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ADULT CARE LICENSURE SECTION
RALEIGH

Division of Health Service Regulation

PRINTED: 11/25/2020
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL092203 | A. BUILDING: _____ B. WING _____ | 11/04/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CHATHAM COMMONS | 809 WEST CHATHAM STREET CARY, NC 27512 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey with an onsite visit on 11/03/20 and a desk review survey on 11/04/20 and a telephone exit on 11/04/20. | D 000 | Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the plan of correction is prepared solely as matter of compliance with state law. | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews the facility failed to be free of hazards as evidenced by storage of furniture and housekeeping chemicals left unsecured and accessible to all residents including five residents known to have dementia and/or wandering behaviors.<br><br>The findings are:<br><br>Observation of an unoccupied resident room (room #204) on the Assisted Living (AL) section of the facility on 11/03/20 at 10:07am revealed:<br>-The entrance room door was in a partially opened position with items in the room visible from the hallway of the facility.<br>-The door was not equipped with a key lock or any other locking mechanism.<br>-There was a square metal bed frame without a mattress with a headboard attached to the frame | D 079 | The Maintenance Director immediately removed the chemicals from the nonsecured room on 11/03.<br><br>The Maintenance Director held an in-service on 11/04 with the Housekeeping staff to review the proper storage of chemicals and cleaners.<br><br>An in-service was held with all staff on 11/06 to review the proper storage of chemicals and cleaners. Reporting any chemicals or cleaners that are found to be unsecured was also covered.<br><br>The Maintenance Director or Designee will make rounds through the community to ensure that there are no chemicals or cleaners in areas that are not secured from residents. He will report his findings during the morning Stand-Up meeting. | 11/03/20<br><br>11/04/20<br><br>11/06/20<br><br>11/04/20 |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Executive Director

(X6) DATE: 12/04/2020

STATE FORM 6899 X86C11 If continuation sheet 1 of 27

* The Plan of Correction was reviewed and accepted on 12-9-20.
Della Sweat

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| D 079 | Continued From page 1<br>stored on the floor on the left side of the room, creating a fall or trip hazard.<br>-There was a floor cleaning machine in the middle of the room's floor causing a fall or trip hazard.<br>-There was an aerosol spray can of "popcorn ceiling texture" stored on a nightstand.<br>-There were dried white colored material specks scattered across the outside of the aerosol can and around the spray nozzle.<br>-There were labeled directions on the front label that read as "DANGER" flammable vapor, contents under pressure, causes eye, skin and respiratory irritation.<br>-There were labeled directions that read if the contents were swallowed and if the person was conscious to rinse the mouth with water. Call Poison Control immediately and do not induce vomiting unless directed to do so by medical personnel.<br>-There were labeled directions that read if the contents were in the eyes, to rinse the eyes for 15 minutes with water.<br>-There were labeled directions that read if the contents were on the skin, to rinse well with soap and water.<br>-There were instructions that read to get medical attention if irritation develops.<br>-There was a plastic container that was approximately 5 pounds (lbs) containing a heavy-duty floor stripper concentrated liquid with slightly less than ½ of the concentrated liquid remaining, stored on the floor against a bed on the right side of the room.<br>-There was a round type lid on the top of the container. The seal around the lid had been broken.<br>-There was labeled directions on the front of the label that read "WARNING" this product can expose you to chemicals which was known to | D 079 | | |

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| D 079 | Continued From page 2<br>cause cancer in a named state.<br>-There were labeled directions that read to avoid contact with skin, mucous membranes and eyes and to avoid breathing vapors or mist of the liquid.<br>-There were labeled directions that read to use safety goggles, chemical resistant gloves and shoe covers when using the concentrated chemical liquid.<br>-Directions read overexposure to the concentrated chemical liquid by inhalation or absorption could produce central nervous system depression resulting in headache, nausea or dizziness. "DO NOT" swallow this product.<br>-There were first aid instructions capitalized to contact the local Poison Control Center for emergency medical assistance.<br>-There were 2 enclosed cardboard boxes containing foaming soap and a small hand tool stored on the floor beside the heavy-duty floor stripper concentrated liquid causing a fall or trip hazard.<br>-There was a two-shelf utility cart with opened storage bins stored beside the bed to the right of the room.<br>-The top storage bins had multiple items including tool parts, screws, a power tool and several hand tools.<br>-There were containers of paint and a container of a liquid used for floor care stored on the second shelf.<br>-There was a 1-gallon container with a long flexible tubing with a spray nozzle on the end attached to the container of insecticide labeled as a bed bug killer with egg kill.<br>-The long flexible tubing for the insecticide was laying against a named brand pineapple flavored soda that had been opened with approximately ½ of the soda remaining, stored directly beside the insecticide container on the second shelf. | D 079 | | |

