STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an onsite state-involved complaint investigation, follow-up, and COVID-19 Focused Infection Control survey on 11/17/20 through 11/19/20.	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: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 2 of 5 sampled residents (#3 and #4) resulting in the residents having multiple falls, being found on the floor, and sustaining multiple injuries to include multiple skin tears from repeated falls (#3) and a skin tear and facial laceration that required stitches. (#4) The findings are: Review of the facility's Falls Policy revealed: -When a fall occurred, the Supervisor would be notified immediately. -Staff did not get the resident up until the supervisor had checked the resident for obvious signs of injury such as bleeding, loss of consciousness, a broken bone, head injury, etc. -After checking the resident thoroughly from head to toe, the supervisor would assess the resident to determine if there were any injuries and if it was safe to move the resident. -If there were any indications of an injury such as	D 270		

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D 270	Continued From page 1	D 270		

severe bleeding, loss of consciousness, a broken bone or head injury, 911 would be called immediately.
-Staff would stay with the resident and attempt to keep them as comfortable as possible until rescue arrived.
-Another staff member would copy the necessary paperwork that would be transported with the resident.
-If the resident had fallen and had a head injury (bump on head, cut on head, etc.) or head injury was suspected, they would be sent the Emergency Room (ER).
-If there was no injury requiring transport, staff would assist the resident to stand and escort them to an appropriate place (bed, chair, w/c, etc.)
-The supervisor would provide any first aid needed such as treatment for skin tear, etc.
-An incident report would be completed detailing what happened, descriptions of injury if any staff actions and who was notified.
-Resident Care Coordinator (RCC) would complete follow-up on incident including physician visit follow up.
-A 72-hour acute monitoring report would be put in place to follow-up on resident's condition.
-If the resident continues to have falls, staff will monitor resident and situation to determine if any type of intervention was needed to keep the resident safe, including meeting with family members and communication with physician.

1. Review of Resident #4's current FL-2 dated 10/29/20 revealed:
-Diagnoses included advanced dementia, symptomatic anemia, and COVID-19.
-The resident was non-ambulatory.

Review of Resident #4's current care plan dated

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D 270	Continued From page 2	D 270		

08/03/20 revealed:
-Resident #4 was sometimes disoriented; but forgetful and needed reminders.
-She was ambulatory with a wheelchair and had limited range motion.
-Resident #4 required extensive assistance toileting, bathing, and dressing.

Review of Resident #4's Care Notes and Incident/Accident reports revealed:
-Resident #4 had 7 unwitnessed falls from 04/24/20 through 10/30/20.
-The resident was sent to the ER for evaluation for 2 of the 7 falls, which resulted in injury.

Review of Resident #4's Care Note dated 04/24/20 at 3:30am revealed:
-The resident was found on the floor in her bedroom.
-No injuries were noted.
-Staff assisted Resident #4 to the recliner.
-The note was signed by a Medication Aide (MA).

Review of Resident #4's Accident/Incident Report dated 04/24/20 at 3:00am revealed:
-Resident #4 was found on the floor in her bedroom.
-No injuries were noted.
-The resident was assisted off the floor and put in the recliner with feet elevated.
-No fall interventions were put into place for the resident.
-Family was notified and the Primary Care Provider (PCP) was not notified.

Review of Resident #4's record revealed no 72 hour monitoring was completed for the fall on 04/24/20.

Review of Resident #4's Care Note dated

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D 270	Continued From page 3 06/20/20 at 6:30am revealed: -The resident was found on the floor in her bathroom. -The time was documented at 6:30am on the entry. -No signs and symptoms of injuries noted. -The note was signed by a MA. Review of Resident #4's Accident/Incident Report dated 06/20/20 at 6:30am revealed: -Resident #4 was found on the floor in her bathroom. -The resident had no complaints of pain and no injuries were noted. -No fall interventions were put into place for the resident. -Family was notified and the PCP was not notified. Review of Resident #4's 72 hour monitoring report dated 06/20/20 revealed the resident was found on the floor and doing ok, no problem noted. Review of Resident #4's Care Note dated 06/20/20 at 2:20pm revealed: -The resident was found on the floor again by staff. -No signs and symptoms of injuries noted. -The note was signed by a MA. Review of Resident #4's Accident/Incident Report dated 06/20/20 at 2:20pm revealed: -Resident #4's roommate reported the resident was on the floor and that she slid out of wheelchair. -The resident had no complaints of pain and no injuries were noted. -No fall interventions were put into place for the resident.	D 270		

