STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

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D 000	Initial Comments The Adult Care Licensure Section and the Carteret County Department of Social Services conducted a complaint investigation with an onsite visit from 01/26/21 - 01/27/21 and a desk review survey from 01/28/21 - 01/29/21 with a telephone exit conference on 01/29/21. The Carteret County Department of Social Services initiated the complaint investigation on 01/14/21.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the floors were kept clean in the hallway, several resident rooms, resident bathrooms and the common bathroom/shower/spa room and on a shower wall in the designated COVID-19 unit. The findings are: Observations in the designated COVID-19 unit on 01/20/21 from 4:00pm to 5:05pm revealed: -There was black dirt/grime on the floors when entering the designated COVID-19 unit and near	D 074		

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the nurses' station.
-There were food particles on the floor near the dining room.
-In resident room #308, there was a black grime build-up around the toilet rim and stains on the toilet seat. There was a trashcan overflowing with trash.
-In resident room #310, there was grime build-up on the shower walls, clumps of hair on the shower floor and two yellow stained towels on the shower floor.
-In resident room #307, there were two trashcans in the room overflowing with trash and the floors had black dirt grime build-up.

Interview with a medication aide (MA) on 01/20/21 at 4:35pm revealed:
-The designated COVID-19 unit had not had a housekeeper in the past two weeks.
-Staff were required to complete housekeeping duties (take out trash and sweep/mop floors), when resident care was completed.
-She had not completed any housekeeping or laundry task today due to having to complete the medication pass and personal care needs of the residents.

Interview with a resident on 01/20/21 at 4:10pm revealed:
-There had been no housekeeping services in the designated COVID-19 unit the past "two weeks".
-The staff would come in their room and take out the trash if they "had time".
-The floors were so dirty in her room, she could feel it on her feet.

Interview with the Administrator on 01/20/21 at 5:20pm revealed:
-The designated COVID-19 unit never had a housekeeper.

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-Staff members were expected to perform housekeeping duties when all personal care and needs of the residents had been met.
-Since opening the designated COVID-19-unit the first part of January 2021, personal care aides (PCAs) and MAs were expected to pick up trash and perform housekeeping duties as necessary.
-She did not know the floors were dirty, showers were not clean, or trash had not been picked up out of residents' rooms.
-She had not gone on the designated COVID-19 unit, she just started working on 01/08/21 and was instructed by the facility's corporate management not to go on the unit.

Observation on the designated COVID-19 unit on 01/21/21 from 2:00pm to 2:45pm revealed:
-There was black grime build-up on the floor near the dining room/patio.
-In resident room #308, there were food particles behind a sitting area and black grime build-up on the floor.
-In resident room #310, the trashcan was overflowing with trash.
-In resident room #310, there was a strong urine odor in the room and a wet incontinent pad in trash can.

Interview with a PCA on 01/21/21 at 2:30pm revealed:
-The MAs and PCAs "usually" did not do housekeeping duties.
-She was just "told today" by the Resident Care Director (RCD) to start doing "some" housekeeping duties, because at that time the floors were looking dirty.
-The designated COVID-19 unit had not had a housekeeper in about two weeks.
-She tried to clean in resident rooms when there were two staff on the unit and the residents'

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personal care had been completed.

Observation of a resident room #305 located on the designated COVID-19 unit on 01/26/21 at 11:03am revealed:
-There was a plastic knife on the floor and a cardboard box filled with trash, stored beside a trash can in the living room area of the room.
-There was a full, closed, clear trash bag containing trash, stored across the top of the opening of the trash can.
-There were small, scattered black stains on the floors in the living room and bedroom.
-There was a laundry hamper that was turned over sideways and clothing items and shoes scattered throughout the room, on the floor and beds in the room.

Interview with a resident residing in resident room #305 at 11:07am revealed:
-The toilet had "been stopped up" since yesterday (01/25/21).
-The resident reported that the toilet was full of feces and would not flush last night (01/25/21).
-She reported it to staff working on the unit last night, however, no one came to repair the toilet.
-The resident was concerned because she shared this bathroom with another resident.
-The resident was concerned about viruses, illnesses and her own safety of using the soiled toilet.
-She had been on the designated COVID-19 unit hall for a few weeks or more.
-No one (staff) cleaned or sanitized high touch areas on the designated COVID-19 unit.
-It had been approximately one week since the floors had been mopped on the COVID-19 designated unit.
-The resident was concerned because her living area had not been cleaned.

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D 074	Continued From page 4 -The resident had attempted to clean the room herself. Observation of the resident assigned to room #305 on 01/26/21 at 11:07am revealed the resident was tearful when discussing the toilet and her living area and conditions on the designated COVID-19 unit. Observation of the residents' bathroom in room #305 on 01/26/21 at 11:04am revealed: -There was a trash can stored on the right side of the entrance door that was approximately 3/4th full. -The toilet bowl was filled with a thick brown substance, scattered brown splatters and white paper material in the toilet bowl. -The thick brown substance exceeded the level of the water inside the toilet bowl. Interview with the MA assigned to the designated COVID-19 unit on 01/26/21 at 11:10am revealed: -She was attempting to clean and sanitize the areas on the COVID-19 unit but had been busy assisting residents, giving medication to the residents and had not had time yet. -She was the only staff working on the designated COVID-19 unit. -The facility had two housekeepers, one housekeeper left the facility and the other housekeeper mostly worked on the other side of the facility (The non-COVID-19 section of the facility). -She was not sure why the housekeepers did not clean and sanitize on the designated COVID-19 unit. -The staff working on the floor were responsible to clean and sanitize the unit. -She did not know the toilet in room #305 was not working.	D 074		

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D 074	Continued From page 5 Observation of the common bathroom/shower/spa room located on the designated COVID-19 unit on 01/26/21 at 11:16am revealed: -There were heavy concentrated black colored stains in the shape of foot tracks on the floor that circled around the sides and front of the toilet. -There were scattered sections of paper towels and toilet paper scattered around the front and sides of the toilet. -Some of the scattered sections of paper towels and toilet paper were wet with yellow colored stains. Interview with the Administrator on 01/26/21 11:30am revealed she did not know about the cleaning needs in the common bathroom, the floors, the toilet in resident room #305 or the trash build-up in residents' room. Observation in the hallway of the designated COVID-19 unit on 01/26/21 at 1:26pm revealed: -The cardboard box filled with trash was in the hallway. -There was a large wheeled garbage can in the hallway. Observation of resident room #309 on 01/26/21 at 1:28pm revealed: -There were black stains and scattered loose debris on the floor of the living room and bedroom. -There was a trash can on the floor stored behind a recliner that was in full view leading into the residents' rooms that was overfilled with trash and some of the trash was scattered on the floor around the trash can. -There was a second trash can in the residents' bedroom filled with incontinent linen savers and	D 074		

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trash.

