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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 12/16/20 and a desk review survey from 12/17/20 to 12/22/20 and a telphone exit on 12/22/20.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications including oral and subcutaneous medications to lower blood sugar, for treatment of anxiety and a blood clot deterrent were administered as ordered for 1 of 1 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 11/22/20 revealed diagnoses included dementia, hyperlipidemia, hypertension, cerebral infarction and displaced intertrochanteric fracture. Review of a care note dated 10/07/20 at 8:53am for Resident #1 revealed the resident was admitted to the hospital for a left hip fracture. Review of a care noted dated 11/30/20 at 7:13pm	D 358		

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for Resident #1 revealed the resident returned to the facility from the hospital on 11/30/20.

a. Review of Resident #1's current FL-2 dated 11/22/20 revealed:
-An order for insulin lispro solution sliding scale insulin (SSI) subcutaneously four times daily according to the following scale: for blood sugar less than 150 give orange juice (OJ); less than 60, call physician; 201-250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-400 give 10 units; 401-450 give 12 units; 451-500 give 14 units; and if greater than 500, notify physician.
-There was no order to check finger stick blood sugar (FSBS) levels.

Review of a Physician's Order form dated 12/08/20 for Resident #1 revealed:
-Orders to check FSBS at 2:00pm every Sunday, Tuesday, Thursday and Saturday and notify the physician for a result greater than 400 or less than 60; check FSBS at 7:00am every Monday, Wednesday and Friday and notify the physician for a result greater than 400 or less than 60.
-There was no order for sliding scale lispro insulin solution.

Review of Resident #1's December 2020 electronic medication record (eMAR) revealed:
-There was an entry to check FSBS at 7:00am every Monday, Wednesday and Friday and notify the physician for a result greater than 400 or less than 60.
-There were 7 FSBS results documented from 12/01/20 to 12/16/20 ranging from 142 - 221, with 3 results of 201 or greater.
-On 12/02/20 at 7:00am the documented FSBS was 221, on 12/04/20 at 7:00am the documented FSBS was 210 and on 12/16/20 at 7:00am the documented FSBS was 201.

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-There was an entry to check FSBS at 2:00pm every Sunday, Tuesday, Thursday and Saturday and notify the physician for a result greater than 400 or less than 60.
-There were 8 FSBS results documented from 12/01/20 to 12/16/20 ranging from 152 - 326, with 2 results of 201 or greater.
-On 12/08/20 at 2:00pm the documented FSBS was 224 and on 12/15/20 at 2:00pm the documented FSBS was 326.
-There was no entry for sliding scale lispro insulin solution and no documentation of administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/22/20 at 1:45pm revealed the pharmacy did not have an order for sliding scale insulin (SSI) for Resident #1; FSBS levels could be elevated if SSI was needed.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to second telephone interview with the MCM on 12/22/20 at 3:42pm.

Refer to telephone interview with Resident #1's PCP on 12/22/20 at 3:22pm.

Refer to telephone interview with the Administrator on 12/22/20 at 5:05pm.

b. Review of Resident #1's current FL-2 dated 11/22/20 revealed an order for aspirin 81mg daily. (Aspirin is used as a blood thinner.)

Review of Resident #1's December 2020

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electronic medication record (eMAR) revealed there was no entry for aspirin 81mg daily and no documentation of administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/22/20 at 1:45pm revealed the pharmacy did not have an order for aspirin for Resident #1.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to second telephone interview with the MCM on 12/22/20 at 3:42pm.

Refer to telephone interview with Resident #1's PCP on 12/22/20 at 3:22pm.

Refer to telephone interview with the Administrator on 12/22/20 at 5:05pm.

c. Review of Resident #1's current FL-2 dated 11/22/20 revealed an order for metformin 500mg twice daily. (Metformin is used to regulate blood sugar levels.)

Review of a Physician's Order form dated 12/08/20 for Resident #1 revealed an order for metformin 1000mg twice daily.

Review of Resident #1's December 2020 electronic medication record (eMAR) revealed:
-There was an entry for metformin 1000mg twice daily.
-Metformin 1000mg was documented as administered twice daily from 12/02/20 at 8:00am through 12/16/20 at 8:00am, except 12/03/20 at

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7:00pm and 12/04/20 at 8:00am and 7:00pm.
-There was no documentation for the reason Metformin was not administered on 12/03/20 and 12/04/20.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm.

Refer to second telephone interview with the MCM on 12/22/20 at 3:42pm.

Refer to telephone interview with Resident #1's PCP on 12/22/20 at 3:22pm.

Refer to telephone interview with the Administrator on 12/22/20 at 5:05pm.

d. Review of Resident #1's current FL-2 dated 11/22/20 revealed an order for haloperidol 1mg one half tablet daily at bedtime and haloperidol 1mg one half tablet twice daily. (Haloperidol is used to treat psychosis.)

Review of a Physician's Order form dated 12/08/20 for Resident #1 revealed an order for haloperidol 1mg twice daily.

Review of Resident #1's December 2020 electronic medication record (eMAR) revealed:
-There was an entry for haloperidol 1mg twice daily.
-The haloperidol was documented as administered 12/02/20 at 8:00am through 12/16/20 at 8:00am, except on 12/03/20 at 7:00pm.
-There was no documentation for the reason haloperidol was not administered on 12/02/20.