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D 270	Continued From page 4 -Family was notified and the PCP was not notified. Review of Resident #4's 72 hour monitoring report dated 06/20/20 revealed the resident was found on the floor and doing ok, no problem noted. Review of Resident #4's Care Note dated 06/25/20 at 12:30am revealed: -The resident stated she was trying to reposition herself in the bed and rolled off. -Staff assisted the resident off the floor and no injuries were noted. Review of Resident #4's Accident/Incident Report dated 06/25/20 at 12:30am revealed: -Resident #4 stated she rolled out of bed onto the floor trying to reposition herself in bed. -The resident was assisted off floor and staff checked for bruises and abrasions and none were noted. -The resident had no complaints of pain and no injuries were noted. -No fall interventions were put into place for the resident. -Family was notified and the PCP was not notified. Review of Resident #4's 72 hour monitoring report dated 06/25/20 revealed: -The resident was sent to ER because of a knot found on her forehead. -The resident returned with no new orders and was doing well. Review of Resident #4's Care Note dated 09/18/20 at 4:00am revealed: -The resident was found on the floor by staff between the bed and the recliner.	D 270		

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D 270	Continued From page 5	D 270		

-Resident #4 stated she rolled off the bed.
-There were two skin tears noted to the right elbow and no other injuries noted.

Review of Resident #4's Accident/Incident Report dated 09/18/20 at 4:00am revealed:
-Resident #4 was found on the floor by staff between bed and recliner.
-Resident #4 stated she rolled off the bed.
-Staff documented Resident #4 had a skin tear near the right elbow and right wrist.
-No fall interventions were put into place for the resident.
-Family was notified and the PCP was not notified.

Review of Resident #4's 72 hour monitoring report date 09/18/20 revealed:
-The resident was doing ok sitting in her wheelchair waiting on breakfast.
-The resident was doing ok and slept.

Review of Resident #4's Care Note dated 09/28/20 revealed:
-The resident was found on the floor by staff.
-Resident #4 stated she slid out of her wheelchair.
-No injuries were noted.
-The time was not documented on the entry.

Review of Resident #4's Accident/Incident Report dated 09/28/20 at 8:00pm revealed:
-Resident #4 was found on the floor in her room.
-Resident #4 stated she slipped out of her wheelchair.
-A full body assessment was completed and Resident #4 was helped to bed.
-The description of injury was documented as "na".
-No fall interventions were put into place for the

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	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

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D 270	Continued From page 6	D 270		

resident.
-Family was notified and the PCP was not notified.

Review of Resident #4's 72 hour monitoring report dated 09/28/20 revealed:
-The resident was found on the floor in her room by the MA.
-There was no injury noted and Resident #4 slept well through the night.

Review of Resident #4's Care Note dated 10/30/20 on 3-11pm(shift) revealed:
-The resident was found on the floor in the bathroom.
-Resident #4 had a laceration to her forehead.
-A full body assessment was completed and Resident #4 was assisted off the floor.
-Emergency services were contacted and Resident #4 was transported to the hospital for evaluation.

Review of Resident #4's Accident/Incident Report dated 10/30/20 at 7:20am revealed:
-The supervisor was notified Resident #4 had fallen and bumped her head.
-Staff noted the resident was laying on her side near the bed.
-Resident #4 stated she hit her head when she fell.
-The description of injury was documented as "cut open area on forehead."
-No fall interventions were put into place for the resident.
-Family was notified and the PCP was notified.

