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D 000	Initial Comments The Adult Care Licensure Section conducted a State involved complaint investigation and a COVID-19 Infection Control Survey with an onsite visit on 08/25/20, a desk review survey on 08/26/20 - 08/28/20 and a telephone exit on 08/31/20.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to rapidly taking action to test staff and all residents and retesting staff and residents that were negative for COVID-19, weekly after an outbreak dated 06/29/20 to reduce risk of transmission and infection. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term care (LTC) facilities dated 06/20/20 revealed:	D 338		

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D 338	Continued From page 1 -Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2 (COVID-19), including close and expanded contacts (e.g., there is an outbreak in the facility). -Perform expanded viral testing of all residents in 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 infection in a resident should be considered an outbreak. -Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission. -If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP). -Repeat Testing in Coordination with the Health Department. -After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. -Repeat testing should be coordinated with the local, territorial, or state health department. -Continue repeat viral testing of all asymptomatic previously negative residents and staff, approximately every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2	D 338		

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infection among residents and HCP for a period of at least 14 days since the most recent positive result.
-This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.

Review of the Guidance from NC DHHS dated 04/15/20 revealed:
-It was recommended after one patient with a positive COVID-19 test result to test all residents and staff regardless of symptoms, when testing capacity permits.
-If testing capacity is limited, priority should be given to testing residents and staff with symptoms or those who had close contact with a case.
-Testing of asymptomatic persons in an LTC facilities should be done in consultation with the local and state public health.

Telephone interview with the Health Director (HD) from the Local Health Department (LHD) Communicable Disease Division on 08/31/20 at 10:30am revealed they supplied all facilities in Lincoln county with the LTC facilities Guidance dated 04/02/20, "Facilities should refer to CDC's guidance on COVID-19".

Review of the COVID-19 LTC Facility Guidance dated 04/02/20 revealed:
-State and local health departments should work together with long-term care facilities in their communities to determine and help address long-term care facility needs for PPE and/or COVID-19 tests.
-Facilities should also refer to CDC's guidance to long-term care facilities on COVID-19.

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D 338	Continued From page 3 Telephone interview with the Communicable Disease (CD) Nurse from the LHD on 08/28/20 at 8:06am revealed they provided the CDC Considerations for Memory Care Units (MCU) in Long Term Care (LTC) Facilities dated 05/12/20 to the Health and Wellness Director (HWD) as an attachment in an email, by the LHD CD Nurse on 07/02/20. Review of the CDC Considerations for Memory Care Units (MCU) in Long Term Care (LTC) Facilities dated 05/12/20 revealed one of the considerations at the time was, when a resident with COVID-19 asymptomatic SARS-CoV-2 infection has been identified, other residents and personnel on the MCU may have already been exposed or infected, and additional testing may be needed. Review of the facility's COVID-19 "Guidance for Community Leaders" dated 05/29/20 from the Divisional Health and Wellness Director (DHWD) revealed: -For the employees who work directly with a resident who tested positive, speak with the impacted employee immediately. -Begin taking temperatures of employees at the beginning, middle and end of shift. -If the employee shows symptoms, contact their contracted agency to triage and report the incident and they will send to a clinic for medical treatment. -If the physician sends them home without a test and says that they conclusively do not have COVID-19, they were on quarantine until symptom free for 72 hours. -If the physician tests them, stay at home until the test results are received. -In State required testing for employees, always follow the guidance from the LHD.	D 338		

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D 338	Continued From page 4 -This was guidance for staff and did not address guidance for testing or retesting residents. Review of the New COVID-19 Outbreaks in Congregate Living Settings Report dated 07/08/20 at 5:00pm revealed: -There were 34 total residents at the facility. -There were 3 lab confirmed COVID-19 positive residents. -There were 0 lab confirmed staff. -There were 0 hospitalized and 0 deaths reported at the facility. Telephone interview with the Adult Home Specialist (AHS) on 08/25/20 at 3:00pm revealed on 07/13/20 she received an electronic mail (email) from the Business Office Manager (BOM) which stated the LHD was aware of the COVID-19 outbreak, and recommendations at that time were to test everyone in the facility including staff and quarantine the positive residents in the MCU. Review of the email from the Assistant Health Director (AHD) from the LHD Communicable Disease Division to the Administrator revealed: -On 06/17/20 at 3:56pm, the email subject was "LTCF COVID-19 Procedures" dated 06/16/20 with instructions to refer to the CDC guidance for the most up-to-date recommendations about infection prevention practices in LTC settings. -On 07/23/20 at 12:41pm, the email subject was "CDC Guidance", and Attachments included; Responding to COVID-19 in Nursing Homes, LTC COVID-19 Outbreak Admission Considerations, Strategies to Mitigate Healthcare Personnel Staffing Shortages and Emergency-Resource-Requests. In the body of the email was the current guidance to test all negative residents and staff weekly until there	D 338		

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were no new positive cases within 14 days of the most recent positive case.
-On 07/21/20 at 8:27am, the email subject was, "Press Release on testing and staffing". A link was included for reference to the press release. The press release had information for testing with a local pharmacy. Resources for requesting additional staffing and Personal Protective Equipment (PPE).

