Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: _____ B. WING _____	C 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	606 EAST MORRIS AVENUE BENSON, NC 27504

(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
C 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey on December 1, 2020 to December 2, 2020.	C 000	RECEIVED JAN 20 2021 ADULT CARE LICENSURE SECTION RALEIGH	
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 5 sampled residents (#1, #3) who had cognitive impairments and/or physical impairments and required verbal prompting to exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/20 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 5 residents resided in the facility on 12/01/20.	C 022	10A NCAC 13G.0302 (b) Design and Construction The Agency has updated its policy and procedure to ensure that all residents evacuation capabilities are in accordance with the evacuation capability listed on the facility's current license. Hereafter, the Administrator will review the result of all fire drills to ensure that residents have evacuation capabilities. If any resident's health condition has deteriorated, the facility in consultation with the residents Primary Care Physician (PCP) and family will transition the individual a more appropriate facility.	01/1/2021 01/01/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elly Bowen TITLE: Administrator (X6) DATE: 1/19/21

STATE FORM 6899 5KZ711 If continuation sheet 1 of 38

* The Plan of Correction with addendums was reviewed and accepted on 01/22/21 and 01/25/21. Refer to pages 2, 11, 20 and 29 of this Statement of Deficiencies — [illegible] 01/25/21

1/19/21

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C 022	Continued From page 1 Interview the live-in medication aide (MA) on 12/01/20 at 8:55am revealed she was the only staff currently on duty. Observations of the facility on 12/01/20 intermittently from 2:00pm-3:00pm revealed: -There was no sprinkler system in the facility. -The facility was ground level with no steps at the exit doors. 1. Review of Resident #1's current FL-2 dated 12/12/19 revealed: -Diagnoses included dementia, hypertension and schizophrenia. -The resident was intermittently disoriented -The resident was ambulatory. Review of Resident #1's Assessment and Care Plan dated 08/15/20 revealed: -The resident was oriented, and her memory was adequate. -The resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring. Review of Resident #1's primary care provider's (PCP's) note dated 11/17/20 revealed the resident's dementia was at baseline with no acute changes and was alert and oriented "x1". Review of Resident #1's PCP's note dated 10/28/20 revealed the resident's dementia was at baseline with no acute changes and was alert and oriented "x1". Review of Resident #1's PCP's note dated 09/23/20 revealed the resident's dementia was at baseline with no acute changes and was alert and oriented "x1".	C 022	Resident 3 was revaluated by her Primary Care Physician and was found to be competent enough to continue to reside in the facility and to have the physical and mental capability to evacuate without prompting. Henceforth, all fired drills will have documentation of the total time for all residents to evacuate. C022 Addendum Per telephone Conversation with Ms. Elsie Ogbonna, Administrater and Mr. Patrick Ogbonna, Executive Officer on 01/22/21: The Administrater reviews the Fire drills quartily. Additional Staff Remain in the facility for Resident #1 until the resident is discharged. 01/22/21	01/01/2021 01/01/2021

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C 022	Continued From page 2 Review of Resident #1's mental health provider visit note dated 09/30/20 revealed: -The resident was seen for a follow up psychiatric medication management. -The resident's diagnoses included dementia and schizophrenia. -During the resident's interview the resident was watching television and talking to herself. -The resident was unable to reliably identify subjective symptoms because of cognitive impairment. -The resident's orientation was to person. -The resident's insight, judgement, abstract reasoning and concentration were impaired. -The resident's general intellectual functioning was limited, and her memory was severely impaired. -In the plan section of the visit note, there was an entry to monitor for falls and other "safety risks". Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed: -Resident #1 had some dementia and required total care from staff. -Resident #1 needed staff assistance to exit the facility during fire drills to ensure she heard the fire alarm when activated and ensure she was exiting toward the correct exit door during the fire drills and following the other residents. -Resident #1 needed verbal prompting from staff to exit during a fire drill and did not require hands on assistance from staff. Observations of a fire drill conducted by the RCC on 12/01/20 between 4:32pm and 4:36pm revealed: -The RCC was standing in the hallway of the facility at the facility's side exit door and initiated a fire drill by activating the audible fire alarm. -Resident #2 was seated in the common living	C 022		

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C 022	Continued From page 3	C 022		

room with three other residents.
-The three residents immediately proceeded to exit the living room and entered the hallway while continuing to verbally prompt Resident #1 to follow them.
-Resident #1 stood from a seated position and followed the other three residents out of the facility through the side exit door.
-At 4:34pm, Resident #1 exited the facility behind the other three residents.
-All 4 residents stopped in the parking lot on the facility grounds.
-The fire drill ended at 4:36pm when all five residents were evacuated in the parking lot.

Telephone interview with Resident #1's mental health provider on 12/02/20 at 2:01pm revealed:
-She had taken over Resident #1's mental health care for another provider not long ago.
-Resident #1 was oriented to person only.
-On visits she had made with Resident #1, it was difficult to get information from the resident because the resident mumbled and did not speak clearly.
-Due to Resident #1's intellectual disabilities, the resident would need prompting from the facility staff to exit the facility in the event of an emergency.
-It was hard to determine the level of staff assistance Resident #1 would need meaning, if the resident would require both physical and verbal prompting in an emergency because she had never been able to get the resident to follow any commands when she visited her.
-She thought Resident #1 would " ...need someone probably touching her and saying come on let's go" if there was an emergency to exit the facility such as a fire.