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D 358	Continued From page 5 Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/22/20 at 1:45pm revealed the pharmacy had an order dated 12/08/20 for haloperidol 1mg twice daily; an increased dose of haloperidol could cause sedation. Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm. Refer to telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm. Refer to second telephone interview with the MCM on 12/22/20 at 3:42pm. Refer to telephone interview with Resident #1's PCP on 12/22/20 at 3:22pm. Refer to telephone interview with the Administrator on 12/22/20 at 5:05pm. _____ Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/22/20 at 1:45pm revealed: -The most recent orders the pharmacy had for Resident #1 were an unsigned Physician's Order form dated 12/06/20 and a signed Physician's Order form dated 12/08/20. -The pharmacy did not have a copy of Resident #1's current FL-2 dated 11/22/20. -The pharmacy was notified by the facility on 11/19/20 that Resident #1 was out of the facility. -The pharmacy record indicated Resident #1 was readmitted to the facility on 12/06/20. Telephone interview with the Memory Care Manager (MCM) 12/22/20 at 3:17pm revealed: -Resident #1 was re-admitted to the facility on	D 358		

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11/30/20 following rehabilitation for a hip fracture sustained on 10/07/20.
-The Resident Care Coordinator (RCC) would have been responsible for faxing the discharge orders and new FL-2 to the pharmacy when Resident #1 was re-admitted.
-He had faxed a Physician's Order form for Resident #1 to the pharmacy on 12/06/20.
-He had contacted the PCP for the verbal order in order to re-order Resident #1's medications.
-He had first contacted the pharmacy to request refills and the pharmacy told him new orders were needed for Resident #1.
-He did not clarify or reconcile Resident #1's orders prior to leaving the facility on 10/07/20 with the new orders at discharge from the rehabilitation facility.
-He printed a Physician's Order form from Resident #1's electronic profile for the PCP to sign.

Second telephone interview with the MCM on 12/22/20 at 3:42pm revealed:
-Resident #1 had "some" medications remaining in the facility from before she went to the hospital and returned with "some" medications from the rehabilitation facility.
-The PCP was at the facility and signed the 12/06/20 Physician's Order form taken as a verbal order on 12/08/20.
-Staff had been following the previous orders entered in the computer system for Resident #1 from 11/30/20 through 12/06/20.

Telephone interview with Resident #1's PCP on 12/22/20 at 3:22pm revealed:
-She had seen Resident #1 once on 12/08/20 after taking over for the previous PCP.
-She did not remember if Resident #1's FL-2 dated 11/22/20 was provided for review at the

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D 358	Continued From page 7 time of the visit. -She did not know if Resident #1's medication orders prior to her hospitalization were reconciled with the FL-2 dated 11/22/20 at discharge from the rehabilitation facility. -Staff had asked her to sign the medication renewal orders on the Physician's Order form dated 12/08/20. -Medications ordered on the FL-2 from the rehabilitation center should have been continued. -Staff should have compared previous orders with the new FL-2 and requested clarification on any new or changed orders if needed. Telephone interview with the Administrator on 12/22/20 at 5:05pm revealed: -The MCM and/or RCC were responsible for faxing re-admission orders to the pharmacy and reviewing the orders on the eMAR. -If a resident returned to the facility on an evening, night or weekend shift, the medication aide (MA) on duty faxed the orders to the pharmacy and the MCM or RCC reviewed the orders on the following day. -She did not know about Resident #1's re-admission orders on the resident's return to the facility on 11/30/20. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Attempted interview with the Resident Care Coordinator (RCC) on 12/22/20 was unsuccessful.	D 358		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention & Control Program (Emer)	D 601		

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D 601	Continued From page 8 10A NCAC 13F .1801 Infection Prevention and Control Program (Emergency Rules) (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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, 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 county health department (LHD) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 to reduce the risk of transmission and infection to residents regarding reporting of current staff testing positive for COVID-19 to the LHD, immediate facility wide testing with a known outbreak, screening of staff and restricting	D 601		

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symptomatic staff from working, separating residents who tested negative for COVID-19 from residents diagnosed with COVID-19 and implementing the proper use of face masks and gowns by staff when working with COVID-19 positive and negative residents.

The findings are:

Review of an electronic mail (email) notification from the county Department of Social Services (DSS) dated 12/15/20 at 3:01pm revealed:
-The subject line documented the email was in reference to an update on the facility's COVID-19 status.
-The facility had two additional residents who had passed away due to COVID-19 on 12/12/20 at the local hospital.
-There were 52 residents and 26 staff who been diagnosed with COVID-19.
-Five residents were currently in the hospital.

Telephone interview with a Registered Nurse (RN) with the local county health department (LHD) on 12/15/20 at 2:33pm revealed:
-He had been working with the facility since the first resident tested positive for COVID-19 at the local hospital (11/27/20).
-He had spoken with the Administrator that weekend (11/28/20) and advised facilty wide testing of all residents and staff that week.
-He spoke with the Administrator via phone approximately every other day for updates on the facility's COVID-19 status.
-He did not have the exact numbers of residents who initially tested positive, but the facility currently had 60 of 66 residents positive for COVID-19.
-There were 4 or 5 residents who had passed away from COVID-19.

