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CLASSIC CARE HOMES # 1	**101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577**

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D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with an onsite visit on 09/15/20 and a desk review survey on 09/15/20 to 09/17/20 and a telephone exit on 09/17/20.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure staff was available to provide supervision to residents with mental health diagnoses and/or cognitive impairments as evidence of no staff in the facility. The findings are: Review of the facility's license revealed the facility was licensed for 12 residents. Interview with the Administrator on 09/15/20 at 4:26pm revealed there were 11 residents who resided in the facility. Review of the facility's Resident Care Contract revealed under a section titled "Services Provided" was documentation of "Twenty-four-hour supervision by capable, caring, and trained staff".	D 270		

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D 270	Continued From page 1 Telephone call to the facility on 09/15/20 at 2:53pm revealed: -A resident answered the telephone. -The Administrator was not in the facility. -There was no staff in the facility. -All the staff were in a sister facility on the same campus. -She would need to take a message because she did not know how to transfer the call to the Administrator. A second telephone call to the facility and interview with a resident on 09/15/20 at 3:08pm revealed: -The same resident answered the telephone. -There was no staff in the facility. -Staff had not been in the facility since approximately 2:50pm -All staff were in a staff meeting located in a sister facility on the campus. -There was supposed to be staff in the facility. -Staff had meetings about one time a month and residents were left unsupervised when staff had meetings. -All staff had left the residents unsupervised twice today, 09/15/20. Once this morning and once currently. -There was no one currently in charge of the facility. -If she needed help, she would wait for staff to return. -The kitchen was accessible to the residents but the residents knew not to go in the kitchen. -Some residents needed help with activities of daily living (ADL's). -If there was an emergency in the facility, she would call 911. -There were two residents sitting outside. There was no staff outside with the residents.	D 270		

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Telephone interview with the resident interviewed by telephone on 09/15/20 at 2:53pm and 3:08pm mental health provider on 09/17/20 at 2:45pm revealed the first resident was oriented and could have a knowledgeable conversation.

Telephone interview with a second resident on 09/15/20 at 3:25pm revealed:
-There were no staff in the facility.
-All staff left the facility to attend a meeting.
-She would call her family member if she needed help.
-She would call 911 if there was an emergency.
-In the past, residents were told by the Administrator and Business Office Manager (BOM) they could not leave the facility when there was no staff present.
-She did not remember when the Administrator and BOM told the residents they could not leave the facility.
-There was one named resident (Resident #1) who was confused at times.
-Staff had left residents unsupervised twice today, 09/15/20.
-The BOM told the residents today, 09/15/20, not to leave the facility when staff were not present.

Telephone interview with the resident interviewed on 09/15/20 at 3:25pm Primary Care Provider (PCP) (date and time withheld to maintain resident confidentiality)
-In her professional opinion the resident's report of no staff in the facility on 09/15/20 was truthful.
-If the resident said there was no staff in the facility, she would believe the resident.

Telephone interview with a third resident on 09/15/20 at 3:32pm revealed:
-There were no staff in the facility.

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-She did not know how long staff had been out of the facility.
-Staff would leave residents unsupervised about three times a day for approximately 15 to 20 minutes each time when going to a sister facility on the same campus to retrieve resident meals and ice.
-There was one named resident (Resident #1) who would curse at staff and residents at times.
-Resident #1 had tried to hit other residents about two weeks ago outside the facility entrance.
-There was one resident who was on oxygen and smoked cigarettes.
-The cigarettes were stored in an unlocked cabinet in the kitchen (accessible to resients).
-Some residents had their own lighters.
-There was one named resident (Resident #2) who was currently outside.
-There was no staff outside with Resident #2.

Based on telephone interviews with three residents on 09/15/20 from 2:53pm - 3:39pm revealed there was no staff in the facility for at the least 46 minutes to provide supervision and monitoring of the residents.

1. Review of Resident #1's current FL-2 dated 01/14/20 revealed:
-Diagnoses included major vascular neurocognitive disorder, intracerebral hemorrhage, gastroesophageal reflux disease, and asthma.
-Resident #1 was ambulatory, intermittently disoriented, and incontinent.
-Resident #1 required assistance with bathing and dressing.

