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RIVERS EDGE OF LUMBERTON	550 BAILEY ROAD LUMBERTON, NC 28359

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation with an onsite visit on 01/19/21 and 01/22/21 and a desk review survey on 01/20/21 - 01/22/21 and 01/25/21 and a telephone exit on 01/25/21. The complaint investigation was initiated by the Robeson County Department of Social Services on 12/31/20.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 1 of 5 residents sampled (#2) related to a home health referral for urinary catheter care and provider notification of a delay for home health wound care. The findings are: Review of the current facility license revealed there was a Change of Ownership (CHOW) on 01/05/21. Review of Resident #2's current FL-2 dated 12/11/20 revealed: -Diagnosis included Alzheimer's dementia, hypertension, and chronic obstructive pulmonary disease (COPD). -The resident was constantly disoriented, wandered, was incontinent of bowel and bladder,	D 273		

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and ambulatory.
-The resident required assistance with bathing, feeding, and dressing.
-There was no documentation of a urinary catheter.

Review of Resident #2's current care plan dated 12/08/20 revealed:
-The resident required limited hands on assistance with transfers and ambulation.
-The resident required extensive hands on assistance with toileting, bathing, and personal hygiene.

a. Review of Resident #2's physicians consultation report dated 12/09/20 revealed:
-There was a handwritten physician signature.
-The resident had a post void residual (PVR) of 385mm (PVR is the amount of urine in the bladder after voiding. Normal PVR is less than 50ml, 200ml or greater is abnormal).
-Diagnoses included urinary retention.
-There was an order for a monthly catheter change to be performed at the facility.

Review of Resident #2's physician progress notes dated 12/15/20 revealed:
-There was a diagnosis of urinary retention.
-The resident had an indwelling urinary catheter.
-The resident was seen for a "face to face" visit for home health (HH) nursing evaluation for urinary catheter management.

Review of Resident #2's physicians order dated 12/16/20 revealed there was a HH nursing order for urinary catheter care.

Review of Resident #2's physician progress note dated 12/18/20 revealed:
-Facility staff reported the resident's urinary

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catheter was pulled out on 12/18/20.
-HH had not been started for the resident's urinary catheter care.
-Orders were given to send the resident out of the facility for urinary catheter replacement.

Review of Resident #2's laboratory urine culture (bacteria in urine grown for several days to detect the specific bacteria) dated 12/22/20 revealed:
-The resident's urine culture was finalized and positive for Escherichia coli (bacterium normally found in the intestines treated with antibiotics) on 12/24/20.
-The resident was given a Rocephin [(an antibiotic used to treat urinary tract infections (UTI's) an infection of the urinary system] injection in the Emergency Department.

Telephone interview with a representative with Resident #2's HH agency on 01/21/21 at 2:06pm revealed:
-The HH agency had not received an order dated 12/16/20 for the resident to have HH nursing urinary catheter care.
-The HH agency first saw the resident on 01/06/21 for wound care.
-Prior to 01/06/21 the resident was last seen in 2019 for HH services.

Telephone interview with Resident #2's previous Primary Care Provider (PCP) on 01/22/21 at 3:00pm revealed:
-She did not know Resident #2's HH order dated 12/16/20 for nursing to perform urinary catheter care was not sent to the HH agency.
-A urinary catheter was an indwelling catheter and was a mode for UTI's because organisms would travel up the tube into the resident's bladder.
-It was possible Resident #2's UTI would have been prevented if the 12/16/20 order had been

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sent to the HH agency.
-HH nursing would have been able to monitor Resident #2 more appropriately than facility staff because staff were not licensed to assess for signs or symptoms of UTIs.
-Resident #2 not having nursing assessment and care for urinary catheter care placed the resident at increased risk for a UTI.

Telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 9:08am revealed:
-She did not know if Resident #2's HH order for urinary catheter care dated 12/16/20 was sent to the HH agency.
-Resident #2's urinary catheter care started in January 2021 when the HH agency began treating the resident for wound care.

Attempted telephone interview with Resident #2's family member on 01/21/21 at 9:15am was unsuccessful.

Attempted telephone interview with a second family member of Resident #2 on 01/21/21 at 9:17am was unsuccessful.

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

Refer to telephone interview with Resident #2's previous Primary Care Provider (PCP) on 01/22/21 at 3:00pm.

Refer to telephone interview with the medication aide (MA) on 01/25/21 at 8:46am.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 9:08am.