Observation of the bathroom in resident room #309 on 01/26/21 at 1:37pm revealed there was scattered loose debris and a soiled disposable wipe on the bathroom's floor.

Observations on the designated COVID-19 unit on 01/26/21 at various times from 1:20pm to 3:00pm revealed:
-In resident room #303, the trash container was overflowing with trash.
-In resident room #307, dirt residue on the floors around the beds and napkins and other debris under the bed.
-In resident room #304, the trash container was overflowing and there was dirt residue on the floor.
-In resident room #308, the trash container was overflowing and there was dirt residue on the floor.
-In resident room #310, there was dirt residue on the floor and the trash container was overflowing with trash.

Observation on the COVID-19 unit at various times between 10:35am - 11:30am and 1:24pm - 2:35pm on 01/26/21 from revealed:
-There were scattered areas /of black stains and debris on the floor in the hallways.
-Staff were not observed cleaning or disinfecting any of the high touch areas on the unit.

Interview with a resident on the designated COVID-19 unit on 01/26/21 at 10:45am revealed:
-She had tested positive for COVID-19 approximately 2 weeks ago and was immediately moved to the COVID-19 unit.
-Since she had been in the unit, there was only one staff, a MA assigned to work 12 hours at a

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time.
-The resident was concerned one MA was not capable to care for all the needs of the residents and perform cleaning and disinfecting needs on the unit.
-The resident had not seen any facility housekeepers cleaning or sanitizing high touch areas in the COVID-19 unit.

Interview with a second resident on the designated COVID-19 unit on 01/26/21 at 1:30pm and on 01/27/21 at 8:16am revealed:
-The facility staff did not sanitize or disinfect the high touch areas of the room such as doorknobs, handrails and faucets.
-The resident could not remember the last time the room was cleaned by staff because it was so sporadic that staff cleaned the resident's room.
-Staff mostly just removed trash from the room approximately twice a week.

Interview with a third resident on the designated COVID-19 unit on 01/26/21 at 1:40pm revealed:
-Staff removed the trash out of her room, however, did not clean and disinfect her room.
-When she was first moved to the COVID-19 unit after testing positive for COVID-19, her room was "filthy".
-She had not observed staff cleaning high touch areas such as door knobs or in the hallway.

Interview with the housekeeper on 01/26/21 at 9:52am revealed:
-There was not a housekeeper assigned to clean the designated COVID-19 unit.
-The housekeeping staff were not allowed to go in the designated COVID-19 unit.
-The PCAs were responsible for housekeeping duties in the designated COVID-19 unit.

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Interview with the Housekeeping Supervisor on 01/26/21 at 10:02am revealed:
-He did not know if cleaning was being done in the designated COVID-19 unit.
-He did not go in the designated COVID-19 unit due to the pandemic.
-The staff in the designated COVID-19 unit were setup to work independently and no one else was allowed to enter.
-There was a MA and PCA scheduled on the designated COVID-19 unit and they were responsible for cleaning the designated COVID-19 unit

Telephone interview with the former Administrator on 01/28/21 at 1:38pm revealed:
-The first residents with COVID-19 were initially diagnosed on 01/04/21.
-The designated COVID-19 unit was completely set up on 01/05/21.
-The MA was responsible for cleaning the designated COVID-19 unit.
-The MA was responsible for sweeping, mopping, sanitizing and taking out the trash.
-Sanitizing and disinfecting were to be done every two hours by the MA.
-She walked through the designated COVID-19 unit one time a day if the RCD was not in the unit working.

Telephone interview with the Administrator on 01/29/21 at 10:54am revealed:
-There were some shifts the MA worked as the only staff in the designated COVID-19 unit.
-The facility was to be sanitized every two hours.
-The MA was responsible for cleaning and sanitizing.
-The RCD and the MAs would have been responsible to notify her of any cleaning and sanitizing needs on the designated COVID-19

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unit.
-The MA and PCAs should have been sanitizing the high touch areas every 2 hours.
-She did not physically monitor the designated COVID-19 unit to decrease spread of the virus in the building and depended on the MA to inform her of any concerns.

Telephone interview with the Communicable Disease Nurse at the local health department on 01/29/21 at 9:40am revealed:
-She understood the facility had maintenance staff that were responsible for cleaning the facility.
-The designated COVID -19 unit needed frequent cleaning, especially of the high touch areas.
-If the designated COVID-19 unit was not kept clean, it could cause more illness.

_____

The facility failed to ensure the floors were kept clean and free of build-up and debris, a resident shower wall was cleaned, resident living areas were free of excess trash in several rooms; and human waste left overnight in a toilet that needed repair in one shared resident bathroom which resulted in emotional distress for one resident; and no sanitizing and disinfecting done for high touch areas every two hours to prevent illnesses in the designated COVID-19 unit of the facility. The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 01/20/21 with an addendum on 01/26/21, 01/27/21, 01/29/21 and 02/19/21.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 15,

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D 074	Continued From page 10 2021	D 074		
D 204	10A NCAC 13F .0604(e)(1)(E) Personal Care and Other Staffing 10A NCAC 13F .0604 Personal Care and Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews and record reviews, the facility failed to provide adequate staffing to meet the needs of residents residing in the designated COVID-19 unit, with a resident census ranging from 7 - 22 for the month of January 2021, for residents who required additional staff assistance with supervision due to disorientation, who were dependent and/or required staff assistance for incontinence care, meal set-up and assistance with eating, transferring, dressing and bathing. The findings are:	D 204		

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D 204	Continued From page 11 Review of a facility census form for January 2021 revealed there were between 7 - 22 residents residing on the designated COVID-19 unit. Review of an assignment sheet dated 01/20/21 revealed: -Staff on duty on second shift on 01/20/21 was 1 medication aide (MA) assigned to the designated COVID-19 unit. -Staff on duty for second and third shift on 01/20/21 was 1 MA assigned to the designated COVID-19 unit. Observations on the designated COVID-19 unit on 01/20/21 from 4:15pm to 5:00pm -The unit had a total of 22 residents. -There was one staff on duty for the 3:00pm-11:00pm shift. -There was a resident sitting in a wheelchair at the entrance to the designated COVID-19 unit yelling and cursing to go back to bed. -There was a second resident crumbling a piece of cornbread walking into another resident's room. -There was a third resident sitting in a wheelchair in the hallway asking to go to bed. -There was a fourth resident requesting assistance for personal hygiene products. -The MA was completing blood sugar checks on assigned residents. Interview with the MA on 01/20/21 at 4:25pm revealed: -She was the only staff working on the unit for the 3:00pm - 11:00pm shift. There was only one staff assigned for the 11:00pm -7:00am third shift. -The designated COVID-19 unit had twenty-two assigned residents on the unit; 4 residents needed assistance with transferring to bed,	D 204		

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toileting and meal set-up.
-She had been working the designated COVID-19 since it opened and there had been only one staff assigned to the unit for each shift.
-She had notified the Administrator (no date provided) and the Resident Care Director (RCD) concerns of one staff taking care of twenty-two residents.
-She was responsible for administering medication to twenty-two residents, giving showers for residents whom are assigned on night shift, delivering dinner trays/evening snacks, assisting with toileting and helping assist residents into bed.
-She had not completed any housekeeping or laundry task due to medication pass, dinner being served/clean-up and helping assist residents with toileting or going back to bed.

