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THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

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D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control and Complaint investigation survey with an on-site visit on 12/15/20 and 12/17/20 and desk review on 12/16/20 through 12/18/20, 12/21/20 and a telephone exit on 12/22/20.	D 000		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention & Control Program (Emer) 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 A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by	D 601		

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the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding testing of residents for COVID-19, isolation of COVID-19 positive residents, lack of signs clearly identifying residents who had tested positive resulting in staff not following recommended infection control practices when providing care to those positive residents, improper donning and doffing of personal protective equipment (PPE) by staff, appropriate use of environmental cleaning products to prevent the transmission of the virus, and not quarantining a resident who was COVID-19 positive after he was re-admitted to the facility from the hospital (Resident #4).

The findings are:

Review of the Center for Disease Control (CDC) recommended infection prevention and control practices when caring for a patient with suspected or confirmed SARS-CoV-2, COVID-19 infection dated 12/14/20 revealed:
-A single new case of COVID-19 infection should be considered an outbreak.
-Perform viral testing of all residents as soon as there is a new confirmed case.
-Testing identifies infected residents quickly to assist in their clinical management and allow rapid implementation of infection prevention and control (IPC) interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent transmission.
-After initially performing viral testing of all residents in response to an outbreak, the CDC recommends repeat testing to ensure there are

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no new infections among residents and staff and that transmission has been terminated.
-Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days since the most recent positive result.
-Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including eye protection (goggles or face shield), gloves, gown, and a N95 respirator or face mask (if a respirator is not available).
-If a gown is available, a gown should be worn for activities where splashes or sprays were anticipated, or high-contact resident care activities.
-High contact activities include transferring, dressing, showering, changing linens and providing toileting assistance.
-PPE must be donned correctly before entering the isolation unit if cohorting.
-PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas.
-PPE must be removed slowly and deliberately in a sequence that prevents self-contamination.
-Ensure environmental cleaning and disinfection procedures are followed consistently and correctly.
-Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered hospital grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings.

Review of the North Carolina Department of

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Health and Human Services (NCDHHS) What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings dated 09/04/20 revealed:
-Facility staff should wear appropriate PPE when caring for residents with undiagnosed respiratory infection or confirmed COVID-19.
-Follow current CDC guidance for testing of residents in long term care settings.
-Any testing of long term care facility residents or staff will be conducted in consultation with your local health department (LHD).
-Consult with your LHD regarding placement of residents testing positive for COVID-19.
-Residents with known or suspected COVID-19 should ideally be placed in a private room with their own bathroom.
-Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility.
-Roommates of COVID-19 positive residents might already be exposed, it is generally not recommended to separate them.
-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.
-Residents with suspected 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 transmission-based precautions. If an asymptomatic resident becomes symptomatic, the duration should be extended based on symptom onset date.

Review of the facility's Infection Control Coronavirus policy dated 10/21/20 revealed:

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D 601	Continued From page 4 -Prior to a Coronavirus outbreak: staff should be instructed about the use of gowns, gloves, facemasks, goggles and hand hygiene. Adequate personal protective equipment (PPE) should always be available and inventory counts conducted weekly by the Director of Resident Care (DRC) or designee. -During outbreak status: residents and/or community staff with Coronavirus like illness, especially 2 or more cases in 24 hours, should be tested for the Coronavirus. Upon receipt of any positive tests for residents or employees, the local health department should be immediately notified. -Once an outbreak has been identified, outbreak prevention and control measures should be implemented immediately: ensure social distancing of at least 6 feet maintained between persons, proper hand hygiene practiced, and ensure masks and tissues were available. -Symptoms of Coronavirus that developed in any resident were reported to the DRC or medication aide (MA) by the staff who witnessed the signs and symptoms. -As soon as a resident developed a Coronavirus like respiratory illness, the symptomatic resident and their roommate stayed in their room for 10 days after the onset of symptoms, or 24 hours after the resolution of fever and respiratory symptoms-whichever was longer. -Staff were to wear gloves, facemask, eye shield and/or goggles, and gown when touching an ill resident or items potentially contaminated by respiratory secretions. -Staff were to change gloves and gowns after each encounter with an ill resident, perform hand hygiene and remove contaminated protective gear when leaving the resident's room to discard in a biohazard linen hamper. -Infectious outbreak signs will be posted on all	D 601		

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entrance doors in the community.
-Enhanced cleaning of environmental surfaces will be implemented. Housekeeping staff will wipe down all exposed surfaces including chairs, tables, wall rails and any other surface commonly touched by residents with designated antibacterial/antiviral solution. Manufacturer's recommendations for the dilution, contact time and handling of disinfectants should be followed.
-Extra linen disposal units will be placed throughout the community for disposal of used protective gear.
-The DRC will develop a case log to track resident illnesses. New cases should be reported and recorded daily using the case log.
-Residents who have been discharged and returned to the community should be maintained on precautions for 14 days after the illness, the same as residents who were ill.
-The LHD personnel could provide information about diagnostic specimen collection and coordination of testing.

Review of the facility census and the actual laboratory results of COVID-19 testing provided by the facility revealed:
-The week of 11/17/20 through 11/24/20, the census was 46 residents (2 residents in the hospital), 16 residents tested positive, 15 residents tested negative and 13 residents were not documented as tested for COVID-19.
-The week of 11/24/20 through 12/01/20, the census was 47 residents (1 resident in the hospital), 10 additional residents tested positive, 2 residents tested negative and 19 residents were not documented as having been re-tested for COVID-19.
-The week of 12/01/20 through 12/08/20, the census was 38 (3 residents in the hospital), 5 additional residents tested positive, 10 residents

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tested negative and 5 residents were not documented as having been re-tested for COVID-19.
-The week of 12/08/20 through 12/15/20, the census was 38 (1 resident in the hospital), 2 additonal positive residents, 8 residents tested negative and 6 residents were not documented as having been re-tested for COVID-19.

Review of the facility staffing census and the facility documented results of the COVID-19 rapid testing revealed:
-The week of 11/17/20 through 11/24/20, staff census was 43, 5 staff tested positive, 17 staff tested negative and 20 staff were not documented as having been tested for COVID-19.
-The week of 11/24/20 through 12/01/20, 4 additional staff tested positive, 21 staff tested negative and 11 staff were not documented as having been re-tested for COVID-19.
-The week of 12/01/20 through 12/08/20, no staff tested positive, 19 staff tested negative and 14 staff were not documented as having been re-tested for COVID-19.
-The week of 12/08/20 through 12/15/20, no staff tested positive, 22 staff tested negative and 9 staff were not documented as having been re-tested for COVID-19.

Interview with the Divisional Vice President of Operations on 12/21/20 at 2:05pm revealed:
-She was aware of the COVID-19 outbreak at the facility.
-The Administrator contacted her on 11/12/20 confirming 2 staff had tested positive for COVID-19.
-She notified the Local Health Department (LHD) on 11/12/20 the community had 2 staff that tested positive for COVID-19.