Review of Resident #1's care plan dated 08/05/19 revealed the resident was disoriented at times, forgetful and needed reminders, and required

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D 270	Continued From page 4 extensive assistance with bathing, dressing, and grooming. Telephone interview with the Administrator on 09/15/20 at 4:26pm revealed: -Resident #1 required staff assistance and supervision with bathing, had a history of a traumatic head injury, could not verbally express herself, smoked, and was being treated by mental health. -Resident #1 would not harm anyone. -Resident #1 kept her own lighter. Review of Resident #1's mental health provider progress note dated 09/09/20 revealed: -The resident was irritable, agitated, anxious, had cognitive impairment, impaired judgment, and difficulty expressing speech. -Staff were instructed to monitor the residents moods and behaviors and offer redirection as necessary. Telephone interview with Resident #1's mental health provider on 09/17/20 at 2:45pm revealed: -Resident #1 had cognitive impairment and a poor memory. -She would be concerned if Resident #1 was left unsupervised by staff because she could wander away from the facility or if she had an emergency there would not be staff available to help. Observation of Resident #1 on 09/15/20 at 9:42am revealed: -She was sitting outside on the front porch breezway. -She was appropriately dressed for season and neatly groomed. -She was oriented to name, confused, could not follow conversation, had difficulty expressing thoughts, and was anxious when spoken to.	D 270		

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-There was another resident sitting with her.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Refer to telephone interview with the Administrator on 09/15/20 at 4:26pm.

Refer to a telephone interview with the personal care aide (PCA) on 09/16/20 at 10:08 pm

Refer to interview with the BOM on 09/16/20 at 11:45am

Refer to telephone interview with a mental health provider for the facility on 09/17/20 at 2:45pm.

Refer to interview with the Clinical Organizer for the facility's contracted medical provider on 09/17/20 at 3:12pm

2. Review of Resident #2's current FL-2 dated 03/24/20 revealed:
-Diagnoses included schizophrenia, essential hypertension, hypothyroidism, diabetes type 2, and asthma.
-Resident #2 was blind and ambulatory.
-Resident #2 needed assistance with bathing and dressing.

Review of Resident #2's Resident Register dated 03/11/20 revealed the resident required assistance with dressing, grooming, orientation to time and place, and was to be led by staff when ambulating due to inability to see.

Review of Resident #2's care plan dated 03/31/20 revealed:
-The resident was oriented, memory was

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adequate, and her vision was very limited because she was legally blind.
-The resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, and personal hygiene, and limited assistance with transfers.

Observation of Resident #2 on 09/15/20 at 10:47am revealed:
-The resident was sitting outside on a bench in front of the facility.
-Resident #1 was sitting with her.
-There was no staff present to supervise the residents.

Telephone interview with the Administrator on 09/15/20 at 4:26pm revealed Resident #2 was partially blind, required staff assistance with bathing and choosing clothing, smoked, and required staff assistance to light cigarettes for safety reasons.

Telephone interview with Resident #2's mental health provider on 09/17/20 at 2:45pm revealed:
-Resident #2 had a mental illness and cognitive impairment.
-She was concerned if Resident #2 was left unsupervised by staff she could wander away from the facility or if she had an emergency there would not be staff available to help.

Review of Resident #2's mental health provider progress note dated 09/09/20 revealed:
-The resident was to be monitored for risk of falls and other safety risks.
-Staff were instructed to monitor the residents moods and behaviors and offer redirection as necessary.

Attempted interview with Resident #2 on 09/15/20

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at 10:24am was unsuccessful.

Refer to telephone interview with the Administrator on 09/15/20 at 4:26pm.

Refer to a telephone interview with the personal care aide (PCA) on 09/16/20 at 10:08 pm

Refer to interview with the Business Office Manager (BOM) on 09/16/20 at 11:45am

Refer to telephone interview with a mental health provider for the facility on 09/17/20 at 2:45pm

Refer to interview with the Clinical Organizer for the facility's contracted medical provider on 09/17/20 at 3:12pm

3. Review of Resident #3's current FL-2 dated 01/14/20 revealed:
-Diagnoses included chronic obstructive pulmonary disorder, bipolar disorder, and peripheral vascular disease.
-Resident #3 was semi-ambulatory and continent.
-Resident #3 required assistance with bathing and dressing.

Review of Resident #3's Resident Register dated 08/05/19 revealed:
-The resident required limited assistance with dressing, bathing, toileting, and grooming.
-The resident was forgetful, needing reminders, and required a wheelchair for mobility, and used Oxygen for shortness of breath.

