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	HAL033005	A. BUILDING: _____ B. WING _____	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 08/24/20 and a desk review survey on 08/24/20 to 08/28/20 and 08/31/20 to 09/04/20 with a telephone exit date on 09/04/20.	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: Based on interviews and record reviews the facility failed to ensure referral and follow up to meet the healthcare needs of 2 of 8 sampled residents (#7 and #8) by failing to notify the residents' primary care provider (PCP) or the registered nurse (RN) for hospice of decreased O2 saturation levels (#7) and by failing to notify the residents' primary care provider (PCP) for a resident that was refusing meals (#8) The findings are: 1. Review of Resident #7's current FL-2 dated 02/04/20 revealed: -Diagnoses included dementia with behavior disturbances, gastroesophageal reflux disease (GERD), hypertension, history of recurrent urinary tract infection, anxiety, depression and constipation. -The resident was semi-ambulatory and used a wheelchair to aid mobility. -The resident required total care.	D 273		

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Review of Resident #7's current care plan dated 02/04/20 revealed that she required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfer.

Review of Resident #7's documented oxygen saturation levels (O2 sats) from 07/02/20 thru 08/26/20 revealed:
-There was documentation for 07/31/20 that Resident #7 had an O2 sat of 72%.
-There was documentation for 08/03/20 that Resident #7 had an O2 sat of 90%.
-There was documentation for 08/07/20 that Resident #7 had an O2 sat of 77%.
-There was no staff name on the handwritten pages that indicated the staff member that obtained or documented the O2 sats for the resident.

Review of care notes provided by the facility revealed there was no documentation regarding decreased O2 sats for Resident #7.

Review of Resident #7's record reveale there was not order for O2 sats to be obtained.

Telephone interview with a medication aide (MA) on 08/25/20 at 11:25am revealed that residents temperature and O2 sat was taken daily on residents that had tested positive for COVID-19.

Telephone interview with the Resident Care Coordinator (RCC) on 09/03/20 at 2:37pm revealed:
-The medication aides (MA) were responsible for obtaining temperature and O2 sats on all COVID-19 positive residents.
-The MA would be responsible for notifying Hospice of any concerns with O2 sats for those residents that were on hospice services.

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-The primary care provider (PCP) should be notified for decreased O2 sats obtained for those residents not receiving hospice services.
-She expected to be notified of decreased O2 sats along with the PCP and/or hospice nurse.
-She was not aware of any O2 sats 90% or less for Resident #7.
-She did not know if Resident #7's PCP or the hospice RN had been notified.

Telephone interview with the RN for the facility's contracted hospice provider on 09/03/20 at 3:30pm revealed:
-She was not notified of Resident #7's decreased O2 sat levels.
-She would expect to be notified of any O2 sat 90% or less.

Telephone interview with the primary care provider (PCP) for Resident #7 on 09/04/20 at 2:50pm revealed:
-The facility had not contacted her regarding decreased O2 sats for Resident #7.
-She expected to be notified of any O2 sat of 92% or less.
-She would be concerned about increased agitation and shortness of breath with decreased O2 sats.
-She would be concerned the need for oxygen administration when O2 levels were low.

Telephone interview with the Administrator on 09/04/20 at 3:10pm revealed:
-The Medication Aides (MA)were responsible for obtaining O2 sats.
-She expected the MA to notify the appropriate care provider if O2 sat level was less than 90%-92% and call emergency medical services if there were any other signs of distress.
-She was not aware of decreased O2 sats for

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Resident #7.
-She expected staff to document low O2 sat, interventions and relevant notifications in a care note.

2.Review of Resident #8's current FL-2 dated 04/10/20 revealed:
-Diagnoses included dementia, neuropathy, hyperlipidemia, coronary artery disease, renal failure, chronic obstructive pulmonary disease, hypothyroidism, and cerebral vascular accident.
-The resident was documented as semi-ambulatory and incontinent of bowel and bladder.

Review of Resident #8's current assessment and care plan dated 04/01/20 revealed:
-The resident was totally dependent with toileting and dressing.
-The resident required extensive assistance with bathing.
-There was documentation Resident #8 needed limited assistance with eating.

Review of Resident #8's progress notes revealed:
-Resident #8 had seven meal refusals in July 2020 on 07/07/20, 07/08/20 ,07/14/20, 07/15/20, 07/16/20, 07/19/20 and 07/26/20.
-Resident #8 had five meal refusals in August 2020 on 08/05/20, 08/11/20, 08/12/20, 08/16/20, and 08/23/20.
-There was no documentation the resident's primary care provider (PCP) was contacted after the meal refusals.