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-The Administrator was on leave and the acting Administrator from a sister community assisted with the facility's Infection Control Coronavirus guidelines.
-The LHD Communicable Disease Registered Nurse (RN) contacted the facility on 11/17/20 and gave additional recommendations to the facility, including testing and re-testing of residents who were negative until the outbreak was over.
-The Administrator reported testing of all negative residents was occurring and being documented every 5-7 days, and the positive residents were being quarantined in a specific location.
-Communal dining and activities were stopped and staff had been instructed on the proper donning and doffing of PPE.
-In addition she was informed the community had substantial PPE.
-She expected the Infection Control Coronavirus guidelines and the guidelines given by the LHD to be followed by the facility.

1. Testing of residents:

Review of an email dated 11/22/20 at 1:14pm from the Communicable Disease (CD) Registered Nurse (RN) of the local health department (LHD) Communicable Disease Division to the Executive Director of the facility revealed:
-There was an attachment which included the Centers for Medicare and Medicaid Services memo dated 08/26/20 related to infection control.
-There was a link to The Long-Term Care Infection Prevention Assessment Tool for COVID-19 which included a process the facility could utilize for reviewing infection surveillance data and infection prevention activities.
-There was a COVID-19 monitoring log provided for the facility to document and track the positive

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D 601	Continued From page 8 and negative test results during the outbreak. Review of the COVID-19 Monitoring Log sent by the CD RN from the LHD revealed: -A spreadsheet which categories included; the name of staff, date of birth, gender,employee title, onset of the date/symptoms, the date symptoms resolved, the date tested and results, if the resident visited the primary care physician (PCP) or Urgent Care date, visited emergency department (ED) the date/location, and the date hospitalized and location. -There was no data entered into the spreadsheet by the facility. Review of the facility's staff COVID-19 spread sheet revealed: -The spread sheet included 37 staff. -The categories included work location, staff name, cell phone number, and employee ID which were completed. -The spread sheet included one test per staff along with the date, time administered and the time read, the result and who administered the test. -The spread sheet did not include all test results from 11/12/20 through 12/15/20. -There were 11 out of 37 staff who tested positive for COVID-19. -There were 21 out of 37 staff who tested negative for COVID-19. -There were 5 out of 37 staff without COVID-19 test results documented. Review of the facility's resident COVID-19 spread sheet revealed: -The spread sheet included 34 residents. -The categories included the resident's name, male or female, one test date, one test result, and outcome.	D 601		

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-The spread sheet did not include all test results from 11/12/20 through 12/15/20.
-There were 24 out of 34 residents who tested positive for COVID-19.
-There were 9 out of 34 residents who tested negative for COVID-19.
-There was 1 out of 34 residents without COVID-19 test results documented.
-There were 7 out of 34 residents documented as expired.
-There was 1 out of 34 residents documented as out of the facility.
-There were 25 out of 34 residents documented as no outcome.

Review of the Communicable Disease RN from LHD's email dated 12/15/20 at 10:43am revealed a form was attached to the email to be used to report any rapid COVID-19 testing of the employees to the LHD.

Review of the Centers for Medicare and Medicaid Services memo attachment dated 08/26/20 sent by the CD RN from the LHD revealed:
-The facility was required to obtain documentation for each instance of testing, date completed and the results of each test and document each completion and result of each test for residents and staff in their resident record. The facility should report all data for all testing completed, for each individual tested.
-The facility should document when the testing was conducted, when the results were obtained, and the actions the facility took based on the results for each resident and staff.
-The facility should report data for all testing completed, for each individual tested.

Telephone interview with the Communicable Disease RN from the LHD on 12/15/20 at 9:27am

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revealed:
-On 11/22/20, she spoke to the Administrator about the test results and was informed by the Administrator the tests were not "available", and he did not have copies of the results.
-The Administrator was responsible for making sure testing was completed on all staff and residents and to maintain records and copies of all testing.
-The COVID-19 outbreak started on 11/12/20.
-On 11/22/20, she sent an email to the Administrator with resources after discussing them with him over the phone.
-There was a Long-Term Care Infection Prevention Assessment Tool for COVID-19 the facility could use, detailing information on developing an infection surveillance spreadsheet to keep track of all testing, and results and to keep copies of all tests performed.
-The Administrator was responsible for sending all COVID-19 test results for residents and staff to her as requested on 11/22/20.
-She received only a few staff results as of 12/15/20.
-On 11/23/20, she informed the Administrator the importance of keeping copies and maintaining accurate records because that could lead to a resident or staff not being placed on isolation fast enough, delay in treatment of the COVID-19 positive residents and staff and confusion in general.
-On 11/23/20 and 12/10/20, she spoke with the Administrator about the number of positive staff and residents at the facility.
-The Administrator did not have records/copies of the COVID-19 positive residents or staff available for review so the current COVID-19 status for all staff and residents was unknown and not available.
-The Administrator also used multiple testing sites

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for residents and staff and not all sites reported the COVID-19 positive test results to the data base, which caused inaccuracy to the COVID-19 positive numbers as well.
-The Administrator was also responsible for reporting the COVID-19 rapid test results to the LHD and that was not done.
-Because she did not receive a copy of the rapid test results, on 12/15/20 she emailed a copy of the reporting form to report rapid COVID-19 testing, that was to be used after the rapid test was performed.
-The facility was using rapid COVID-19 tests on all staff members starting on 11/22/20.
-On 11/22/20 and 12/15/20, the LHD RN gave instructions on the reporting results of the rapid test to her.

Telephone interview with the County Emergency Management Planner on 12/15/20 at 4:51pm revealed:
-The facility did not use a single lab for testing, which was an issue in reporting and documentation.
-The facility used at least 3 different physician's office for the residents.
-The facility used a community health center for the staff as well as the staff's primary care physician.
-Testing results depended on the laboratory's turn around time which could lead to delays in reporting and isolation of residents and in turn could lead to an increase spread or transmission of COVID-19.

Review of the LHD's County Long-Term Care Resource Visit dated 11/23/20 at 2:00pm revealed there were a combination of testing and labs used for staff and residents.

