published by the federal Centers for Medicare & Medicaid Services (CMS) in QSO-20-38-NH (the federal requirements) and as established in

Under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.31(b)(2), the Governor may impose prohibitions and restrictions on the operations of business establishments, along with other places at which people may congregate. Under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.30(b)(5), the Governor may impose prohibitions and restrictions on other activities or conditions which are reasonably necessary to control in order to protect lives during the state of emergency. Under N.C. Gen. Stat. § 166A-19.10(b)(3), the Governor may delegate this authority. In Executive Order No. 165, the Governor delegated to the undersigned the authority to prohibit and restrict activities and operations of long term care facilities, including nursing homes, under N.C. Gen. Stat. §§ 166A-19.30(c) and 166A-19.30(b)(2) and (5).

Based upon the foregoing and pursuant to the authority delegated to me by Governor Cooper in Executive Order No. 165, I find that the following restrictions for nursing homes, a subset of long term care facilities regulated by the Department of Health and Human Services (DHHS), are reasonably necessary to maintain order and protect lives during the State of Emergency and are required to slow the spread of COVID-19.

This Order replaces Secretarial Order No. 2 and applies only to nursing homes, including nursing home beds

Section I. Mandatory Testing

Adherence to Screening and Testing Guidelines

As a general practice, nursing homes need to continue screening and testing residents and staff for COVID-19 indicated in the CDC's Testing Guidelines for Nursing Homes.

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For Nursing Homes in Which There Is One or More Positive Case(s)

Consistent with CDC recommendations and aligned with federal requirements, nursing homes with one or more positive case(s) will test residents and staff at least weekly. Facilities will continue to test residents and ff at least weekly until "testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result" after which, the facility will resume Routine

For Nursing Homes Conducting Routine Staff Testing

Federal requirements establish Routine Testing Intervals based on the facility's county positivity rate. This Order adopts this federal standard to determine required testing frequency under this Order. Nursing homes shall test all staff who have the potential for direct or indirect exposure to patients with a frequency based on their county's Community COVID-19 Activity Level extracted from Table 2 in QSO-20-38-NH, copied below. As noted in QSO-20-38-NH, a county's Community COVID-19 Activity level is determined by its county positivity rate. This data are available on the federal webpage, CMS COVID-19 Nursing Home Data, under the COVID-

Table 2: Routine Testing Intervals Vary by Community COVID-19 Activity Level

Community COVID-19 Activity Low	County Positivity Rate in the past week	Minimum Testing Frequency
Medium		Once a month
High	>10%	Once a week*
	3079	Twice a week*

^{*}This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site

acility will evaluate and apply its county's positivity rate on a schedule and with a frequency specified in 450-20-38-NH

Facilities do not need to retest asymptomatic staff that have tested positive in the 3 months prior to the most recent round of testing. If new positive cases for COVID-19 are identified, facilities shall immediately report cases to their local health department and initiate testing of both residents and staff on a schedule consistent

Clarification on Applicable Testing Interval

If a facility has one or more positive case(s) and is in a county with a High Community COVID-19 Activity level, the nursing home will adhere to the more rigorous testing schedule (twice a week).

Section II. Mandatory Reporting

DHHS will provide nursing homes with additional guidance and instructions for completing the testing reports required under this Order. Nursing homes shall continue to report all testing activity to DHHS in compliance with the DHHS reporting guidance and instructions.

Section III. Effect of this Secretarial Order on Federal Requirements

This Order in no way replaces or otherwise abridges a nursing home's responsibilities under the federal requirements cited within this Order.

Under Secretarial Order No. 2, DHHS allocated \$25M of CARES Act (P.L 116-136) funding to support nursing bomes with required staff testing. While subject to funding availability, this resource remains available to fund ing requirements covered under the prior Secretarial Order No. 2, including all staff in combination facilities as defined by DHHS that have assisted living/adult care home licensed beds within the same building as nursing home licensed beds. Nursing home providers are strongly encouraged to seek any additional support needed through the federal Provider Relief Fund or other payment mechanism.

Section V. Distribution.

This Secretarial Order shall be: (1) distributed to the news media and other organizations calculated to bring its contents to the attention of the general public; and (2) distributed to nursing home administrators and to others as necessary to ensure proper implementation of this Secretarial Order.

Section VI. Effective Date.

This Secretarial Order is effective immediately. This Secretarial Order shall remain in effect, unless rescinded or replaced with a superseding Secretarial Order. An Executive Order rescinding the Declaration of the State of Emergency will automatically rescind this Secretarial Order.

Signed this the 21st day of September 2020.

Mandy K. Cohen, MD, MPH

Secretary