Interview with a Medication Aide (MA) on 09/01/20 at 4:22pm revealed:
-There were times Resident #8 refused to get out of bed to eat.
-Staff would ask Resident #8 several times to get

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up for meals and resident would say "no".
-She had been given no training on how to respond to a resident who refused meals.

Interview with a personal care aide (PCA) on 09/02/20 at 4:38pm revealed:
-There were times Resident #8 refused to get out of bed for meals.
-She and other staff would return a second time to encourage Resident #8 to get up.

Interview with the Administrative Assistant (AA) on 09/03/20 at 11:36am revealed:
-Meal refusals should be documented in the progress notes.
-The policy for any refusals was to notify residents PCP of any meal refusals and document in progress notes.
-The expectation would be to notify the PCP of two consecutive days of meal refusals.

Interview with the Resident Care Coordinator (RCC) on 09/03/20 at 4:09pm and 09/04/20 at 11:55am revealed:
-There were times Resident #8 refused to get up for meals.
-Staff would request to assist Resident #8 and he would say "no".
-MAs were expected to document in progress notes any refusals of meals.
-MAs should report meal refusals to the RCC and the Administrator.
-Once notified, the MAs were expected to call the PCP.
-The MA and AA were responsible for notifying the PCP, and the MA should write a note and fax to PCP office regarding any meal refusals.
-If there was no response from the PCP within 3 consecutive days, they would refax the notice of meal refusals until they received a response.

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D 273	Continued From page 5 -The facility had no process for tracking meal refusals. -There was no documentation Resident #8's PCP was notified about any meal refusals. Interview with AA on 09/04/20 at 12:22pm revealed: -She was unsure if the RCC had been notifying the PCP of Resident #8's meal refusals. -It was the responsibility of the RCC to notify the PCP of meal refusals. -There was no designated person to monitor if the RCC had contacted the PCP. Attempted telephone interview with Resident #8's responsible party on 09/02/20 at 9:05am and 09/03/20 at 2:01pm was unsuccessful. Attempted telephone interview with Resident #8's PCP on 09/03/20 at 1:32pm was unsuccessful.	D 273		
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 This Rule is not met as evidenced by:	D 324		

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D 324	Continued From page 6 TYPE B VIOLATION Based on interviews and virtual observations, the facility failed to ensure residents who had tested positive for Coronavirus (COVID-19) and were quarantined due to their diagnosis had access to a telephone to make and receive calls. The findings are: Telephone interview with a medication aide (MA) on 08/25/20 at 2:48pm revealed: -COVID-19 positive residents did not have access to a telephone to communicate with their families. -There was a telephone located on the hall that did not have quarantined residents for the residents to use. -The COVID-19 positive residents didn't have access to the telephone because they were on the quarantined hall. Telephone interview with another MA on 09/03/20 at 10:24am revealed: -The quarantined residents did not have access to a telephone because the only phone on the quarantined hall was at the nurse's station. -There was only one resident on one of the COVID-19 positive halls who had their own cellular phone. -The MA would contact the families for the quarantined residents if they asked her. Telephone interview with the Resident Care Coordinator (RCC) on 08/27/20 at 9:11am revealed: -The residents who were quarantined for COVID-19 did not have access to a telephone to be able to communicate with their families. -The family members of residents who were quarantined would call and speak with the MA to	D 324		

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find out how their family member was doing.
-The families of the COVID-19 positive residents had been notified they were in quarantine.

Telephone interview with the Administrative Assistant on 09/03/20 at 11:50am revealed:
-The facility did not have cordless telephones for the COVID-19 positive residents to use.
-The telephones were corded and located at the nurses' station on the quarantined hall.

Telephone interview with Resident #4's family member on 08/28/20 at 1:25pm revealed:
-He had called the facility on 08/22/20 to speak to Resident #4 and again on 08/24/20 to speak to the resident but he was told he was unable to speak to the resident because was "quarantined."
-The last time he talked to the resident was on 08/15/20.
-On admission, Resident #4 had his own personal cell phone.
-He had tried to call the resident's cell phone to speak with him, but he was unable to get through on the resident's cell phone.
-Prior to 08/15/20, he talked Resident #4 on the resident's personal cell phone once a day for an hour.
-The resident would be "impacted greatly" emotionally and the resident would become depressed because he was unable to talk to his family.