A second interview with the MA on 01/20/21 at 4:35pm revealed:
-There needed to be at least two staff a MA and a personal care aide (PCA) on this unit.
-She was unable to complete her tasks as MA and perform personal care needs of the residents.
-The staffing issue had been happening since the designated COVID-19 unit was set up the first of January 2021.
-"It's difficult to keep an eye on all these residents".
-She had made management aware of needing more staff and no response was provided.

Interview with a resident on 01/20/21 at 4:45pm revealed:
-There was only one staff in the unit at all times.
-She had not received a shower "in weeks", due to there was not enough staff to assist her.
-The MA was trying to administer medications

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and help all the other residents, and she "hated" to ask for a shower.
-She had not seen a housekeeper since she was transferred to the designated COVID-19 unit, the MA would take out trash and help with laundry.

Interview with Administrator on 01/20/21 at 5:15pm revealed:
-She was staffing to the aide hours of needs which was 20 hours.
-She requested additional staffing from sister facilities and corporate had reached out to the Emergency Operation Center (EOC) for additional assistance with staffing.
-Her expectations were for staff to let her know if they were needing additional assistance with providing care to the residents.

Telephone interview with a resident's family member on 01/19/21 at 10:00am revealed:
-There were not enough care staff to provide care to the residents.
-The resident had not had a shower in days, due to staff shortages.
-This had been a problem at the facility for months.
-The PCA staff had to complete housekeeping and personal care for all the residents on the designated COVID-19 unit.
-She attempted to notify the administrator via telephone but was unable to reach anyone.

Review of an undated and unlabeled list of residents' residing on the COVID-19 unit on 01/26/21 - 01/27/21 revealed:
-There was documentation of two residents who were disoriented "at times" and one resident that was disoriented.
-There were two residents requiring extensive staff assistance with bathing and two residents

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requiring staff supervision for bathing.
-There was a third resident listed under bathing needs with no documentation for the level of care required from staff.
-There were 5 residents that required assistance from staff for incontinence care.
-There was one resident that required assistance from staff with eating.
-There were two residents that required staff assistance with transferring.
-There were three residents that required staff assistance with dressing.

Interview with the Divisional Vice President of Operations (DVPO) on 01/27/21 at 5:00pm revealed the facility had been attempting to hire and bring in more staff for the last few weeks.

Interview with the Administrator on 01/27/21 at 12:36pm revealed the facility had utilized and remained on a list for needed staff assistance from EOC.

Interview with a MA assigned to the designated COVID-19 unit on 01/26/21 at 10:37am revealed:
-She was the only staff working on the designated COVID-19 unit today (01/26/21).
-She was working today (01/26/21) from 7:00am - 7:00pm.

Observations on the designated COVID-19 unit on 01/26/21 intermittently between 10:37am - 11:29am revealed:
-The MA was up and down the halls assisting residents.
-There were times when the MA could not be seen from the hallways while residents were up and down the halls, in the common dining area, one resident going outside to smoke, and residents going in and out of their rooms.

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D 204	Continued From page 15 Interview with a resident on the designated COVID-19 unit on 01/26/21 at 10:45am revealed: -There were times since she had been on the designated COVID-19 unit there would only be one staff, a MA assigned to work 12 hours at a time. -The resident was concerned one MA was not capable to care for all the needs of the residents, medications and perform cleaning and disinfecting needs on the unit. -Most of the residents would be moving out of the designated COVID-19 unit this week. Interview with a second resident on the designated COVID-19 unit on 01/26/21 at 1:40pm revealed: -There was not enough staff working each shift, "We don't have any help". -On 01/21/21, a PCA had to leave early, leaving one MA to care for all the residents on the unit. -When there was not enough staff on the unit, it caused a delay in care for the residents. -The resident was independent with her toileting needs, however there were some residents on the designated COVID-19 unit that were completely dependent on staff to assist them with toileting. -The resident knew at least 2 named residents that were dependent on staff for toileting needs. -She was concerned because she knew there were times the two residents (named) had to "lay" in their urine because a bad urine odor was observed on the residents. Observation on the designated COVID-19 unit on 01/26/21 from approximately 1:50pm - 2:02pm revealed: -A female resident's pants was wet and a linen saver in her wheelchair was wet.	D 204		

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-The resident was attempting to transfer herself to her bed and required physical support to prevent her from falling.
-The MA was verbally prompted and transferred the resident back into the wheelchair.
-A second female resident was walking in and out of resident rooms.
-The resident was tearful and was repeating "was the baby okay".
-The MA was busy in and out of other resident rooms assisting other residents down the hall.

Interview with the MA on 01/26/21 at 2:27pm revealed:
-She was not able to do everything needed when she worked by herself in the designated COVID-19 unit.
-The residents on the designated COVID-19 unit needed at least two staff in order to get the resident needs completed.
-She had one resident that had slipped off her bed and onto the floor earlier today (01/26/21) when attempting to transfer herself from the wheelchair to the bed.
-She did not witness the resident's incident.
-The named resident was not injured and was not sent to the emergency department for evaluation.
-The named resident's primary care provider was notified.

Telephone Interview with a family member on 01/26/21 at 3:30 pm revealed:
-The designated COVID-19 unit had only 1 MA on staff on all shifts, this had been happening the past two weeks.
-Residents were not being properly taken care of due to having one staff member on duty.
-Residents had to wait to get showers or assistance because there was only one staff on the unit at all times.