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-The Administrator reported having an adequate supply of personal protective equipment (PPE).
-He visited the facility on 12/01/20 and conducted training based on what he saw.
-Initially when there were 6 or 7 residents who had tested positive for COVID-19, he had advised keeping those residents quarantined and cohorted together away from the other residents in a designated COVID-19 positive area.
-He told the Administrator to keep staff exclusive to the COVID-19 positive area and away from the rest of the resident population.

Telephone interview with a second RN with the LHD on 12/15/20 at 3:16pm revealed as of 12/14/20, the facility had 57 of 66 residents and 26 of 42 staff test positive for COVID-19 and 5 residents who had died due to COVID-19.

Telephone interview with the Administrator on 12/15/20 at 5:52pm revealed:
-Residents who had tested positive for COVID-19 were in the COVID-19 positive area at the facility and residents who had tested negative were in the COVID-19 negative area.
-The men's hall was the COVID-19 negative area and had a plastic barrier separating those residents.
-The residents on the women's hall and the special care unit (SCU) had all tested positive for COVID-19.
-Staff entered the COVID-19 negative are from the outside entrance on the men's hall so they did not go through the COVID-19 positive area.

1. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed:
-Immediately notify the local health department if COVID-19 is suspected or confirmed among

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residents or facility personnel.
-A single case of COVID-19 in any staff should be considered an outbreak; testing of all residents should be performed if an outbreak occurs.
-Persons with COVID-19 and experiencing symptoms should not be around others for 10 days since symptoms first appeared, 24 hours with no fever without the use of fever reducing medications and other symptoms of COVID-19 are improving.
-Persons with COVID-19 and not experiencing symptoms should not be around others until 10 days after a positive test for COVID-19.

Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed:
-Staff should be actively screened for fever and respiratory symptoms prior to starting their shift.
-Residents should be actively screened for fever and respiratory symptoms at least daily.
-Social distancing should be implemented among the residents.

Review of the facility's infection control policies and procedures revealed:
-The facility was to prepare and take steps to minimize a COVID-19 outbreak.
-A COVID-19 Outbreak was defined as a sudden increase in acute respiratory illness cases over the normal background rate or when two or more residents have been diagnosed with COVID-19 within 72 hours.
-Fever greater than 100 degrees Fahrenheit (may be absent or low in elderly residents), new onset of cough and/or sore throat; chest discomfort; sneezing, nasal congestion, feeling ill, fatigue or weakness, chills, muscle aches, joint aches, or headache, change in respiratory status, change

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in mental status or appetite and/or vomiting and diarrhea.
-Residents and/or Community staff with COVID-19-like illness, especially if there is a cluster (two or more cases of COVID-19-like illness within 72 hours) should be tested for COVID-19.
-Contact the local health department (LHD) via telephone for appropriate diagnosis laboratory test recommendations.
-The LHD could coordinate prompt COVID-19 testing.
-Upon any receipt of any positive test results for residents or employees, the LHD should be immediately notified via telephone and documentation of this notification should be maintained by the Administrator.
-Once an outbreak has been identified, outbreak prevention and control measures should be implemented immediately and the LHD must be notified.
-During an outbreak, once a single laboratory-confirmed case of COVID-19 has been identified, it is likely there were other cases among exposed persons.

Interview with the Memory Care Manager (MCM) on 12/16/20 at 2:07pm revealed:
-The facility had done rapid COVID-19 testing on all staff on 11/23/20.
-All staff had tested negative.
-He did not know what had prompted the testing.

Interview with the Administrator on 12/16/20 at 4:10pm revealed:
-The first COVID-19 testing of all facility staff was done using rapid tests at the facility on 11/23/20.
-The testing was conducted after the corporate office had instructed her to complete the testing because the facility had not yet done any

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D 601	Continued From page 13 COVID-19 testing. -Two staff tested positive for COVID-19 on 11/23/20. -Facility wide testing of all staff and residents was done on 12/01/20; there was a total of 47 positive results: 34 residents and 13 staff. -Facility wide testing was initiated after the first resident tested positive at the local hospital on 11/27/20. Telephone interview with a personal care aide (PCA) on 12/18/20 at 11:23am revealed: -A personal contact told her they had tested positive for COVID-19 on 11/20/20; she had been in close prolonged contact with that person on 11/16/20. -She told the Resident Care Coordinator (RCC) and Administrator on 11/20/20 that she had been exposed to COVID-19; the Administrator told her she could not leave work to get tested because she did not have any symptoms at that time. -The Administrator told her to wait to get tested until the facility conducted testing of staff on 11/23/20. Second telephone interview with the PCA on 12/21/20 at 4:24pm revealed: -She and the RCC spoke with the Administrator on 11/20/20 regarding her exposure to COVID-19. -She tested negative for COVID-19 on 11/23/20. -She started not feeling well while at work on 11/28/20 and contacted the Administrator. -The Administrator told her she could not leave work. -She was tested for COVID-19 by an outside provider on 11/28/20 after work; her test result came back positive early the morning of 11/29/20. -She called the RCC and Administrator on 11/29/20 and remained out of work until 12/07/20.	D 601		