Review of the facility's Monitoring Grid and the Resident's test results revealed 19 residents tested positive for COVID-19 and 16 residents tested negative for Covid-19.

After review of the facility's Monitoring Grid and the resident's negative COVID-19 test results it was determined 9 of the 16 residents who tested negative for COVID-19, were not retested.

Review of the New COVID-19 Outbreaks in Congregate Living Settings Report dated 07/08/20 at 5:00pm revealed there were 40 total staff at the facility.

Review of the facility's Monitoring Grid and the Staff's test results revealed only 19 total staff were tested and 13 tested positive for COVID-19, 5 staff tested negative for Covid-19 and 1 staff had no results.

After review of the facility's Monitoring Grid and the Staff's negative COVID-19 test results it was determined 5 of the 5 staff who tested negative for COVID-19, were not retested.

Telephone interview with the facility physician on 08/27/20 at 1:51pm revealed:
-She saw 10 residents in the facility on a weekly basis.

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-There were 5 residents in the MCU she provided services for.
-Of the 5 residents on the MCU, 4 were positive for COVID-19.
-She consulted with the LHD about her 4 COVID-19 positive residents who resided on the MCU and 6 COVID-19 negative residents who resided in the AL and 1 on the MCU, and was directed to test weekly all her negative COVID-19 residents until there were no new positive COVID-19 residents.
-She wrote an order for the facility to test her 6 COVID-19 negative residents on a weekly basis.
-She expected the facility to follow the CDC/LHD guidelines.
-Because she contacted the LHD for guidance, she ordered her residents who tested COVID-19 negative to be retested as directed by the LHD.

Interview with a Housekeeper on 08/25/20 at 9:35am revealed:
-She worked in the MCU since January 2020.
-In the middle of July 2020, she had a headache, congestion, difficulty breathing due to the congestion, and a temperature of 100 -101 degrees Fahrenheit for a few days.
-She went to her physician and tested negative for COVID-19 but had an upper respiratory infection.
-The MCD or the Administrator was responsible for directing her to be retested.
-She was not directed to be tested after the COVID-19 outbreak in the MCU at the beginning of July 2020.
-She was not directed to get retested.

Interview with a personal care aide (PCA) on 08/25/20 at 10:01am and 10:30am revealed:
-She worked first shift in the MCU.
-The facility admitted a resident to the MCU

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before his test results were back.
-That resident was the first to show symptoms and tested positive for 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.
-The resident was out in the hall without a mask several times.
-She developed a fever of 103 degrees Fahrenheit during the first week of July 2020 and was told to go get tested by the Administrator.
-There was no facility wide testing when the COVID-19 outbreak occurred.
-The Memory Care Director (MCD) and the Administrator told the staff they should go and get tested by their physician if they displayed symptoms.
-She went to an urgent care and was tested about 3-4 days after she had the temperature of 103 degrees Fahrenheit.
-She tested positive for COVID-19 and the Administrator told her to stay home for 10 days.
-Not everyone in the facility including staff and residents were tested on 07/09/20.
-Only the residents in the MCU that displayed symptoms were tested on 07/09/20 and only some of the residents in AL.
-The only retesting performed was of the residents who tested positive for COVID-19.
-The retesting was to be done on the COVID-19 positive residents in order to get 2 negative COVID-19 test results in order to come off isolation.

Interview with a second PCA on 08/25/20 at 10:30am revealed:
-She worked on the MCU on 1st shift.
-She started working at the facility around the end of July 2020.
-She was told by the Administrator there was a

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COVID-19 outbreak at the facility, and she would be working with COVID-19 positive residents.
-The MCD and the Administrator told her she would only be tested if she displayed symptoms of COVID-19.
-She did not know if the residents were retested or not.
-She was never tested for COVID-19. and did not have any symptoms of COVID-19.