Telephone interview with the Administrator on 09/15/20 at 4:26pm revealed:
-Resident #3 required a wheelchair for ambulation, staff assistance with transfers, toileting, and dressing, was total care for bathing,

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had shortness of breath, and needed Oxygen.
-Resident #3 required staff assistance to exit the facility during the fire drill conducted by the facility in August 2020.

Telephone interview with Resident #3's mental health provider on 09/17/20 at 2:45pm revealed:
-Resident #3 did not wander and did not have a cognitive impairent.
-She would be concerned if Resident #3 was left unsupervised by staff if she had an emergency there would not be staff available to help.

Review of Resident #3's mental health provider progress note dated 09/09/20 revealed:
-The resident had cognitive impairment, moderately impaired memory, impaired reasoning, and a movement disorder.
-The resident had diagnosis of bipolar type schizoaffective disorder and anxiety.
-The resident was to be monitored for risk of falls and other safety risks.
-Staff were instructed to monitor the residents moods and behaviors and offer redirection as necessary.
-Staff were instructed to contact Resident #3's mental health provider with any increase in symptoms/adverse reactions to medications.

Refer to telephone interview with the Administrator on 09/15/20 at 4:26pm.

Refer to a telephone interview with the personal care aide (PCA) on 09/16/20 at 10:08 pm

Refer to interview with the Business Office Manager (BOM) on 09/16/20 at 11:45am

Refer to telephone interview with a mental health provider for the facility on 09/17/20 at 2:45pm

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D 270	Continued From page 9 Refer to interview with the Clinical Organizer for the facility's contracted medical provider on 09/17/20 at 3:12pm 4. Review of Resident #4's current FL-2 dated 03/10/20 revealed: -Diagnoses included hypertension, mild mental retardation, mood disorder, depression, and bipolar disorder. -The resident required assistance with bathing and dressing. Observation and interview of Resident #4 on 09/15/20 at 10:27pm revealed: -The resident was sitting alone in the facility's television room wathcing television. -The resident was oriented with a delayed response to conversation. Telephone interview with the Administrator on 09/15/20 at 4:26pm revealed Resident #4 was not confused and did not wander. Telephone interview with Resident #4's Primary Care Provider (PCP) on 09/16/20 at 4:39pm revealed: -The resident had a diagnosis of Down's Syndrome and functioned on the level of a 6 to 8-year-old child. -The most important reason the resident was in an Assisted Living Facility (ALF) was to have staff assistance and help if needed. -The resident required staff prompting for grooming and toileting hygiene. -In her professional opinion, she felt the resident would be alright to be left unsupervised for about an hour at this point in her life because the resident had learned life skills throughout her life. -The resident would be able to recognize an	D 270		

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emergency and would call her family member if help was needed.

Refer to telephone interview with the Administrator on 09/15/20 at 4:26pm.

Refer to a telephone interview with the personal care aide (PCA) on 09/16/20 at 10:08 pm

Refer to interview with the Business Office Manager (BOM) on 09/16/20 at 11:45am

Refer to telephone interview with a mental health provider for the facility on 09/17/20 at 2:45pm

Refer to interview with the Clinical Organizer for the facility contracted medical provider on 09/17/20 at 3:12pm

____

Telephone interview with the Administrator on 09/15/20 at 4:26pm revealed:
-There were no residents with behavior issues or safety concerns.
-The residents were never left alone in the facility.
-All residents required staff assistance to exit the facility in the event of an emergency.
-Staff would leave the facility three times a day to retrieve resident meals from the sister facility.
-The residents were never left alone when staff visited the sister facility to retrieve the meals.
-The residents were not left unsupervised today, 09/15/20.
-There was a (PCA) in the facility the "entire" time today, 09/15/20.
-The residents would normally answer the telephone.
-There were two staff in the facility from 2:53pm - 3:39pm today, 09/15/20.
-There was always staff available onsite in an emergency.