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D 601	Continued From page 14 Telephone interview with the Administrator on 12/21/20 at 3:34pm revealed: -The PCA did not directly tell her of the COVID-19 exposure on 11/20/20; she did not remember who told her or when. -The PCA did not have symptoms, she was "scared and wanted to leave work to get tested." -She told the PCA she was conducting rapid COVID-19 tests on all staff the next day (11/23/20). -The PCA did not test positive from the rapid test; she did not know when the PCA tested positive for COVID-19. -There was a newly hired staff that tested positive and was told to quarantine at home on 11/23/20. -She thought a reportable outbreak was two or more and did not report the staff testing positive to the LHD on 11/23/20. Telephone interview with a Registered Nurse (RN) with the LHD on 12/21/20 at 11:14am revealed he did not have any record of the facility contacting the LHD regarding a COVID-19 outbreak prior to 11/30/20. 2. Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed: -Residents testing positive for or having symptoms of COVID-19 should be immediately separated. -The number of staff having face to face interactions with residents who have suspected or confirmed COVID-19 should be minimized. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in long term care facilities revealed:	D 601		

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D 601	Continued From page 15 -Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff (i.e. the same staff interact with symptomatic residents and residents who test positive for COVID-19 on an ongoing basis, and do not interact with uninfected residents). -Residents with suspected COVID-19 (i.e., have symptoms of COVID-19 but have not yet tested positive for COVID-19) should be housed in individual rooms and should not be housed with people who have tested positive for COVID-19. -All residents who have tested positive for COVID-19 must be placed on infection control precautions until they meet the criteria for discontinuation of infection control precautions. If COVID-19 is identified in the facility, have the staff wear all recommended personal protective equipment (PPE) (including surgical facemask OR N95 respirator [if available], gown, gloves, and face shield) for care of all residents in isolation or quarantine, regardless of the presence of symptoms. Review of the facility's policy infection control policies and procedures dated 10/20/20 revealed to help control transmission (of COVID-19), separate residents who are ill from residents who are asymptomatic. Telephone interview with a medication aide (MA) on 12/17/20 at 11:49am revealed: -The first resident went to the emergency room (ER) and tested positive for COVID-19 on 11/27/20. -The Administrator told staff the resident had tested positive on 11/27/20, but did not give staff any instructions related to caring for remaining residents and use of PPE.	D 601		

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-That weekend at least 5 more residents went to the ER and tested positive for COVID-19; she contacted the Administrator after each positive result.
-On 11/30/20, the Maintenance Director put up the plastic barrier to set up a COVID-19 positive area for the hospitalized residents to come back to at the facility.
-All residents were tested on 12/01/20, and as test results came back the numbers of residents who were positive for COVID-19 increased.
-On 12/04/20, staff had not been told which residents had tested positive for COVID-19.
-The Memory Care Manager (MCM) had a list for the special care unit (SCU) and 16 of the 23 residents had tested positive by that weekend (12/05/20 and 12/06/20).
-There was no quarantine for residents who tested positive for COVID-19 in the SCU.
-Staff were not told how to protect residents who had tested negative for COVID-19 in the SCU.
-Staff were not instructed to do anything differently when going between COVID-19 positive and negative residents on the SCU.

Telephone interview with the MCM on 12/22/20 at 3:42pm revealed:
-On 12/02/20, the Administrator told him there were residents who had tested positive for COVID-19, but did not say how many residents had tested positive.
-He found out there were 8 residents in the COVID-19 positive area on the assisted living (AL) side by going down to that hall and asking the staff how many residents were there.
-On 12/04/20, he went to the Administrator and was told there were 5 or 6 residents on the SCU who had tested positive for COVID-19.
-He had to ask for the names of the residents, for PPE and if the residents who had tested positive

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for COVID-19 on the SCU should be moved to the COVID-19 positive area.
-The Administrator said she was waiting to hear back from the corporate office on whether to move the SCU residents who had tested positive.
-On 12/05/20, the barrier to the COVID-19 positive area on the AL side had been taken down.
-On 12/05/20, none of the staff knew how many residents in the facility had tested positive for COVID-19.
-On 12/06/20 and 12/07/20 he found out from the Administrator more residents had tested positive for COVID-19.
-None of the residents on the SCU were moved.
-All the residents on the SCU, both COVID-19 positive and COVID-19 negative were quarantined to their rooms.

Telephone interview with a second MA on 12/21/20 at 2:35pm revealed:
-He was not instructed on how to work between COVID-19 positive and negative residents.
-Staff had not been told which residents were negative and which were positive for COVID-19.
-Staff wore the same gown and face mask for the shift without changing between COVID-19 positive and negative residents.

Telephone interview with the Administrator on 12/18/20 at 9:50am revealed:
-There were 31 residents who tested positive from the facility wide testing that was done on 12/01/20.
-She received the results by email starting on 12/05/20 and received more results on 12/06/20 and 12/08/20.
-There were two residents who had tested positive for COVID-19 from the assisted living (AL) side who were moved to the SCU because

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there were so many residents who had tested positive.
-On 12/05/20, the barrier for the COVID-19 positive area on the women's hall was taken down because there were more COVID-19 positive residents than COVID-19 negative residents.
-A barrier was then put up at the end of the men's hall for the COVID-19 negative area because the rest of the building was positive.
-She did not know when the barrier was put in place for the COVID-19 negative area.
-Residents on the SCU were not moved because they had symptoms.
-All other residents on the SCU had tested positive, "so we just left them there."
-The Registered Nurse (RN) from the LHD had told her to leave residents on the SCU because they already had symptoms.