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D 204	Continued From page 17 Interview with a MA on 01/27/21 at 7:40am revealed: -She had been working at the facility in the designated COVID-19 facility for the last "2 weeks" on the 7:00pm-7:00am shift. -There had been times within the last week that she worked her 12 hour shifts without any other staff. -She was able to complete all needed tasks such as personal care, assisting residents, housekeeping and cleaning tasks because there was not a lot to do at night for the residents. -She was concerned if something happened such as an emergency on the floor or when staff were busy assisting one resident and felt concerned how could the other residents be monitored during that time; "you can't be in two places" at one time. -She had never told management her concerns of working alone because management was aware the facility was short staffed. -She had worked alone in the COVID-19 unit on some shifts caring for as many as 22 residents. -She was not able to recall how many times she had worked alone in the designated COVID-19 unit, but had worked as the only staff more than she had worked with another staff. -There were approximately 3 residents that had some dementia, but thought all the residents on the designated COVID-19 unit had some level of dementia. -There were currently five residents who were dependent on staff for incontinent care. -There were two residents that required staff assistance to transfer. Interview with a resident on 01/27/21 at 8:46am revealed the designated COVID-19 unit had been understaffed for a few months and	D 204		

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the MA was the only staff who worked in the designated COVID-19 unit and did all the work for the last few months.

Interview with the Administrator on 01/27/21 at 2:29pm revealed:
-She realized there was not enough staff to care for the residents on 1st shift.
-She had been staffing according to the numbers but would be staffing according to the residents needs.
-She expected staff to let her know if they were "overwhelmed" or needed help to care for the residents.

Telephone interview with the Administrator on 01/29/21 at 10:54 revealed:
-The RCD was responsible for scheduling while she was employed at the facility.
-The RCD 's last day of employment was 01/18/21.
-The RCD would complete the staff schedule and hang it on the bulletin board in office.
-The Administrator became responsible for staffing on 01/14/21.
-Her concern was she was new in learning the residents.
-She had not been made aware of residents personal care needs not being met due to staffing.
-The MA and the RCD were responsible to monitor the designated COVID-19 unit.
-The MA and the RCD would have been responsible to report any issues or concerns in the designated COVID-19 unit to her.
-After the RCD's employment ended, the MA would have been responsible to report any issues or concerns to her in the designated COVID-19 unit.
-She had not been making physical rounds on the

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D 204	Continued From page 19 designated COVID-19 unit in an attempt to limit exposure to the residents and staff throughout the remainder of the facility. -She knew there was a need to staff according to the residents' needs. Refer to Tag 0269 10A NCAC 13F .0901(a) Personal Care and Supervision The facility failed to ensure adequate staffing to provide direct personal care assistance and supervision needed by the residents residing in the designated COVID-19 unit with a census ranging from 7 up to 22 residents for the month of January, which included residents who were disoriented requiring supervision and redirection, at least two residents requiring extensive staff assistance with bathing and grooming needs, 5 residents that required assistance from staff for incontinence care, one resident that required assistance from staff with eating, two residents that required staff assistance with transferring and three residents that required staff assistance with dressing. The facility routinely staffed one person on each shift on the designated COVID-19 unit, leaving staff responsible for administering medications, housekeeping/sanitizing and laundry duties, meal set up, personal care assistance and supervising residents. This failure placed the residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/20/21 and an addendum on 1/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 28, 2021.	D 204		

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 3 of 7 sampled residents (#6, #5, and #1) who required staff assistance with transferring and incontinence care (#6, #5) and a resident who needed assistance with bathing (#1). The findings are: 1. Review of Resident #6's FL-2 dated 12/10/20 revealed: -Diagnoses included Alzheimer's disease, shortness of breath, anxiety, vertigo, depression, schizoaffective, hypertension and history of left hip repair. -She was non-ambulatory with the use of a wheelchair. Review of Resident #6's licensed health professional support (LHPS) evaluation dated 09/01/20 revealed: -She was able to stand with stand-by assistance. -She transferred in and out of her wheelchair with assistance from staff. -She was incontinent of bowel and bladder.	D 269		

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D 269	Continued From page 21 -She completed her activities of daily living (ADLs) with the assistance from staff. Review of Resident #6's current Assessment and Care Plan dated 04/23/20 revealed: -Resident #6 needed a walker for ambulation/locomotion. -Resident #6 was sometimes disoriented. -Resident #6's memory was adequate. -Resident #6 needed limited assistance with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and transferring. Observation of Resident #6 on 01/26/21 at 1:51pm revealed: -The resident was observed standing up in her bedroom with her wheelchair behind her and both hands on the bed. -Resident #6 had incontinent linen savers positioned over the seat of her wheelchair. -The incontinent linen savers were soaking wet and a urine odor was detected. -Resident #6's pants were saturated. -The resident was slightly leaning over the bed while attempting to raise her legs up on the bed. -There was no staff visible. -Loud verbal attempts were made several times to alert the medication (MA) that Resident #6 needed assistance immediately. -The MA verbally responded from down the hallway that she was coming to the resident's room. -Resident #6 continued to attempt to raise her legs on the bed, the resident's head was face down on the bed, legs bending at the knee and the resident was progressively falling toward the left. -The resident was supported on both sides of her body until the MA entered the room and assisted	D 269		

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Resident #6 to sit in the wheelchair.

Interview with the MA on 01/26/21 at 2:27pm revealed:
-She was not able to do everything needed when she worked by herself in the designated COVID-19 unit.
-The residents on the designated COVID-19 unit needed a MA and a personal care aide (PCA) in order to get the residents needs completed.
-Resident #6 required incontinent care every 2 hours.
-She knew Resident #6 was soiled and needed incontinence care provided after lunch but she had not had a chance to assist Resident #6.
-She last provided incontinent care for Resident #6 at the beginning of her shift which started at 7:00am on 01/26/21. Incontinence care should be performed every 2 hours, however, she had not yet had time to provide incontinent care for Resident #6 since after breakfast this morning (01/26/21).
-Resident #6 needed staff assistance to transfer but had a tendency to attempt to transfer herself.
-Resident #6 was at risk for falling when she attempted to transfer independently.

Interview with a MA on 01/27/21 at 7:40am revealed:
-Resident #6 was dependent on staff to transfer.
-Resident #6 was dependent on staff for incontinent care.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

Telephone interview with the Administrator on 01/29/21 at 10:45am revealed:
-Skin breakdown for Resident #6 was a concern

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when she was wet with urine and had not received every 2 hour incontinent checks from staff.
-Staff were not required to document when every 2 hour incontinent checks were done.

Refer to the interview with the Administrator on 01/27/21 at 2:29pm.

Refer to the telephone interview with the former Administrator on 01/28/21 at 1:38pm.

Refer to the telephone interview with the Administrator on 01/29/21 at 10:54am.

2. Review of Resident #5's current FL-2 dated 01/25/21 revealed:
-Diagnoses included chronic pain, hypertension, pneumonia, "COVID", failure to thrive, transurethral resection of the prostate, hydronephrosis, and arthritis.
-The resident was intermittently disoriented.
-The resident was incontinent of bowel and bladder.