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D 270	Continued From page 11 -The BOM was in the facility all day. -The telephone was located in the hallway beside her and the BOM's office. -The BOM did not hear any residents on the telephone today, 09/15/20. -The BOM could have been in a sister facility on the same campus during the time of the telephone call with the three residents. -Resident cigarettes were kept in an unlocked cabinet in the kitchen and was accessible by the residents. -The residents did not go into the kitchen because they knew staff were there to monitor. -She and the Business Office Manager (BOM) were in the facility throughout today, 09/15/20. -She did not know why multiple residents reported there was no staff in the facility today, 09/15/20. Telephone interview with the PCA on 09/16/20 at 10:08 pm revealed: -She was in the facility between 2:53pm - 3:39pm on 09/15/20 and had a staff meeting in the facility via telephone at approximately 3:30pm today. -Second shift was available onsite to care for the residents during the phone meeting. -The BOM was in the facility between 2:53pm - 3:39pm on 09/15/20. -The telephone was located in the hallway beside the Administrator and BOM's office. -Sometimes, resident phone conversations could be heard in the BOM's office. -The cook would deliver resident meals to the facility from a sister facility on the same campus. -Staff would not leave the facility to retrieve resident meals. -Staff did not leave the facility to go to sister facilities on campus. -There was always one PCA in the facility. -She did not know why multiple residents reported	D 270		

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that staff left the building to get resident meals.

Telephone interview with the BOM on 09/16/20 at 12:11pm revealed:
-She had been in the facility all day on 09/15/20, and had not left the facility.
-She had been in her office on 09/15/20 from 2:53pm to 3:40pm.
-No residents checked to see if she was in her office on 09/15/20.
-The telephone that residents used was in the hallway to the left of her office.
-Sometimes she had to close her office door when taking work calls on her cell phone.
-She could hear residents when they were on the phone if she had not been on the phone.
-She did not hear residents talking on the phone on 09/15/20 from 2:53pm to 3:40pm.
-She was on the phone in her office on 09/15/20 from 2:53pm to 3:40pm.
-There was always at least one staff member in the facility.
-Staff informed her if they had to leave the facility.
-The residents were never left unsupervised without staff in the facility.
-She did not know why residents were saying that there was no staff in the facility on 09/15/20 from 2:53pm to 3:40pm.

Telephone interview with a mental health provider for the facility on 09/17/20 at 2:45pm revealed:
-She provided care for residents who had cognitive decline and/or a mental health diagnosis.
-She expected the residents to be supervised by staff at all times.
-All the residents she provided care for had cognitive decline and/or a mental health diagnoses.
-She expected staff to always be in the facility to

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supervise the residents because of their cognitive impairments.
-She was concerned about staff not being in the facility to supervise the residents.
-An example of concern was that if a resident were to fall, there would be no staff available to assist.
-She did not think the residents would wander away from the facility, but it was a possibility they may.
-She was concerned the residents could access the stove in the kitchen and start a fire.
-She was concerned the residents could access knives and other utensils in the kitchen that they should not have access to because of their cognitive impairments.
-The residents would not know what steps to take in the event of an emergency.
-She had concerns that if any of the resident were left unsupervised by staff that if a resident went into cardiac arrest the other resident would not know what to do.
-The residents would know to look for staff to help in the event of an emergency but staff was not in the facility.
-Every time she had visited the facility, she had never seen the residents unsupervised.

Interview with the Clinical Organizer for the facility's contracted primary care provider (PCP) on 09/17/20 at 3:12pm revealed:
-Email correspondence she received from the PCP contained documenation which read the residents were in an assisted living facility, because they were unable to care for themselves and she did not expect them to be left alone.
-Email correspondence she received from the PCP contained documenation which read the PCP's concerns would be that the residents could wander out of the building, the residents could fall

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D 270	Continued From page 14 and get hurt and no staff would be present to assist with the emergency. ___________________ The facility failed to provide supervision to 4 of 4 sampled residents (#1, #2, #3, #4) by leaving them unsupervised intermittently when staff went next door to a sister facility on the same campus. Resident #1 had a diagnosis of major neurocognitive disorder and was intermittently disoriented; Resident #2 was blind and required extensive assistance from staff with ambulation and toileting; Resident #3 had a diagnosis of depression and who was forgetful and required a wheelchair for mobility; Resident #4 had a diagnosis of mental retardation and the mental capacity of a 6 to 8 year old child. All residents required monitoring, supervision, and re-direction by staff as needed. The facility's failure resulted in the residents being left alone for at least 46 minutes on 09/15/20 which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. __________________ The facility provided a plan of protection for this violation on 09/16/20 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	D 270		
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.	D 338		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global Coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of COVID-19 as related to the use of personal protective equipment (PPE) by staff and residents, practicing social distancing, and use of Environmental Protection Agency (EPA) approved disinfectant cleaners were available and used.