Telephone interview with a Registered Nurse form the LHD on 12/21/20 at 12:00pm revealed:
-When he visited the facility on 11/30/20, residents in the SCU had not tested positive for COVID-19 so he advised the Administrator to leave those residents on the SCU.
-As residents on the SCU started testing positive for COVID-19, he advised the Administrator to separate the negative from the positive on the SCU.

a. Review of Resident #2's current FL-2 dated 09/24/20 revealed diagnoses included dementia, fall, chronic obstructive pulmonary disease, atrial fibrillation and acute ischemic heart disease.

Review of the facility's resident roster dated 12/15/20 revealed:
-There were 21 residents on the SCU.
-Resident #2 was one of two residents on the

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D 601	Continued From page 19 SCU listed as having an unknown COVID-19 status. Interview with the Administrator on 12/16/20 at 1:00pm revealed: -She had not had a chance to review the test results from the COVID-19 testing done on 12/09/20. -She did not know the results of 3 residents listed on the resident roster dated 12/15/20 as unknown for their COVID-19 status, including Resident #2. Review of a laboratory report for Resident #2 revealed: -A SARS CoV-2 specimen was collected from Resident #2 on 12/01/20. -The result of no SARS CoV-2 detected was reported on 12/07/20. Review of a second laboratory report for Resident #2 revealed: -A SARS CoV-2 specimen was collected from Resident #2 on 12/09/20. -The result of no SARS CoV-2 detected was reported on 12/11/20. Observations of the special care unit (SCU) on 12/16/20 from 1:40pm to 2:00pm revealed: -Resident #2 was walking around his room and into the hallway several times (more than 3 in the 20-minute period) looking out of the exit door window. -Resident #2 did not have a face mask on. -Staff redirected Resident #2 to return to his room once. Interview with a personal care aide (PCA) on 12/16/20 at 2:00pm revealed: -She did not know Resident #2 had tested negative for COVID-19 on 12/01/20.	D 601		

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D 601	Continued From page 20 -She thought all the residents on the SCU had tested positive for COVID-19. -She wore the same face mask, face shield and gown from room to room on the SCU. Interview with a medication aide (MA) on 12/16/20 at 2:07pm revealed: -Resident #2 had not tested negative for COVID-19. -All residents were kept in their rooms for quarantine as a means of separating residents who had tested positive from those who had tested negative on the SCU. -She had tested positive for COVID-19 from the testing done on 12/01/20 at the facility. -She did not have any symptoms and had not missed any days of work. -She had administered medications to all residents in the facility; she had not been told not to work with residents who had tested negative for COVID-19. Interview with the Memory Care Manager (MCM) on 12/16/20 at 2:07pm revealed: -The first facility wide COVID-19 testing of all staff and residents was done on 12/01/20; he did not know how many residents on the special care unit (SCU) had tested positive. -Initially all residents who had tested positive for COVID-19 on the special care unit (SCU) were moved to the COVID-19 positive hall on the assisted living (AL) side. -When the test results came back from the 12/01/20 COVID-19 testing, there were more positive than negative results for residents. -All residents from the SCU who had tested positive for COVID-19 and had been moved to the designated COVID-19 positive area were then moved back to the SCU.	D 601		

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D 601	Continued From page 21 Telephone interview with a Registered Nurse (RN) from the LHD on 12/21/20 at 11:14am revealed: -He advised the Administrator to cohort residents who had tested positive to minimize spread of COVID-19. -He advised to pool staff to work only with COVID-19 positive residents and use full PPE (face mask, face shield, face mask and gloves) in COVID positive areas. -Recommended COVID-19 positive staff work with COVID-19 positive residents. -If in a staffing crisis, if staff must go between positive and negative areas, staff should change PPE. -PPE worn in COVID-19 positive areas should not be worn in COVID-19 negative areas. -Staff should change gown, gloves and face mask when going between COVID-19 positive and negative areas. Interview with the Administrator on 12/16/20 at 4:10pm revealed: -There were no MAs who had tested negative for COVID-19; 26 staff had tested positive. -The Memory Care Manager (MCM) was able to administer medications to the residents who had tested negative for COVID-19. -Staff had not been instructed on changing their face mask and gowns prior to providing care for the residents who had tested negative for COVID-19 because she did not know they should have. -There was no way to separate the two residents on the SCU who tested negative from all the rest who had tested positive. Second interview with the Administrator on 12/16/20 at 4:10pm revealed: -She did not yet know the result of Resident #2's	D 601		

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COVID-19 test done on 12/09/20.
-The regional nurse had given her the guidance regarding the interventions she put in place (resident placement and instructions to staff) to protect residents from further spread of COVID-19 throughout the COVID-19 outbreak.

Third interview with the Administrator on 12/16/20 at 5:05pm revealed Resident #2 had a negative result for the COVID-19 test done on 12/09/20.

Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.

Based on observations, interviews and record reviews, Resident #2 remained on the SCU during the COVID-19 outbreak with 20 -22 residents who had tested positive for COVID-19 without any intervention to prevent transmission of COVID-19 despite negative COVID-19 tests results on 12/01/20 and 12/09/20.

c. Review of Resident #4's current FL-2 dated 04/22/20 revealed diagnoses included chronic obstructive pulmonary disease, possible sepsis due to lower extremity wounds, chronic diastolic heart failure and hypertension.

Review of facility's resident roster dated 12/15/20 revealed Resident #4 was positive for COVID-19.

