

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/08/2020
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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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 from 10/05/20 to 10/06/20, and a desk review survey from 10/07/20 to 10/08/20, and a telephone exit on 10/08/20.	D 000	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with state regulations. The facility has taken or will take the action set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date, or dates indicated.	
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE) when providing care to residents who tested positive for COVID-19, posting signage relating to airborne precautions in isolation areas and residents maintaining a social distance of 6 feet. The findings are: Review of the CDC and DHHS guidelines for the	D 338		

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

Palmyra Guine

TITLE

Administrator

(X6) DATE

DATE FORM

6899

CGL711

If continuation sheet 1 of 10

*Reviewed & Accepted
11/19/20 ND*

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D 338	<p>Continued From page 1</p> <p>prevention and spread of the Coronavirus (COVID-19) disease in long-term care facilities revealed personnel should wear the appropriate PPE when in contact with a resident diagnosed with COVID-19, post signage relating to airborne precautions in isolation areas and residents maintain social distance of 6 feet.</p> <p>1. Observation of a personal care aide (PCA) standing in the doorway to room 335 on the women's hall on 10/06/20 from 12:54pm to 12:55pm revealed:</p> <ul style="list-style-type: none"> -She was standing inside of the doorway to the room talking with the resident. -She had on a mask and gloves. -She had a large rollaway trashcan positioned in the doorway. -She left the room pushing the trashcan. -She did not change her mask or gloves. -She pushed the trashcan down the women's hallway. <p>Interview with the PCA on 10/06/20 at 12:56pm revealed:</p> <ul style="list-style-type: none"> -She had gone into room 335 to pick up the resident's trash to discard it. -She knew the resident had tested positive for COVID-19 and was placed in quarantine. -She had not thought about putting on full PPE before going into the resident's room. -She was in the room for "a second to grab the trash". -She had completed training on PPE in August 2020 (she could not recall a specific date). -She was only picking up the trash from the resident's room. <p>Interview with the medication aide (MA) on 10/06/20 at 1:02pm revealed:</p> <ul style="list-style-type: none"> -The PCA had not been assigned to provide care 	D 338	<p>On 10/06/2020 PCA was terminated for deficient practice as it pertains to noncompliance with following Infection Control policy and procedure that which she received training on 9/25/2020 with return demonstration</p> <p>The administrator provided reeducation/competency with return demonstration to all department which includes but was not limited to infection control, basic hand hygiene, how COVID-19 is transmitted, What is droplet precautions; use of Personal Protective Equipment (PPE) donning and doffing PPE and wearing facemask continuously and the zero tolerance directive for failure to comply. Staff will continue to be instructed on facility's zero tolerance stance with non compliance during this pandemic following progressive disciplinary actions.</p>	<p>10/06/2020 10/09/2020</p> <p>11/05/2020 and ongoing</p>

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D 338	<p>Continued From page 2</p> <p>for the two residents in quarantine on the designated COVID-19 area on the women's hall.</p> <ul style="list-style-type: none"> -There were staff assigned to provide care for the two residents in quarantine. -She had noticed the PCA entering room 335. -She had not spoken to the PCA about entering the room because she had been busy on the medication cart. -If a resident diagnosed with COVID-19 needed assistance, staff were to suit up in full PPE, including, mask, face shield, gloves, and gown. -The housekeeper was responsible for collecting the trash on the COVID-19 women's hall. -There was full PPE available to staff. -She was responsible for supervising for the PCAs who were not assigned to work COVID-19 women's hall. <p>Interview with the Resident Care Coordinator (RCC) on 10/06/20 at 12:32pm revealed:</p> <ul style="list-style-type: none"> -There were 9 residents who had a COVID-19 diagnosis. -There were 2 women who had been in quarantine in a designated area on the women's hall, 5 men in quarantine in a designated area on the men's hall and 2 residents had been currently hospitalized. -There was one staff assigned to care for all of the residents in quarantine on 10/06/20. -There was not any "cross contamination of staff"; only the assigned staff were to work with the residents diagnosed with COVID-19. -The assigned staff worked on both of the designated quarantine areas. -The MAs who were not assigned to the COVID-19 positive areas, provided supervision to the non COVID-19 assigned PCAs. -She complete routine walk throughs of the facility every two hours. -She along with the Assistant Administrator and 	D 338	<p>MA was reeducated on the potential to be affected by the alleged deficient practice. The MA was reeducated that consistent staff are scheduled on the COVID unit and staff entering COVID positive rooms will be limited to staff assigned, housekeeping, physicians and EMT as needed and should a staff member be observed entering a COVID positive residents room and they are not properly donned in full PPE including mask, faceshield gloves and gown that it is her responsibility to say something immediately.</p> <p>Effective 10/06/2020, no staff will be able to begin their shifts until education regarding PPE, zero tolerance has been complete and competency acknowledged by the trainer</p>	<p>10/09/2020 10/09/2020</p>