Interview with a medication aide (MA) on 08/25/20 at 11:08 revealed:
-She was told there was a COVID-19 outbreak in the MCU on 07/05/20, by the MCD after 1 resident and 1 staff member tested positive for COVID-19.
-The staff was not tested for COVID-19.
-If a staff member displayed symptoms, they were instructed to go get tested on their own.
-The MCD told her that all the staff would be tested at some point but that did not happen.
-She did not display symptoms and was never tested.
-The MCU was where the symptoms were happening and the AL did not have any symptoms.
-The residents were not tested all at once, some were tested at the beginning of July 2020 when they displayed symptoms and others tested later when they displayed symptoms.
-Some of the residents were tested while they were at the hospital with symptoms or for other reasons.

Interview with the MCD on 08/25/20 at 11:21am revealed:
-There was an outbreak of COVID-19 on 07/09/20.
-All residents were tested on 07/09/20.
-The Administrator kept a "monitoring grid" of

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residents and staff which included symptoms, testing and deaths.
-The Administrator instructed the staff who displayed symptoms to go to their physician's office and get tested.
-On 07/08/20, she did not report to work because she developed a fever, chills and loss of smell.
-She reported the symptoms to the Administrator on 07/08/20.
-She was tested on 07/09/20 at the lab as directed by her physician.
-There were 2 or 3 other staff directed by the Administrator to report to their physician and be tested because they displayed symptoms.
-The Administrator informed her the residents who tested positive for COVID-19 would be retested until they had 2 negatives so they could come off isolation.
-She was out of work from 07/09/20 to 07/20/20, because she tested positive for COVID-19.
-The health department informed her she could return to work on 07/20/20 if she was out 10 days and 72 hours without symptoms.

Interview with the Administrator on 08/25/20 at 12:20am and 3:35pm revealed:
-She did not test all residents and staff on 07/09/20.
-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.
-The monitoring grid was where she recorded testing dates and results, onset date and time of symptoms, treatments or remedies, date and time the community was notified the date they were placed on the list.
-She kept all test results for the residents and staff.

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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 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 responsible for the reporting the COVID-19 outbreak to the LHD, and following the recommended guidance given from the LHD. -The BOM and the HWD spoke with the LHD and received recommendations and reported those to the DHWD. -She 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	D 338		

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DHWD instructed.
-All COVID-19 additional training/updates were handled by the HWD, and the HWD reported to the DHWD for guidance.
-Any information she received related to COVID-19, was discussed with the DHWD and she followed the DHWD guidance.
-The DHWD instructed 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 were symptomatic were instructed to notify their physician for testing and there was no re-testing of all residents and staff who tested negative for COVID-19, weekly for 14 days from the latest COVID-19 positive case to make sure there were no new COVID-19 cases as recommended by the LHD.
-There were 9 residents and 1 staff member that passed away from COVID-19 in the facility.

Telephone interview with the AHD of the LHD on 08/26/20 at 9:15am revealed:
-According to her records, on 07/02/20, their CD Nurse spoke with the HWD about the first reported case of COVID-19 and their recommendations were to test all residents and staff in the facility and then retest all residents and staff weekly for 14 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 recommendations to test all staff and residents and to retest all COVID-19 negatives weekly until there were no new COVID-19 positives within 14 days of the most recent COVID-19 positive case.
-On 07/23/20, she emailed the Administrator with the current recommendations, again, as

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mentioned in the 07/21/20 email and a link to use as a testing resource and how to request additional staff.
-From 07/02/20 - 07/17/20, there were multiple emails and phone calls with the current guidelines, the need for the facility to return the LHD's phone calls left on voice mail messages, and requests by email for updates on the facility's status, but there was no return communication from the facility staff.
-The lack of response from the facility caused alarm for her.
-With the outbreak already started, not following the CDC/LHD recommendations for testing and retesting could increase the risk of the spread of COVID-19 in the facility.
-The negative COVID-19 cases could turn to positive COVID-19 cases and if they were not retested then the negative COVID-19 cases could increase the risk of the spread of COVID-19 in the facility.
-She considered the increased risk of death in this population of elderly residents to be very high.

Telephone interview with the BOM on 08/26/20 at 3:00pm revealed:
-The HWD was in charge while the Administrator was out of the facility 07/02/20 - 07/20/20.
-Any email correspondence regarding guidance she received from the LHD, was given to the HWD and Administrator.
-The HWD was responsible for communicating with the DHWD and the Administrator about the LHD recommendations.
-The Administrator received all guidance from the DHWD concerning the testing and retesting of the residents.
-She was told by the Administrator COVID-19 testing required an order which was easier with

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

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the residents but not the staff, and that's why all staff needed to get testing guidance by their physician.
-The Administrator maintained communication with the her, HWD and the DHWD during the COVID-19 outbreak in the MCU.
-The Administrator was responsible for handling all the COVID-19 outbreak testing and retesting.
-The Administrator had residents in the MCU tested after they displayed symptoms and after receiving a physician's order to have a COVID-19 test performed.
-The Administrator informed the staff they did not have a contract with the lab to test them and if they displayed symptoms, to go get tested on their own.