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 wear a facemask at all times while they are in the facility.
-Encourage residents to wear a face masks when in the faciilty whenever they are around others, including when they leave their rooms and when they leave the facility (e.g., residents receiving hemodialysis).
-Implement social distancing of at least six feet apart.
-Ensure adequate cleaning and disinfection supplies are available. Provide EPA-registered disposable disinfectant wipes so that commonly used surfaces can be wiped down.
-Use regular cleaners, according to the directions on the label. For disinfection, refer the EPA website for a list of products that are

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D 338	Continued From page 16 EPA-approved for use against the virus that causes COVID-19. Follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method and contact time). Review of the NC Dept of Health and Human Services Update for Communal Dining and Indoor Activities or Adult Care Homes revealed: -Residents must wear a face covering at all times when not in their room. -Ensure 6 feet of space between each individual and each table. If possible, space should be marked designating 6 feet of separation between tables and stagger mealtimes. Review of the facility's Coronavirus Policies and Procedure revealed: -Staff would wear a face mask at all times. -Staff would "try" to implement six-foot social distancing throughout the facility. -There was no documentation referencing residents and face masks. -There was no documentation referencing residents and social distancing. Review of faxed information provided by the Administrator and identified as COVID-19 staff inservice on 09/15/20 revealed: -There was a document from the CDC titled "How to Safely Wear and Take Off a Mask". -There was a document from the CDC titled "Coronavirus Disease. How COVID-19 Spreads". The document had an electronic last updated date of 06/16/20. -There was a document from the CDC titled "Coronavirus Disease. Social Distancing". The document had an electronic last updated date of 07/15/20. -There was a staff signature sheet dated	D 338		

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04/22/20.

1. Observation of the facility on 09/15/20 at 9:49am revealed:
-The dining room was on the left when entering the facility.
-There was a window to the left wall when entering the facility allowing visualization of the dining room.
-There were three residents in the dining room without face masks.
-Two of the residents were not practicing social distancing.
-The Business Office Manager (BOM) was walking through the dining room.
-The BOM did not prompt the residents to wear a face mask or practice social distancing.

Interview with a Personal Care Aide (PCA) on 09/15/20 at 9:49 am revealed:
-She had been employed at the facility for about one month.
-She had not received Infection Control training or COVID-19 training.
-The Administrator told her what needed to be done regarding COVID-19 which was to wear a face mask and gloves, use hand sanitizer, staff were to be six feet apart, and not to report to work if sick.
-The COVID-19 policy required staff to wear gloves and a face mask at all times.
-Residents were not required to wear face masks.
-Residents were not required to social distance.
-All residents ate together in the dining room seated two to three residents at each table.
-All residents performed communal activities together in the dining room.
-The dining room tables were placed six feet apart.
-Residents did not need to practice social

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distancing when eating because they did not talk when dining.
-Residents were not practicing social distancing because all the residents resided together in the same facility.
-If residents had a fever, she would tell the Administrator or BOM. She did not know what else to do.

Interview with the Business Office Manager (BOM) on 09/15/20 at 9:49am revealed:
-She had understood that if the facility had COVID-19 positive residents, then the residents would be required to wear face mask.
-Since the facility did not have COVID-19 positive residents, the resident were not required to wear face
-She had received the information on residents use of face mask from the Department of Health and Human Services.

-Observation of the dining room on 09/15/20 from 9:54am - 10:00am revealed:
-There were four tables in the dining room. Two tables on the left and two tables on the right.
-Each table was approximately 3 feet square.
-Three residents were in the dining room without face masks.
-One of the residents was sitting at the table on the left closest to the dining room entrance.
-The Administrator was standing to the right between the other two residents.
-The Administrator and the residents were not social distancing.
-The Administrator was wearing a face mask and pulled the face mask out and down below her nose.
-The Administrator and the residents were talking.
-The Administrator did not prompt the residents to wear a face mask or utilize social distancing.