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D 601	Continued From page 12 Interview with the Administrator on 12/15/20 at 4:10pm revealed: -The first week of the facility wide COVID-19 testing, 11/17/20 through 11/24/20, the laboratory used by their corporate office conducted the testing. -After the first week, he was informed the corporate laboratory would be unable to continue weekly testing due to the high demand for their services. -So for the subsequent weekly testing they had to employ the individual residents' physician's laboratory for testing, resulting in 4 different laboratories providing COVID-19 testing. -Some of these laboratories would take up to a week to report results, and results were sporadic. -He was receiving verbal reports from the physician's offices of testing results, not laboratory documentation. -Due to the outbreak, he was consumed with implementing infection control protocols for the residents and the staff and maintaining the health and safety of the residents. He did not keep up with the facility's COVID-19 spreadsheet. Telephone interview with the Administrator on 12/21/20 at 9:22am revealed: -The first positive cases of COVID-19 in the building were on 11/13/20. -On 11/17/20, the Divisional Vice President of Operations spoke with the LHD and received recommendations to test all of the residents and staff for COVID-19. -It took time to arrange COVID-19 testing for all the residents and staff. -The laboratory they tried to use for the facility wide COVID-19 testing was unable to do the testing, so it was determined they could use the 4 separate primary care providers for all of the resident testing.	D 601		

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D 601	Continued From page 13 -The testing arrangements for all of the residents were made with 4 different primary care offices and one 3rd party agency. -The staff primarily were to be tested by the Community Health Center (CHC). -The test results were coming in verbally by telephone but there were no hard copies sent to him. -The spreadsheet that he used to fill in the testing results but was not complete. -He requested the copies of the staffs results from the CHC on 12/18/20 and was told he needed to supply the CHC with a blanket statement giving him permission to receive the results. -The staff received some rapid tests at the facility and he did not know he was to fill out a paper to send to the LHD with the rapid test results so they were not reported to the LHD. -There were several residents test results missing from the 3rd party agency and some for the primary care offices as well. -He did not know if all of the tests had been reported to the LHD. -He did not know he was responsible for reporting all of the staff's rapid tests results completed at the facility to the LHD. Review of the COVID-19 spreadsheet provided was incomplete and the Administrator was unable to produce a complete testing spreadsheet for residents and staff during the survey. The absence of an accurate weekly tracking of COVID-19 testing results during an outbreak prevented the facility from implementing proper infection control measures and placed the residents and the staff at risk for contracting the virus and infecting others in the community. 2. Isolation and cohorting of infected residents	D 601		

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D 601	Continued From page 14 Review of the Centers for Medicare and Medicaid Services memo dated 09/17/20 revealed effective cohorting of residents was a core principle of COVID-19 infection prevention. Review of the Mecklenburg County Long-Term Care Resource Visit dated 11/23/20 at 2:00pm revealed: -The 100 hall was deemed the COVID-19 positive hall. -A suggestion was made to place a second plastic barrier at the wall a little before the current plastic barrier into the wing for an extra protection. Review of the Communicable Disease Registered Nurse (RN) from the Local Health Department (LHD) Communicable Disease Division emails on 11/22/20 at 1:14pm revealed: -There were instructions to place all residents who tested positive for COVID-19 on isolation. -It was recommended to confine all COVID-19 positive residents to one wing or location to prevent the spread of COVID-19. Telephone interview with the Communicable Disease RN from the LHD on 12/15/20 at 9:27am revealed: -According to their records, on 11/12/20 the facility contacted the LHD, but she was not assigned to the case until 11/17/20. -On 11/17/20, she spoke with Divisional Vice President of Operations regarding the current recommendation to designate a COVID-19 positive area and cohort all COVID-19 positive residents to that area. -The Administrator designated the 100 Hall the COVID-19 positive wing from rooms 108-120. -On 12/15/20, the Administrator called her and	D 601		

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informed her, he wanted to move the dedicated COVID-19 positive wing from the 100 hall to the 200 hall because of the increase in positive COVID-19 residents in the 200 hall.
-She recommended not moving the COVID-19 residents on the 100 hall to the 200 hall.
-She recommended the facility concentrate on the residents who have been negative since the outbreak and keep them together on the 200 hall and designate staff to take care of just the COVID-19 residents.
-On 11/22/20, she sent an email to the Administrator outlining the current recommendations and to provide links for re-enforcement of their communications and recommendations.
-It was her expectation the facility would follow the current CDC, NC DHHS and LHD recommendations to stop the spread and decrease the transmission of COVID-19.

Interview with the Administrator on 12/15/20 at 11:40am revealed:
-There were 2 halls with resident rooms in the facility, the 100 Hall and the 200 Hall.
-The 100 Hall was previously the COVID-19 isolation hall.
-The residents in the 100 Hall, who previously tested positive for COVID-19, were past their 14 day isolation period and were symptom free.
-At the present time, the 200 Hall was designated as the COVID-19 isolation hall.
-The residents on the 200 Hall had tested positive for COVID-19 and were on isolation precautions, or had tested positive for COVID-19 and completed their isolation period.

Interview with the Administrator on 12/15/20 at 11:51am revealed there was a resident on the 100 Hall that was currently in isolation due to a

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D 601	Continued From page 16 positive COVID-19 rapid test that was administered on the morning of 12/15/20. Observation of the 200 Hall on 12/15/20 at 12:00pm revealed: -The fire doors to the 200 Hall were closed. -There was no signage on the doors reminding staff of the proper usage of PPE. -There was a card table to the left of the fire doors before entering the hall. -On the table were several surgical masks in a cardboard container and a box of tissues. -There was no trash receptacle outside of the 200 Hall or inside the hall. -Both housekeepers were in the 200 hallway and in Room 200 cleaning. -Both housekeepers had on a gown, a N95 mask, gloves and shoe coverings. -The second housekeeper finished cleaning the room (200) and left with the cleaning cart to clean the common areas and the 100 Hall. -She did not remove her gown and mask when she left the 200 Hall. -There were several residents in the 200 hall, walking or sitting at tables outside their rooms, and 2 care staff. Interview with 2 personal care aides (PCAs on the 200) Hall on 12/15/20 from 12:08pm through 12:27pm revealed there were no COVID positive residents on the 200 Hall. Observations on the 100 and 200 halls on 12/15/20 from 12:10pm through 1:45pm revealed staff did not change their gowns, gloves or shoe coverings when providing care and/or administering medications between the COVID positive residents and the COVID negative residents.	D 601		

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Telephone interview with a third shift medication aide (MA) on 12/17/20 at 7:36am revealed:
-When a resident was identified as COVID-19 positive, the resident was moved to the quarantine area.
-The 200 Hall was currently the COVID-19 quarantine area.
-"We have dedicated staff that work the 100 and 200 Halls."

Telephone interview with the Administrator on 12/21/20 at 9:22am revealed:
-He notified the LHD he wanted to move the COVID-19 positive hall from the 100 hall to the 200 hall and was told to concentrate on keeping the COVID-19 negative residents together.
-He consulted the corporate office and was given the approval to move the designated COVID-19 positive hall, which was the 100 hall to the 200 hall because the 100 hall residents were off quarantine at that point.
-He did not consult the LHD in relation to if the quarantine could be lifted for any resident.
-He did not have hard copies for all of the residents to base the decision to remove the residents from quarantine status, but because he thought the last positive resident in the building was 21 days ago, corporate decided to move the COVID-19 hall to the 200 hall.
-On 12/14/20, he moved 4 or 5 COVID-19 negative residents from the 200 hall to the 100 hall and 1 COVID-19 positive resident from the 100 hall to the 200 hall making the 200 hall now the designated COVID-19 wing.
-He switched the halls because he only had 4-5 residents that tested negative every time tested since the outbreak.
-He could not give a definitive answer why there were 4-5 residents who tested negative since the outbreak began because he could not refer to all

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of the residents' tests results due to not having them.