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| D 079 | Continued From page 3<br>-There was opened large plastic container without a lid to close the container labeled as a high traffic floor polish with a small amount of the polish remaining in the container (the liquid polish only covered the bottom of the container).<br>-There were labeled directions that read the product was an eye and skin irritant.<br>-There were cans of paint that had been opened with dried paint on the outside of the containers stored between the head of the bed and the wall of the room.<br>-There were large containers of unopened paint stored on the floor, a large step ladder (with a least 4 steps) and lamps with cords on the floor, stored at the foot of the bed causing a fall or trip hazard.<br><br>Observation on the left hallway of the facility on 11/03/20 at 10:07am revealed:<br>-There were occupied resident rooms around room #204.<br>-There were residents walking and propelling wheelchairs up and down the hallways without staff.<br><br>Interview with a resident on 11/03/20 at 3:40pm revealed:<br>-The resident had observed room #204 being used for storing items for approximately the last 3 months.<br>-The resident saw boxes and a utility cart stored in the room.<br>-The resident knew some residents were confused and wandered in the facility because some of the residents had wandered into his room.<br><br>Interview with a resident on 11/03/20 at 3:31pm revealed:<br>-Room #204 had been used for storage about 2 | D 079 | | |

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| D 079 | Continued From page 4<br><br>weeks.<br>-The door to room #204 was left open at times.<br><br>Interview with a medication aide (MA) on 11/03/20 at 3:45pm revealed:<br>-She had not observed any of the residents going into the unoccupied resident room #204.<br>-She could not provide any information regarding the contents stored in resident room #204 because she had not paid any attention to the room when she walked down the hallway.<br><br>Interview with a personal care aide (PCA) on 11/03/20 at 4:05pm revealed:<br>-She was not sure what was stored in resident room #204.<br>-The entrance door to resident room #204 was usually closed.<br>-She would have concerns if chemicals were stored in an unsecured manner in resident room #204 because of confused and wandering residents could open the door, have unsupervised access to the items in the room and could possibly drink a harmful liquid.<br><br>Telephone interview with Divisional Director of Clinical Services, on 11/04/20 at 2:38pm revealed:<br>-She expected all chemicals within the facility to be stored properly.<br>-She expected the Maintenance Director to store all chemicals within the facility to be locked in the designated areas.<br>-The importance of properly storing all chemicals within the facility was so the resident could not access them and ingest them.<br><br>Telephone interview with the Maintenance Director on 11/04/20 at 2:58pm revealed:<br>-There were two designated areas within the | D 079 | | |

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facility for chemical storage.
-The two designated areas within the facility for chemical storage were rooms 100 and 200 which had a key lock and code entries.
-To monitor the proper storage of chemicals, he would walk the hallways of the facility as much as he could to verify the proper storage of the facility's chemicals.
-Room 204 was not a storage room for incontinent pads/briefs, soaps, ladders, bed bug spray, the maintenance cart with tools, or staff's drinks.
-The previous night (11/02/20), he had left the chemicals in room #204.
-He could not track over the waxed floor to retrieve the chemicals in room 204.
-He did not secure the door of room 204 prior to the leaving the facility the night of 11/02/20.
-The square cans of the chemicals observed in room 204 were floor strippers.
-The drink left in room 204 was a resident's concern due to the possibility of a resident inadvertently ingesting a corrosive chemical versus the drink left in room 204.
-All chemicals within the facility were supposed to be locked up.

Interview with the Administrator on 11/03/20 at 10:22am revealed:
-Room #204 was an unoccupied room used for storage.
-She was not sure how long the chemicals and other items had been stored in room #204 but knew staff started stripping the floors a week or so ago at the facility.
-There were residents residing on the AL section of the facility that had dementia.
-She was not sure if any of the residents would accidentally ingest a harmful chemical but "you never know".