Review of Resident #4's 72 hour monitoring report dated 10/30/20 revealed:
-The resident was sent out to Emergency room due to a fall.

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D 270	Continued From page 7 -The resident rested well through the night with no complaints. Interview with a Personal Care Aide (PCA) on 11/19/20 at 10:12am revealed: -Resident #4 was not able to stand independently. -Resident #4 was a two person assist and had fallen two weeks ago. -She did not work that day and did not recall the events of the fall for Resident #4. -She was only aware of one fall for Resident #4. -She did not think Resident #4 could press her call bell if needed so she monitored Resident #4 often. -She had to monitor Resident #4 every 30 minutes since the last fall she could not recall exact date and time of the fall. -The process for falls was to notify the Supervisor and check the resident's blood pressure and temperature. -A 72- hour monitoring was also initiated when residents fell. -If a resident had a head injury or was experiencing chest pain, staff would send them to the ER to be evaluated. -She was not aware of any interventions put into place for Resident #4 other than a call bell. Observation of Resident #4 on 11/19/20 at 10:30am revealed: -There was a dime size skin tear to Resident #4's left lower leg with bright red blood noted on the residents sock. -The MA cleaned Resident #4's left lower leg with a cleaning solution and applied gauze. Interview with a MA on 11/19/20 at 12:35pm revealed: -She usually worked third shift.	D 270		

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D 270	Continued From page 8 -Resident #4 fell out of bed approximately two weeks ago. -She did not work that day. -She was aware of Resident #4 having falls in the past. -Resident #4 slept in a twin bed and "it was more like she rolled out of her bed." -Resident #4 used a wheelchair but would also sit in her recliner. -Resident #4 could not get out of her recliner but could get out of her wheelchair independently. -She was not aware of any interventions put in place for Resident #4's falls. -If a resident fell, the process was to notify the RCC and complete an incident report. -The fall would also be documented in the care notes. -The RCC would contact the PCP if the resident was hurt or there was an injury noted. -Resident #4 required stitches from a previous fall. -Safety checks were to be completed every two hours for Resident #4. -The only intervention for falls for Resident #4 was the call bell in her room. -She did not know if there was a fall policy or where it was located. -If a resident had a fall, she would check their temperature and blood sugar and complete an incident report. -If a resident had a head injury, they would send them out to the ER. Telephone interview with a representative from Resident #4's PCP's office on 11/19/20 at 1:47 pm revealed: -Resident #4 had not seen her PCP since January 2020. -The facility had not contacted the PCP office regarding any falls from April 2020 through	D 270		

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D 270	Continued From page 9 October 2020. -The RCC stated the family did not want Resident #4 going out to the PCP office. Interview with the Administrator on 11/19/20 at 1:35pm revealed: -She was aware of Resident #4 having falls. -There were times Resident #4 had fallen out of bed and tried to get up. -Resident #4 had a roommate and she had called for help and 911 was contacted for Resident #4. -If a resident experienced a fall it was the responsibility of the supervisor to assess for pain and injuries. -If there were no concerns of injury the resident was assisted back in bed or the chair. -An incident report would be completed, and family would be notified and the PCP. -The incident report was completed by the supervisor and PCP would be notified if there was an injury. -Resident #4 had a fall on 10/30/20 and was sent to the hospital. -The interventions put in place for Resident #4 was a reclining chair and the call bell. Attempted telephone interview with Resident #4's responsible party on 11/18/20 at 2:50pm was unsuccessful. 2.Review of Resident #3's current FL-2 dated 12/12/19 revealed: -Diagnoses included Parkinson's, heart failure, osteoarthritis, sleep apnea and peripheral neuropathy. -Resident #3 was semi-ambulatory and used a walker and a wheelchair. Review of Resident #3's resident register dated 09/14/18 revealed: -Resident #3 had limited range of motion.	D 270		