Review of a laboratory report for Resident #4 revealed:
-A SARS CoV-2 specimen was collected from Resident #4 on 12/01/20.
-The result of no SARS CoV-2 detected was reported on 12/04/20.

Review of a second laboratory report for Resident

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D 601	Continued From page 23 #4 revealed: -A SARS CoV-2 specimen was collected from Resident #4 on 12/09/20. -The result of detected "abnormal" was reported on 12/11/20. Interview with Resident #4 on 12/16/20 at 3:10pm revealed: -She wore a mask when she left her room to smoke outside. -She was aware that she had to wear a mask when she left her room to go smoke. -She could not remember the date she was tested for COVID-19. -She had not had any symptoms of COVID-19. 3. Review of the Centers for Disease Control and Prevention (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed: -Signage should be posted at all entrance regarding current visitation policies or restrictions and a reminder to visitors and staff not to enter if they have a fever or symptoms consistent with COVID-19. -All essential visitors and personnel should be screened for the presence of fever and symptoms of the virus when entering the building. -Persons with COVID-19 and experiencing symptoms should not be around others for 10 days since symptoms first appeared, 24 hours with no fever without the use of fever reducing medications and other symptoms of COVID-19 are improving. -Persons with COVID-19 and not experiencing symptoms should not be around others until 10 days after a positive test for COVID-19. Review of the North Carolina Department of Health and Human Services (NC DHHS)	D 601		

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guidelines for the prevention and spread of COVID-19 in long term care facilities revealed:
-Staff should be actively screened for fever and respiratory symptoms prior to starting their shift.
-Residents should be actively screened for fever and respiratory symptoms at least daily.

Review of the facility's infection control policies and procedures dated 10/20/20 revealed:
-The community will ensure all employees are screened upon entry into the community for signs and symptoms of COVID-19 (e.g., temperature checks and symptom questions) using the electronic Coronavirus Visitor Screening tool during an active pandemic.
-Any employee exhibiting signs or symptoms should be denied entry.
-All staff must answer questionnaire and have temperatures taken upon arrival before beginning shift.
-If signs and symptoms of COVID-19 develop in any caregiver during a working shift shall be reported by the caregiver to their immediate supervisor as soon as possible.
-The caregiver's supervisor requests the caregiver to go home and then reports the event to the Administrator.
-At the beginning of each shift, all staff are asked about any symptoms they might exhibit that are consistent with COVID-19.

Review of the facility's staff schedule and COVID-19 Screening Log dated from 11/01/20 to 12/18/20 revealed:
-There were columns for the submitted date/time, employees name, temperature and screening questions for all staff which included management, medication aides, personal care aides, housekeeping, dietary and maintenance.
-The facility's staff COVID-19 Screening Log

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report was generated for 11/01/20 to 12/18/20 with a run time of 11:08am.
-One staff worked two consecutive days with a temperature of 99.7 degrees Fahrenheit (F) on 12/03/20 and 100.1 degrees F on 12/07/20.
-Nine staff worked at the facility after recording yes to 2 or more COVID-19 screening questions (11/16/20, 12/01/20, 12/03/20, 12/04/20, 12/08/20, 12/09/20, 12/12/20 and 12/13/20).
-Three staff worked at the facility and answered yes to 2 or more COVID-19 screening questions on 12/03/20.
-Three staff worked at the facility after recording yes to 3 COVID-19 screening questions (11/11/20, 11/13/20, 12/10/20 and 12/11/20).
-One staff worked at the facility and answered yes to 2 or more COVID-19 screening questions on 11/16/20, 12/01/20, 12/08/20, 12/09/20, 12/12/20 and 12/13/20.
-One employee recorded yes to 2 or more COVID-19 screening questions on 4 days (12/08/20, 12/09/20, 12/12/20 and 12/13/20).
-One employee recorded yes to 3 COVID-19 screening questions on 2 consecutive days (12/10/20 and 12/11/20).
-On 12/03/20 at 7:21am a personal care aide (PCA) recorded a temperature of 99.7 degrees F.
-On 12/07/20 at 8:06am the same PCA recorded a temperature of 100.1 degrees F.
-On 11/11/20 at 3:00pm an employee answered yes to three COVID-19 screening questions.
-On 11/13/20 at 3:00pm a medication aide (MA) answered yes to three COVID-19 screening questions.
-On 11/16/20 at 2:48pm an employee answered yes to two COVID-19 screening questions.
-on 12/01/20 at 9:39am an employee answered yes to two COVID-19 screening questions.
-On 12/03/20 at 9:52am an employee answered yes to two COVID-19 screening questions.

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-On 12/03/20 at 3:16pm an employee answered yes to two COVID-19 screening questions.
-On 12/03/20 at 3:33pm an employee answered yes to two COVID-19 screening questions.
-On 12/08/20 at 9:17am a PCA answered yes to two COVID-19 screening questions.
-On 12/09/20 at 7:07am the same PCA answered yes to two COVID-19 screening questions.
-On 12/12/20 at 7:10am the same PCA answered yes to two COVID-19 screening questions.
-On 12/13/20 at 7:13am the same PCA answered yes to two COVID-19 screening questions.
-On 12/10/20 at 3:08pm an employee answered yes to three COVID-19 screening questions.
-On 12/11/20 at 12:06pm the same employee answered yes to three COVID-19 screening questions.