Review of the documented COVID-19 laboratory results and the facility census on 12/15/20 revealed:
-Two residents on the 100 Hall were COVID positive and within their 14 day isolation status.
-Two residents on the 100 Hall continued to test negative during the COVID-19 outbreak.
-Five residents on the 200 Hall were COVID positive and within their 14 day isolation status.
-Seven residents on the 200 Hall continued to test negative during the COVID-19 outbreak.

The absence of the proper identification of positive COVID-19 residents, and the subsequent lack of isolation of these residents during their contagious period, placed both the staff and the residents at risk for transmission of the COVID-19 virus.

3. Use of appropriate PPE when providing care to residents who were on transmission based precautions due to poor communication amongst management and staff in identifying residents who tested COVID positive,

Interview with the Administrator on 12/15/20 at 4:15pm revealed:
-A resident on the 100 Hall was identified as COVID-19 positive this morning.
-He had communicated this information to the MA on the morning shift.
-He assumed she had communicated this information to the staff on the 100 Hall.
-It was his expectation the staff would don the full PPE when providing care to this newly positive resident.
-He expected the staff to doff the PPE when

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leaving the resident's room and disposing in the trash can outside the exit door at the end of the 100 Hall.
-He did not know there was no PPE at the entrance of the 100 Hall.
-He did not know the staff providing care on the 100 Hall were unaware of a newly diagnosed COVID-19 positive resident.

Interview with a MA assigned to the 100 Hall on 12/15/20 at 3:35pm revealed there were no COVID-19 positive residents on the 100 Hall.

Interview with a second shift PCA assigned to the 100 Hall on 12/15/20 at 4:10pm revealed there were no COVID-19 positive residents on the 100 Hall.

An interview with a PCA on 12/15/20 at 1:42pm revealed:
-She did not change gowns after providing patient care.
-She was not instructed to change gowns after providing care to patients.
-PPE was kept at the PCA station outside of the dining room at the front of the facility.
-She changed her gown anytime she went outside to take trash to the dumpster.
-She did not think she needed to change her gown because she thought all the residents on the 100 hall were COVID-19 negative.
-She provided care to a resident on the 100 Hall..
-She did not know there was a resident who tested positive for COVID-19.

Telephone interview with a third shift medication aide (MA) on 12/17/20 at 7:36am revealed:
-She worked on the COVID-19 quarantine area (200 Hall).
-The Memory Care Manager and Administrator

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were responsible for communicating resident COVID-19 status to the MAs.

Telephone interview with a third shift personal care aide (PCA) on 12/17/20 at 10:44am revealed:
-She worked on the COVID-19 positive quarantine area (200 Hall).
-The MA on her assigned hall let her know which residents were COVID-19 positive.
-There was "plenty" of personal protective equipment (PPE).
-She was not aware of any staff who worked on the isolation area leaving a used gown on and going into the break room with other staff.

The facility failed to ensure staff were aware of a resident who tested positive for COVID-19 on the 100-hall of the facility. This failure resulted in staff not appropriately using PPE to care for the COVID-19 positive resident which placed all residents at risk of being exposed to and possibly contracting COVID-19.

4. Improper donning and doffing of personal protective equipment (PPE) by staff.

Review of the emails dated 11/22/20 at 1:14pm from the the Communicable Disease Registered Nurse (RN) of the local health department (LHD) to the Administrator revealed:
-There were links provided in the email for the proper technique of donning and doffing personal protective equipment (PPE).
-The Long-Term Care Infection Prevention Assessment Tool for COVID-19 link included direction of appropriate personnel received job-specific training and competency validation on proper use of PPE.
-The Long-Term Care Infection Prevention

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D 601	Continued From page 21 Assessment Tool for COVID-19 link included elements to be assessed for the facility to routinely audit (monitor and document) adherence to PPE use (e.g., adherence when indicated, donning/doffing of PPE). -The Long-Term Care Infection Prevention Assessment Tool for COVID-19 link included elements to be assessed for supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms). Review of the NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities, dated April 2020 provided by the Communicable Disease RN at the LHD on 11/22/20 revealed a two-minute video demonstrating proper donning (putting on) and doffing (taking off) of PPE and a PPE Competency Validation which could be used to assess if all staff members knew how to appropriately use PPE. Telephone interview with the Communicable Disease RN from the LHD on 12/15/20 at 9:27am revealed: -On 11/22/20, she sent an email to the Administrator with resources after discussing them with him over the phone. -On 11/22/20 she sent video links to the Administrator on donning and doffing of PPE to help reinforce the current recommendations. -It was her expectation the facility would follow the current CDC, NC DHHS and LHD recommendations to stop the spread and decrease the transmission of COVID-19. Review of the Mecklenburg County Long-Term Care Resource Visit report dated 11/23/20 at 2:00pm revealed:	D 601		

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D 601	Continued From page 22 -The facility had N95 masks, face shields, gowns, gloves and shoe coverings for the staff to wear. -The current recommendation was to have the donning and doffing for COVID-19 to continue at the outside door to the COVID-19 wing. -The N95 mask was the current mask they required for COVID-19 and non-COVID-19 areas. -It was noticed that the staff in full PPE would go outside and around the building between the non-COVID-19 empty dining area to the COVID-19 wing. -There was no donning or doffing noted when leaving the positive wing and going into a back door of the building or back inside. Telephone interview with the Mecklenburg County Emergency Management Planner on 12/15/20 at 4:51pm revealed: -On 11/23/20, the facility had N95 masks, gowns, gloves, face shields and shoe covers to use during the COVID-19 outbreak. -The staff were wearing the same PPE outside the building, on the non-COVID-19 hall, in areas other than the designated COVID-19 hall which the Administrator identified as rooms 108-120. -The staff was not donning and doffing in the designated COVID-19 hall. -The recommendation was made to place a second sheet at the wall a little before the sheet already at the entrance into the COVID-19 hall as an extra barrier. -The recommendation was the staff would use the donning and doffing for the COVID-19 wing at the outside door and not wear the same PPE throughout the facility in order to contain the positive cases in the COVID-19 wing and decrease the spread of COVID-19. Interview with the Administrator on 12/15/20 at 11:40am revealed:	D 601		