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| D 079 | Continued From page 6<br>-She would have someone monitor the doorway of room #204 immediately until the items could be removed and secured.<br><br>Telephone interview with the Administrator on 11/04/20 at 4:19pm revealed:<br>-She expected whomever was using any chemicals at the facility to lock it up when completed in either housekeeping closet.<br>-She expected every chemical at the facility to be locked to not allow access to residents.<br>-The Administrator monitored chemicals were properly secured on her daily walk through the facility.<br>-On her daily walk through all areas of the facility, she laid eyes on all the residents in assisted living and the memory care unit to allow them an opportunity to voice their opinion or concerns, and she verified the cleanliness of the facility (assisted living, memory care unit, and kitchen).<br>-She thought the items observed in room #204, incontinent pads/briefs and bed frame had been there about a week.<br>-She was not sure how long the paint had been in room #204.<br>-The Maintenance Director and the Administrator were responsible to verify every chemical at the facility was secured in the housekeeping closets.<br><br>Review of the facility's policy for Housekeeping Chemical Handling and Storage revealed:<br>-The policy was dated effective 11/04/20 and planned to review on 11/01/21.<br>-The purpose of the policy was to ensure all housekeeping chemicals were handled and stored properly.<br>-The measures were to be used in all areas of the facility and utilized by any staff using housekeeping chemicals.<br>-The definition section read: Safety data sheets | D 079 | | |

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were furnished by the vendor or manufacturer.
-The definition for locked storage was proper location of chemical storage or locked for limited access by staff only.
-All cleaning or housekeeping chemicals would be maintained in proper containers, labeled and stored in housekeeping closets with cloaked doors.
-When chemicals were not in use, they would be locked in the proper storage closet.
-The Administrator and the Maintenance Manager would monitor chemical use and ensure that chemicals were used and stored properly.
-No cleaning supplies or chemicals could be left un-supervised in resident rooms or common rooms when residents were present or could be present.
-The Administrator and Maintenance Manager would ensure new employees were trained and oriented to the chemical use and storage guidelines.

1. Review of Resident #1's current FL-2 dated 05/28/20 revealed:
-Diagnoses included dementia, Parkinson's disease, asthma, rhinitis, coronary obstructive pulmonary disease, gastroesophageal reflux disease, atrial fibrillation and hypertension.
-The resident was semi-ambulatory with a rollator.
-The resident was constantly disoriented and wandered.

Review of Resident #1's Assessment and Care Plan dated 07/07/20 revealed:
-The resident wandered and ambulated with a walker.
-The resident was always disoriented and had a significant memory loss and required direction.

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| D 079 | Continued From page 8<br><br>Observation of Resident #1 on 11/03/20 at 9:52am revealed the resident was lying in her bed holding a stuffed animal.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:<br>-Resident #1 was able to ambulate by herself.<br>-Resident #1 got confused about date, time, and location.<br>-Resident #1 knew where her room was located.<br><br>Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:<br>-Resident #1 was only oriented to person.<br>-Resident #1 ambulated with a walker, and had been observed in the facility's hallway, dining room, and an old room (resident room #109).<br>-Resident #1 required re-direction back to her room.<br>-Resident #1 was observed in her old room daily.<br>-Resident #1 just moved from her old room to her new room about a month ago.<br>-Resident #1's wandering occurred daily.<br><br>Based on observations, interviews and record reviews, Resident #1 was not interviewable.<br><br>2. Review of Resident #2's current FL-2 dated 05/28/20 revealed:<br>-Diagnoses included hypotension, coronary artery disease, paranoid schizophrenia, coronary obstructive pulmonary disease, diabetes type 2, anemia, and active encephalopathy.<br>-The resident was semi-ambulatory with a rollator.<br>-The resident was constantly disoriented.<br><br>Review of Resident #2's Assessment and Care Plan dated 08/21/20 revealed:<br>-The resident ambulated with a walker. | D 079 | | |

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| D 079 | Continued From page 9<br>-The resident was always disoriented and was forgetful, requiring reminders.<br><br>Observations of Resident #2 on 11/03/20 intermittently from 9:15am - 4:45pm revealed the resident was walking up and down both hallways with a rollator of the AL section of the facility without staff.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:<br>-Resident #2 always used a walker to ambulate.<br>-Resident #2 was disoriented to date and time.<br>-Resident #2 had to be re-directed back to his room.<br>-Resident #2 did not go into other residents' rooms however he had been observed in the facility's hallways and dining room.<br><br>Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:<br>-Resident #2 always used a walker to ambulate.<br>-Resident #2 was only oriented to person.<br>-Resident #2 had to be re-directed back to his room.<br>-Resident #2 would ambulate in the hallway, dining room, in the medication room.<br><br>Interview with a medication aide (MA) on 11/03/20 at 3:45pm revealed Resident #2 walked or sat in the hallways often of the facility but she had not observed the resident entering resident rooms.<br><br>Based on observations, interviews and record reviews, Resident #2 was not interviewable.<br><br>3. Review of Resident #3's current FL-2 dated 04/23/20 revealed:<br>-Diagnoses included a type 2 odontoid c2 fracture, history of dementia, history of cerebral | D 079 | | |

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vascular accident, and a history of hypertension.
-The resident was non-ambulatory.
-The resident was constantly disoriented.