Telephone interview with Resident #1's PCP on

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C 022	Continued From page 4 12/02/20 at 3:16pm revealed: -Resident #1 was oriented to person only and was not oriented to place, date or time. -Resident #1 would be capable of exiting the facility in an emergency when both physical and verbal staff assistance was provided due to the resident's intellectual disabilities. -He had safety concerns for the residents if there was only one staff working at the facility and an emergency occurred because Resident #1 would require hands on and verbal direction in order to exit the facility. Confidential interview with two residents revealed for the past year or more, Resident #1 required physical and verbal prompting from staff during all fire drills because of the resident's dementia. Interview with the Administrator on 12/02/20 at 5:30pm revealed: -She was aware that the facility's ambulatory license required all residents to be able to respond and evacuate without physical assistance or verbal prompting. -There were different levels of dementia, however, Resident #1's dementia had progressed since her admission to the facility. -She was seeking other placement for Resident #1 due to her dementia however, due to the pandemic of COVID-19 placement had been difficult. Based on observations, record reviews and interviews, Resident #1 was not interviewable. Attempted telephone interview with Resident #1's guardian was unsuccessful on 12/02/20 at 8:20am Refer to the review of facility's "Fire Drill Quarterly	C 022		

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C 022	Continued From page 5 Record". 2. Review of Resident #3's current FL-2 dated 11/06/20 revealed: -There was an entry in the admitting diagnoses section to "See DC Summary H&P". -In the admission diagnoses/discharge section of the hospital discharge summary, diagnoses included altered mental status, fall, and subarachnoid hemorrhage with loss of consciousness, closed fracture of the left orbital floor and nasal bone fracture. -In the past medical history, the resident's diagnoses included, seizures, acute kidney failure, anxiety, congestive heart failure, multiple gastric ulcers, post traumatic stress disorder, stroke and supraventricular tachycardia. -The resident was intermittently disoriented. Review of Resident #3's Assessment and Care Plan dated 12/02/20 revealed: -The resident was oriented, and her memory was adequate. -The resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming. -The resident had limited ability to ambulate. Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed: -Resident #3 had lived at the facility since October 2020. -Resident #3 needed "a lot" of hands on assistance from staff to dress herself and required staff reminders to complete oral care and perform toileting needs. -Resident #3 could not walk without falling when she was first admitted to the facility, however the resident had "got a whole lot better" with falls. -Resident #3 was sometimes able to follow	C 022		

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C 022	Continued From page 6	C 022		

directions when given and sometimes she was not because of her mental health diagnosis.
-Resident #3 was not able to make safe self-decisions due to her mental health diagnosis.
-Resident #3 required staff supervision to ensure she had her walker within reach and in place because the resident would forget her walker, proceeding to walk without the walker and become shaky and then she was at risk for falling.
-She had not observed how Resident #3 responded in fire drills because no fire drills had been performed since the resident was admitted to the facility.

Observations of Resident #3 intermittently on 12/01/20 from 9:00am - 5:00pm revealed Resident #3 was ambulating in the hallway with the use of a rollator.

Observations of a fire drill conducted by the RCC on 12/01/20 between 4:32pm and 4:36pm revealed:
-The RCC was standing in the hallway of the facility at the facility's side exit door and initiated a fire drill by activating the audible fire alarm.
-Resident #3 was in her room with the door closed.
-Resident #3 remained in her room.
-One resident yelled, "Fire! Come on" from the hallway.
-She did not exit her room until the Administrator went into her room asking if she had heard the fire alarm.
-After being verbally prompted by the Administrator, Resident #3 exited the facility.
-The fire drill ended at 4:36pm when all five residents were evacuated in the parking lot.

Interview with Resident #3 on 12/02/20 at 9:49am

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C 022	Continued From page 7 revealed: -She heard the alarm but did not know it was a fire drill. -She thought maintenance had been working on the front entrance door. -The fire drill was Resident #3's first time hearing the fire alarm. -She recognized the sound of the fire drill. -She had not participated in a fire drill before because she had been in the hospital when the last fire drill occurred. Interview with the Administrator on 12/02/20 at 5:30pm revealed: -She was aware that the facility's ambulatory license required all residents to be able to respond and evacuate without physical assistance or verbal prompting. -Resident #3 did not respond to the fire drill because the facility's exit doors needed repair and were alarming frequently yesterday (12/01/20). -She would have Resident #3 re-evaluated to determine if she was able to independently evacuate in an emergency and without requiring staff assistance. Telephone interview with Resident #3's primary care provider (PCP) on 12/02/20 at 3:16pm revealed: -Resident #3 was alert and oriented to person, place and time. -Resident #3 would need physical assistance in an emergency to exit the facility due to unsteadiness when walking and using a walker. Refer to the review of facility's "Fire Drill Quarterly Record". _____ Review of facility's "Fire Drill Quarterly Record"	C 022		

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C 022	Continued From page 8 revealed: -There was documentation of a fire drill on 01/10/20 at 9:30am on 1st shift, with 3 residents and one staff participating in the drill. All residents were evacuated safely from the front door. -There was documentation of a fire drill on 01/15/20 at 4:00pm on 2nd shift, with 3 residents and one staff participating in the drill. There were no issues with evacuation, all evacuated safely. -There was documentation of a fire drill on 01/18/20 at 6:00am, with 3 residents and one staff participating in the drill. There was an entry "safely done". -There was documentation of a fire drill on 04/10/20 at 5:00pm on 2nd shift, with 3 residents and one staff participating in the drill. There was an entry "all safely evacuated". -There was documentation of a fire drill on 04/10/20 at 10:00am on 1st shift, with 3 residents and one staff participating in the drill. There was an entry that everyone evacuated safely. -There was documentation of a fire drill on 04/10/20 at 6:00am on 2nd shift, with 3 residents and one staff participating in the drill. -There was documentation of a fire drill on 07/15/20, on 1st shift (no time was documented), with 3 residents and one staff participating in the drill. There was an entry "all evacuation done safely". -There was documentation of a fire drill on 07/15/20 at 4:00pm, on 2nd shift, with 3 residents and one staff participating in the drill. There was an entry "no issues with evacuation". -There was documentation of a fire drill on 10/05/20 at 4:00pm, on 2nd shift, with 5 residents and one staff participating in the drill. There was an entry "all evacuated without any problems". -There was documentation of a fire drill on 10/06/20 at 5:30am, on 3rd shift, with 5 residents and one staff participating in the drill.	C 022		

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C 022	Continued From page 9 -There was no total time documented for all residents to evacuate the facility on any of the fire drills reviewed. _____ The facility failed to ensure the building was equipped and maintained to allow 2 of 5 residents living in the facility who had physical and cognitive deficits to evacuate independently in case of an emergency such as a fire. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 12/01/20 with an addendum on 12/02/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 16, 2021	C 022		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff, (Staff A and Staff B), had a nationwide criminal background check completed upon hire. The findings are:	C 147	Reference 10A NCAC 13G.0406 (a) (7) Other Staff Qualification The facility will henceforth in addition to the consent for background check imbedded in the application form, will have a specific consent for background check attached to the application package. All new applicants who have not resided in the state of North Carolina more thank 5 years will have both State and Federal criminal background check conducted.	01/01/2021