Review of Resident #5's current Assessment and Care Plan dated 12/29/20 revealed:
-The resident was always disoriented and had significant memory loss and required direction.
-The resident required limited staff assistance with eating, extensive staff assistance with transferring and dependent on staff for toileting needs.

a. Observation of Resident #5 on 01/26/21 at 11:20am revealed the resident was lying in bed with his eyes closed in his room.

Interview with the medication aide (MA) on 01/26/21 at 2:27pm revealed incontinence care

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should be performed every 2 hours, however, she had not yet had time to provide incontinent care for Resident #5 since after breakfast this morning (01/26/21).

Telephone interview with the Administrator on 01/29/21 at 10:45am revealed:
-She had concerns why staff were not providing every 2 hour incontinent checks for the residents.
-Staff were not required to document when every 2 hour incontinent checks were done.

Refer to the interview with the Administrator on 01/27/21 at 2:29pm.

Refer to the telephone interview with the former Administrator on 01/28/21 at 1:38pm.

Refer to the telephone interview with the Administrator on 01/29/21 at 10:54am.

b. Review of an undated and unlabeled list of residents' residing on the COVID-19 unit on 01/26/21 - 01/27/21 revealed
Resident #5 required assistance from staff with transfers.

Interview with a MA on 01/27/21 at 7:40am revealed:
-Resident #5 was dependent on staff to transfer.
-Resident #5 was dependent on staff for incontinent care.

Interview with a personal care aide (PCA) working on the designated COVID-19 unit on 01/27/21 at 8:35am revealed:
-Today (01/27/21) was her first day working at the facility.
-She thought every resident had gotten out of bed this morning (01/27/21).

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-She was not aware Resident #5 needed transfer assistance from staff.
-She was not aware Resident #5 was on the unit.
-She would find out what type of assistance the resident needed and would follow-up.

Observation of the PCA on 01/27/21 at 8:44am revealed:
-The PCA entered Resident #5's room.
-The room light was off.
-The PCA called Resident #5's name a few times before the resident answered.
-Resident #5 told the PCA to leave the room.

Interview with a MA working on the designated COVID-19 unit on 01/27/21 at 8:44am revealed Resident #5 had a routine of getting out of bed around lunch, some days he got out of bed earlier.

Telephone interview with the Administrator on 01/29/21 at 10:45am revealed:
-She had concerns that the PCA was not told about Resident #5 and his needs for staff assistance.
-The MA would have been responsible to ensure the PCA was aware of what type of assistance Resident #5 required.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

Refer to the interview with the Administrator on 01/27/21 at 2:29pm.

Refer to the telephone interview with the former Administrator on 01/28/21 at 1:38pm.

Refer to the telephone interview with the

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Administrator on 01/29/21 at 10:54am.

3. Review of Resident #1's current FL-2 dated 07/26/20 revealed:
-Diagnoses included chronic obstructive pulmonary disease, hypertension, macular degeneration, polymyalgia, rheumatica, iron deficiency, and actinic keratosis.
-The resident was semi-ambulatory with the use of a walker.
-The resident's orientation section was blank.

Review of Resident #1's current Assessment and Care Plan completed on 01/21/21 revealed:
-There was a handwritten entry on the care plan "waiting on md to sign".
-The resident was oriented, and her memory was adequate.
-The resident required extensive staff assistance with bathing.
-The resident required limited staff assistance with ambulation and transferring.

Review of Resident #1's previous Assessment and Care Plan dated 12/13/19 revealed:
-The resident's assistance level for bathing was blank.
-There was a handwritten entry of "yes" for personal care service need for a tub bath or shower.

Interview with Resident #1 on the designated COVID-19 unit on 01/26/21 at 1:30pm and on 01/27/21 at 8:16am revealed:
-The resident was unsteady and her eyesight was decreased.
-The resident needed staff assistance with bathing and assistance in and out of the shower because she did not want to fall.
-Staff were previously (approximately one month

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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ago) helping her with bathing.
-The resident had been independently sponge bathing and using wet wipes to bathe for approximately one month.
-The resident had been using a dry shampoo product to wash her hair.
-She had not asked staff for assistance and staff had not offered any assistance with her bathing and personal care for about one month.
-Staff had assisted her prior to the last few weeks to bathe and wash her hair.
-She thought staff did not have time to help her with bathing because staff were working alone in the unit.

Interview with the MA on 01/26/21 at 2:27pm revealed the residents on the designated COVID-19 unit needed a MA and a personal care aide (PCA) in order to get the residents needs completed.

Telephone interview with Resident #1's family member on 01/27/21 at 11:27am revealed:
-The resident was "feeble" and had visual impairments.
-A few months ago, the resident called the family member and requested dry shampoo and wet wipes.
-The family member asked the resident why she needed these items and the resident responded "just in case".
-The resident was asked if staff were assisting her with bathing, and at first the resident did not want to tell the family member but later on reported staff had stopped assisting her with bathing.
-On 01/13/21, the Resident Care Director (RCD) contacted the family member concerning the resident's COVID-19 test results.
-The resident called the family member on

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01/14/17 and sounded "distraught".
-The family member had never heard the resident sound "that way".
-The resident told the family member that she had to help them (the residents).
-The resident reported she was "dirty".
-The family member then sent the RCD a text on her personal cell phone that was provided on 01/13/21.
-The RCD had "yet" to call her back.

Review of a text message sent from Resident #1's family member to the RCD's personal phone with a time stamp on 01/14/21 at 1:30pm revealed:
-There was no one around to assist the residents.
-The resident reported that she was dirty.
-The family member requested for the RCD to have the Administrator contact her since the family member could "never get through to anyone there".

Telephone interview with the Administrator on 01/29/21 at 10:45am revealed:
-The RCD never reported any concerns of a text or call related to Resident #1 or a request for her to call Resident #1's family member.
-The RCD would have been responsible to notify her of the message from Resident #1's family member.
-The RCD was not available for interview.

Attempted telephone interview with Resident #1's PCP was unsuccessful on 01/29/21 at 9:24am.

Refer to the interview with the Administrator on 01/27/21 at 2:29pm.

Refer to the telephone interview with the former Administrator on 01/28/21 at 1:38pm.