Review of Resident #3's Assessment and Care Plan dated 07/07/20 revealed:
-The resident wandered and was ambulatory with a wheelchair.
-The resident was always disoriented and had significant memory loss and required direction.

Observation on the right hallway of the AL section of the facility on 11/03/20 at 9:29am revealed:
-Resident #3 was propelling herself in a wheelchair in the hallway.
-Two other female residents questioned Resident #3 why she was in their room a few minutes ago.

Observations of Resident #3 on 11/03/20 intermittently from 9:29am - 4:45pm revealed the resident was propelling herself up and down both hallways of the AL section of the facility without staff.

Interview with a medication aide (MA) on 11/03/20 at 3:45pm revealed Resident #3 wandered into rooms at the facility but would enter the room and then came back out.

Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:
-Resident #3 was able to propel her wheelchair independently.
-Resident #3 was disoriented to date and time.
-Resident #3 required staff re-direction back to her room.
-Resident #3 wandered and had been observed in the facility's hallway.
-There were times Resident #3 would enter into other residents' rooms and had to be redirected

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by staff.

Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:
-Resident #3 was able to propel her wheelchair independently.
-Resident #3 was only oriented to person.
-Resident #3 required staff re-direction back to her room.
-Resident #3 wandered and had been observed in the facility's hallways, dining room, and other residents' rooms.
-In other residents' rooms Resident #3 would pick up items within in their rooms.
-She had observed Resident #3 with other resident's drinks.
-She knew Resident #3 had been in other residents' rooms because the other residents would tell her.

Based on observations, interviews and record reviews, Resident #3 was not interviewable.

4. Review of Resident #4's current FL-2 dated 10/20/20 revealed:
-Diagnoses included dementia with behaviors, hypertension, bipolar hypomania, and diabetes mellitus.
-The resident's orientation status indicated she was intermittently disoriented.
-She was ambulatory.
-The assistive device was blank.

Observations of Resident #4 on 11/03/20 intermittently from 10:02am - 4:45pm revealed the resident was walking up and down both hallways of the AL section of the facility without staff.

Interview with a medication aide (MA) on 11/03/20

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| D 079 | Continued From page 12<br><br>at 3:45pm revealed Resident #4 wandered in the hallways of the facility, but she had not observed the resident entering resident rooms.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:<br>-Resident #4 had to be told the date, time, and place.<br>-Resident #4 knew she was not at her house.<br>-Resident #4 required re-direction back to her room.<br>-Resident #4 had been observed in the facility's hallways and front area of the facility.<br>-She had not observed Resident #4 in another resident's room.<br>-Resident #4 was a new admission to the assisted living side of the facility from the memory care unit and she was still getting the "hang" of her new location.<br><br>Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:<br>-Resident #4 was only oriented to person.<br>-Resident #4 did wander and had been observed in the facility's hallways.<br><br>Based on observations, interviews and record reviews, Resident #4 was not interviewable.<br><br>5. Review of Resident #5's current FL-2 dated 03/27/20 revealed:<br>-Diagnoses included traumatic brain injury, dementia, depression, and hypertension.<br>-The resident's orientation status indicated he was constantly disoriented.<br>-He was ambulatory.<br>-His assistive device was indicated as a walker.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed: | D 079 | | |

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| D 079 | Continued From page 13<br>-Resident #5 ambulated with his walker but basically stayed in his room.<br>-Resident #5 was disoriented to date and time, he needed reminders.<br><br>Based on observations, interviews and record reviews, Resident #5 was not interviewable. | D 079 | | |
| D 601 | 10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program<br><br>10A NCAC 13F .1801 Infection Prevention and Control Program<br>(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.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, interviews and observations, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (DHHS) were implemented and maintained when | D 601 | | |