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D 601	Continued From page 23 -At the present time, the 200 Hall was designated as the COVID-19 isolation Hall. -The 100 Hall was previously the COVID-19 isolation hall. -The residents in the 100 Hall, who previously tested positive for COVID-19, were past their 14 day isolation period and were symptom free. -The residents on the 200 Hall had tested positive for COVID-19 and were on isolation precautions, or had tested positive for COVID-19 and completed their isolation period. Interview with the housekeeper on the 200 Hall on 12/15/20 at 12:05 revealed: -She was one of two full time housekeepers, and worked on the 200 Hall. -The second housekeeper worked on the 100 Hall. -They both shared the cleaning of the common areas in the facility. -The 200 Hall was the COVID-19 positive hall, closed off from the main building by fire doors. -She donned a gown, gloves, shoe coverings and an N95 mask when she cleaned the rooms and hallway. -She was assigned to this hall and the other housekeeper was assigned to the 100 hall. -The housekeepers only worked in the hall they were assigned each shift since the COVID-19 outbreak. -She could wear the same gown, shoe coverings and face mask all day during her shift if she did not leave the building. -The employee lounge was outside the fire doors of the 200 Hall at the end of a common corridor. -The corridor past the medication room, the Business Office Manager's office and the Marketing office. -She ate her lunch in the employee lounge with other staff present.	D 601		

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-She did not remove her gown or change her face mask when she left the 200 Hall to go to lunch or break.
-If she left the building she would exit by the door next to the employee lounge, dispose of her gown, gloves and shoe coverings, sanitize her hands and re-enter the building at the front entrance.
-She would then get a new gown, gloves and shoe coverings before entering the 200 Hall.
-But she never left the building for breaks during her shift.

Interview with a personal care aide (PCA) on 12/15/20 at 12:08pm revealed:
-She was responsible for working on the 100-hall.
-There were no residents who were COVID-19 positive on the hall.
-She was responsible for wearing personal protective equipment (PPE) including gloves, masks, gowns, and shoe covers.
-She did not have access to N-95 masks, so she wore a surgical mask.
-She was not required to wear a face shield.

Observation of the 200 hall on 12/15/20 at 3:30 pm revealed:
-The receptionist entered the 200 hall to go into the Director of Resident Care (DRC) office.
-The receptionist exited the 200 hall by using her hands to touch the door.
-The receptionist only wore a surgical mask.
-After leaving the area, she did not use hand sanitizer and did not go to the bathroom to wash her hands.

Interview with another PCA on 12/15/20 at 12:27pm revealed:
-She worked on the 200 Hall providing personal care to the residents.

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-Staff were assigned to one hall for their entire shift.
-She wore a gown, gloves, a surgical mask and shoe coverings for her shift.
-She wore the same gown, surgical mask and shoe coverings for the entire shift if she did not leave the building.
-She ate her lunch in the employee lounge with other staff members in their gowns and shoe coverings.
-There were no COVID-19 positive residents on the 200 Hall so she did not have to change her PPE in between providing care to residents.
-The disposal receptacle for the PPE was outside the exit door next to the employee lounge.
-She disposed of her PPE after her shift in the receptacle outside.

Interview with a third PCA on 12/15/20 at 12:45pm revealed:
-She worked the 200 Hall assisting the residents with their personal care.
-She helped to feed the residents in their rooms if they needed assistance.
-She put on a gown, gloves, a surgical mask and shoe coverings when she entered the facility.
-There were no positive cases of COVID-19 on the 200 Hall so she was able to wear her PPE the entire shift unless it became soiled.
-She ate her lunch in the 200 hall at one of the tables in the hall or in the employee lounge.
-She would dispose of her PPE at the end of the shift when she exited through the back door near the employee lounge.

Interview with the receptionist on 12/15/20 at 3:58pm revealed:
-She went to the 200 hall to give faxed documents or messages to the DRC throughout the day.

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-She knew there were residents on the 200 hall who tested positive for COVID-19.
-She came in contact with residents occasionally but did not stay in the unit for very long.
-She was told she did not need to put on additional PPE because she was not providing patient care.
-She frequently sanitized her hands in her office.

Interview with a medication aide (MA) on 12/17/20 at 1:40pm revealed:
-She administered medications to the residents on the 200 Hall.
-She did not know if any of the residents were COVID-19 positive and still in their isolation precaution status.
-She would remove her gown, gloves, and surgical mask each time she left the 200 Hall and put on new PPE.
-She was not instructed to don and doff PPE each time she entered and exited the 200 Hall, she just felt it was safer.
-She spent most of her time in between administering medications, on the 200 hall, in the medication room by herself.
-She did not take her breaks in the employee lounge with other staff.

Interview with a second MA on 12/17/20 at 2:20pm revealed:
-She worked as a MA on the 100 Hall when it was designated as COVID-19 positive.
-She passed medications to the residents who were COVID-19 negative first and then to the COVID-19 positive residents.
-There was a trash receptacle outside the door at the end of the 100 hallway.
-She exited the building through that door after her medication pass, disposed of her PPE in the trash receptacle, sanitized her hands and entered

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back into the building through the front door.
-She did this after each medication pass.
-Currently there were no COVID-19 positive residents in the 100 Hall, so the staff only wore surgical masks at this time and did not need to change them after the resident's personal care or medication administration.

Interview with the Administrator on 12/15/20 at 4:12am revealed:
-He did not know the PCAs on the 200 Hall did not know there were residents that tested positive for COVID-19 and were still in their isolation status.
-The PCAs should receive report from the MAs or PCAs on the previous shift as to the status of the residents.
-He expected the staff to change their PPE after providing care or medications to a resident in isolation status and residents that were negative for COVID-19.
-He expected the DRC or the MAs to provide each hall with the appropriate supply of PPE for the staff.

Observation of the employee lounge on 12/15/20 at 4:35 pm revealed:
-There were 2 staff in the lounge with their gowns on.
-There was a single table, the size of a card table and three chairs around the table.
-The housekeeper, assigned to the 200 Hall, was eating at the table.
-The second staff was getting her food from the refrigerator and then sat at the table, within approximately 3 feet of each other.

The facility failed to ensure staff properly donned and doffed personal protective equipment (PPE), this was evidenced by staff not changing PPE

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after caring for residents, prior to leaving a COVID-19 positive residents' room, wearing contaminated PPE while in the staff breakroom, and not using a N95 mask while caring for residents who were COVID-19 positive or while on the COVID-19 positive hall. This failure increased the risk of staff spreading the COVID-19 virus to residents throughout the facility.

5. Appropriate use of environmental cleaning products to prevent the transmission of the virus.

Review of the Center for Disease Control (CDC) guidelines for cleaning and disinfecting a facility dated 07/28/20 revealed:
-Clean the surfaces using soap and water, then use the disinfectant.
-More frequent cleaning and disinfection may be required based on level of use.
-High touch surfaces required more frequent cleaning including, tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc.
-Disinfect with a household disinfectant on List N: Disinfectants for use against COVID-19.
-Follow the instructions on the label to ensure safe and effective use of the product.
-Many products recommend keeping surfaces wet for a period of time (see product label) and precautions such as wearing gloves and making sure you have good ventilation during use of the product.