Telephone interview with Resident #4 on 09/02/20 at 10:45am revealed:
-He last talked to his family member two months ago.
-He wanted to talk to his family member to make sure he was ok.

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-He did not know where his cell phone was.
-He had asked a medication aide to find his cell phone, but she did not know where his phone was.
-He could not remember the name of the medication aide that he talked to.
-He did not know if there was another telephone available for him to use.
-His family member would call him once a week on his personal cell phone.
-He began to cry during the telephone interview, because he did not know how his family was doing.
-He was concerned because did not know if his family member was dead or hurt.
-He knew something was wrong with his family member, because he had not heard from him.
-The facility staff had not told him anything about his family member or his cell phone.

Interview with a MA on 09/02/20 at 11:40am revealed:
-Resident #4's cell phone was locked in the medication room on D hall because Resident #4 resided on D hall.
-Resident #4 took his cell phone to the nurses stated three weeks ago to have it charged and placed in the medication room.
-She was the MA that charged Resident #4's cell phone and placed the phone in the medication room.
-Resident #4 always took his phone to the nurse's station when he finished using it so it could be locked up.

Telephone interview with a personal care aide (PCA)/transporter on 09/02/20 at 1:40pm revealed:
-Resident #4 had been quarantined on D hall.
-Quarantined residents did not have access to a

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telephone.
-Resident #4 was more cheerful when he first came to the facility, because his family was very active in seeing the resident.
-Resident #4's family would come to visit him weekly and take him out of the facility to eat at restaurants before the facility stopped visitors.
-Resident #4 no longer was his usual happy self because he had not seen his family.
-Resident #4's cell phone was locked up in the medication room on D hall when he was not using it.
-Anytime he wanted his cell phone, he would ask the medication aides and they would give it to him.
-She did not know why his cell phone had been locked in the medication room.
-The facility did not have a telephone that resident who were quarantined could use.

Telephone interview with the RCC on 09/03/20 at 10:17am revealed:
-Resident #4 was able to ask for his cell phone whenever he needed to use it.
-Resident #4's cell phone was "lost."
-She had looked for it "yesterday" in his room.
-She had not looked in the medication room.
-Resident #4 would request to have his cell phone locked in the mediation room; it was not a facility policy to have his phone locked up.
-Resident #4 would ask the medication aide to charge his cell phone and ask them to lock it up after it charged.

Virtual observation of the medication room on C and D hall on 09/03/20 at 11:18 revealed:
-Resident #4's cell phone was not in the cubby with his name on it.
-Resident #4's cell phone charger was in his cubby.

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D 324	Continued From page 10 Telephone interview with the Administrator on 09/03/20 at 4:19pm revealed: -Residents quarantined on the COVID-19 halls did not have access to a telephone unless the resident had their own personal phone. -The MAs would call families for the quarantined residents or take a message from their families to give to the residents. -She did not know how the facility could get a phone for the COVID-19 positive residents to use. -The telephones on the quarantined hall were at the nurses' station and the residents were quarantined to their rooms. _____ The facility failed to ensure residents who were positive for COVID-19 and were quarantined had access to a telephone to keep in touch with their family members which resulted in Resident #4 not being able to speak with his family member since 08/15/20 and crying during a telephone interview about him not being able to talk to his family. The facility failed to develop a system for quarantined residents to have access to a telephone to contact their families. The facility's failure was detrimental to the well-being of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/04/20 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 19, 2020.	D 324		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 11 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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance for screening, personal protective equipment (PPE)/masks, social distancing with smokers, social distancing in the dining room, and infection control measures, established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) and were implemented and maintained to provide protection of residents in a facility with known residents with positive test results for coronavirus (COVID-19) during a global coronavirus pandemic, and to ensure residents were free of physical abuse regarding allegations of being grabbed and shoved by a staff, and verbal abuse regarding the way staff talked to residents. The findings are: 1. Review of the Center for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) guidelines for the prevention and spread of the coronavirus disease in long term care facilities revealed: -Personnel should always wear a face mask while in the facility. -Visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Personnel should practice social distancing	D 338		

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(remain at least six feet apart) when in common areas.
-Social distancing should be implemented among residents.
-If COVID-19 is identified in the facility, restrict all residents to their rooms.
-Residents with known or suspected COVID-19 should be cared for using recommended personal protective equipment (PPE) including eye protection, gloves, gowns, and face mask.