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D 269	Continued From page 29 Refer to the interview with the Administrator on 01/29/21 at 10:45am. _____ Interview with the Administrator on 01/27/21 at 2:29pm revealed she expected all residents to be checked every two hours. Telephone interview with the former Administrator on 01/28/21 at 1:38pm revealed: -The staff were trained to check on all residents every two hours. -All staff knew what the residents personal care needs were from the electronic system under the Activities of Daily Living (ADL) section. -The medication aides (MAs) and the personal care aides (PCAs) could provide personal care to a resident. -Her expectation was for the residents to receive the personal care they needed every two hours. -If a resident refused personal care the PCA would let the MA know and the MA would let the Resident Care Director (RCD) know. -Residents who refused care were discussed in the monthly meetings. Telephone interview with the Administrator on 01/29/21 at 10:45am revealed: -She expected all residents personal care needs to have been met. -The MA would have been responsible to report any personal care issues or concerns to her. -She had not received any issues or complaints from staff. _____ The facility failed to provide personal care assistance for 3 of 7 sampled residents including a resident who was fully dependent on staff for her toileting, safe transferring needs and at risk for falling as evidenced by staff who was aware	D 269		

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D 269	Continued From page 30 the resident was soiled with urine around lunch and had not provided the resident with incontinence (due to one staff caring for all of the needs of the resident) care until approximately 7 hours later when the resident was observed without staff, saturated in urine, attempting to transfer herself alone to her bed and from her wheelchair (#6); a resident who had not received assistance with incontinence care on 01/26/21 and staff not aware the resident was on the unit on 01/27/21 (#5); and a resident who required staff assistance with bathing and had not been provided personal care needs in approximately one month. This failure resulted in substantial risk of physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 28, 2021.	D 269		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and (3) It is not the home's obligation to pay for a resident's toll calls	D 324		

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This Rule is not met as evidenced by:
Based on interviews and record review the facility failed to ensure residents had access to a telephone to receive calls as evidenced by residents' family members being unable to reach residents when calling the facility.

The findings are:

Telephone interview with a resident's family member on 01/19/21 at 10:00am revealed:
-The family member tried to call the facility's main telephone number numerous times and was unable to get in contact with anyone.
-The number that was called, transferred to a sister facility and informed the family member "no one was picking up" or "the staff were busy taking care of residents at that time", and was given an option to leave a message.
-The family member had left numerous messages and was still waiting on a call back from the facility.

Telephone interview with a second resident's family member on 01/26/21 at 3:30 pm revealed:
-The family member had called the facility's main telephone number "several" times with no response.
-The family member could not reach the facility because the phone calls were being transferred to a sister facility.
-The Administrator did not return telephone calls when a message was left for her.
-A resident's family had to give messages to a medication aide (MA) to call family member regarding care.
-In the past two months, the Administrator's

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voicemail had been full.

Telephone interview with a third resident's family member on 01/27/21 11:27am revealed:
-On 01/13/21, the Resident Care Director (RCD) contacted the family member by telephone regarding the resident's diagnostic testing performed.
-The RCD informed the family member after their telephone conversation to contact the facility if she had any concerns.
-The family member informed the RCD that no one at the facility was able to be contacted due to the telephone system.
-When attempts were made to call the facility, there would be no answer, the voice mailbox was full and they were unable to leave a message.
-The call would be redirected to a sister facility and when a message was left, a returned call was not received.
-There had been a communication issue with the telephone system for "months and months".
-The RCD offered and provided the family member with her personal cell number because of the difficulty the family member had when calling the facility.
-The resident called the family member on 01/14/17 and sounded "distraught".
-The family member had never heard the resident sound "that way".
-The resident told the family member that she had to "help them" (the residents).
-The family member immediately called the facility and when the family member received a ring tone, the call disconnected.
-The family member then sent the RCD a text on her personal cell phone provided on 01/13/21.
-The RCD had not responded to the text message.

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Review of a text message sent from Resident #1's family member to the RCD's personal phone with a time stamp on 01/14/21 at 1:30pm revealed:
-There was documentation the family member had called the facility again to speak with the Administrator and no one answered, the voicemail was always full and then the call would automatically disconnect.
-The resident had just called the family member and was "frantic" and the "desperation" in her voice was "disturbing".
-The resident reported that the residents in the "COVID unit" were neglected and last night the resident and her roommate were freezing.
-There was no one around to assist the residents.
-The resident reported that she was dirty.
-The family member requested for the RCD to have the Administrator contact her since the family member could "never get through to anyone there".
-There was documentation the family member requested the RCD to make sure the heat was turned on and up for now.

Telephone interview with the Administrator on 01/29/21 at 10:45am revealed:
-The RDC's last day of employment was 01/27/21 and the last day the RCD was working inside the facilty was 01/18/21.
-She verified the RCD's personal cell number.
-The RCD never reported any concerns of a text or call from a resident's family or a request for her to call the family for specific concerns.
-The RCD would have been responsible to notify her when the message was received from the resident's family member.
-The RCD was not available for interview.

Interview with a MA on 01/27/21 at 1:30pm and at

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3:00pm revealed:
-The designated COVID-19 unit had a stationary phone at the nurse's station.
-There were times she could not answer the telephone when calls were received because she would be busy assisting residents down the hall.
-There was a "glitch" in the phone system.
-There had been an incident when she attempted to call the facility and her call was transferred automatically to a sister facility.
-This incident occurred about one month ago and she reported it to the RCD.

Telephone interview with a fourth resident's family member on 01/27/21 at 1:31pm revealed:
-She had called the facility's main telephone number "a couple of times" and was not able to get an answer.
-She had some of the staffs' personal cell phone numbers.
-She would call the staff if she wanted to find out about her family member.

Telephone interview with a fifth family member on 01/27/21 at 1:37pm revealed:
-The family member attempted to call the facility a few weeks ago and was not able to reach anyone.
-The family member notified the RCD of the telephone concern.

Telephone interview with the former Administrator on 01/28/21 at 1:38pm revealed:
-All calls went to a main call center until 7:00pm or 8:00pm after that the calls would go straight to the community.
-She had been aware there was a problem reaching the facility after the call center quit answering the phone at night.
-She had given families her personal cell phone

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number.
-When there was no staff in the office then the floor staff had to answer the phone and they might have been busy at times and unable to answer the telephone.

Telephone interview with a sixth family member on 01/28/21 at 3:12pm revealed:
-The family member had challenges trying to reach the facility via telephone.
-The family member attempted to call the facility a few weeks ago and received a message the voicemail box was full.
-The family member notified the current Administrator of the telephone concern.

Interview with another resident's family member on 1/28/2020 at 3:35 pm revealed:
-In the past 3 months, she had been unable to reach the facility via phone or email.
-She had emailed the Administrator and Business Office Manager (BOM) several times with no response.
-When calling the facility, calls were transferred to the Corporate Office or to a sister facility.
-The Corporate Office and the sister facility that the telephone calls were being transferred to would not know who was in charge at the facility.
-When asked for a call back, the Administrator did not call the family back.

Telephone interview with the Administrator on 01/29/21 at 10:54am revealed:
-She had recently requested cordless telephones so when no one was in the office the floor staff would be able to answer the telephone.
-She knew the voicemail box was full.
-She had not been able to "figure out" the voicemail box system and was attempting to locate which extension had the full voicemail.