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| D 601 | Continued From page 14<br><br>caring for residents during the global Coronavirus (COVID-19) pandemic as related to screening of staff, practicing social distancing; and maintaining environmental cleanliness and precautions to reduce the risk of transmission and infection.<br><br>The findings are:<br><br>Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed:<br>-Personnel should be screened for the presence of fever and symptoms of COVID-19 before starting each shift.<br>-Implement social distancing among residents.<br><br>Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of coronavirus in LTC facilities revealed:<br>-Residents and staff should be screened daily for signs and symptoms of COVID-19.<br>-Social distancing should be implemented among the residents.<br><br>Review of the facility's infection control policies and procedures revealed:<br>-All staff must answer questionnaire and have temperatures taken upon arrival before beginning shift.<br>-The questionnaire was completed via an iPad.<br>-All staff and essential personnel must have a mask on when entering the facility.<br>-Exposed areas should be wiped down with the appropriate antibacterial/antivirucide cleanser on at least a weekly basis.<br><br>1. Review of the facility's staff schedule and COVID-19 Screening Log for 10/21/20 to | D 601 | Beginning 11/03, until infection control guidelines change, all residents, including those with cognitive impairments, will be encouraged to wear masks. All staff are responsible for encouraging mask wearing during their assigned shift. The SIC is responsible for monitoring compliance with mask wearing, during their assigned shift. The Executive Director and Care Managers or Designee will make rounds daily to ensue compliance.<br><br>Beginning 11/03, and until infection control guidelines change, all residents, including those with cognitive impairments will be encouraged to social distance. All staff are responsible for encouraging social distancing during their assigned shift. The SIC is responsible for monitoring compliance with social distancing during their assigned shift. The Executive Director and Care Managers or Designee will make rounds daily to ensure compliance.<br><br>Beginning 11/03, the Executive Director and Divisional Director of Clinical Services started providing in-services on infection control measures with staff that were currently on duty. Topics included proper donning of PPE, encouraging residents to wear masks and disinfecting high touch areas including but not limited to handrails.<br><br>In-services were held on 11/06 regarding updated infection control measures. These in-services were provided in conjunction with the Care Managers, Executive Director and Divisional Director of Clinical Services. Topics included COVID-19 related process.<br><br>Beginning 11/03, the facility rearranged furniture in common areas including but not limited to dining areas to assist in social distancing. Furnishings will continue to be arranged in a manner that promotes social distancing until infection control guidelines change. | 11/03/20<br><br>11/03/20<br><br>11/03/20<br><br>11/06/20<br><br>11/04/20 |

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| D 601 | Continued From page 15<br><br>10/31/20 revealed:<br>-There were columns for the submitted date/time, screened name, screener name, screen type, symptoms, temperature, COVID-19 facility flag, COVID-19 contact flag, COVID-19 pending flag.<br>-On 10/21/20, there were 15 out of 25 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/22/20, there were 16 out of 24 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/23/20, there were 8 out of 27 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/24/20, there were 12 out of 23 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/25/20, there were 12 out of 22 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/26/20, there were 15 out of 26 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/27/20, there were 12 out of 28 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/28/20, there were 13 out of 30 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/29/20, there were 12 out of 27 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/30/20, there were 20 out of 29 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 10/31/20, there were 16 out of 23 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-Staff included management, medication aides, personal care aides, dietary, housekeeping, | D 601 | The Executive Director contacted all staff on all shifts on 11/03 to remind them about the policy of performing the screening tool before beginning work each day.<br><br>In-services were completed on 11/06 regarding compleing the screening tool before beginning work.<br><br>The Executive Director will review the screening report daily to ensure that all employees are being properly screened before they begin work each day. | 11/03/20<br><br>11/06/20<br><br>11/06/20 |

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| D 601 | Continued From page 16<br>laundry, and maintenance.<br>-Multiple staff did not sign in consistently each shift they worked at the facility.<br><br>Review of the facility's staff schedule and COVID-19 Screening Log for 11/01/20 to 11/03/20 revealed:<br>-There were columns for the submitted date/time, screened name, screener name, screen type, symptoms, temperature, COVID-19 facility flag, COVID-19 contact flag, COVID-19 pending flag.<br>-On 11/01/20, there were 9 out of 18 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 11/02/20, there were 12 out of 25 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-On 11/03/20, there were 17 out of 29 total staff members who did not sign the COVID-19 Screening Log at the beginning of shift.<br>-This was all staff which included management, medication aides, personal care aides, dietary, housekeeping, laundry, and maintenance.<br>-Multiple staff did not sign in consistently each shift they worked at the facility.<br><br>Interview with a medication aide (MA) on 11/03/20 at 3:45pm revealed:<br>-Staff were responsible to ensure they were screened in prior to entering the facility which included having their temperature taken and answering questions.<br>-She was not aware of any staff not screening when arriving to the facility.<br><br>Interview with the Memory Care Manager on 11/03/20 at 3:54pm revealed:<br>-Currently, she was the care manager for both sides of the facility, assisted living and memory care unit. | D 601 | | |