Telephone interview with a third MA on 08/26/20 at 6:30pm revealed:
-She worked mainly second shift in the MCU.
-There were some residents in the MCU who displayed symptoms who tested positive for COVID-19 on 07/02/20 and the facility was considered in an outbreak.
-On 07/09/20, only the MCU residents were tested as directed by the Administrator.
-She did not know about testing on the AI side because she only worked the MCU and was not allowed to cross over to that section.
-There was no testing of the staff unless they were symptomatic and then staff were directed to see their own physician.
-There was no retesting of the COVID-19 negative residents or staff.
-There was testing of COVID-19 positive residents in order to get two negative test results so they could come off isolation.

Telephone interview with the DHWD on 08/28/20 at 4:47pm revealed:

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-On 05/29/20, she sent the updated version of COVID-19 Guidance for Community Leaders to the HWD.
-This guidance was created by herself and other corporate administration and updated as needed.
-This pertained to CDC guidance for employees who tested positive for COVID-19 and it did not include residents who tested positive for COVID-19.
-This guidance was to follow the LHD first and if there was no guidance from the LHD then follow the test-based strategy.
-On 07/02/20, she was notified by the HWD two residents tested positive that day.
-It was considered an outbreak after the second person tested positive for COVID-19.
-On 07/07/20, she spoke with the Health Director (HD) of the LHD, and was given the most recent CDC/LHD recommendations and guidelines.
-Since they were not mandated by the CDC/LHD she went off the corporate guidance to test only the residents, and staff if they showed symptoms, they were to go to their physician and to retest all positives until they resulted in two negatives.
-When staff became symptomatic the staff were told to go home, contact their physician and get tested.
-The upper management met and discussed the outbreak and made the decision to test all the residents on the MCU because they were "fragile" and where it started, and only some in the Assisted Living (AL).
-On 07/07/20, there was COVID-19 testing performed on all the MCU residents and some of the AL the residents.
-There were no conversations with upper management regarding retesting all the COVID-19 negative residents.
-They decided just the remaining residents on the AL side that were not tested on 07/07/20 and

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retesting only the MCU residents who tested positive.
-Sporadically, 7 days after the results came back for the residents on the MCU tested on 07/07/20, they performed additional testing of the AL residents and the retesting of the positive MCU residents was completed on 07/09/20, 07/11/20, 07/26/20 and 07/28/20.
-The HWD was responsible for directing all activities related to the outbreak because the Administrator was out of the facility 07/02/20 - 07/20/20.
-On 07/06/20, the Administrator was out and kept in touch with the HWD and her while at home.
-On 07/10/20, the HWD was out of the facility.
-On 07/10/20, the Administrator was responsible for the activities related to the outbreak, with the help of the HWD by telephone communication.
-On 07/20/20, the Administrator returned to the facility.
-The HWD cut off communication with her and according their records, his last day was 08/20/20.

Telephone interview with the HWD on 08/28/20 at 5:45pm was unsuccessful.

Review of the electronic mail from the Communicable Disease (CD) Nurse from the Local Health Department Communicable Disease Division to the HWD, and the BOM revealed:
-On 07/02/20 at 4:24pm, an email was sent to the HWD, the subject was, "more guidance", Attachments included; Considerations for MCU in LCTF dated May 12, 2020.
-On 07/31/20 at 11:31am, an email was sent to the Business Office Manager (BOM), subject was, guidance regarding "move-in, the body of the email included; the CD Nurse questioned if the facility had the facility completed testing all

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negative residents and staff and was the facility continuing to test weekly until they have gone 14 days without a case?
-On 08/17/20 at 4:47pm, an email was sent to the HWD, subject was CDC Guidance, attachments included; Responding to COVID-19 in Nursing Homes dated 06/11/20, Preparing for COVID-19 in Nursing Homes dated 07/02/20.