Telephone interview on 12/22/20 at 1:38pm with a personal care aide (PCA) revealed:
-She checked her own temperature at the beginning of her shift.
-She entered her temperature and answered the COVID-19 Screening Log questions on the tablet.
-She had a temperature of 100.1 degrees F on 12/07/20.
-She recorded a temperature of 100.1 degrees F on the COVID-19 Screening Log on the tablet on 12/07/20.
-Her supervisor was the Memory Care Coordinator (MCM).
-She informed her MCM that she had a temperature of 100.1 degrees F on 12/07/20.
-Her supervisor informed her that she could go home if she needed to since she had a temperature.
-She informed the MCM that she would work her shift since there was not anyone to cover her shift and she felt "fine."
-She was not instructed by the MCM that she had

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to leave the facility due to her temperature of 100.1 degrees F on 12/07/20.
-She worked an 8- hour shift or a 12- hour shift on 12/07/20.
-There was not anyone to cover her shift and she felt "fine."

Telephone interview with the Memory Care Manager (MCM) on 12/22/20 at 3:03pm:
-Staff with a temperature of 99.6 degrees or higher should leave the facility.
-Staff with a temperature of 99.6 degrees higher could be positive for COVID-19.
-Staff should be tested for COVID-19.
-The Administrator should be notified if staff entered the facility with a temperature of 99.6 degrees or higher.
-He did not remember the PCA that worked on 12/07/20 informing him that she had a temperature of 100.1 degrees.
-If he had been notified, he would have informed the Administrator.
-The Administrator would inform staff if they needed to be sent home due to a temperature of 99.6 degrees or higher.

Telephone interview with the Administrator on 12/21/20 at 3:30pm revealed:
-She checked the staff screening log daily to assess if any staff had COVID-19 symptoms or a temperature.
-She would walk the halls and check each department to ensure all staff had completed the screening log.
-There were times when staff entered in information on the iPad staff screening log incorrectly.
-When she noticed a temperature was too high on the staff screening log, she would ask the MA if the temperature recorded was correct.

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D 601	Continued From page 28 -She would also be notified by the corporate office if a staff had recorded a temperature over 99.6 degrees. -She would have the MA recheck the staffs' temperature to ensure it was not entered incorrectly. -She did not think any of the staff had ever answered yes to any of the screening questions that would cause them not to be able to work. -She was unable to remember of the exact screening questions because her corporate office had changed them. -Her Vice President of Regional Operations would call her if she observed any concerns on the symptom login. -She would call her corporate office for guidance if she had concerns about staff exhibiting COVID-19 symptoms. A second telephone interview with Administrator on 12/22/20 at 5:05pm revealed: -She was notified by the Vice President of Regional Operations that a PCA had a temperature of 100.1 degrees F on 12/07/20. -She asked a medication aide (MA) to retake the PCA's temperature. -The MA notified her that the PCA had entered her temperature of 100.1 incorrectly. -She did not have documentation of the correct temperature taken by the MA on 12/07/20. -She did not know if the temperature was corrected on the COVID-19 Screening Log. -She could not remember which MA retook the PCA's temperature. -Staff had been trained on contacting her if they had a temperature or any other symptoms of COVID-19. -She was unable to explain why the PCA worked on 12/07/20 with a temperature of 100.7 degrees F recorded on the Screening Log tablet.	D 601		

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D 601	Continued From page 29 Telephone interview with the Dietary Manager on 12/18/20 at 10:23am revealed: -He was sick and off work on 11/29/20 but came to work because a dietary aide became sick at work. -He thought had only had a cold because he was not feeling well. -He could not remember if he completed the Screening Log on 11/29/20. -He did not inform the Administrator that he was not feeling well on 11/29/20. -He was not aware that he needed to inform the Administrator that he was not feeling well. -He was tested at the facility on 12/01/20 and 12/09/20. -He understood that the Administrator would notify staff of their test results. -He received a call from the local health department (LHD) on 12/09/20 that he tested positive for COVID-19 on 12/01/20. -He was also notified by the Administrator on 12/09/20 that he tested positive for COVID-19 on 12/01/20. -He continued to work his regular schedule from 11/29/20 to 12/09/20. -He was not aware that he tested positive until the LHD contacted him by phone on 12/09/20. -He completed the COVID-19 Screening Log at the beginning of his shift. -He was unable to take his temperature several times because the thermometer was not working correctly and had a low battery. -He did not notify the Administrator that he did not complete the Screening Log when he was unable to take his temperature. -He was not aware that he needed to notify the Administrator if he was unable to complete the Screening Log -He did not complete the COVID-19 Screening	D 601		

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Log when the thermometer was not working correctly.
-Occasionally he had to walk thru the facility when he began his shift to find a MA or member of management to take his temperature and complete his COVID-19 symptoms questionnaire.

Telephone interview with a second PCA on 12/21/20 at 5:52pm revealed:
-She had not received any training on what to do if she became sick while working.
-She did not have anyone take her temperature or complete the COVID-19 Screening Log prior to her shift.
-She took her own temperature and recorded it in the COVID-19 Screening Log.
-She answered her own questions and recorded them in the COVID-19 Screening Log.