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D 324	Continued From page 36 -She had concerns about the telephone system because the residents' families should be able to get in touch with their family members. -She had provided families her email address. -The RDC's last day working inside the facilty was 01/18/21.	D 324		
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 record reviews and interviews, the facility failed to contact the Power of Attorney for 1 of 1 sampled resident (#7) related to the resident being diagnosed with COVID-19. The findings are: Review of Resident #7's current FL-2 dated 05/07/20 revealed diagnoses included memory loss, dementia, hyperlipidemia, macular degeneration, osteoarthritis and hypothyroidism. Telephone interview with Resident #7's Power of Attorney (POA) on 01/28/21 at 3:35 pm revealed: -Resident #7's POA was never notified Resident #7 was tested for or was diagnosed with COVID-19. -The POA was notified of positive test results after Resident #7 was transferred off the designated COVID-19 unit two weeks later. -The POA's contact information was provided to the facility and documented on the resident register form on admission.	D 338		

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D 338	Continued From page 37 Review of Resident #7's Progress noted dated 01/07/21 at 7:16 pm revealed there was an entry by the Resident Care Director (RCD), attempted to call POA to update on resident condition including COVID-19 testing and absence of signs and symptoms related to residents positive COVID-19 test. Telephone interview with the Administrator on 01/29/21 at 1:39pm revealed: -The Administrator was unaware the family member was not contacted about Resident #7 being tested or being diagnosed with COVID-19. -Anytime a resident was being tested for COVID-19 or tested positive for COVID-19 the RCD was responsible for contacting the family member and documenting the notification. -The RCD would have been responsible to continue attempts to contact the family member and document those attempts in the residents' electronic progress notes. -The RCD would have been responsible to notify the Administrator when attempts to contact the residents' family member were unsuccessful and a letter would have been sent to the residents' family to update the contact information.	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 disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and	D 612		

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D 612	Continued From page 38 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: TYPE B VIOLATION 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) and the Local Health Department (LHD) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to staff not wearing personal protective equipment (PPE) as evidenced by staff wearing face masks below the nose and mouth while in close proximity with residents and staff 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 (LTC) facilities dated 12/14/20 revealed: -Residents and visitors should wear their own cloth mask (if tolerated) upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a facemask or cloth mask. -Residents may remove their cloth mask when in their rooms but should put it back on when	D 612		

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around others (e.g., when visitors enter their room) or leaving their room.
-The staff should wear a facemask at all times while they are in the healthcare facility, including in breakroom's or other spaces where they might encounter co-workers.
-Staff working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with COVID-19 infection.
-If COVID-19 infection is not suspected in a patient presenting for care (based on symptom and exposure history), staff should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).
-They should also wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters.
-Recommended PPE 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 available) and gown and gloves should be used in addition to PPE listed above for direct contact.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed:
-Face masks should be worn throughout the facility by all residents, staff and visitors.
-If COVID-19 was identified in the facility, staff should wear recommended PPE of facemask or N95 mask (if available), gown, gloves and face shields to care for residents in isolation or quarantine.

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D 612	Continued From page 40 Review of the census provided on 01/26/21 revealed there was a total of 44 residents residing in the facility. Interview with the Administrator on 01/26/21 at 8:45am revealed: -The facility was performing weekly COVID-19 testing for all residents and staff through an outside provider. -The facility was also performing additional "in-house" testing. -The facility was following guidance provided by DHHS, CDC, and the local health department (LHD). -There were residents at the facility and there were facility staff who had tested positive for COVID-19. -The facility had established a designated COVID-19 unit on the 300 hallway of the facility around the first of January 2021. -There were currently 16 residents on the designated COVID-19 unit. -There were 14 out of the 16 residents residing on the designated COVID-19 unit that would be eligible to be moved out of the unit this week due to reaching fourteen days of quarantine and being asymptomatic. -There were three residents who had been hospitalized who tested positive for COVID-19. -One of the residents hospitalized returned to the facility yesterday, (01/25/21) and was assigned to a room on the designated COVID-19 unit for 14 days. -A second resident currently hospitalized was scheduled to return to the facility today (01/26/21) or tomorrow (01/27/21). -A third resident had been in the hospital 3 weeks with no current estimated date for discharge.	D 612		

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D 612	Continued From page 41 A second interview with the Administrator on 01/28/21 at 9:00am revealed the facility had not had any deaths related to COVID-19. Review of an undated facility staff roster with COVID-19 testing and read dates revealed there were 15 facility staff who tested positive for COVID-19 from 12/15/20 - 01/22/21. a. Observations on 01/20/21 from 4:00pm to 5:05pm revealed at the entrance/exit of the designated COVID-19 unit there was no personal protection equipment (PPE) station set-up for staff to retrieve PPE when entering or to dispose/replace PPE when exiting the COVID-19 unit. Observation of the first medication aide (MA) in the designated COVID-19 unit on 01/27/21 at 7:27am revealed she walked in the hallway talking on a cellphone with her mask pulled down to her chin. Observations on the designated COVID-19 unit 01/27/21 intermittently from 6:44am -7:40am revealed: -The third shift MA entered the hallway wearing a surgical face mask. -At 6:48am, she was in the hallway with her face mask below her nose. -At 6:49am, the third shift MA was talking with a resident in the hallway with her face mask below her nose. -The third shift MA and the resident both had their face masks positioned below their nose and were not socially distanced 6 feet apart. -At 6:52am in the hallway, the third shift MA had her face mask positioned below her nose talking with a resident who also had her face mask below her nose.	D 612		

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D 612	Continued From page 42 -At 7:05am, the third shift MA was walking in the hallway and at nurse's station and was not socially distanced of 6 feet apart to the first shift MA with her face mask below her nose. -At 7:13am, the third shift MA was observed with her mask below her mouth and nose talking with two other staff less than 6 feet apart from one another. -At 7:14am, the third shift MA continued to wear her face mask below her mouth and nose and was in the hallway, talking with a resident who was also wearing her face mask below her nose. -At 7:23am the third shift MA was wearing her face mask below her nose when talking with the first shift MA and not socially distanced and less than 6 feet apart from one another. -At 7:24am, the third shift MA had her face mask positioned below her nose while talking with the first shift MA. -At 7:30am, the third shift MA had her face mask positioned below her nose and not socially distanced less than 6 feet apart from the first shift MA. Interview with the third shift MA on 01/27/21 at 7:40am revealed: -She had been working at the facility in the designated COVID-19 facility for the last 2 weeks on the 7:00pm-7:00am shift. -She had not seen the Administrator monitoring the unit to ensure proper PPE was worn by staff. -She was not aware she had pulled her face mask below her nose and below her mouth and nose at times, it was "a habit". Interview with a MA on 01/20/21 at 4:35pm revealed: -Staff were required when entering the designated COVID-19 unit to wear a face mask, face shield and gown at all times.	D 612		