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D 270	Continued From page 10 -Resident #3 used a walker and a wheelchair. -Resident #3's memory was adequate Review of Resident #3's current care plan dated 12/12/19 revealed: -He required assistance as needed with toileting and dressing. -Resident #3 required assistance with dressing. -He required assistance with meal prep and clean up. Review of Resident #3's Care Notes and Incident/Accident reports from 05/01/20-11/02/20 revealed Resident #3 fell and was found on the floor on 9 different occasions. Review of Resident #3's Care Note dated 05/01/20 at 3:00pm-11:00pm revealed: -A Personal Care Aide (PCA) notified the Medication Aide (MA) that Resident #3 was found on the floor. -When the MA went to assess Resident #3, he had managed to get off the floor independently. -The MA completed a full body assessment and reported no injuries. -The note was signed by a MA. -The MA notified Resident #3's family member and the Administrator. Review of Resident #3's Incident/Accident Report dated 05/01/20 at 5:15pm revealed: -The resident was found sitting on the floor in his room. -No injuries were noted. -The family was notified but the Primary Care Provider (PCP) was not notified. -The Resident Care Coordinator (RCC) followed up with a note dated 05/04/20 stating that the resident was "doing okay" and voiced no complaints.	D 270		

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D 270	Continued From page 11 Review of Resident #3's Care Note dated 06/17/20 at 7:30am revealed: -A PCA found Resident #3 on the floor at the foot of his bed. -Resident #3 reported that he was in his wheelchair and slid to the floor when he attempted to get out of his wheelchair. -Resident #3 had a skin tear on each arm. -The MA notified Resident 3's family member and the RCC. Review of Resident #3's Incident/Accident Report dated 06/17/20 at 7:30am revealed: -The resident was found on the floor. -He reported he slid from his chair. -Staff assisted him back to his chair. -Resident #3 had a skin tear on his elbow which staff cleaned and bandaged. -The family nor the PCP were notified. -The RCC followed up with a note dated 06/18/20 that resident stated, "he is doing fine." Review of Resident #3's Care Note dated 06/29/20 with no entry time revealed: -The PCA found Resident #3 on the floor and reported to the MA. -The MA observed Resident #3 lying on the floor on his back with his head on his walker, which was also on the floor. -Resident #3 reported to the MA that he lost his balance when he attempted to stand from his chair to his walker. -Resident #3 did not hit his head but had "some" skin tears on his right arm. -The MA notified Resident #3's family and the RCC. Review of Resident #3's Incident/Accident Report dated 06/29/20 at 8:20am revealed:	D 270		

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D 270	Continued From page 12 -Resident #3 was found by staff on the floor in his room. -The resident stated he lost his balance and fell landing on his back but did not hit his head. -Resident had a small skin tear on his left arm. -The family was notified but the PCP was not notified. -The RCC followed up with a note dated 06/29/20 that the resident was "doing okay." Review of Resident #3's Care Note dated 07/16/20 with no entry time revealed: -The MA found Resident #3 on the floor of his bedroom. -Resident #3 reported that he was "just fell" when he attempted to walk to the restroom. -There was a small skin tear on his right elbow that the MA treated. -The MA notified Resident #3's family and the FCC. Review of Resident #3's Incident/Accident Report dated 07/16/20 at 3:50pm revealed: -Resident #3 was found on the floor in his bedroom trying to get to the restroom and "just fell." -The Incident/Accident Report dated 07/16/20 also noted that Resident #3 was found on the floor of his room two more additional times on 07/16/20. -The resident was found on the floor on 07/16/20 at 8:40pm and 9:20pm by staff. -Resident #3 had small skin tears to his right elbow and a small abrasion over his right eye. -The family was notified but the PCP was not notified. -The RCC followed up with a note dated 07/17/20 that she spoke with the resident about using the call bell to ask for assistance when getting up.	D 270		