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D 273	Continued From page 4 Refer to telephone interview with the Administrator on 01/25/21 at 12:30pm. b. Review of Resident #2's home health (HH) order dated 12/31/20 revealed: -There was an order for HH nursing to evaluate a sacral wound and pressure ulcer to the chest. -There was an order to apply a foam dressing every three days and as needed to the chest pressure ulcer. -There was an order to apply a foam dressing every three days and as needed to the sacral ulcer. -There was an order for HH nursing to remove staples to the back of the head. Telephone interview with Resident #2's HH agency on 01/22/21 at 2:06pm revealed: -Resident #2's HH order dated 12/31/20 was not received until 01/06/21. -The HH agency was closed on 01/01/21. -If the order was sent to the agency on 12/31/20, it was possible the resident could have been seen on the weekend of 01/02/21 if HH staff were available. -The resident first received wound care by the HH agency on 01/08/21. Telephone interview with Resident #2's previous Primary Care Provider (PCP) on 01/22/21 at 3:00pm revealed: -The resident had developed a Stage I ulcer (a pink blanchable area with closed skin) to her chest from a cervical collar and a Stage II ulcer (a shallow crater with open skin) to her sacrum. -She did not know there was a delay in sending the residents 12/31/20 order for nursing to evaluate for wound care to the HH agency. -Resident #2 was thin in body size, had boney	D 273		

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prominence's and was elderly.
-Resident #2 was placed at increased risk for skin break down from the delay in referral for wound care because of her age and size.

Attempted telephone interview with Resident #'2 family member on 01/21/21 at 9:15am was unsuccessful.

Attempted telephone interview with a second family member of Resident #2 on 01/21/21 at 9:17am was unsuccessful.

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

Refer to telephone interview with Resident #2's previous Primary Care Provider (PCP) on 01/22/21 at 3:00pm.

Refer to telephone interview with the medication aide (MA) on 01/25/21 at 8:46am.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 01/25/21 at 9:08am.

Refer to telephone interview with the Administrator on 01/25/21 at 12:30pm.

_____

Telephone interview with Resident #2's previous Primary Care Provider (PCP) on 01/22/21 at 3:00pm revealed:
-She expected the facility to send orders to the HH agency as soon as the order was written even if the agency was closed to ensure there would not be a delay in care for the resident.
-If the HH agency was closed when the order was sent, the order would be there when they opened.
-She wanted to be told if an order was not sent to

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HH so she could send the order herself or delegate someone else to send as to not delay resident care.
-She expected skilled nursing to evaluate and treat Resident #2 as soon as possible because facility staff were not licensed staff.

Telephone interview with the medication aide (MA) on 01/25/21 at 8:46am revealed:
-She was the Resident Care Coordinator (RCC) until about October 2020 when at that time she transitioned to a MA.
-It had been the responsibility of the RCC to call and fax HH orders to the HH agency.
-The MA would fax the orders to the HH agency in the absence of the RCC.
-Normally the HH agency would be called to inform of the HH order then the order would be faxed.

Telephone interview with the RCC on 01/25/21 at 9:08am revealed:
-She was the Administrator for the facility prior to the CHOW.
-She became the RCC at the time of the CHOW.
-The previous RCC would have been responsible for sending orders to the HH agency.
-She expected the previous RCC to have obtained the orders from the PCP, fax the order to the referral source as soon as received from the PCP, and call the referral source to confirm receipt.
-The order would have been filed in the resident's facility file after faxed.
-It was not documented when orders were sent to a referral source.
-She did not have a process in place to ensure HH orders were complete.
-The urinary catheter and wound care were started by HH at the same time in January 2021.

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D 273	Continued From page 7 Telephone interview with the Administrator on 01/25/21 at 12:30pm revealed it was expected the RCC to fax HH orders when received. The facility failed to ensure Resident #2 had a home health (HH) referral for urinary catheter care as ordered by the Primary Care Provider (PCP) which placed the resident at increased risk for developing a urinary tract infection (UTI). The resident was diagnosed with a UTI during a hospital visit on 12/22/20 and required an antibiotic injection. The resident had an order dated 12/31/20 for wound care from HH which was not faxed to HH until 01/06/21 resulting in a delay in care. The facility's failure was detrimental to health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01-25-21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2021.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure residents who were quarantined due to a COVID-19 outbreak had access to a	D 338		

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telephone to make and receive calls.

The findings are:

Observation of the Memory Care Unit (MCU) on 01/19/20 at 11:00am revealed:
-The MCU was the designated COVID-19 hall.
-There was no designated telephone for the residents to use.

Telephone interview with a medication aide (MA) on 01/21/21 at 1:30pm revealed:
-The facility did not have a designated telephone for residents who were diagnosed with COVID-19 to use on the Assisted Living (AL) side or in the Memory Care Unit (MCU).
-The facility did not have cordless telephones.
-Most residents who could talk had personal cell phones.
-She had not received any concerns from residents about not having a telephone to speak with family members.
-She had not received any concerns from family members about not being able to speak with residents.