Interview with a second MA on 12/16/20 at 1:33pm revealed:
-There was not a designated staff person responsible for screening staff for COVID-19 symptoms or taking their temperature.
-After entering the side entrance of the facility, he had to walk to the front of the building to get screened
-The MA began feeling sick on 11/29/20.
-He did not inform the Administrator that he was not feeling well.
-The MA had not received training from the Administrator on what to do if he had COVID-19 symptoms.
-He tested positive for COVID-19 on 12/01/20.

Telephone interview with a Registered Nurse (RN) with the local health department (LHD) on 12/21/20 at 11:10am revealed:
-He completed a telephone assessment with Administrator on 11/30/20.

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D 601	Continued From page 31 -He advised the Administrator that staff should be assessed for COVID-19 symptoms and have their temperature taken at the beginning of their shift. -Staff exhibiting a fever, loss of taste, headache, chills, body aches should not work. 4. Review of the Centers for Disease Control and Prevention (CDC) guidelines for the prevention and spread of COVID-19 in assisted living facilities revealed: -Personnel should wear a face mask; visitors should wear a face mask; and residents should be encouraged to wear a face mask when out of their rooms and when leaving the facility. Review of the North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of COVID-19 in long term care facilities revealed: -Staff should use the appropriate personal protective equipment (PPE) when providing resident care. Review of the facility policy infection control policies and procedures dated 10/20/20 revealed: -Staff and residents should be instructed about the use of gowns, gloves, googles, facemasks and hand hygiene. Education about the use of facemasks should result in the understanding and acceptance of use by both staff and residents. -Adequate personal protective equipment (PPE) should always be available. -Droplet precautions (respirator masks used to prevent the spread of germs that are transmitted through coughing, sneezing, and talking (if employee cannot wear a respirator mask for documented medical reasons) surgical masks, eye shields and/or goggles, gloves, gowns, hand hygiene, environmental cleaning, etc.) should be worn by employees caring for resident's onset of	D 601		

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illness and 24 hours without a fever and requiring no fever reducing medications.
-Staff should wear gloves, facemasks, eye shields and/or goggles and gowns when touching an ill resident, potentially contaminated environmental surfaces, or items potentially contaminated with respiratory secretions, contaminated tissues, vomit or fecal matter.

Interview with a personal care aide (PCA) on 12/16/20 at 2:00pm revealed:
-Staff were not given a new clean face mask each day for work during the COVID-19 outbreak at the facility.
-She removed her face mask at the end of each shift, placed the mask in her bag and hung the mask in her closet at home or in her car for the next day.
-She had not been told how to put on, take off or clean PPE.

Interview with the Memory Care Manager (MCM) on 12/16/20 at 2:00pm revealed:
-PPE was stored in the Administrator's office on the assisted living (AL) side.
-He had a supply of gloves; surgical face masks and foot covers in his office on the special care unit (SCU).
-He did not have gowns or face shields available in his office on the SCU.
-Gowns were stored in the Administrators office.
-All staff entered the facility through the side door near the entrance of the SCU and directly across from the staff lounge.
-Staff went to the staff lounge and changed their clothing and put on their PPE including the face shield, gown and foot covers.
-All staff had to have a mask on to enter the facility.
-At the end of the shift, staff removed and

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discarded their gown, gloves and foot covers; masks and face shields were cleaned and reused unless soiled or damaged.
-Masks were sprayed with a disinfectant spray and stored in a brown paper bag.
-Face shields were sprayed with a disinfectant spray.

Observations of the staff lounge on 12/16/20 at 2:35pm revealed:
-There was a bag on the table in the changing area with approximately five to ten-foot covers.
-There were no masks, face shields, gowns or gloves available in the staff lounge.

Interview with the Administrator on 12/16/20 at 3:20pm revealed:
-There was an ample supply of PPE including surgical face masks, face shields, gowns, gloves and foot covers that she kept stored in her office.
-She did not make PPE readily available in direct care areas because she did want to deplete her supply with misuse of the PPE by staff.

Second interview with the Administrator on 12/16/20 at 4:03pm revealed:
-She usually stocked the staff lounge with new gowns before she left in the evening.
-There were face masks kept on the medication carts.
-Staff would text her if they needed a face mask to enter the facility.
-Misuse of PPE meant the staff would remove and discard the gown after the care of one resident.
-She had instructed staff to wear the gown throughout the shift unless it was soiled.
-She had instructed staff to sanitize their mask and store in a brown paper bag unless it was soiled.

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D 601	Continued From page 34 The failure of the facility to adhere to the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and local health department (LHD) recommendations and guidance by notifying the LHD of an outbreak, staff screenings, quarantining positive residents and the availability of personal protective equipment (PPE) for staff resulted in an increased risk of transmission and infection from COVID-19. The facility's failure resulted serious harm and neglect of resident(s) and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/16/20 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 21, 2021.	D 601		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from neglect as related to infection prevention and control program. The findings are:	D914		

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D914	Continued From page 35 Based on observations, interviews and record reviews, 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 county health department (LHD) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 to reduce the risk of transmission and infection to residents regarding reporting of current staff testing positive for COVID-19 to the LHD, immediate facility wide testing with a known outbreak, screening of staff and restricting symptomatic staff from working, separating residents who tested negative for COVID-19 from residents diagnosed with COVID-19 and implementing the proper use of face masks and gowns by staff when working with COVID-19 positive and negative residents. [Refer to Tag D601, 10A NCAC 13F .1801 Infection Prevention and Control Program (Type A1 Violation)].	D914		