Review of the Communicable Disease Registered Nurse (RN) from the local health department (LHD)'s email to the Executive Director (ED) dated 11/22/20 at 1:14pm revealed:
-Follow appropriate infection prevention guidelines and use proper cleaning supplies,

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including a link to NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities, dated April 2020 provided.
-The Long-Term Care Infection Prevention Assessment Tool for COVID-19 link included elements to be assessed for the facility to have a written cleaning/disinfection policies which included cleaning and disinfection of high-touch surfaces in common areas.
-The Long-Term Care Infection Prevention Assessment Tool for COVID-19 link included guidance that personnel received job-specific training and competency validation on cleaning and disinfection procedures within the past 12 months and to routinely audit (monitor and document) quality of cleaning and disinfection procedures.

Telephone interview with the Communicable Disease RN from the LHD on 12/15/20 at 9:27am revealed:
-On 11/17/20, she gave verbal instructions via a telephone conversation to the Divisional Vice President of Operations, related to the current recommendations with cleaning and disinfection during COVID-19.
-On 11/22/20, she emailed the Administrator information including a link related to a cleaning and disinfecting procedure during COVID-19 as well as a link related to the approved disinfecting agents.
-It was her expectation the facility would follow the current CDC, NC DHHS and LHD recommendations to stop the spread and decrease the transmission of COVID-19.

Review of the NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities, dated April 2020 provided by the Communicable Disease RN at the LHD on

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D 601	Continued From page 30 11/22/20 revealed: -There was an Infection Prevention Module which included "Environmental Disinfection" during the COVID-19 pandemic. -There was a CDC Mini-Webinar Series-COVID-19 Prevention Messages for Long-Term Care Staff; 5-7 minutes videos on infection prevention, PPE, and disinfection. Review of the Centers for Medicare and Medicaid Services memo dated 09/17/20 revealed cleaning and disinfection high frequency touched surfaces in the facility often was a core principle of COVID-19 infection prevention. Observation of the cleaning supplies on 12/15/20 at 12:11pm revealed: -There were 4 bottles of the one-quart [named] disinfectant cleanser spray bottles available for use. -The instructions advised the surface to remain wet for one minute to kill hepatitis B, hepatitis c, and human immunodeficiency virus (HIV) and for all other organisms allow surface to remain wet for "three minutes". Observation of the 100 hall on 12/15/20 from 11:55am-1:15pm revealed: -The 100 hall did not have signage posted to indicate if the hall was designated for COVID-19 positive or negative residents. -Throughout the hall there were tables in the hallway outside of resident's rooms. -The tables had two chairs which allowed residents to sit approximately 2 feet away from each other. -Resident were eating lunch from Styrofoam boxes. -After residents ate their food the personal care aides (PCA) collected boxes, placed in a trash	D 601		

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bag and gave to the housekeeper to discard.
-The tables were not cleaned after the residents ate lunch.
-The PCA and the medication aide (MA) assisted any residents who required assistance with eating to their rooms.

Interview with a PCA on 12/15/20 at 12:08pm revealed:
-She was responsible for working on the 100 hall.
-Some residents ate in their bedrooms and some can eat in the hallway.
-The tables outside of the room were cleaned after meals.
-She sprayed the solution on the table and waited for 2 minutes and then wiped it cleaned.
-She used her common knowledge to properly clean.
-She had no training on how to properly clean.
-She cleaned areas according to the instructions on the bottle.

Interview with the MA on 12/15/20 at 12:15pm revealed:
-She assisted residents with feeding and care.
-She was responsible for cleaning surfaces including tables, door knobs, and rails when she worked.
-She would spray the table and leave the solution on the surface for "30 seconds" and wipe clean.
-She used the cleaning supplies provided by the housekeeping staff.

Observation of the 100 hall on 12/17/20 at 1:00pm revealed:
-There were tables located outside of the resident's rooms throughout the hall.
-The tables were soiled and had food substance on several tables.
-There was a table with salt spilled on the table

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and on the chairs.
-There tables were not cleaned and had been used.
-There were a several residents walking through the hall and a few residents sitting at the tables socializing.

Interview with the PCA on 12/17/20 at 1:04pm revealed:
-The residents ate lunch at 11:30pm.
-The PCAs were responsible for cleaning the tables after each meal.
-She had not had the opportunity to clean the tables.
-When she cleaned, she would spray the solution, leave it on for "less than a minute" and wipe down the surface.
-She used the cleaning solution provided by the housekeeping staff.
-She remembered having COVID-19 training, however did not remember being trained on using the cleaning supplies.

Interview with a second PCA on 12/15/20 at 12:55pm revealed:
-She worked on the 200 Hall providing personal care to the residents.
-The housekeepers did most of the cleaning on the hall, but the PCAs helped out if needed.
-If there was a mess that needed to be taken care of and the housekeepers were not working, the PCAs would help out.
-The tables in the hall were used by the residents to socialize and eat their meals.
-During the week, the housekeepers would clean the tables in the hall after the residents ate their meals.
-The housekeepers would come back to the hall after meals and clean the tables.
-If they did not, the PCAs would get the spray

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bottle from the housekeeping cart and spray down the tables.
-There was a cloth on the housekeeping cart to wipe the tables down.
-She did not wait any length of time after spraying the disinfectant before wiping the tables down.
-She had not been instructed as to the proper usage of the disinfectant.
-The tables were not wiped down in between meals unless soiled.

Interview with another PCA on 12/17/20 at 2:15pm revealed:
-She worked on the 100 Hall and provided personal care for the residents.
-The housekeepers cleaned the resident rooms, the tables in the hall and the common areas.
-She would assist if needed, but housekeeping usually took care of all the cleaning.
-She could wipe down the tables in the hall if they were soiled.
-She would spray the disinfectant on the table and wipe down with a cloth from the housekeeping cart.
-She had not been instructed on the proper usage of the disinfectant cleaner.

Telephone interview with the Maintenance Director on 12/21/20 at 10:25am revealed:
-There were two housekeeping staff available in the facility.
-Each staff was responsible for a hall in the building and were not allowed to go on the hall that they were not assigned to prevent cross contamination.
-Both housekeepers were responsible for cleaning the common areas.
-The housekeepers were responsible for cleaning surfaces such as railings, tables, door knobs twice daily.

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D 601	Continued From page 34 -Since the COVID-19 pandemic, the facility provided different cleaning supplies to clean with staff were instructed to clean more frequently. -He had not trained the staff on how to properly use cleaning supplies. -The Administrator had a meeting with all staff in November 2020 regarding how to properly use cleaning supplies. -The Administrator discussed dwelling time of cleaning supplies during the meeting. Interview with the Director of Resident Care (DRC) on 12/15/20 at 3:13pm revealed: -She conducted an infection control training at the end of October 2020 for all staff. -She did not train the staff on how to properly use cleaning supplies. -She thought the housekeeping staff provided training to the PCAs and MAs on how to properly use the disinfectant. -The PCAs and MAs were responsible for reading instructions on the bottle and cleaning accordingly. Interview with the Administrator on 12/22/20 at 4:45pm revealed: -There were cleaning products ordered by corporate for all staff to use. -He expected all surfaces to be cleaned after use by PCAs and MAs on each hall. -He expected the staff to read the instructions on the back of the bottle and leave solution on the surfaces as indicated. -He had an in-service "last week" with all staff regarding how to properly use cleaning products. The facility failed to use environmental cleaning products appropriately to prevent the transmission of the virus related to cleaning and disinfection of high frequency touched surfaces in	D 601		

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the facility often and after meals, following the manufactures instructions on contact time of the disinfectant before wiping the area, and training/instruction on how to use the disinfectant resulting in high frequency touched surfaces not being disinfected correctly exposing staff and residents to the transmission of COVID-19.