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C 147	Continued From page 10 1. Review of Staff A, medication aide (MA), personnel record revealed: -Staff A was hired on 08/15/20. -There was no documentation of a signed consent for a criminal background check for Staff A. -There was documentation of a state-wide criminal background check completed for Staff A on 06/23/20. -There was not documentation of a national criminal background report. Review of Staff A's passport revealed she had been a US resident since 02/01/2020. Interview with Staff A on 12/02/20 at 3:47pm revealed: -She had been employed since July 2020. -She had completed a criminal background check. -She did not know which type of criminal background check was completed. -She had been residing in North Carolina since June 2020. Refer to interview with Administrator on 12/02/20pm at 4:20pm. 2. Review of Staff B, medication aide (MA), personnel record revealed: -Staff B was hired on 11/24/19. -There was documentation of a state-wide criminal background check completed for Staff B on 10/11/19. -There was not documentation of a national criminal background report. Review of Staff B's passport revealed she had been a US resident since 03/31/2016.	C 147	Any applicant who has resided in the State of North Carolina for more than 5 years will continue to have State criminal background check conducted on that applicant. Meanwhile, national background checks have been done for Staff A and Staff B. An updated result placed in their respective employee charts. C147 Addendum per telephone Conversation with MS. Elsie Ogbonna, Administrator and MR. Patrick Ogbonna, Executive officer On 01/22/21: All ~~staff~~ not resided in N.C. more than 5 years will have a national Background Check (criminal) upon hire. The Administrator is responsible for staffs Completion on hire for criminal background Checks. 01/22/21	01/012021 01/01/2021

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C 147	Continued From page 11 Telephone interview with Staff B on 12/02/20 at 3:58pm revealed: -She started living in the "states' approximately one year ago. -She completed and signed a consent for a criminal background check to be done when she first began her employment with the facility. -She knew a criminal background checkwas completed but she was not sure what kindof check was done. Refer to interview with Administrator on 12/02/20pm at 4:20pm. Interview with the Administrator on 12/02/20 at 4:20pm revealed: -She was responsible for completing criminal background checks for all employees. -She was responsible for maintaining personnel records. -She thought any form of a criminal background check could be used for staff.	C 147		
C 191	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the	C 191	10A NCAC 13G.0601 (d) Management and other Staff Resident #3 PCP has re-evaluated her condition and stated that she is capable to be evacuated during emergencies without prompting. The staff have been trained to do rounds every 3 hours on the residents. Staff have further been re-trained that under no circumstance would they leave the building with a relieve staff.	01/01/2021

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supervision needs for 2 of 5 sampled residents (#1, #3) and failed to ensure staff were accessible to the residents by leaving the facility unattended.

The findings are:

Review of the facility's current license effective 01/01/20 revealed the facility was licensed for 6 ambulatory residents.

Review of the daily census revealed 5 residents resided in the facility on 12/01/20.

Review of the facility's "Resident Contract" revealed services provided to the residents included twenty-four-hour supervision by capable, caring and trained staff.

Confidential interview with a resident revealed staff did not make rounds to check on the residents at night after 11:00pm, she had never seen any staff checking on her.

Interview with a live-in medication aide (MA) on 12/01/20 at 9:08am revealed:
-She was the only staff currently on duty.
-She worked a 24-hour 7 day on and 7 day off schedule.
-She rotated the 24 hour work schedule with another MA on her days off.

Second interview with a live-in medication aide (MA) on 12/02/20 at 12:43pm revealed:
-She slept at night from 11:00pm -11:30pm to 5:30am in the live-in quarters of the facility.
-She was the only staff present in the facility during the night.
-There was a room connected to the staff office that was designated for staff to sleep overnight .
-There was one resident diagnosed with

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C 191	Continued From page 13 dementia who resided in the facility. -All the residents living at the facility could activate the call light system if staff assistance was needed during her sleeping hours. -She checked on residents two times each night during her sleeping hours when she worked. -When a residents' call light system was activated, the illuminated light and audible alarm was deactivated by pulling the string connected to the call light system in the residents' rooms. Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed: -The MAs that worked at the facility were live-ins. -There was always one live-in MA on duty. -The live-in MAs rotated and worked one week on duty and off duty the following week schedule. -The live in MAs worked one week starting on Mondays at 8:00am through the following Monday at 8:00am. -The live-in MAs could sleep during the night but were responsible to complete rounds on every resident every 2-3 hours during the night to ensure where the residents were and if any staff assistance was needed. -Staff could also monitor the residents' movements in the hallways at night by making observations of the camera located in the live-in quarters. -The facility had an audible call system that was activated when a resident pulled a "light string" that was located at each residents' bedside. -The call system's main unit hub was in the office at the door leading into the live-ins' sleeping quarters. -When the call system was activated by a resident, an audible alarm was activated and an indicator light illuminated. -There were no residents living at the facility that wandered.	C 191		

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C 191	Continued From page 14 -There was only one resident living at the facility with a diagnosis of dementia. Confidential interview with a resident revealed staff did not make rounds to check on the residents at night after 11:00pm, she had never seen any staff checking on her. Interview with the Administrator on 12/02/20 at 5:25pm revealed: -She thought a resident had to be diagnosed with "severe dementia" in order to have an awake overnight staff. -Staff did sleep at night. 1. Review of Resident #1's current FL-2 dated 12/12/19 revealed: -Diagnoses included dementia, hypertension and schizophrenia. -The resident was intermittently disoriented -The resident was ambulatory. Review of Resident #1's Assessment and Care Plan dated 08/15/20 revealed: -The resident was oriented, and her memory was adequate. -The resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring. Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed Resident #1 had some dementia and required total care from staff. Interview with the live-in medication aide (MA) on 12/02/20 12:43pm revealed: -Resident #1 did not wander at night. -Resident #1 needed assistance with toileting occasionally at night.	C 191		