Telephone interview with the CD Nurse from the LHD on 08/28/20 at 8:06am revealed:
-On 07/02/20, she spoke with the HWD at the facility about the first COVID-19 case and testing at the facility and the policy for staff to be permitted to return to work after being symptomatic or testing positive for COVID-19.
-On 07/02/20, she emailed the HWD CDC's considerations for MCU in LTC dated 05/29/20.
-The CDC's considerations for the MCU was a resource used with an emphasis on testing and re-testing because after one resident or staff member tested positive for COVID-19, there were others exposed or infected but asymptomatic for COVID-19, therefore the recommendation to test all staff and residents and to re-test all negative COVID-19 weekly for 14 days after the most recent positive COVID-19 case was important.
-On 07/07/20, she spoke with the DHWD regarding the LHD's recommendation to do facility wide COVID-19 testing which included residents and staff and retest all COVID-19 negatives weekly until there were no new COVID-19 positives within 14 days of the most recent positive COVID-19 case.
-On 07/08/20, she emailed the HWD the outbreak information with recommendations.
-On 07/31/20 at 11:31am, she sent an email to the BOM, with a question if the facility had completed testing on all negative residents and staff and was the facility continuing to test weekly

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until they have gone 14 days without a case. There was no reply to that question.
-It was not until 08/27/20 the Administrator contacted her requesting guidance.

Telephone interview with the HD from the Local 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 department.
-His CD Nurse sent out guidelines and recommendations to test all staff and residents and to retest all COVID-19 negatives weekly until there were no new COVID-19 positives within 14 days of the most recent positive COVID-19 case, on 07/02/20 after they were notified of the breakout.
-He received only "minimal reports" from the facility, lacking the information such as how many residents and staff were tested, how may positives and negatives from the testing and when the negatives were to be tested again as recommended.
-There was no request for a consultation or 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 guidance.
-The 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 reply from the facility in relation to the need for assistance with testing.

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D 338	Continued From page 18 -The AHD of the LHD sent out guidance/resources for testing and staffing to the HWD on 07/21/20 and 07/23/20. -He expected the facility to contact them if they needed assistance with testing the residents and staff so that he could accommodate their needs. -The facility was to have a plan in place for testing of all staff and residents during an outbreak and if the plan was not working, 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 facility to follow the guidance and recommendations set forth by the LHD and to test all staff and residents and to retest all staff and residents weekly until there were no new positive cases within 14 days of the most recent positive case. -The failure to test and retest residents and staff fully could increase the risk of exposure to COVID-19 because there would be no way to know who to quarantine or isolate to prevent further spread. -The facility did not follow the CDC/LHD recommendations and guidelines provided which led to an increase in of positive cases, which also led to loss of life. -He had strong concerns related to the facility not following the CDC/LHD recommendations. Review of the Death Certificates revealed: -On 07/20/20, a resident died of COVID-19 Pneumonia. -On 07/21/20, a resident died from Chronic Obstructive Pulmonary Disease resulting from COVID-19 infection. -On 07/22/20, a resident died of Pneumonia secondary to COVID-19. -On 07/31/20, a resident died from COVID-19 respiratory failure.	D 338		

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D 338	Continued From page 19 -On 08/01/20, a resident died of Senile Degeneration of the Brain with complications resulting from presumed of COVID-19. -On 08/03/20, a resident died from complications of Alzheimer's Disease. -On 08/03/20, a resident died from Ischemic cardiomyopathy secondary to complications of presumptive COVID-19 infection. -On 08/03/20, a staff member died from COVID-19 Pneumonia and Ischemic Bowel. -On 08/09/20, a resident died of COVID-19 Pneumonia, Sepsis Syndrome, Advance Alzheimer's Disease and Atrial Fibrillation. -On 08/17/20, a resident died from COVID-19. -A total of 9 residents had Covid-19 documented as a cause of death. -One of the 10 deaths was a resident who tested negative for COVID-19, was not retested per the LHD recommendations, died from ischemic cardiomyopathy secondary to complications of presumptive COVID-19 infection. _____ The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), 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 related to a delay of facility wide testing from 06/29/20 to 07/09/20, not testing all residents and staff and not re-testing the residents and staff that tested negative for COVID-19, weekly after an outbreak in efforts to reduce risk of transmission and infection. The lack of testing in accordance with the guidance led to to the inability to determine who may have been asymptomatic and this increased	D 338		

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D 338	Continued From page 20 opportunity for disease transmission. These failures resulted in serious physical harm and death constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 08/25/20. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 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 observation, interview, and record review, the facility failed to ensure all residents were free from neglect related to Resident Rights. The findings are: 1. The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), 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 related to a delay of facility wide testing from 06/29/20 to 07/09/20, not testing all residents and staff and not re-testing the	D914		

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D914	Continued From page 21 residents and staff that tested negative for COVID-19, weekly after an outbreak in efforts to reduce risk of transmission and infection. The lack of testing in accordance with the guidance led to to the inability to determine who may have been asymptomatic and this increased opportunity for disease transmission. These failures resulted in serious physical harm and death constitutes a Type A1 Violation. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D914		