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D 338	<p>Continued From page 3</p> <p>Administrator were responsible for supervising the MAs.</p> <p>Interview with the Assistant Administrator on 10/06/20 at 1:17pm revealed:</p> <ul style="list-style-type: none"> -The MAs and PCAs were not allowed to provide care to the identified residents who had tested positive for COVID-19 if they were assigned to the hall without residents with COVID-19. -Only in an emergency could the staff not assigned to the COVID-19 areas provide care to the residents diagnosed with COVID-19. -Staff not assigned to the COVID-19 areas must inform the MAs if they needed to enter the room of a resident who had been placed in quarantine. -All staff must wear full PPE, including a mask, face shield, gloves, gown and shoe coverings prior to entering a room of a resident in quarantine. -All PPE must be discarded immediately after exiting a room of a resident in quarantine and the staff must immediately wash and sanitize their hands and place on new PPE. <p>Interview with the Administrator on 10/06/20 at 2:16pm revealed:</p> <ul style="list-style-type: none"> -There were 9 residents who had been diagnosed with COVID-19. -There were 2 female residents quarantined in a designated area on the women's hall, 5 male residents quarantined in a designated area on the men's hall, and 2 residents had been hospitalized. -The first resident tested COVID-19 positive on 06/06/20 for 1 resident, the second resident tested COVID-19 positive on 06/08/20 and the third resident tested positive on 08/28/20. -There were 16 residents who had tested positive for COVID-19 on 09/10/20. -The facility had been free of COVID-19 from 	D 338		

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D 338	<p>Continued From page 4 07/14/20 to 08/27/20.</p> <ul style="list-style-type: none"> -There was a MA and PCA designated on each shift to provide care to all residents diagnosed with COVID-19. -All staff were trained on how put on and discard their PPE. -There was full PPE available to staff at all times. -The PCA had completed training on infection control and PPE. -Staff who worked with the residents in quarantine were to wear full PPE and must be in full PPE prior to entering the room no matter how long they were to be in the room. -She was responsible for providing infection control training on COVID-19 to the staff. -The COVID-19 infection control trainings were on proper use of PPE, the different types of PPE, proper handwashing and hand sanitizing, how to properly use hand sanitizer, universal precautions, screening tools, and sanitation. -She received guidance related to COVID-19 from the CDC and DHHS websites and was on their email listing. -She received guidance from the local LHD. -She completed walk throughs of the facility every two hours. -She was responsible for supervising all management staff and clinical staff. <p>2. Observation of residents' bedrooms 335 and 336 on the women's hall on 10/05/20 from 11:52am-11:54am revealed:</p> <ul style="list-style-type: none"> -The bedroom doors were opened. -There was no isolation signage posted on the room doors. <p>Interview with the Administrator on 10/05/20 at 11:55am revealed:</p> <ul style="list-style-type: none"> -There should be an isolation sign on the two residents' rooms who tested positive for 	D 338	<p>On 10/5/2020, visual poster/ tools provided by the CDC where placed back on the bedroom doors during survey.</p> <p>On 10/6/2020 the RCC and or disignee will begin conducting enhanced surveillance observation every 2 hours for compliance to all infection control practices, signage, observing for facemask in place, hand hygiene before entering rooms, gloves worn in room and randomly asking staff about droplet precautions. These observation will be conducted on every shift and documentation for a period of 3 months. Zero tolerance for compliance will be adhered too. The RCC or disignee will immediately educate or correct any staff member found to be deficient in practice. cont next page</p>	<p>LI 10/5/2020 10/09/2020</p> <p>umari JT 10/09/2020</p>

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D 338	<p>Continued From page 5</p> <p>COVID-19.</p> <ul style="list-style-type: none"> -The residents' doors should remain closed but the housekeeper had just finished mopping and the area needed to dry out. -All staff was responsible for replacing signage that had fallen off doors throughout the facility. -Staff was aware which residents were positive for COVID-19 on the women's hall. -Rooms 335 and 336 were designated for residents who tested positive for COVID-19. <p>3. Observation during the site visit on 10/05/20 from 10:40am-10:43am revealed:</p> <ul style="list-style-type: none"> -There was a sign posted next to the back door on the men's hall that read "Only 2 residents at a time are allowed in their smoking area". -There were four residents in the smoking area. -The residents were not distanced six feet apart. -Two residents were not wearing masks and they did not have masks with them. <p>Interview with a resident, who was not wearing a mask in the smoking area, on 10/05/20 at 10:43am revealed:</p> <ul style="list-style-type: none"> -The normal smoking area on the front side of building was closed because of the isolation area. -They were not aware of the number of residents allowed in the smoking area at one time. -He left his mask in his room because he could not wear it while he was smoking. <p>Interview with a medication aide (MA) on 10/05/20 at 10:45am revealed:</p> <ul style="list-style-type: none"> -All staff was responsible for ensuring there were no more than two residents in the smoking area. -Staff monitored the smoking area while they performed other tasks on the hallway. -There was no frequency to when staff monitored the smoking area. 	D 338	<p>All education and observation documentation will be reviewed monthly by Administrator for 3 months to evaluate improvement and consistency. After 3 months Administrator will determine if further monitoring is necessary in accordance with this plan of correction.</p> <p>On 10/7/2020, residents were reeducated in respect to social distancing at 6ft. and wearing their facemask when outside of their rooms.</p> <p>Further, the facility implemented a resident smoking schedule and every resident that smokes signed for further compliance. All staff was also informed that signature will be required by the staff member that supervises residents at assigned times to assure 6ft social distancing and adherence to 2 residents at a time in smoking area. Lastly facility placed 6ft markers in smoking area to remind residents and staff of social distancing as well.</p>	<p>01/06/2021</p> <p>10/9/2020</p>