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C 191	Continued From page 15 -Resident #1 was able to activate her call light during the night if she needed assistance from staff. Confidential interview with a resident revealed she thought Resident #1 could not activate her call light at night if she needed assistance because of the resident's confusion. Telephone interview with Resident #1's primary care provider (PCP) on 12/02/20 at 3:16pm revealed: -Resident #1 was oriented to person only and was not oriented to place, date or time. -Resident #1 needed 24 hour supervision from awake staff at all times for assistance, monitoring and safety due to her diagnosis of dementia. Based on observations, interviews and record review, Resident #1 was not interviewable. Refer to the telephone interview with a PCP for the facility on 12/02/20 at 3:16pm. 2. Review of Resident #3's current FL-2 dated 11/06/20 revealed: -There was an entry in the admitting diagnoses section to "See DC Summary H&P". -Diagnoses included altered mental status, fall, and subarachnoid hemorrhage with loss of consciousness, closed fracture of the left orbital floor and nasal bone fracture. -In the past medical history, the resident's diagnoses included seizures and post traumatic stress disorder. -The resident was intermittently disoriented. Review of Resident #3's Assessment and Care Plan dated 12/02/20 revealed: -The resident was oriented and her memory was	C 191		

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adequate.
-The resident required limited assistance eating, toileting, ambulation, bathing, dressing, grooming.
-The resident had limited ability to ambulate.

Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed:
-Resident #3 needed "a lot" of hands on assistance from staff to dress herself and required staff reminders to complete oral care and perform toileting needs.
-Resident #3 could not walk without falling when the resident was first admitted to the facility, however the resident had "got a whole lot better" with falls.
-Resident #3 required staff to remind her of the time of day.
-Resident #3 was sometimes able to follow directions when given and sometimes she was not because of her mental health diagnosis.
-Resident #3 was not able to make safe self-decisions due to her mental health diagnosis.
-Resident #3 required staff supervision to ensure she had her walker within reach and in place because the resident would forget her walker, proceeding to walk without the walker and become shaky and then she was at risk for falling.

Refer to the telephone interview with a primary care provider (PCP) for the facilty on 12/02/20 at 3:16pm.

3. Interview with a resident on 12/01/20 at 11:11am revealed:
-Staff had left the residents alone in the facility daily for at least 30 minutes to an hour at a time.
-The staff locked the staff office door before leaving the building.
-Residents did not have access to use the

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C 191	Continued From page 17 telephone when the office was locked and the staff was not in the building. -When staff left the building unattended that made her feel concerned because no one was there to address emergencies. -Staff would not tell the residents when they were leaving the building. -She noticed staff were not in the building when she would go to the office to ask for assistance or to use the phone. -She did not know where staff had gone. -She did not tell the Resident Care Coordinator (RCC) or the Administrator. Interview with a second resident on 12/01/20 at 11:18am revealed: -Staff had left the building for about 30 minutes the other day (the day was not specified). -No other staff came over to the building to relieve the staff. -Staff had gone pick up the mail and lunch one day last week. -She did not feel safe when staff was not in the building. Interview with a third resident on 12/01/20 at 3:39pm revealed: -Staff was not on site for at least an hour about a month ago and there had been a resident who needed to go to the hospital. -Staff would leave the building unattended at least two or three times a week. -The staff would leave the building unattended and not let the residents know they had left. -"It was not safe to leave us here alone because people have medical issues." Interview with the live-in medication aide (MA) on 12/02/20 12:43pm revealed: -She was not aware of any staff leaving the	C 191	Telephones have been placed to be easily accessible to the residents.	01/01/2021

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C 191	Continued From page 18 facility unattended without staff present with the residents. -She was instructed by the RCC and the Administrator prior to leaving the facility another staff member had to be present. Interview with the RCC on 12/02/20 at 3:49pm revealed: -She was not aware of any incidences of staff leaving the facility unattended at any time. -Staff had been instructed to never leave the residents in the facility and should always wait for another staff to arrive inside the facility prior to exiting the facility. Interview with the Administrator on 12/02/20 at 5:30pm revealed: -She was not aware of any incidences when the residents at the facility were left unattended without staff. -She expected staff to never leave the facility until another staff was present in the building. Refer to the telephone interview with a primary care provider (PCP) for the facility on 12/02/20 at 3:16pm. _____ Telephone interview with a primary care provider (PCP) for the facility on 12/02/20 at 3:16pm revealed: -He was the PCP for 4 of the residents residing at the facility. -He was not aware staff were not awake during the night. -When he gave an order for a resident to be admitted to the facility, he was ordering 24-hour care and not for staff to sleep at night. -The residents at the facility needed 24-hour care. -He had concerns if there was an emergency, the residents would be unable to move and evacuate	C 191		

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C 191	Continued From page 19 adequately, and if there was an emergency situation it could result in a resident's fatal demise without staff. -Leaving the residents unattended in the facility at any time should not have occurred at any time. -The facility was responsible to ensure staff did not leave the residents without the attendance of a staff present at all times. -The facility staff should "never" leave the facility until another staff arrived at the facility. -The facility should have staff always present in the facility 24 hours a day, 7 days a week in order to maintain and ensure the safety of all the residents. Refer to Tag C 0022, 10A NCAC 13G .0302 Design And Construction The facility failed to have awake staff on duty and awake at all times to meet the supervision needs of a resident with a dementia diagnosis (#1), residents' who were unable to evacuate the facility independently in case of an emergency without prompting from staff (#1, #3) and failed to ensure 5 of 5 residents were not left alone in the facility without a staff member present. The facility's failure placed the residents at substantial risk of serious neglect and constitutes a Type A 2 Violation. A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 12/02/20. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 01, 2021.	C 191	Awake staff at night to monitor resident with dementia until discharge to appropriate memory care facility. Discharge in progress.	01/01/2021

C 191 Addendum Per telephone with MS. Elsie Ogbonna, Administrator and mr. Patrick Ogbonna, Executive Offier on 01/22/21: The Administrator monitors awake Staff and Staff Present periodically by physical Observations and phone calls — 01/22/21

C 191 Addendum Per telephone with mr. Patrick Ogbonna, Executive Offier on 1/25/21: Page 12 should reflect Staff retrained by the Administrator under no Circumstances would they leave the Building without a ~~Staff~~ (OA) a staff present in the facility. — 01/25/21