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	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 Review of Resident #3's Care Note dated 07/17/20 with no entry time revealed: -A PCA reported to the MA that Resident #3 was on the floor in his room. -The MA and RCC assisted Resident #3 up from the floor. -Resident #3 reported he "fell back" when he attempted to get his cellular telephone. -Resident #3 had no injuries. -The MA notified Resident #3's family. Review of Resident #3's medical record on 11/19/20 revealed: -There was not an Incident/Accident Report dated 07/17/20. -There was not documentation that 72 Hour Monitoring had been implemented. Review of Resident #3's Care Note dated 07/26/20 with no entry time revealed: -The MA found Resident #3 on the floor of his room beside the end of his bed. -Resident #3 reported that he slipped when he was attempting to walk to the restroom. -The MA reported that Resident #3 was doing "okay, just a very bad skin tear" to this right arm. -The MA cleaned and bandaged the skin tear on his right arm. -The MA notified Resident #3's family and the RCC. Review of Resident #3's Incident/Accident Report dated 07/26/20 at 7:30am revealed: -Resident #3 was found on the floor of his room at the end of his bed. -He reported to staff that he tried to walk to the restroom alone. -The resident had a skin tear to his right arm. -The family was notified but the PCP was not notified.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

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D 270	Continued From page 14 -The RCC followed up with a note dated 07/27/20 that the resident was "doing okay." Review of Resident #3's Care Note dated 09/09/20 with no entry time revealed: -The MA found Resident #3 on the floor in his restroom. -Resident #3 was attempting to stand but lost his balance. -There were no injuries observed. -The MA notified Resident #3's family, the RCC and hospice. Review of Resident #3's medical record on 11/19/20 revealed there was not an Incident/Accident Report dated 09/09/20. Review of Resident #3's Care Note dated 09/29/20 at 2:15am revealed: -The MA found Resident #3 on the floor in his room next to the air conditioning unit. -Resident #3 reported that he slipped when using his urinal. -He had abrasions on his left shoulder and his right knee. -The MA notified Resident #3's family and the RCC. Review of Resident #3's Incident/Accident Report dated 09/29/20 at 2:15am revealed: -Resident #3 was found by staff on the floor in his room next to the air conditioning unit. -Resident #3 reported that he slipped while using his urinal. -He had an abrasion on his left shoulder and his right knee with bleeding from his previous bandage. -The MA notified Resident #3's family and the RCC.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 15	D 270		

Review of Resident #3's Care Note dated 11/02/20 with no entry time revealed:
-Resident #3 was found by staff on the floor between his bed and his chair.
-The MA noted that Resident #3 appeared to have a medium skin tear on his right arm.
-The MA notified Resident #3's family, the RCC and hospice.

Review of Resident #3's Incident/Accident Report dated 11/02/20 at 3:00pm revealed:
-Resident #3 was found by staff laying on his left side in his restroom.
-Resident #3 reported that he as trying to wash his hands at the sink and went down on his side.
-He had a small skin tear to his left elbow.
-The family and hospice were notified.
-The RCC followed up with a note dated 11/02/20 that Resident #3 was "doing okay" and she advised him to call for assistance.

Interview with a Medication Aide (MA) on 11/19/20 at 12:45pm revealed:
-She usually worked third shift.
-Resident #3 was unsteady on his feet and had frequent falls.
-Resident #3 was a high fall risk due to his frequent falls.
-Resident #3 was on safety checks and was checked every 2 hours.
-Safety checks included a 72 Hour Monitoring Process in which staff were expected to monitor a resident every 2 hours to prevent additional falls.
-The only intervention for falls for Resident #3 was to use the call bell in his room.
-There were notices placed in Resident #3's room to help remind him to use the call bell before attempting to get up on his own.
-Resident #3's family member had provided him with a non-skid mat at the right side of his bed to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 16	D 270		

help him with his balance once he got out of bed.
-Resident #3 was unsteady on his walker.
-He would forget to use the call bell to ask for assistance before getting up.
-If a resident fell, the process was to notify the RCC and complete an incident report.
-The fall would also be documented in the care notes.
-The RCC would contact the PCP if the resident was hurt or an injury was noted.
-She did not know if there was a fall policy or where it was located.
-If a resident had a fall, she would check their temperature and blood sugar and complete an incident report.
-If a resident had a head injury, they would send them out to the ER.