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D 338	Continued From page 19 -The BOM and another staff walked into the dining room both wearing face masks. -The three residents, Administrator, BOM, and the PCA were not social distancing. -Two of the three residents exited the dining room without face masks. -The residents were not social distancing when exiting the dining room. -One of the residents approached another resident in the hallway and walked together towards the end of the hall. -The two residents did not have a face mask and were not social distancing. Interview with a resident on 09/15/20 at 10:00am revealed: -She did not have a face mask. -If she had wanted a face mask, she could get a face mask from the staff that worked in the facility. -She did not have to wear face mask in the facility. -She was required to wear face mask when she went to doctor's appointments. Interview with a second resident on 09/15/20 at 10:10 revealed: -She did not have to wear a face mask, unless she went to a doctor's appointment. -Her family member sent her a face mask to wear. -The Administrator had told her that staff had to wear a face mask all day while in the facility. -Three residents sit per table in the dining area during meal times. -She had not been told anything about social distancing by staff. Second interview with the BOM on 09/15/20 at 10:15am revealed:	D 338		

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D 338	Continued From page 20 -All staff were supposed to wear a face mask to cover the nose and under the chin. -The facility pharmacist and the Administrator had provided staff education regarding the proper way to wear a face mask. -The Administrator had educated all staff to social distance. -Residents were practicing communal dining. -Residents were not required to social distance because there was not a positive case of COVID-19 in the facility. -Residents were not required to wear a face mask because there was not a positive case of COVID-19 in the facility. -If a resident contracted COVID-19 then the residents would be required to wear face masks and social distance. 2. Interview with the first housekeeper on 09/15/20 at 9:56am revealed: -She was a wearing a mask during the interview. -She wore a mask everyday she worked. -She had worked at the facility for 3 years. -She worked Monday through Friday, 4 hours per day. -She cleaned the resident rooms, mopped, cleaned the bathrooms, and "sanitized" the resident common areas. -She used bleach and a cleaner mixed with laundry detergent that disinfected surfaces. -She purchased the cleaning supplies to clean the facility. -She had volunteered to purchase the cleaning supplies. -She mixed a cleaner and laundry detergent together that she used to clean the facility. -She had not recalled receiving any training on COVID-19. -She had been instructed by the Administrator that she needed to wear a mask while she was in	D 338		

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D 338	Continued From page 21 the facility. Interview with the second housekeeper on 09/15/20 at 10:02am revealed: -The Administrator had provided COVID-19 training one month ago to the entire staff. -The training was to wear a face mask to cover the nose and mouth. -He did not wear a face mask over his nose because it was hard to breath when cleaning. -He did not know if the Administrator knew he wore the face mask below his nose. -He would mop the floors with laundry detergent. -He would clean the door knobs with window cleaner. -He did not use bleach or other sanitizers when cleaning. -He had not received education regarding expected cleaning agents to use for cleaning and disinfecting. Review of a container identified by the second housekeeper as contents used for mopping floors revealed: -The container had a manufacturer's label "laundry cleaner plus fabric softener". -There was no Environmental Protection Association (EPA) identification number listed on the container. Observation of the second housekeeper on 09/15/20 from 10:02am - 10:05am revealed: -The housekeeper was sweeping the hallway floor in front of the Administrator's office. -The Administrators office door was open. -The Administrator was standing in the office with view of the housekeeper. -The housekeeper was wearing a cloth face mask below his nose resting on his top lip. -The housekeeper did not reposition the face	D 338		

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mask to cover his nose during the interview.
-The Administrator did not prompt him to wear his mask correctly.

Observation of the first housekeeper on 09/15/20 at 10:14am revealed she was mopping the floor wearing a cloth face mask below her nose.

A second interview with the first housekeeper on 09/15/20 at 10:14am revealed the face mask would slip below her nose.

Observation of the Administrator's office on 09/15/20 at 10:22am revealed:
-The Administrator was sitting at her desk talking on the phone.
-The Administrator was wearing a face mask pulled below her chin not covering her nose or mouth.
-A staff member wearing a face mask was sitting across from the Administrator's desk.
-The BOM wearing a face mask was standing behind and to the right of the new employee.

Interview with a third resident on 09/15/20 at 10:25am revealed:
-Three residents sat per table in the dining room during meal times.
-The Administrator had talked to her about social distancing.
-She could not recall when the Administrator talked to her or what the Administrator told her about social distancing.

Interview with the Administrator on 09/15/20 at 10:32am revealed:
-Staff were required to wear face masks at all times when working.
-It was expected staff to wear the face mask over the nose, covering the mouth, and under the chin.