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C 601	Continued From page 20	C 601		
C 601	10A NCAC 13G .1701 (a) (b) Infection Prevention and Control Program 10A NCAC 13G .1701 Infection Prevention and Control Program (a) In accordance with Rule .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 B VIOLATION 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) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to screening of visitors, staff, and residents, and posting of signage notifying visitors of restrictions. The findings are: Review of the Center for Disease Control (CDC)	C 601	10A NCAC 13G.1701 (a) (b) The Facility has re-trained its staff to ensure that recommendations and guidance established by the Center for Disease Control and Prevention (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and Johnston County Health Dept. are being implemented and maintained to provide protection of residents and staff during the global pandemic of COVID-19. The training included ensuring that all staff are screened and documented for temperature at the beginning of work shift and daily for live-in aides; monitored for signs and symptoms of COVID-19. All residents will be actively monitored upon admission and at least daily documented for fever and screened for signs and symptoms of COVID-19. All essential visitors are also required to be screened and documented for signs and symptoms of COVID-19 before they could be allowed to enter the facility.	01/01/2021 01/01/2021 01/01/2021 01/01/2021

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C 601	Continued From page 21 guidelines for the prevention and spread of the coronavirus disease in Long Term Care (LTC) facilities last updated 11/20/20 revealed: -All health care personnel should be screened at the beginning of their shift by actively checking their temperatures for fever and screening for other symptoms of COVID-19; and document the absence of those symptoms. -Actively monitor all residents upon admission and at least daily for fever (Temperature greater than 100.0 Fahrenheit (F) and symptoms consistent with COVID-19. -Screen visitors for fever (Temperature greater than 100.0 F symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed: -Residents and staff should be screened daily for signs and symptoms of COVID-19. -All essential visitors should be screened for signs and symptoms of COVID-19 before entering the building. Review of the facility's undated Prevention and Control Practices revealed: -All employees were to self-monitor for signs of COVID-19 if they suspected possible exposure. -Restrict visitors from the facility unless in rare cases with Administrator approval. Review of the facility's plan for Responding to the COVID-19 Pandemic revealed: -The facility's top priorities were the health and safety of residents, patients and associates. -The facility had restricted visitors except for	C 601	Having reviewed the screening log, the staff will henceforth document all temperature checks and screening for other symptoms of COVID-19 for staff.	01/01/2021

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end-of-life situations or pursuant to the guidance of public health officials.
-In those cases, visitors would continue to need to be screened prior to entry and restricted to their loved one's room or another designated area within the community,
- "We are" conducting health screenings on anyone coming into the community.
-Responsive measures included implementing daily health screenings on all residents.
-Implemented daily health screenings of staff as they reported to work daily.
-Conducting health screenings of anyone coming into the community.

Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed:
-The Administrator provided updates related to COVID-19 and infection control to all staff.
-The Administrator provided updates to staff within the last 2 weeks when she was out of work.
-Resident visitation was currently not permitted at the facility.

Interview with the Administrator on 12/01/20 at 11:40am and 4:10pm revealed:
-Her last COVID-19 training for staff was provided around 11/16/20 when a COVID-19 outbreak was identified at an adjacent sister facility on campus.
-Staff training topics included cleaning/disinfecting, personal protective equipment, monitoring and screening for COVID-19.
-There were two live-in medication aides (MA) and the RCC who had tested positive for COVID-19 around 11/15/20.
-Staff were expected to notify her or the RCC if staff or residents had a temperature obtained greater than 100.
-All staff and residents at the facility were tested

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for COVID-19 a few weeks ago and all residents tested negative for COVID-19.
-All staff and residents were re-tested for COVID-19 yesterday, (11/30/20).
-The COVID-19 test results for the staff and residents' completed on 11/30/20 had not been received yet.

Review of the facility's staff and resident Screening Log forms revealed:
-There was no designated space to check for COVID-19 screening questions or predefined screening questions on some of the forms.
-Staff and resident temperature screenings were documented on an unlabeled form with instructions to please report respiratory symptoms including fever, cough, with shortness of breath or 2 of these symptoms: Fever (temperature greater than 100 or feeling feverish), sore throat muscle pain, headache, chills, new loss of taste or smell.

Review of the facility's "Visitation Log, One Hour/Social Distancing" form revealed there were columns for the submitted date/time-in, visitor name, screener name, temperature and 3 predefined questions related to fever, respiratory symptoms, travel outside the country and contact with someone with possible COVID-19.

a. Interview with the Resident Care Coordinator (RCC) on 12/01/20 at 9:57am revealed:
-There were no COVID-19 positive staff working at the facility.
-She tested positive for COVID-19 on 11/17/20 and returned to work yesterday, (11/30/20).
-There was another staff that tested positive for COVID-19, but that staff did not provide resident care at the facility and worked at an adjacent sister facility on the same campus of the facility.

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C 601	Continued From page 24 Interview with the Administrator on 12/01/20 at 11:40am revealed: -The live in medication aide (MA) on duty today, (12/01/20) tested positive for COVID-19 on 11/17/20. -The live-in MA on duty today developed mild cough symptoms one week prior to 11/17/20 but did not have an elevated temperature. -The live-in MA on duty at the facility worked the week of 11/17/20. -She had calculated back 10 days of the live-in MA developing symptoms to determine when the live-in MA would return to work which was 11/30/20. -Live-in MAs were required to perform self-screening daily for COVID-19 by checking a questionnaire, obtaining their temperature and were responsible to document the screening and temperatures were completed. Review of the screening logs for staff revealed : -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff from 04/21/20 - 04/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff the month of May 2020. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff from 06/09/20 -06/30/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff the month of July 2020. -There was no documentation of temperature checks or a screening for other symptoms of COVID-19 for staff on 08/01/20 and 08/02/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff on 09/01/20 - 09/27/20.	C 601		