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| D 601 | Continued From page 17<br>-She expected the oncoming medication aide on assisted living to arrive at the facility prior to their shift starting to screen all oncoming staff.<br>-She expected all staff to sign in and screen every time they arrived or returned to the facility.<br><br>Interview with a personal care aide (PCA) on 11/03/20 at 4:05pm revealed:<br>-She worked 2nd shift.<br>-The MAs were responsible to screen in staff when reporting to work at the facility.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:<br>-When staff or visitors entered the facility, they were required to sign in, have their temperature checked, and answer COVID-19 questions through the electronic system.<br>-If the electronic system for staff or visitor sign was not working, they were use the paper sign-in.<br>-Staff and visitors "must" sign in upon entering the facility.<br>-It was important for staff and visitors to sign in upon entering the facility to confirm if a high temperature was present because it could be a sign of COVID-19.<br><br>Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:<br>-It was the staff's responsibility to check their temperatures every time upon entering and returning to the facility.<br>-The Medication Aide on the assisted living side of the facility or the business office manager were responsible to check staff and visitor's temperatures.<br>-There was usually someone there to screen staff and visitors.<br>-The COVID-19 screening was always done electronically. | D 601 | | |

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| D 601 | Continued From page 18<br>-There was not a time when the electronic system was not working.<br><br>Telephone interview with Divisional Director of Clinical Services, on 11/04/20 at 2:38pm revealed:<br>-Her expectation was everybody, all staff including dietary, housekeeping, and management, were expected to sign in and screen every time they arrived or returned to the facility.<br>-If the electronic screening system was not operating, the screening paperwork would be implemented.<br>-The corporate office kept track of the facility's daily COVID-19 screening logs.<br>-There were quarterly reports sent from corporate which outlined the number of staff/visitors screening in at the facility.<br>-She had not reviewed the facility's daily COVID-19 screening logs.<br>-She did remember receiving an email from corporate related to the facility's screening logs, and there were no issues/concerns identified related to the number of staff/visitors screening in at the facility, no additional details provided.<br><br>Telephone interview with the Maintenance Director on 11/04/20 at 2:58pm revealed:<br>-For the screening process, there was supposed to be a nurse at front screening staff/visitors entering the facility.<br>-Staff/visitors should sanitize their hands, check their temperature, and answer the COVID-19 screening questions.<br>-The last time the electronic COVID-19 screening system was not operating was sometime last week.<br>-He had not reviewed any of the COVID-19 employee screening logs to verify if the | D 601 | | |

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| D 601 | Continued From page 19 | D 601 | | |

housekeeping or maintenance staff had signed in prior to their starting their shift.
-He was not at the facility on 10/26/20 and 10/27/20.
-The week of 10/19/20, he worked some days but not the entire week.
-He had not completed the electronic COVID-19 employee screening log everyday like he should upon his arrival to work because he was just "trying" to do the job.
-Across the board "everyone" should be completing the COVID-19 screening upon entering the facility to make sure we are staying free of COVID-19 in the facility.

Refer to the interview with the Communicable Disease Registered Nurse at the local health department on 11/04/20 at 3:54pm.

Refer to the interview with the Administrator on 11/04/20 at 4:19pm.

2. Review of a dining room seating chart posted in the Assisted Living (AL) hallway of the facility near the left side of the dining room entrance revealed:
-There were two seating charts for breakfast, lunch and dinner.
-Fourteen named residents were served breakfast at 8:00am for the first seating and twenty named residents were served breakfast at 8:30am for the second seating.
-Fourteen named residents were served lunch at 12:00pm for the first seating and twenty named residents were served lunch at 12:30pm for the second seating.
-Fourteen named residents were served dinner at 5:00pm for the first seating and twenty named residents were served dinner at 5:30pm for the second seating.

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Observations in the facility's Assisted Living (AL) dining room on 11/03/20 at 10:05am revealed:
-There were 13 tables and 24 chairs.
-The dining room tables were positioned in aligned rows.
-There were two aligned rows with 4 tables and two aligned rows with 3 tables.