6. Signage

Based on observations, interviews and LHD recommendations, the facility failed to post signage in the facility regarding infection control precautions and practices resulting in the lack of communication of the designated COVID-19 unit and type of PPE to be used exposing staff and residents to the transmission of COVID-19.

Review of the Centers for Medicare and Medicaid Services memo dated 09/17/20 revealed instructional signage throughout the facility on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of masks, specified entries, and exits and routes to designated areas, and hand hygiene) was a core principle of COVID-19 infection prevention.

Observation of the facility on 12/15/20 from 11:55am -12:45pm revealed:
-There was no signage on the front entrance of the facility regarding infection control precautions or facility practices (e.g., use of masks, specified entries. no visitors etc).
-The fire doors leading to the 200 hall of the facility were closed.
-There was no signage posted on the door to indicate the COVID-19 status.
-There were no signs in the common areas of the facility indicating the core principles of COVID-19

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D 601	Continued From page 36 infection prevention. Observation of the 100 hall on 12/15/20 from 11:55am-1:15pm revealed: -There were doors that led to the 100 hall of the facility. -There was no signage posted on the door to indicate the COVID-19 status. -There was no signage outside of the newly diagnosed COVID-19 positive resident's door indicating he was on isolation. Review of the Communicable Disease (CD) Registered Nurse (RN) from the local health department (LHD) Communicable Disease Division email dated 11/22/20 at 1:14pm revealed: -A link to the NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities. -The Long-Term Care Infection Prevention Assessment Tool for COVID-19 link included elements to be assessed for the facility to post signs at entrances with instructions to individuals with symptoms of respiratory infection to: cover their mouth/nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions. Review of the NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities dated April 2020, provided by the CD Nurse at the LHD on 11/22/20 revealed: -There were COVID-19 Signs the facility could post in the facility for transmission-based precautions and visitor screening/restriction. -There were signs for staff to refer to re-enforce proper donning and doffing of PPE.	D 601		

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Telephone interview with the Communicable Disease RN from the LHD Communicable Disease Division on 12/15/20 at 9:27am revealed:
-On 11/17/20, she gave verbal instructions via a telephone conversation to the Divisional Vice President of Operations, related to the current recommendations using signage.
-On 11/22/20, she emailed the Administrator information including a link to NC DHHS Infection Prevention Education Resources for Long-Term Care Facilities, dated April 2020 and The Long-Term Care Infection Prevention Assessment Tool for COVID-19, which included signage recommendations.
-It was her expectation the facility would follow the current CDC, NC DHHS and LHD recommendations to stop the spread and decrease the transmission of COVID-19.

Review of the Mecklenburg County Long-Term Care Resource Visit dated 11/23/20 at 2:00pm revealed no signage was noted as reminders for the infection prevention precautions.

Telephone interview with the Mecklenburg County Emergency Management Planner on 12/15/20 at 4:51pm revealed there was no signage posted related to transmission-based precautions and visitor screening/restriction.

Interview with the Administrator on 12/15/20 at 11:51am revealed:
-There was a resident on the 100 hall currently in isolation due to a positive COVID-19 rapid test that was administered on the morning of 12/15/20.
-The 100 hall was initially the quarantine hall, but now they were in the process of changing that hall to be COVID negative.

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D 601	Continued From page 38 Interview with the Administrator on 12/17/20 at 3:15pm revealed: -He had requested signage from a community association-he could not remember the name of the association. -He was told the signage would be delivered this week. The facility failed to post signage in the facility regarding infection control precautions and practices resulting in the lack of communication of the designated COVID-19 unit and type of PPE to be used exposing staff and residents to the transmission of COVID-19. 7. Quarantining a Resident upon Readmission w/Unknown COVID-19 status and Other Breaches of IC Based on observations, interviews and the LHD recommendations, the facility failed to quarantine a resident upon readmission with unknown COVID-19 status resulting in the resident (Resident #4) not being placed on quarantine since being readmitted from the hospital on 12/08/20 without a confirmed COVID-19 test, and testing COVID-19 positive on 12/15/20 resulting in staff and residents being exposed to the transmission of COVID-19. Review of the NC DHHS Long Term Care Setting Considerations for Residents Admission/Readmission during COVID-19 Outbreak dated 05/08/20 revealed: -Residents with negative or unknown COVID-19 status should be kept in quarantine until 14 days after admission or readmission. -All recommended personal protective equipment should be worn during the care of residents in the quarantine area.	D 601		

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D 601	Continued From page 39 Telephone interview with the local health department (LHD) Communicable Disease Nurse on 12/15/20 at 9:27am revealed: -If a resident has been hospitalized, upon return to the facility, they should be kept in quarantine until 14 days after readmission -Residents can come out of quarantine status after 10 days if the resident tests negative for COVID-19 and is asymptomatic. -She provided all recommended guidance to the Executive Director (ED) during her communication in November 2020 when the facility was determined to be in an outbreak. Review of Resident #4's current FL2 dated 12/07/20 revealed diagnoses included Alzheimer's dementia, hyperlipidemia, hypertension, and COVID-19. Review of Resident #4's hospital discharge summary dated 12/08/20 revealed: -The resident was admitted to the hospital on 12/01/20. -The primary diagnosis was documented as COVID-19 virus infection. -There was documentation, the resident tested positive for COVID-19 on 11/28/20 as reported by the staff at the facility. Review of Resident #4's progress notes revealed there was documentation on 12/01/20 at 11:54am, Resident #4 was running a temperature of 100.3 and was experiencing "shakes", the paramedics were called and the resident was transported to the hospital. Interview with the Administrator on 12/15/20 at 11:51am revealed: -Resident #4 was currently in quarantine due to a	D 601		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PARC AT SHARON AMITY	4025 N SHARON AMITY DRIVE CHARLOTTE, NC 28205

(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
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positive COVID-19 rapid test that was administered on the morning of 12/15/20.
-Resident #4 was discharged from the hospital on 12/08/20 and he did not know if he was positive for COVID-19.
-Resident #4 did not have a COVID-19 test since before he was discharged from the hospital.
-He did not know why staff told the paramedics Resident #4 tested positive for COVID-19.
-He thought Resident #4 had been on quarantine since being discharged from the hospital on 12/08/20, however he was unsure why no signage was posted or why PPE was not available near the residents room.