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CARE ONE ASSISTED LIVING OF GREENVILLE **2060 WEST FIFTH STREET**
GREENVILLE, NC 27836

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D 338	<p>Continued From page 6</p> <p>Interview with a personal care aide (PCA) on 10/05/20 at 10:50am revealed that all staff was responsible for monitoring the smoking area.</p> <p>Interview with the Administrator on 10/06/20 at 2:16pm revealed: -Two residents were allowed in the smoking area at a time. -The floor staff was responsible for monitoring the smoking area. -The management team, which included the Administrator, Assistant Administrator, and Resident Care Coordinator (RCC), completed walk through rounds every two hours to ensure staff was appropriately enforcing guidelines. -It was her expectation that staff monitored the smoking area every 30 minutes to ensure that there were no more than two residents in the smoking area.</p> <p>Observation of the TV room on the women's hallway on 10/05/20 at 11:00am revealed: -There were six residents seated in the TV room. -Four of the residents were seated six feet apart, one of which wore a mask. -Two of the residents were not seated six feet apart, one of which wore a mask. -There were four residents without masks in the TV room.</p> <p>Interview with a resident on 10/05/20 at 11:00am revealed: -The residents were to always wear masks when outside of their rooms. -She was not aware of the number of residents allowed in the TV room at one time.</p> <p>Interview with a MA on 10/05/20 at 11:02am revealed: -Five residents were allowed in the TV room at a</p>	D 338	<p>On 10/6/2020, the facility closed all congregate areas to avoid further alleged non compliance and reeducated residents on safe practices to include proper hand hygiene, social distancing at 6ft. and the use of facemask as they should always be worn to cover both nose and mouth when outside of their rooms to avoid transmission of COVID-19</p>	10/09/2020

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D 338	<p>Continued From page 7</p> <p>time.</p> <ul style="list-style-type: none"> -The residents were to wear their masks while in the TV room. -It was the staffs' responsibility to make sure there were no more than five residents in the TV room. -It was the staffs' responsibility to make sure that residents were wearing their masks while in the TV room. <p>Interview with the Administrator on 10/06/20 at 2:16pm revealed:</p> <ul style="list-style-type: none"> -Four residents were allowed in the TV room at a time. -Residents should have their masks on in the TV room. -The floor staff was responsible for monitoring the TV room. -The TV room was closed at night to prevent congregation of residents. -The management team, which included the Administrator, Assistant Administrator, and Resident Care Coordinator (RCC), completed walk through rounds every two hours to ensure staff was appropriately enforcing guidelines. -It was her expectation that staff monitored the TV room every 30 minutes to ensure residents were practicing social distancing and wearing masks. <p>Refer to the telephone interview with the Local Health Department (LHD) employee.</p> <p>Telephone interview with the LHD's Public Health Nurse on 10/06/20 at 8:54am revealed:</p> <ul style="list-style-type: none"> -She had last spoken with the facility's Administrator on 10/02/20. -She had provided the CDC and DHHS website links related to COVID-19 to the facility Administrator. 	D 338		

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D 338	Continued From page 8 -The Administrator provided a required listing of all new COVID-19 cases of residents and staff weekly. -The facility had followed the CDC and DHHS guidelines for quarantining the residents who tested positive for COVID-19. The failure of the facility to adhere to the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) and Local Health Department (LHD) guidelines for COVID-19 to include recommendations as related to staff appropriately wearing personal protective equipment (PPE) when providing care to residents who tested positive for COVID-19, posting signage related to airborne precautions in isolation areas and residents maintaining a social distance of 6 feet was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-37 on 10/05/20 and an addendum was obtained on 10/06/20 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 5, 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.	D914		

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D914	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from neglect as related to residents' rights pertaining to COVID-19 infection control.</p> <p>The findings are:</p> <p>Based on interviews, observations 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 (DHHS) were implemented and maintained when caring for residents during the global Coronavirus (COVID-19) pandemic as related to staff appropriately wearing personal protective equipment (PPE) when providing care to residents who tested positive for COVID-19; posting signage related to airborne precautions in isolation areas and residents maintaining a social distance of 6 feet. [Refer to Tag 338 10 NCAC 13F .0909 Residents Rights (Type B Violation)].</p>	D914		