Observation in the AL dining room during the resident's lunch meal on 11/03/20 revealed:
-At 12:35pm, there were 26 residents in the dining room.
-There were two residents seated at each table.
-There were 8 residents seated back to back in the aligned rows of the 4 tables that were approximately 2 feet (ft) from one another.
-There were two residents seated approximately 2 ft from one another and after completing their meal and had repositioned their chair causing the residents to become side by side approximately 2ft apart instead of being back to back from each other.

Interview with a resident on 11/03/20 at 9:35am revealed:
-At the beginning of the pandemic of COVID-19, residents were served meals in their room.
-The residents were currently served meals in the dining room.
-Only two residents could be seated at one dining room table during the residents' meals.

Interview with a personal care aide (PCA) on 11/03/20 at 1:01pm revealed the seating and the number of residents served in the dining room today (11/03/20) was the normal daily process for serving the residents in the dining room. Interview with a resident on 11/13/20 at 3:31pm revealed:
-Staff directed residents to social distance but

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| D 601 | Continued From page 21<br>residents did not adhere to the direction.<br><br>Telephone interview with a personal care aide (PCA) on 11/04/20 at 1:25pm revealed:<br>-She had a COVID-19 Inservice back in August 2020.<br>-The topics reviewed included wearing gowns and gloves, maintaining 6 feet, and the importance of handwashing.<br>-The residents were not able to maintain a distance of 6 feet apart in the dining room during lunchtime yesterday, 11/03/20.<br>-The residents were not 6 feet apart in the dining room yesterday, 11/03/20 and that was the normal flow of lunch.<br>-Today on 11/04/20, there was 1 resident per table.<br>-There were different meal times when the residents came to the dining room.<br>-The three different meal times were 11:45am, 12:15pm, and 12:30pm.<br>-Residents had been served in the dining room for the last 2 months by having 2 meal settings and prior to that the residents were served their meals in their room because of the pandemic of COVID-19.<br>-She had noticed residents could not be spaced at least 6 ft apart in the dining room during past meal services.<br>-She did not ask her supervisor for feedback related to the resident being less than 6 feet apart in the dining room.<br>-Management did not monitor meal times however the management team did complete walk thru the hallways of the facility.<br><br>Telephone interview with a second PCA on 11/04/20 at 2:06pm revealed:<br>-She had a COVID-19 Inservice back in March 2020. | D 601 | | |

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| D 601 | Continued From page 22<br>-She was aware of the importance of maintaining 6 feet distance between residents and seating two residents at a table during meal times.<br><br>Telephone interview with Divisional Director of Clinical Services, on 11/04/20 at 2:38pm revealed:<br>-The residents and staff have been observed to group together and she expected them to maintain 6 feet of social distancing when out of their rooms.<br>-She had identified issues/concerns related to residents and staff "sometimes. "<br>-She had observed some staff and residents not socially distanced in the facility's hallway, no additional details provided.<br>-She had been in the dining room previously during a meal time, no additional details provided.<br>-She did not feel there was an issue with the residents being socially distanced during meal times until the survey team mentioned the situation to her yesterday, 11/03/20.<br>-The 4 tables in the facility's dining room were not 6 feet apart.<br><br>Refer to the interview with the Communicable Disease Registered Nurse at the local health department on 11/04/20 at 3:54pm.<br><br>Refer to the interview with the Administrator on 11/04/20 at 4:19pm.<br><br>3. Interview with a housekeeper on 11/03/20 at 11:48am revealed:<br>-The facility used an Environmental Protection Agency (EPA) approved disinfectant spray to wipe down high touch areas since the pandemic of COVID-19 began in March 2020.<br>-He cleaned all areas of the handrails on the AL side of the facility on Mondays, Wednesdays, and | D 601 | | |

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| D 601 | Continued From page 23<br>Fridays.<br><br>Observation of the handrails on the left hallway on the AL section of the facility intermittently between 12:00pm - 12:15pm revealed:<br>-There was a wooden type handrail on both sides of the hallway with an enclosed area between the wall and the handrails.<br>-There was loose debris, rolled thin grey colored stripping, greyish dust scattered in areas behind the handrails on the left hallway of the AL side of the facility.<br>-There was a heavy concentration of a scattered brown substance in the enclosed area behind the handrail on the left hallway of the facility near the men's shower room.<br><br>Confidential staff interview revealed:<br>-The staff had not observed any staff cleaning high touch areas including the handrails.<br>-The staff had not been trained or instructed to clean any high touch areas within the facility to help prevent the spread of COVID-19.<br><br>Interview with a resident on 11/03/20 at 3:40pm revealed:<br>-The resident saw housekeeping staff clean the handrails in the hallway today.<br><br>Interview with the laundry staff on 11/03/20 at 12:03pm revealed:<br>-She worked in laundry and some in housekeeping.<br>-She was instructed by the Maintenance Director and the Administrator that high touch areas such as the handrails in the facility's hallways were disinfected every day or more often than daily as needed.<br><br>Interview with the Maintenance Director on | D 601 | | |