Interview with a second MA on 01/25/21 at 8:37am revealed:
-There were no portable phones in the building.
-The residents that had tested positive for COVID-19 did not have access to a facility phone to be able to communicate with their families.
-She knew some of the staff would use their personal phones and called family for the residents.
-When the Resident Care Coordinator (RCC) was at the facility, she had a work cell phone that she would let the resident use if a family member called and wanted to speak with them.
-When the RCC would leave for the day there

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D 338	Continued From page 9 was no access for the residents with a diagnosis of COVID-19. -The residents with a diagnosis of COVID-19 did not have access to the telephone because they were on the quarantined hall. -If a family member of a resident who had a diagnosis of COVID-19 called she would let them know how they were doing. Interview with the current RCC on 01/25/21 at 9:08am revealed: -There were no cordless phones in the facility. -The Administrator was working on getting the facility wired for cordless phones. -The residents who had a diagnosis of COVID-19 and were on the quarantine hall did not have access to a facility phone. Interview with the current Administrator on 01/25/21 at 9:50am revealed: -There were no cordless phones in the facility for the residents who had a diagnosis of COVID-19 to use. -The building was old, and the phones could not be unplugged so a cordless phone could be plugged in. Attempted telephone interview with a resident's family member on 01/21/21 at 9:15am was unsuccessful.	D 338		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious	D 612		

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disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance from the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to staff wearing masks appropriately; performing hand hygiene; and redirection of residents to use face masks when out of their rooms.

The findings are:

Review of the Centers for Disease Control (CDC) recommendations for long term care facilities dated 11/20/20 revealed:
-Residents should be encouraged to wear face coverings (if tolerated) whenever they are around others, including when they leave their rooms and when they leave the facility.
-Recommended personal protective equipment (PPE) for staff to use for close contact with residents included: eye protection (goggles or face shield) and an N95 mask or higher-level respirator (or a face mask if respirators are not

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available) and gown and gloves should be used in addition to PPE listed above for direct contact.
-Staff using PPE should have received training on PPE selection, use of PPE and demonstrated the use and removal of PPE to prevent self-contamination.

Review of the CDC recommendations for Infection Prevention and Control Guidance for Memory Care Units (MCUs) dated 05/12/20 revealed residents should be reminded and assisted with frequent hand hygiene, social distancing, redirecting to their rooms and use of face coverings when they were out of rooms.

Review of the North Carolina Department of Health and Human Services (NCDHHS) What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings dated 09/04/20 revealed:
-Facility staff should wear face masks when caring for residents with undiagnosed respiratory infection or confirmed COVID-19.
-It was expected that LTC settings reviewed and implemented the policies and procedures implemented in the CDC guidance.

Review of the facility's undated "SIC Check Off Log" revealed:
-Staff hands should be sanitized before having direct contact with residents.
-Hands should be washed after contact with blood, body fluids or excretions, mucous membranes, non-intact skin or wound dressings.
-Hands should be sanitized after contact with a residents' intact skin.
-Hands should be sanitized after contact with inanimate objects in the immediate vicinity of the resident.
-Hands should be sanitized after gloves are

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removed.
-Masks should cover both nose and mouth.

Review of the facility's "Sequence for Donning and Removing Personal Protective Equipment" (PPE) revealed that hand hygiene should be performed immediately after removing all PPE.

Review of the facility's undated Infection Control policy revealed:
-Hand hygiene should be performed: before direct contact with residents; after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings; after contact with a resident's intact skin; moving from a contaminated site of a resident's body to a clean body site during resident care; after contact with inanimate objects in the immediate vicinity of the resident and after gloves are removed.
-If soap and water were not available and hands were not visibly soiled, an alcohol-based hand sanitizer that contained at least 60% alcohol can be used.

Interview with the Resident Care Coordinator/Co-Administrator on 01/19/21 at 12:03pm revealed:
-COVID-19 training was provided by the facility's Nurse Practitioner sometime before Christmas 2020 to 1st, 2nd and 3rd shift staff.
-There were residents with a positive COVID-19 diagnosis that resided on the Memory Care Unit (MCU) and Assisted Living.
-PPE required for staff caring for residents who had a COVID-19 diagnosis included: face shields, facemasks, isolation gowns and gloves

1. Observations of the kitchen on 01/19/21 at 10:15am revealed:
-There was a dietary aide wearing her facemask

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below her nose.
-The dietary aide pulled her facemask below her chin as she spoke to the surveyor.
-The dietary aide pulled her facemask up and over her nose as she walked toward the surveyor.
-There was a second dietary aide wearing her facemask below her nose.
-The second dietary aide pulled her facemask up and over her nose as she walked toward the surveyor.
-The second dietary aide's mask slipped below her nose as she spoke with the surveyor.
-The first dietary aide again pulled her facemask below her chin as she talked to the surveyor.
-The first dietary aide required prompting to reposition her facemask over her nose and mouth.
-The second dietary aide required prompting to reposition her facemask to cover her nose.