Interview with the Administrator on 11/19/20 at 1:35pm revealed:
-The facility did not feel a fall mat was a safe intervention for Resident #3.
-The facility was concerned that Resident #3 would trip over a fall mat.
-The facility had posted a sign on his closet door to help remind him to call for assistance.
-Staff had to remind Resident #3 constantly to use his call bell.
-Staff had rearranged his room so that his walker and wheelchair were closer to his bed.
-The RCC had called the PCP on all falls to notify him of Resident #3's falls, however there was not documentation that the PCP had been notified by the RCC.

Attempted telephone interview with Resident #3's PCP on 11/19/20 at 1:30pm was unsuccessful.

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	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 601	Continued From page 17	D 601		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) 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 not wearing proper personal protective equipment (PPE) (masks, gowns, gloves), staff not properly disposing of PPE (masks, gowns, gloves), not cleaning and sanitizing the	D 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 601	Continued From page 18	D 601		

prescreening thermometer equipment and prevention of cross contamination.

The findings are:

Review of the CDC guidelines for the prevention and spread of COVID-19 last updated on 11/17/20 revealed:
-Ensure cleaning and disinfection supplies are available for use.
-Disinfect common areas and objects that are frequently touched at least once daily.
-Personnel must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly put on, use, and dispose of PPE in a manner to prevent self-contamination.

Review of the NCDHHS guidelines for the prevention and spread of COVID-19 last updated on 11/17/20 revealed:
-If COVID-19 has been identified in the facility, have all health care personnel wear all recommended PPE including a surgical mask or N95 respirator (if available), gown, gloves and face shield for the care of all residents in quarantine, isolation, regardless of the presence of symptoms.
-Cleaning and disinfecting high frequency touched surfaces in the facility often, designated visitation areas after each visit.
-Appropriate staff use of PPE.

1. Observation of two notices posted at the nurse's station and the entrance of the Special Care Unit (SCU) on 11/17/20 at 10:16am revealed:
- All quarantine measures will remain in place for both halls.
-Staff must wear all PPE: gowns, masks, gloves,

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D 601	Continued From page 19 etc. until further notice. Observation of the staff office on 11/17/20 at 11:03am revealed: -There were three clear covered containers each with masks, gowns and shoe coverings placed on the desk. -There was a box of gloves placed on the staff desks. Interview with a Medication Aide (MA) on 11/18/20 at 11:08am revealed: -The COVID-19 positive residents have a sign on their room doors notifying staff to wear face shields, masks, gloves and gowns in the resident room. -She was assigned to work on the SCU from 7am to 7pm but sometimes she was assigned to assist on the assisted living unit. -She has been working at the facility for 3 weeks and PPE training has not been provided for her by the facility. -She knew how to don and doff PPE because she had read information from the CDC website. -There were 3 COVID-19 positive residents in the facility on 11/18/20. Observation of the SCU on 11/18/20 at 2:14pm to 2:15pm revealed: -The door to room 102 was opened where two residents who had COVID-19 resided. -Both residents in room 102 were lying in their beds. -Two residents were walking up and down the hallway without masks. Observation of the SCU on 11/18/20 at 2:15pm to 2:17pm revealed: -Two personal care aides (PCA) were in the hallway wearing only a mask.	D 601		