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C 601	Continued From page 25 -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff on 10/26/20 - 10/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for staff on 11/01/20 - 11/16/20 (prior to facility staff testing positive for COVID-19 on or around 11/17/20). Interview with the RCC on 12/01/20 at 9:57am revealed: -All staff were required to have a completed screening before each shift. -All staff were responsible for documenting their daily temperature checks in a "tablet" for daily COVID-19 screenings. -Staff self-screened for symptoms of COVID-19. Review of the RCC's screening logs revealed: -On 11/01/20, the RCC's temperature was documented on the facility's "Visitation Log, One Hour/Social Distancing" form with no entries documented for any of the three predefined questions. -On 11/06/20, the RCC's temperature was documented on the facility's "Visitation Log, One Hour/Social Distancing" form with no entries documented for any of the predefined questions. Interview with the RCC on 12/01/20 at 9:57am and 1:52pm revealed: -She had been out since 11/16/20 due to having COVID-19 and could not find her screening logs. -The RCC's office was not inside the facility. -Her office was in a separate building, adjacent to the facility and on the same grounds of the facility. -She went into the facility daily, each day she worked. -She kept her screening documents in her office.	C 601		

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C 601	Continued From page 26 -There were some days she might not have completed the documentation for her COVID-19 screening at the beginning of her shifts, but she always self-screened and self-monitored for any respiratory symptoms prior to reporting to work. -She would provide her screening documentation when she located them. -She did not complete a COVID-19 screening prior to starting her shift today (12/01/20) because she came straight to the surveyors at the facility. Second interview with the RCC on 12/02/20 at 9:35am revealed: -She was responsible for reviewing the staff and residents' screening logs for COVID-19. -She was not aware there were times the live-in MAs were not completing the daily screenings but she asked staff if they had completed the screenings daily. -She last reviewed COVID-19 screenings in October 2020 and noticed there were days when staff were not documenting the screenings but she did not inform the Administrator of this. -She did not review the screening logs for COVID-19 on a daily basis. -She was continuing to look for her daily screening logs. Third interview with the RCC on 12/02/20 at 5:30pm revealed: -She had located some of her screening documents. -She would provide a copy of the screening documents for review. There was no further documentation provided for the RCC's screening logs at the time of exit on 12/02/20 at 6:00pm.	C 601		

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C 601	Continued From page 27 Refer to the interview with the Administrator on 12/02/20 at 5:25pm. Refer to the telephone interview with the public health nurse at the local health department (LHD) on 12/02/20 at 8:42am. b. Observation of the front entrance of the facility on 12/02/20 at 8:55am revealed: -The facility's front entrance door was not closed and not flush with the door frame leaving the door's latching mechanism exposed to the outside. -A live-in medication aide (MA) opened the entrance door after knocking on the door. -The live-in MA requested for the surveyors to wait outside until she notified the Resident Care Coordinator (RCC) by telephone. Interview with the live-in MA on 12/01/20 at 8:56am revealed: -She had spoken with the RCC, "You can come in". -There were no residents with COVID-19 residing at the facility. Observation in the living room section immediately after entering the facility on 12/01/20 at 9:03am - 9:06am revealed: -The live-in MA was prompted if she had any COVID-19 pre-screening procedures to complete. -The live-in MA responded yes, "I need to take your temperature". -The live-in MA left the room and returned with an infrared thermometer. -The live-in MA completed the temperature checks. -The live-in MA was prompted a second time by the surveyor if she had any COVID-19 screening questions and the live-in MA questioned "have	C 601	The facility's front entrance door which was not flushing with the door frame has been repaired and now flushes with the door frame.	01/01/2021

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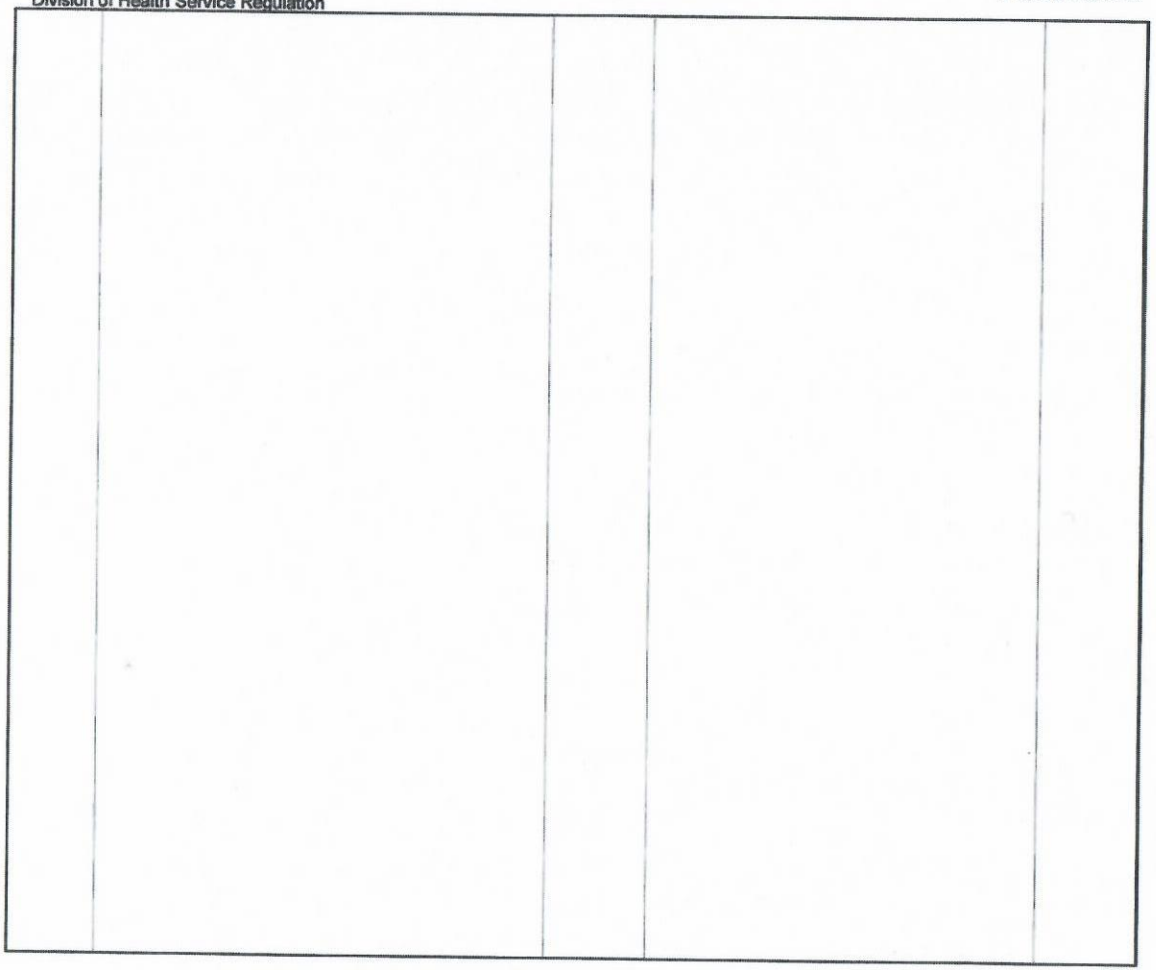
C 601	Continued From page 28 you had your COVID test?". -The live-in MA did not ask any additional screening questions. -There was one resident sitting on the left side of the room watching television without a face mask (In the same room with the surveyors seated at least 6ft away prior to the MA completing a temperature check and the one screening question). Interview with the RCC on 12/01/20 at 9:57am revealed: -The live-in MAs were responsible to complete a daily screening for visitors and or medical providers. -She would provide all visitor or outside providers' documented screenings for COVID-19. -The live-in MAs were responsible for completing temperature checks and screening questions before anyone was allowed into the facility which included any family and medical providers and home health. -There was not a predefined screening questionnaire used however, MAs were expected to question anyone entering the facility if the individual had been out of the state or having any respiratory symptoms. -The live-in MA did not do a complete pre-screening for the surveyors because the live-in MA thought the "state" would not be required to have a pre-screening prior to entering the facility. Interview with the live-in MA on 12/02/20 at 1:50pm revealed: -She had never had the "state" to visit the facility while she was on duty and was having anxiety. -She was responsible for pre-screening everyone entering the facility and document the temperature screenings.	C 601	The staff have been re-trained to ensure that predefined screening questionnaire are used all time for staff and essential visitors. The predefined screening questionnaire are incorporated in both visitor's log and staff log. Face mask are enforced in the facility for both staff and residents and anyone entering the facility.	01/01/2021