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D 338	Continued From page 23 -She had educated staff on the proper way to wear a mask. -It was unacceptable to wear a face mask below the nose because it would not cover the nose. -The two housekeepers probably pulled down their masks below their noses to "catch" their breath. -It was expected for staff to exit the facility if staff needed to pull the face mask below their noses. -It was possible the two housekeepers had not been educated regarding the proper way to wear a face mask because they were part time staff and she could have missed educating them. -The first housekeeper probably had been educated the proper way to wear a face mask but did not remember how to wear the face mask. -Residents were not required to wear face masks because there was not a positive case of COVID-19 in the facility. -Residents were not required to social distance because there was no COVID-19 in the facility. -Residents could sit together because there was not a positive case of COVID-19 in the facility and no one had been exposed to COVID-19. -Residents could eat together without social distancing during meals. -Staff did not social distance because the facility was small and social distancing was not possible. -COVID-19 staff education was provided one month ago by the facility pharmacist. -She pulled her face mask down when talking to others because it was difficult for others to hear her talk when wearing the face mask. -She should not have pulled her face mask down because she was not practicing the social distancing policy or following CDC guidelines. -She did not know about the CDC guidelines recommending the need for residents to wear face masks. -She did not know about the CDC guidelines	D 338		

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recommending the need for social distancing among residents.
-She had received updated CDC COVID-19 guidance from the Adult Home Specialist (AHS) via email.
-The COVID-19 emails were received by the BOM.
-The BOM would print the emails, the Administrator and BOM would review and discuss the emails, then review with staff.
-She had not received CDC guidelines regarding residents wearing face masks and social distancing.
-The BOM may have received the CDC guidelines regarding residents wearing face masks and social distancing.

A third interview with the BOM on 09/15/20 at 10:50am revealed:
-She would receive and read COVID-19 emails from NC DHHS.
-If the emails contained a COVID-19 form to be completed or contact information she would print the form and/or contact information.
-She thought she printed the CDC and NC DHHS guidelines regarding residents wearing face masks and social distancing.
-She though she educated staff about the CDC and NC DHHS guidelines regarding residents wearing face masks and social distancing.
-She did not remember when she received the CDC and NC DHHS guidelines regarding residents wearing face masks and social distancing.
-The CDC and NC DHHS guidelines stated residents did not need to wear face masks if there was not a positive case of COVID-19 in the facility.
-The CDC and NC DHHS guidelines stated residents did not need to social distance if there

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was not a positive case of COVID-19 in the facility.
-The CDC and NC DHHS guidelines stated face masks and social distancing were required for residents if there was a positive case of COVID-19 in the facility.

A telephone interview with the Administrator on 09/16/20 at 11:38 am revealed:
-She would tell housekeeping staff to begin using a sanitizing agent to clean the floors and door knobs and touchable surfaces.
-There was no other response to questions regarding the floors being mopped with laundry detergent.
-There was no other response to questions regarding the door knobs being cleaned with window cleaner.
-She did not know the CDC guidelines for environmental cleaning.

Telephone interview with a mental health provider for the facility on 09/17/20 at 2:26pm revealed:
-She would go to the facility to consult residents.
-Her last visit to the facility was 09/09/20.
-She had never seen residents in the facility wear face mask.

____
The facility failed to implement and maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) related to social distancing, communal dining, and use of personal protective equipment (PPE), for infection prevention and transmission of coronavirus (COVID-19) during the COVID-19 pandemic. The facility failed to ensure that housekeeping staff used EPA approved sanitizing agents recommended by the CDC to sanitize and disinfect the facility. The

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D 338	Continued From page 26 facility's failure placed the residents at increased risk for contracting and transmitting COVID-19, which was detrimental to the health, safety, and welfare of the residents, and consitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/16/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 1 , 2020.	D 338		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect as related to personal care and supervision and resident rights pertaining to COVID-19 infection control. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to ensure staff was available to provide supervision to residents with mental health diagnoses and/or cognitive impairments as evidence of no staff in the facility. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).]	D914		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 1	101 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 27 2. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global Coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of COVID-19 as related to the use of personal protective equipment (PPE) by staff and residents, practicing social distancing, and use of Environmental Protection Agency (EPA) approved disinfectant cleaners were available and used. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type B Violation).]	D914		