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D 601	Continued From page 20 -One of the two PCAs put on a gown. Interview with a PCA on 11/18/20 at 2:23pm revealed: -He had been trained on when to wear PPE a few weeks ago. -He knew to wear full PPE (mask, gown, gloves, face shield) when working on the SCU. -He had been assigned to work on the SCU. -He had provided care to the three residents who had COVID-19. -He was to wear full PPE only when going into the residents' room who had COVID-19. -He had put on the PPE because he did not want to be questioned by the surveyor as to why he had not had on full PPE. Observation of the Laundry Aide at the nurse's station in full PPE on 11/18/20 at 2:37pm revealed: -She was wearing a mask, gown and gloves. -There was a large trash can with a cover at the nurses' station. -She exited the SCU wearing full PPE: gloves, mask and gown. -She stopped at the nurse's station to talk with two staff. -She did not remove the PPE and discard the PPE in the trash can. -She walked down the hall towards the laundry room wearing the PPE. Interview with the Laundry Aide on 11/18/20 at 2:38pm revealed: -She would normally take off and dispose of her PPE immediately after exiting the SCU. -She had gone on the SCU to give the residents' snacks to the PCAs. -She knew to dispose of her PPE at the trash can nearest the nurse's station.	D 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 601	Continued From page 21 -She had been talking with another staff and forgot to take off of her PPE. Interview with a second MA on 11/18/20 at 2:46pm revealed: -She had been employed for 3 weeks. -She had not completed any training on the use of PPE: gloves, gowns, masks and face shields. -She knew to wear PPE because she had received the information for the CDC website. -She obtained her information about COVID-19 from the CDC website. -She did not know who was responsible for training on COVID-19. -The PCAs were required to wear full PPE, masks, gowns, face shields and gloves when working on the SCU and in direct care of the residents. -All of the staff started wearing full PPE on 11/23/20. -She did not know why the PCAs were not wearing full PPE. -She was the PCAs' supervisor. -The PCAs had provided care to the three residents who had been diagnosed with COVID-19. -The PCAs had only worked on the SCU. -There was a supply of PPE at all times on the SCU for staff to use. Interview with the housekeeper on the SCU on 11/18/20 at 2:50pm revealed: -She had not received training on how to wear appropriate PPE for COVID-19. -She wore the PPE that she felt provided her with the best protection which include a gown and mask. -She cleaned all rooms in the facility including COVID-19 rooms. -She did not know that she needed to change her	D 601		

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	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 601	Continued From page 22 PPE after cleaning a residents' room with COVID-19. -She did not know that she needed to remove her PPE after cleaning a residents' room with COVID-19. Observation of the SCU on 11/18/20 at 3:25pm revealed: -The housekeeper and a PCA began to leave the SCU without removing their PPE and exiting to the facility lobby. -A surveyor stopped the housekeeper and PCA from exiting the SCU. -The housekeeper and PCA reported that they were not aware that they needed to remove their PPE before exiting the SCU to the facility lobby. Interview with the housekeeper on the SCU on 11/18/20 at 3:27pm revealed: -She was not aware that she needed to dispose of her PPE on the SCU prior to entering the facility lobby. -There was a trash can on the SCU at the exit doors, but she did not know that she should dispose of her PPE prior to entering the facility lobby. -She had not received training on how to properly remove her PPE. -She had not received training on how to prevent cross contamination from the SCU to other parts of the facility. Observation of the SCU on 11/18/20 at 3:27pm revealed: -A PCA exited the SCU wearing a gown and gloves carrying a trash can into facility lobby. -He did not change his PPE on the SCU prior to exiting and re-entering the SCU. He continued to wear the same PPE.	D 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 601	Continued From page 23 Interview with the RCC on 11/18/20 at 3:40pm revealed: -She had been trained on the use of PPE on 10/23/20 by the Administrator. -The Administrator was responsible for facilitating all COVID-19 trainings. -She did not remember the dates for the other COVID-19 trainings. -She did not know if the PCAs had been trained on wearing PPE -Staff were to be dressed in full PPE, gloves, gowns, masks and face shields, when working on the SCU. -Staff were to remove all PPE when exiting the SCU and after providing direct care with the residents. -The MAs were to be aware of all of the PCAs wearing full PPE. Interview with the Administrator on 11/18/20 at 4:10pm revealed: -She provided training on how to wear PPE, gloves, gowns, masks and face shields on 10/23/20. -The nurse had completed the annual infection control training for all staff in August 2020. -She did not know when the last training on PPE was held. -The PPE was kept in the office on the SCU for the staff to use. -Staff only had to wear full PPE when completing direct care for residents that had COVID-19. -She did not see any issues with staff working on the SCU and not dressed in full PPE, masks, gloves, gowns and face shields. Interview with the Business Office Manager (BOM) on 11/19/20 at 10:25am revealed: -Staff only wore masks when they entered residents rooms who had not tested positive for	D 601		