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|---|---|---|---|
| | HAL092203 | A. BUILDING: _____ B. WING _____ | 11/04/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHATHAM COMMONS | 809 WEST CHATHAM STREET CARY, NC 27512 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 601 | Continued From page 24<br><br>11/03/20 at 1:05pm revealed:<br>-He was responsible for housekeeping staff and overseen the cleaning needs of the facility.<br>-He had a cleaning schedule with tasks to be done daily as soon as staff arrived to work which included "five major points" to ensure they disinfect daily in the living room, nurses' station, employee break room, dining room and entrance area of the AL side.<br>-He expected and had instructed staff to clean the handrails and door knobs of the facility at least daily periodically throughout the day because these areas were touched multiple times per day.<br>-He had reiterated to staff the need to ensure the handrails were cleaned often because he had noticed some staff had were not been cleaning the handrails as often as they should have been approximately 2 months ago.<br><br>Interview with a resident on 11/03/20 at 3:31pm revealed:<br>-The resident observed hand rails were cleaned about every 3 or 4 weeks.<br>-She had noticed the debris, which had been there a long time, inside the handrails.<br><br>Telephone interview with the Maintenance Director on 11/04/20 at 2:58pm revealed:<br>-His expectation for cleaning for the staff was to disinfect as much as possible.<br>-The staff should be cleaning and sanitizing the facility throughout the day.<br>-The handrails should be cleaned daily at least three times per day and as much as needed.<br>-The handrails should be cleaned by the housekeeping staff when they arrived at work, after lunch, and before the housekeeping staff left for the day.<br>-The cleaning of the facility's handrails had to be done more "frequently." | D 601 | | |

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|---|---|---|---|---|
| D 601 | Continued From page 25<br>-It was hard to say when the last time the handrails were disinfected.<br>-The handrails should have been disinfected daily.<br><br>Refer to the interview with the Communicable Disease Registered Nurse at the local health department on 11/04/20 at 3:54pm.<br><br>Refer to the interview with the Administrator on 11/04/20 at 4:19pm.<br><br>Telephone interview with the Communicable Disease Registered Nurse at the local health department on 11/04/20 at 3:54pm revealed:<br>-Emails along with phone communications had been sent to all long-term care facilities in the county which included the latest Centers for Disease Control guidance relevant to healthcare workers.<br>-The information distributed to all long-term care facilities in the county included the following topics listed below:<br>Cleaning the facility, no additional details provided related to the specific recommendation.<br>The importance of residents and staff to be social distanced or at least 6 feet apart at the facility.<br>How to properly wear PPE<br>Handwashing<br>Anyone including staff upon entering the facility should be checking their temperatures and completing COVID-19 related questions.<br>An RN from the LHD would complete an onsite assessment if a facility had two or more positive residents with COVID-19.<br>A long-term care facility would be on the LHD's watch lists if a facility had less two positive COVID-19 cases related to a resident or staff | D 601 | | |

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|---|---|---|---|---|
| D 601 | Continued From page 26<br>member.<br>If a facility had two or more positive residents with COVID-19 the LHD would enter the facility onsite to complete an RN assessment.<br><br>Telephone interview with the Administrator on 11/04/20 at 4:19pm revealed:<br>-She expected all staff including dietary, housekeeping, maintenance staff, and management, to sign in and screen every time they arrived or returned to the facility.<br>-She had received email notifications from corporate, one in October 2020 and one prior with no additional details provided, related to low numbers on the COVID-19 screening logs.<br>-She should have been looking at the COVID-19 screening logs daily; "we have a responsibility to ensure the facility stays free of COVID-19".<br>-She did not know why staff was not completing the COVID-19 screening log upon entering the building because they have received in services training.<br>-She expected staff and residents to social distance at the facility.<br>-She monitored the staff and residents were social distancing during her walk through the facility. If there were issues, she would discuss immediately with the staff/resident.<br>-She monitored one meal per day at the facility, it was either lunch or dinner.<br>-She had not noticed the residents who were back to back in the dining room were not socially distance until yesterday, 11/03/20. | D 601 | | |