Interview with the first dietary aide on 01/19/21 at 10:17am revealed:
-There was no reason her facemask was below her nose.
-She pulled her facemask below her chin to speak to the surveyor.
-She had been trained by a medication aide/supervisor (MA/S) to wear her facemask over her nose and under her chin.
-She would pull her facemask below her chin to speak so the other person could clearly hear what was being said.

Interview with the second dietary aide on 01/19/21 at 10:19am revealed:
-There was no reason why her facemask was below her nose.
-Facemasks were to be work over the nose and under the chin.

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D 612	Continued From page 14 Interview with the Administrator on 01/19/21 at 12:10pm revealed all staff were expected to wear face masks at all times while in the facility to protect the residents from COVID-19. Refer to telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm 2. a. Observation of the Memory Care Unit (MCU) on 01/19/21 at 10:35am revealed: -This area of the MCU was designated as a COVID-19 positive hall. -The Medication Aide/Supervisor (MA/S) put on PPE to enter a resident's room who was diagnosed with COVID-19. -The PPE included: a face shield, N95 facemask, gloves and an isolation suit. -The MA/S held onto the residents' room door with her gloved right hand. -The MA/S removed her PPE before exiting the resident's room; the MA/S did not perform hand hygiene after she removed her PPE. -There was no hand sanitizer available on the supply cart. Interview with the MA/S on 01/19/21 at 10:37am revealed: -There were two supply carts on the MCU where isolation supplies were kept for the residents diagnosed with COVID-19. -Isolation supplies were always to be readily available for the staff. -The MA/S would stock the cart at the end of their shifts. -She stocked one of the two isolation carts on the MCU prior to the shift on 01/19/21 however she did not stock the isolation cart located outside of the resident's room diagnosed with COVID-19. -Hand hygiene should be performed before and	D 612		

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after providing patient care and after PPE being removed.
-She did not complete hand hygiene when she removed her PPE because hand sanitizer was not available on the supply cart.

Interview with the Resident Care Coordinator/Co-Administrator (RCC/co-Administrator) on 01/19/21 at 12:03pm revealed face shields should be disinfected between residents using disinfectant wipes, isolation gowns and gloves should be changed between each resident and hand hygiene should be performed between providing care to each resident and as needed.

Interview with the current Administrator on 01/19/21 at 12:08pm revealed:
-Isolation carts were located on the designated COVID-19 positive units that had clean PPE readily available.
-It was the responsibility of the MA/S and management to ensure that isolation carts were stocked with supplies and PPE needed to care for residents.

Refer to telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm.

b. Observation on the Memory Care Unit on 01/19/21 at 10:42am revealed:
-A personal care aide (PCA) exited a resident's bathroom wearing a N95 facemask, face shield, isolation gown and gloves.
-She entered the hallway with the same N95 facemask, face shield, isolation gown and gloves that she used while in the resident's bathroom.
-The PCA walked over to another resident sitting in a wheelchair in the hallway.

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-The PCA touched the shoulder and wheelchair of a resident diagnosed with COVID-19 with her right hand wearing the contaminated gloves.
-The PCA removed her gloves and performed hand hygiene after about five seconds.
-The PCA did not disinfect her face shield and she did not change her isolation gown.

Interview with the PCA on 01/19/21 at 10:48am revealed:
-She provided toileting assistance to a resident by pulling down the resident's pants, assisted on and off the toilet, and pulled up the resident's pants.
-She did not remove her gloves after leaving out of the resident's bathroom because she did not physically touch the resident.
-She assisted the resident with pulling up her pants and no assistance was provided with anything else.
-She was "unsure" if she should have changed her gown when she exited the resident's room.
-The isolation carts were located on the outside of the double doors on the Memory Care Unit (MCU) where staff retrieved clean PPE supplies before services were rendered to other residents.
-She did not get more PPE from outside of the double doors at the time because she was keeping an eye on a resident while another PCA was with another resident.
-She was educated by the current Resident Care Coordinator (RCC) about 1 week ago to change gloves, perform hand hygiene, and clean her face shield between resident care.