C601 Addendum Per telephone with ms. Elsie Ogbonna, Administrator and mr. Patrick Ogbonna Executive Officer On 01/22/21 : Re-education to Staff Provided by the Administrator. Re-education including signs on entrance doors restricting visitors. The RCC randomly monitors visitor restriction signs daily on the entrance doors. 01/22/21



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C 601	Continued From page 29 -She received the visitor screening form today, (12/02/20) from the RCC. -She had never used the visitor screening forms and it was "an oversight" that the forms were not provided until today for her to use. Review of the facility's "Visitation Log, One Hour/Social Distancing" revealed there were no screening logs documented for visitors or any health care providers on any date. Interview with the RCC on 12/02/20 at 9:35am revealed: -She did not review the screening logs for COVID-19 daily. -She was not sure if the medical providers were screened prior to entering the facility to visit the residents because she was not present in the facility the days the visits were made. -The visitor screening form was implemented today, (12/02/20) for everyone entering the facility other than facility staff. Interview with the Administrator on 12/01/20 at 11:40am revealed it was expected when the residents' mental health providers or health care workers visited the facility, the live-in MAs were responsible for requesting the individual to use alcohol hand-based sanitizer, obtain a temperature reading and question if they had experienced any respiratory symptoms or contact with anyone diagnosed with COVID-19. Telephone interview with a mental health provider on 12/02/20 at 3:58pm revealed: -She provided mental health services to some of the residents residing at the facility. -The residents' mental health visits were done inside the facility. -She had visited the facility within the last 3	C 601		

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C 601	Continued From page 30 months. -Staff at the facility had never asked her any screening questions or taken her temperature on arrival or prior to entering the facility to visit the residents. Telephone interview with a resident's guardian on 12/02/20 at 8:22am revealed: -The guardian visited with the resident outside on the porch of the facility or outside in front of the facility's main office located next to the facility. -Staff at the facility had never asked her any screening questions or taken her temperature when she arrived at the facility to visit and deliver the resident's requested items. -The guardian and resident maintained at least 6 ft distance from each other during visits. -The resident's guardian last visited the resident at the facility around 11/04/20. Refer to the interview with the Administrator on 12/02/20 at 5:30pm. Refer to the telephone interview with the public health nurse at the local health department (LHD) on 12/02/20 at 8:42am. c. Review of the screening logs for the residents' revealed: -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for residents from 04/21/20 - 04/31/20. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for residents the month of May 2020. -There was no documentation of temperature checks or screening for other symptoms of COVID-19 for residents from 06/09/20 -06/30/20. -There was no documentation of temperature checks or screening for other symptoms of	C 601	Following the review conducted, staff have been re-trained to ensure that there is documentation in the resident's screening log to indicate when they are screened for temperature and signs and symptoms of COVID-19. The RCC will henceforth audit this log weekly to ensure compliance.	01/01/2021 01/01/2021

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C 601	Continued From page 31 COVID-19 for residents the month of July 2020. -There was no documentation of temperature checks or a screening for other symptoms of COVID-19 for residents on 08/01/20 and 08/02/20. Interview with a resident on 12/01/2020 at 9:14am revealed, staff had not screened her for symptoms of COVID-19 on a daily basis. Interview with a second resident on 12/01/20 at 9:30am revealed staff had not screened her for symptoms of COVID-19 on a daily basis. Interview with the Resident Care Coordinator (RCC) on 12/02/20 at 9:35am revealed: -She was responsible for reviewing the staff and residents' screening logs for COVID-19. -She was not aware there were times the live-in MAs were not completing the daily screenings but she asked staff if they had completed the screenings daily. -She last reviewed COVID-19 screenings in October 2020 and noticed there were days when staff were not documenting the screenings but she did not inform the Administrator of this. -She did not review the screening logs for COVID-19 on a daily basis. Second interview with the RCC on 12/02/20 at 2:47pm revealed the residents' COVID-19 testing completed on 11/30/20 were all negative for the virus. Refer to the interview with the Administrator on 12/02/20 at 5:30pm. Refer to the telephone interview with the public health nurse at the local health department (LHD) on 12/02/20 at 8:42am.	C 601		