Observation of Resident #4's room on 12/15/20 at 12:00pm revealed:
-The resident resided in a private room on the 100 hall of the facility.
-There was no signage posted to reflect the resident was in quarantine.
-There was no personal protective equipment (PPE) located inside or near the resident's room for staff to doff PPE after providing care.
-A personal care aide (PCA) assisted Resident #4 to eat in his room and did not change PPE after leaving the resident's room.

Interview with a personal care aide (PCA) on 12/15/20 at 12:08pm revealed:
-She was responsible for working on the 100 hall.
-There were no residents who were COVID-19 positive on the hall.
-There were no residents on quarantine due to COVID-19.
-She was not notified of any resident on the 100 hall who recently tested positive for COVID-19 or who was on quarantine.
-She was responsible for wearing PPE including gloves, surgical masks, gowns, and shoe covers

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while working in the building.
-She did not change PPE in between caring for any residents on the 100 hall.
-The Administrator and the Director of Resident Care (DRC) had daily meetings and informed them of residents who were positive for COVID-19 or who was on quarantine.
-The Administrator and DRC had not informed her of any residents on quarantine for COVID-19 on the 100 hall.
-She did not know Resident #4 was supposed to be on quarantine since being readmitted from the hospital.

A second interview with a PCA on 12/15/20 at 1:42pm revealed:
-She did not change gowns after providing patient care.
-She was not instructed to change gowns after providing care to patients.
-She did not know Resident #4 tested positive for COVID-19.
-She did not know Resident #4 was supposed to be on quarantine since returning from the hospital on 12/08/20.
-She did not know she needed to change her gown after providing care for Resident #4.
-She changed her gown anytime she went outside to take trash to the dumpster.
-She did not think she needed to change her gown because all the residents on the 100-hall were COVID-19 negative.
-There was no one residing on the 100 hall in quarantine.

Telephone interview with a medication aide (MA) on 12/18/20 at 4:04pm revealed:
-She was the MA on duty on the 100 hall when Resident #4 went to the hospital on 12/01/20.
-The 100 hall was the hall designated for

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residents who were positive for COVID-19 on 12/01/20.
-Resident #4 was residing on the 100 hall when he was sent out to the hospital.
-To her knowledge Resident #4 was positive for COVID-19 when he was sent out to the hospital because he was on residing on the 100 hall.
-He returned from the hospital on 12/08/20.
-Resident #4 was not on quarantine when he returned from the hospital.

Interview with the Director of Resident Care (DRC) on 12/15/20 at 3:13pm revealed:
-All the residents on the 100 hall were COVID-19 negative and the 200 hall was set aside of COVID positive residents.
-During the morning meeting on 12/15/20, the Administrator informed that all residents were negative on the 100 hall.
-Resident #4 was currently on quarantine because he was discharged from the hospital on 12/08/20.
-Resident #4 was supposed to be moving to the 200 hall because the rapid COVID-19 test administered on 12/15/20 revealed he was COVID-19 positive.
-Staff were to change PPE after providing care for residents on isolation or quarantine for COVID-19.
-She was responsible for making sure PPE was available for staff to change after caring for Resident #4.
-She had not put PPE on the 100 hall near Resident #4's room, "I got busy doing paperwork".
-The Administrator informed her Resident #4 was positive after a rapid test was completed before lunch on 12/15/20.
-Resident #4 came from the hospital on 12/08/20, however there was no COVID-19 test results, so

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he needed to be tested.
-She did not realize there was no signage available to alert staff Resident #4 was on quarantine.

Interview with the Administrator on 12/15/20 at 2:06pm revealed:
-Resident #4 had been on quarantine since being discharged from the hospital on 12/08/20.
-Prior to 12/15/20, he did not know if Resident #4 had ever tested positive for COVID-19.
-He could not provide COVID-19 results that was completed for Resident #4 prior to 12/15/20.
-On 12/15/20, he completed a rapid test on Resident #4, and he was found to be positive for COVID-19.
-He completed the test because the resident was hospitalized "a week ago" and did not come back with a COVID-19 test.
-He told staff on 12/15/20 verbally during the morning meeting that Resident #4 was positive for COVID-19.
-He had not had time to put personal protective equipment (PPE) outside of Resident #4's room because he found out the status that morning (12/15/20).
-He was in the process of transitioning all COVID-19 positive residents to the 200 hall.
-The 100 hall was for residents who were not COVID-19 positive.
-He was in the process of moving Resident #4 to the 200-hall of the facility.
-Residents who were COVID-19 positive and on quarantine were required to stay in their room.
-If a resident was on quarantine, staff were required to have on PPE before going into the resident's room and were to remove PPE before leaving the resident's room.
-Trash cans were supposed to be outside of the resident's rooms for staff to dispose of PPE.

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D 601	Continued From page 44 The facility failed to quarantine a resident upon readmission from the hospital on 12/08/20, with unknown COVID-19 status, who subsequently tested positive for COVID-19 on 12/15/20, resulting in staff and residents being exposed to the transmission of the COVID-19 virus from 12/08/20 through 12/15/20. The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS), and the facility's Infection Control Coronavirus Policy and Procedures for infection prevention and transmission during the COVID-19 pandemic related to the not testing the residents and staff during a COVID-19 outbreak as directed by the LHD, which led to not identifying and isolating some COVID-19 positive residents and staff not donning and doffing the proper PPE when providing care to COVID-19 positive residents and negative residents on the same hall. The staff also co-mingled from both halls, including the housekeepers, in the employee lounge without changing their gowns, and eating at the same table. The facility's failure to follow the guidance related to infection prevention for COVID-19 increased the risk for the virus to spread in the facility, resulting in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 12/15/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 21, 2021.	D 601		

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D 601	Continued From page 45 3. The facility failed to ensure staff were aware of a resident who tested positive for COVID-19 on the 100-hall of the facility. This failure resulted in staff not appropriately using PPE to care for the COVID-19 positive resident which placed all residents at risk of being exposed to and possibly contracting COVID-19. The facility failed to ensure staff properly donned and doffed personal protective equipment (PPE), this was evidenced by staff not changing PPE after caring for patients, prior to leaving a COVID-19 positive residents' room, wearing contaminated PPE while in the staff breakroom, and not using a N95 mask while caring for residents who were COVID-19 positive or while on the COVID-19 positive hall. This failure resulted in the staff possibly spreading the COVID-19 virus to residents throughout the facility.	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. The findings are:	D914		

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D914	Continued From page 46 Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding testing of residents for COVID-19, isolation of infected residents, lack of signs clearly identifying residents who had tested positive resulting in staff not following recommended infection control practices when providing care to those residents, improper donning and doffing of personal protective equipment (PPE) by staff, and appropriate use of environmental cleaning products to prevent the transmission of the virus. [Refer to Tag 601, 10A NCAC 13F .1801(c)1(E) Infection Prevention and Control (Type A2 Violation)].	D914		