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D 612	Continued From page 43 -Staff retrieved PPE from the nurse's cart or medication room located at the nurse's station on the designated COVID-19 unit. Interview with a personal care aide (PCA) on 01/21/21 at 2:30pm revealed: -Staff were required to wear a face mask, face shields and gowns at all times when on the designated COVID-19 unit. -The supplies were located on the nurses' cart or medication room. Interview with the Administrator on 01/20/21 at 5:20 pm revealed: -Staff were required to enter/exit from the patio to the designated COVID-19 Unit. -There were PPE supplies on the designated COVID-19 unit for all staff members. -Staff were required to wear full PPE (facemasks, gowns, face shields and gloves). -She had not visited on the designated COVID-19 unit and was instructed by corporate not to go on the designated COVID-19 unit. Observation of the facility's supply of PPE in the main office of the facility on 01/27/21 at 8:30am revealed: -There were seven large cardboard boxes of gowns. -There were at least two large clear bags of face shields. -There were several boxes of gloves. Telephone interview with the former Administrator on 01/28/21 at 1:38pm revealed: -The staff had training on wearing face masks, face shields, gowns and gloves. -The staff providing direct care to residents who tested positive for COVID-19 were to wear face shields, face masks and gowns.	D 612		

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D 612	Continued From page 44 -There was a hook outside the residents' rooms, and the staff could hang their gowns up and disinfect them as needed. -Her expectation was always for the staff to wear gowns and face masks on the designated COVID-19 unit. -She did not know of any issues with staff not wearing a gown and face masks on the designated COVID-19 unit. Telephone interview with the Administrator on 01/29/21 at 10:54am revealed: -Staff in the designated COVID-19 unit should be wearing a face mask, face shield and gown at all times. -She had not been on the designated COVID-19 unit, so she was not aware staff did not have on proper PPE. -Wearing the face mask, face shield and gown would help prevent the spread of COVID-19. -She did not physically monitor the designated COVID-19 unit to decrease spread of the virus in the building and depended on the MA to inform her of any concerns. Telephone interview with the Communicable Disease Nurse at the local health department on 01/29/21 at 9:40am revealed: -Staff should keep full PPE on while in the designated COVID-19 unit because it protected them and others from further spread of COVID-19. -The facility needed a non-touch receptacle to dispose of PPE when coming off the designated COVID-19 unit. b. Observations on 01/20/21 from 4:00 pm to 5:05 pm revealed no re-direction from the medication aide (MA) was provided to three residents about wearing face mask.	D 612		

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D 612	Continued From page 45 Interview with a MA on 01/20/21 at 4:35pm revealed: -Residents were asked when they left their room to wear their face mask at all times, unless taking medication or eating/drinking. -She let the residents know when she saw them not wearing a face mask, to put their face mask on or ask if they need a new face mask. Interview with a personal care aide (PCA) on 01/21/21 at 2:30pm revealed she tried to remind the residents to wear their face masks. Interview with a resident on 01/20/21 at 4:10pm and on 01/26/21 at 1:30pm pm revealed: -She wore her face mask every time she left her room. -She had seen a lot of residents not wearing their face masks and staff did not say anything to them. -Residents were told to wear their face masks when leaving their rooms. -"Some" staff would tell residents to put a face mask on or pull up their mask over their nose. Observations of the residents in the designated COVID-19 unit on 01/27/21 between 6:48am to 8:10am revealed staff were in the hallway with residents and did not provide any redirection to residents to reposition or pull up their face masks. Observations on the designated COVID-19 unit 01/27/21 intermittently from 6:44am -7:40am revealed: -The third shift MA did not redirect the resident to practice social distancing or reposition her face mask over her nose. -At 7:10am, the MA did not prompt a resident to adjust her face mask above her nose.	D 612		

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D 612	Continued From page 46 -At 7:11am, two MAs at the nurse's station did not redirect a resident to adjust her face mask. -At 7:14am, the third shift MA did not redirect a resident to adjust her face mask above her nose. Interview with the third shift MA on 01/27/21 at 7:40am revealed: -She was trained to redirect residents to wear a face mask when in the hallways. -She knew to redirect residents to apply a face mask and make sure the face mask covered the residents' mouth and nose when seen in the hallway without a face mask or attempt to redirect the resident to their room. -She was unable to provide an answer why she did not provide any redirection to the residents when the residents were in the hall without a face mask covering their nose. Interview with a MA on 01/27/21 at 1:30pm revealed staff had been trained to redirect residents to apply a face mask when leaving their rooms. Interview with Administrator on 01/20/21 at 5:20 pm revealed staff were instructed to redirect residents to wear their face masks when out of the room. _____ The facility failed to follow the Centers for Disease Control (CDC), North Carolina Department of Health and Human Services (NC DHHS) and the Local Health Department (LHD) guidelines and recommendations for coronavirus (COVID-19) during the global pandemic which resulted in residents not being redirected by staff to wear face masks when in the hallway and staff observed wearing face masks below the nose and/or mouth to prevent the spread of COVID-19 which placed residents at risk for increased	D 612		

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D 612	Continued From page 47 transmission and spread of COVID-19. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/26/21 with an addendum on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 15, 2021	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 regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 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 housekeeping and furnishings. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure the floors were kept clean in the hallway, several resident rooms, resident bathrooms and the common bathroom/shower/spa room and on a shower wall in the designated COVID-19 unit. [Refer to Tag 0074, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings (Type B Violation)].	D912		

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D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect as related to personal care, infection prevention and control, and personal care and other staffing. The findings are: 1. 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) and the Local Health Department (LHD) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to staff not wearing personal protective equipment (PPE) as evidenced by staff wearing face masks below the nose and mouth while in close proximity with residents and staff and redirection of residents to use face masks when out of their rooms. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)]. 2. Based on observation, interviews and record reviews, the facility failed to provide adequate staffing to meet the needs of residents residing in the designated COVID-19 unit, with a resident census ranging from 7 - 22 for the month of January 2021, for residents who required	D914		

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D914	Continued From page 49 additional staff assistance with supervision due to disorientation, who were dependent and/or required staff assistance for incontinence care, meal set-up and assistance with eating, transferring, dressing and bathing. [Refer to Tag D0204, 10A NCAC 13F .0604(e)1(E) Personal Care and Other Staffing (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 3 of 7 sampled residents (#6, #5, and #1) who required staff assistance with transferring and incontinence care (#6, #5) and a resident who needed assistance with bathing (#1). [Refer to Tag D0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].	D914		