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C 601	Continued From page 32 d. Observation of the front entrance of the facility on 12/02/20 at 8:55am revealed: -The facility's front entrance door was not closed and not flush with the door frame leaving the door's latching mechanism exposed to the outside. -There was no posted signage at the facility's front entrance providing guidance related to restrictions and/or requirements prior to entering the facility due to COVID-19. Interview with the RCC on 12/01/20 at 9:57am revealed: -She was not aware there was no signage posted at the facility's entrance doors, there was a sign previously and she thought the wind must have blown the sign off the door. -The live-in MA on duty would have been responsible to report that the posted signs on the entrance door were gone. Refer to the interview with the Administrator on 12/02/20 at 5:30pm. Refer to the telephone interview with the public health nurse at the local health department (LHD) on 12/02/20 at 8:42am. Interview with the Administrator on 12/02/20 at 5:30pm revealed: -She monitored the facility's COVID-19 screenings especially for the residents' screening (The Administrator did not provide how often she monitored the COVID-19 screenings). -She last monitored the facility's prescreening the first part of November 2020. -During her review, she had noticed that occasionally a staff had not documented the screening for that day but would complete the	C 601	The facility currently has posted signage at the front entrance that provides guidance related to restrictions and/or requirements prior to anyone entering the facility due to COVID-19.	01/01/2021

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C 601	Continued From page 33	C 601		

screening documentation later in the day.
-She expected staff to ensure a prescreening was done on anyone entering the facility.

Telephone interview with the public health nurse at the local health department (LHD) on 12/02/20 at 8:42am revealed:
-She was notified by the Administrator on 11/15/20 concerning two staff testing positive for COVID-19.
-Two COVID-19 cases at a facility was considered a "cluster/outbreak".
-She was not given specific information regarding staff assignments or where each resident resided on the facility grounds.
-The Administrator required a lot of guidance regarding guidelines for COVID-19.
-She spent a lot of time working with Administrator the week of 11/15/20 related to education regarding PPE, not moving residents from one facility to another on the facility grounds, symptoms of COVID-19 and lack of symptoms and having COVID-19, staffing patterns for the facility and to avoid moving staff from one facility to another facility and deep cleaning.
-She talked with the Administrator about screening the staff for illness and if any staff were sick to stay home.
-She also sent the Administrator a link for long term care facility's that included education for weekly COVID-19 testing.
-Information was sent to the Administrator related to guidelines and recommendations related to staffing when staff had tested COVID-19 positive and COVID-19 testing was done the week of 11/15/20.
-Initially, the Administrator told her the facility was not a long-term care facility or an assisted living facility and thought the facility did not have to follow some of the guidelines provided and

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C 601	Continued From page 34 continued to state the facility was a "home care facility". -She verified the facility was a congregate living facility and notified the Administrator that the facility would be responsible for testing for COVID-19 every 3-7 days until there were no positive COVID-19 results in 2 weeks and testing for prior positive staff or residents did not have to be completed. -A named staff had tested positive for COVID-19 on 11/14/20. -A second named staff (the MA working at the facility on 12/01/20 and 12/02/20) tested positive on 11/17/20. -The RCC tested positive for COVID-19 on 11/15/20. -It was important for the facility to have a system in place to ensure that everyone entering the facility was screened due to COVID-19 for infection prevention to avoid either persons entering the facility being sick or a positive COVID-19 person who was asymptomatic that could potentially expose the whole facility. -It only took one person to enter the facility and spread COVID-19 throughout the facility. -It was important to have documentation of all screenings done on anyone entering the facility to hold everyone accountable and if the screenings were not documented then there was no proof the screenings were completed. -Any person with co-morbidities was at increased risk for affects from COVID-19 with varying affects which could include death from the virus . _____ The facility failed to follow the Centers for Disease Control (CDC), North Carolina Department of Health and Human Services (NC DHHS) and Local Health Department (LHD) guidelines for coronavirus (COVID-19) during the global pandemic for visitor, staff and resident	C 601		

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C 601	Continued From page 35 screenings placing the residents at increased risk for transmission and infection of the deadly COVID-19 virus. The facility's failure was detrimental to the residents' health, safety and welfare constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/01/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 16, 2021	C 601		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to design and construction and infection prevention and control program. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 5 sampled residents (#1,	C 912	G. S. 131D-21 (2) Declaration of Resident's Rights The facility remains committed to re-training the staff to ensure that every resident receives care and services which are adequate, appropriate and in compliance with relevant Federal and State laws and rules and regulations. The administrator provided additional training to ensure compliance. The facility is committed to ensuring residents evacuation capabilities are in accordance with evacuation capability listed on the facility's current license. Resident #3 has been re-evaluated by her Personal Care Physician (PCP) and found to be appropriate for meeting the evacuation capability listed on current license.	01/01/2021 01/01/2021 01/01/2021

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C 912	Continued From page 36 #3) who had cognitive impairments and/or physical impairments and required verbal prompting to exit the facility during a fire drill. [Refer to Tag C0022, 10A NCAC .0302(b) Design and Construction (Type B Violation)]. 2. 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) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to screening of visitors, staff, and residents, and posting of signage notifying visitors of restrictions. [Refer to Tag C0601, 10A NCAC .1701 Infection Prevention and Control Program (Type B Violation)].	C 912	The facility has reviewed, updated and implemented processes that ensure compliance to the recommendations and guidance established by the Center for Disease Control (CDC), the North Carolina department of Health and Human Services (NC DHHS) and Johnston County Health Department. The facility now has documented screening logs for visitor, for staff and for residents. There is also posting of signage notifying visitors of restrictions displayed on the main entrance door.	01/01/2021 01/01/2021
C 914	G.S 131D-21(4) Declaration Of Resident's 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 record reviews, interviews and observations, the facility failed to ensure each resident was free of neglect related to management and other staff. The findings are: Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the supervision needs for 2 of 5 sampled residents	C 914	G. S 131D-24 (4) Declaration of Resident's Rights The Facility continues to be committed to ensuring every resident have the right to be free of mental and physical abuse, neglect and exploitation. Additional training has been provided to the staff to ensure compliance that under no circumstance will a staff member leave the residents unattended. The Facility will incorporate this training as part of in-service training and will be conducted semi-annually.	01/01/2021 01/01/2021

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C 914	Continued From page 37 (#1, #3) and failed to ensure staff were accessible to the residents by leaving the facility unattended. [Refer to Tag C0191, 10A NCAC .0601(d) Management and Other Staff (Type A2 Violation)].	C 914		