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D 601	Continued From page 24 COVID-19.. - A mask, gown, gloves, face shield, and booties were worn in COVID-19 positive resident rooms. -She had not walked down the resident halls since the first COVID-19 positive case in the facility. -The only training she had on PPE was given today (11/19/20) by the Administrator on how to wear PPE, where, and when. -She was told to wear a mask and gloves in SCU if not in COVID-19 positive resident room and wear full PPE in COVID-19 positive resident rooms. Observation on 11/19/20 at 1:45pm revealed the Administrator was not wearing a mask as she walked from her office down the hall to the RCC's office to pick up paperwork. 2. Observation of the pre-screening procedures on 11/17/20 at 10:00am revealed: -There were two bottles of alcohol-based hand sanitizers. -There were three different thermometers: digital oral with disposable probe covers, long distance hand-held infrared, and tympanic (ear), sitting in a tray. -There was not any disinfectant cleaners, i.e., alcohol wipes, at the pre-screening station to clean and sanitize the thermometers after each use. Observation of the front lobby and COVID-19 staff screening area on 11/19/20 at 8:35am revealed: -The Resident Care Coordinator (RCC) entered the front entrance of the facility without a facemask. -The RCC went into the front sitting area and spoke with the Hospice nurse.	D 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

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D 601	Continued From page 25 -The RCC put on her mask before exiting the front sitting area to complete her self-screening for COVID-19 symptoms. -The RCC was observed taking her own temperature with a long distance hand-held infrared thermometer. -She was observed returning the thermometer to the sitting tray and then completing the facility COVID-19 symptom log. -She was not observed disinfecting the thermometer before or after she took her temperature. Observation of a staff entering in the facility and completing a pre-screening on 11/19/20 at 12:36pm revealed: -She used one of the long distance hand-held infrared thermometer to take her temperature -She did not clean and sanitize the thermometer before and after the use. Telephone interview with the Local Health Department (LHD) Infection Control Nurse on 11/19/20 at 9:21am revealed: -She spoke with the Administrator at least daily. -She had provided education and instructions to the Administrator to check staff temperatures of staff and residents daily. -She had provided education to the NC DHHS Dashboard for COVID-19 to ensure residents and staff safety.and instructions to the Administrator on the importance of training staff on the proper use of PPE. -She had instructed the Administrator to refer -The facility should only be using an infared thermometer; an oral thermometer was not recommended. -All thermometers should be sanitized with alcohol between each use since staff were screening themselves.	D 601		

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	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 601	Continued From page 26 -Best practice would include a designated staff person for each shift to complete the staff temperatures and COVID-19 screening forms. -Staff should always wear a mask when they enter the facility to prevent the spread of COVID-19. -Staff entering the facility without a mask increased the risk of spreading COVID-19 and put the staff person at risk of contracting COVID-19. 3. Observation on 11/18/20 at 2:35pm revealed: -A resident came out of room #105 into the hall in the Special Care Unit (SCU) without wearing a mask. -Her room adjoined a room with a COVID-19 positive resident. -Staff assisted her to the bathroom in the resident room across the hall. -A COVID-19 positive resident in room #105 shared the bathroom with 2 COVID-19 negative residents in room #103. Interview with a PCA in the SCU on 11/18/20 at 2:54pm revealed: -The doors to the common bathroom between room #105 and room #103 were not locked on either side. -She did not know how often the bathrooms were cleaned. -Housekeeping staff was responsible for cleaning. -Residents only wore masks when making visits to the physician. -A gown, gloves, mask and face shield were worn in COVID-19 positive rooms. -She was not trained on how to wear PPE, she just knew what to do. -She would redirect residents back to their room if they came out.	D 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: _____ B. WING _____	R-C 11/19/2020

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D 601	Continued From page 27 -When coming out of a COVID-19 positive room she would change everything except the mask.	D 601		