Interview with the Resident Care Coordinator/Co-Administrator on 01/19/21 at 12:03pm revealed face shields should be disinfected between residents using disinfectant wipes, isolation gowns and gloves should be changed between residents and hand hygiene

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should be performed between residents and needed.

Refer to telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm

3. a. Observations of the Assisted Living hall on 01/19/21 from 10:16am - 10:21am revealed:
-A resident was observed walking down the hall with a facemask underneath the chin.
-The same resident walked past two staff members who did not prompt the resident to put on a facemask.
-Another resident was observed self-propelling a wheelchair in the hall with no facemask.
-A staff member opened the back door of the facility to let the resident with no mask in a wheelchair outside, the staff member did not prompt the resident to put on a mask.

Interview with the AL personal care aide (PCA) on 01/19/21 at 10:21am revealed:
-She had training on COVID-19 related to infection control 2 weeks ago from the Administrator.
-She did not remember the exact material covered in training.
-Residents were supposed to wear a facemask when they were out of their room and in the hallways.
-She was supposed to prompt residents to wear a facemask if they were observed without a facemask on in the hallway.
-She had been told by the Administrator to prompt residents to wear a facemask when out of their room.

Interview with the AL medication aide (MA) on 01/19/21 at 10:36am:

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D 612	Continued From page 18 -Residents were required to wear a facemask when they were out of their room and in the hallway. -She was supposed to prompt residents to put on a facemask if they were out of their room without a facemask on. Observations of the AL during the facility tour on 01/19/21 from 11:37am - 11:55am revealed: -A resident was sitting in a wheelchair near the front entrance of the facility with her mask below her nose and underneath the chin. -The maintenance staff was observed walking past the resident in the wheelchair; the maintenance staff did not prompt the resident to pull the mask up over the nose. -Another resident was walking down the hall talking to the housekeeper with their mask below the nose and underneath the chin. -The housekeeper did not prompt the resident to pull their mask over their nose. -The same resident with their mask below their nose and underneath their chin walked past the MA; the MA did not prompt the resident to pull the facemask over her nose. Interview with the current Administrator on 01/19/21 at 12:37pm revealed: -Residents were supposed to wear a facemask when they were out of their rooms. -Staff were supposed to prompt residents to wear facemask if they were observed without a facemask on when they were out of their rooms. -Staff were required to prompt residents to wear facemask to protect the residents and staff from transmission of COVID-19. -She was not aware that her staff did not prompt residents to wear their facemask when they were outside of their rooms.	D 612		

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D 612	Continued From page 19 Refer to telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm b. Observations of the MCU on 01/19/21 at 1:03pm revealed: -A resident ambulated out of his room into the hallway without wearing a mask and was within eye sight of the medication aide/supervisor (MA/S). -The MA/S did not encourage the resident to wear a mask and did not encourage him to return to his room. -There were two residents who had a COVID-19 diagnosis and resided on the end of the same hallway. -The MA/S was prompted to provide the resident with a mask and mask was provided. Interview with the MA/S on 01/19/21 at 1:04pm revealed: -The resident in the hall without a mask was not diagnosed with COVID-19. -All residents were provided with a mask however some would take the off. -She tried to keep the resident in his room, but he would often come out and wander into the hallways and he would not always wear a mask. -She did not think the resident would allow her to apply a facemask. -The other two residents who resided at the end of the hallway were diagnosed with COVID-19 and stayed in their room with the door closed. Interview with the current Administrator on 01/19/21 at 12:40pm revealed: -Residents were expected to wear masks when they were out of their rooms. -Staff were responsible to encourage residents to wear masks and should continue to encourage	D 612		

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D 612	Continued From page 20 residents to wear masks even if they refused. -She believed that because some residents refused to wear masks often, staff stopped reminded them to wear one. -Reeducation would be provided to all staff to ensure that they continue to encourage residents to wear masks. Interview with the current Administrator on 01/22/20 at 9:00am revealed the MCU resident observed to be ambulating in the hall without a face mask on 01/19/21 had since tested positive for COVID-19. Refer to telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm _____ Telephone interview with the Local Health Department (LHD) Registered Nurse on 01/22/21 at 12:01pm revealed: -She referred facilities to the Long-Term Care toolkit on the NC Communicable Disease website related to the use of PPE and infection control prevention. -PPE required when caring for patients with a COVID-19 diagnosis included: facemasks, face shields, isolation gowns, gloves. -Hand hygiene should be performed between patients and after PPE was removed for infection control.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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	D912		

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D912	Continued From page 21 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 1 of 5 residents sampled (#2) related to a home health referral for urinary catheter care and provider notification of a delay for home health wound care. [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		