Based on observations, interviews, and record reviews the facility had thirty-four COVID-19 positive residents on 08/24/20. There were twenty one COVID 19 positive residents residing on A hall and thirteen COVID-19 positive residents residing on D hall. The residents and staff were retested on 08/29/20. There were 29 more residents that tested COVID -19 positive on 08/28/20. Two of the original thirty four COVID 19 positive residents tested negative on 08/28/20. The total number of COVID 19 positive residents was fifty nine on 08/29/20. Five staff members tested COVID-19 positive on 08/28/20. Three of the staff that tested COVID-19 positive on 08/29/20 were observed to be on duty on 08/24/20.

Review of undated resident rosters provided by the facility on 08/25/20 revealed:
-The total census was 89 residents.
-The facility was divided into four halls lettered A, B, C, and D halls.
-The A and D halls were designated COVID-19 positive halls.
-The B and C halls were designated COVID-19 negative halls.
-There were 21 residents quarantined on the A hall.
-There were 15 residents quarantined on the D

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hall.
-There were 23 residents residing on the B hall.
-There were 30 residents residing on the C hall.
-A resident who resided on the A hall, was listed as the first COVID-19 positive resident and was identified on 08/14/20 while hospitalized.

a. Observations upon entering the facility on 08/24/20 at 11:20am revealed there were no screening questions asked of the survey team by the Administrator prior to admittance to the facility.

Review of the facility temperature log dated 08/23/20 - 08/24/20 revealed:
-There were 48 entries documented.
-There were 45 documented temperatures.
-There was a name documented dated 08/23/20 with no temperature reading documented.
-The Administrator documented "8/24/20 took temperature of state inspectors".
-There were no documented temperature results for the surveyors.
-The last entry on the document was undated and only listed a company name with no temperature reading documented.

Observations of a visitor who entered the facility on 08/24/20 at 11:24am revealed there were no screening questions conducted regarding symptoms and/or exposure to COVID-19.

Telephone interview with outside provider on 08/31/20 at 10:39am revealed:
-She visited the facility last week and had her temperature checked upon entering the facility.
-There had been a checklist added in addition to the temperature checks; prior to last week she was only required to check her temperature.

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Telephone interview on 08/31/20 at 3:35pm with the visitor observed entering the facility on 08/24/20 revealed:
-She was a nurse with a local home health agency and visited the facility 1 - 2 times a week.
-When she visited the facility, she stopped in the first room to the right of the entry door, wrote her name down, and "generally" checked her own temperature.
-There "usually" was not anybody in the room.
-She cleaned the thermometer with an alcohol wipe.
-The first day she filled out a screening form/questionnaire was 08/27/20.

Observations of a staff who entered the facility on 08/24/20 at 11:25am revealed the staff entered another room and was observed to check her own temperature with a non-touch temporal thermometer, and there were no screening questions conducted regarding symptoms and/or exposure to COVID-19.

Telephone interview with the MA on 08/25/20 at 10:53am revealed:
-Each staff checked their temperature when the staff arrived in the facility.
-She checked her own temperature when she came to work and logged the results in the temperature notebook kept in the front office.
-Staff had been checking their temperatures "a while" and could not really say when temperature checks started but had been doing them in July and August.
-The Administrator initiated temperature checks and she did not remember the start date.
-There was a note posted at the front of the facility about temperature checks.

Telephone interview with a second MA on

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D 338	Continued From page 15 08/25/20 at 11:26am revealed: -Staff temperatures were checked upon arrival to work at the facility. -The supervisor checked staff temperatures, or the staff could check their own temperature. -After checking their temperature, staff were to report to their assigned work station. -The Administrator had instructed staff if running a temperature, the staff was not allowed to work. -She considered a temperature to be a reading of 99 degrees Fahrenheit (F) and above. -No one had ever said to her what was considered a temperature. Telephone interview with the Administrator on 08/26/20 at 10:32am revealed: -She received COVID-19 information via emails from their provider association. -All information she had received indicated to wear face mask, stay six feet apart, and wash hands. -She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department. -She knew there were screening questions for monitoring COVID-19 transmission. -She did not think she had the COVID-19 facility self screening questionnaire in the facility. b. Observation of a resident walking on the B hall on 08/24/20 at 11:26am revealed: -Upon entry, residents were observed walking in the halls with no face masks/coverings in place. -There were seven residents not social distancing who were observed in the dining room without face masks or face coverings in place. -There was no redirection provided from staff standing in the entryway to the residents to put on a face mask/covering or return to their room. -There was no face mask/coverings offered to the	D 338		

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residents to wear by the staff.
-One resident approached the medication cart where the medication aide (MA) was standing.

Observation of the MA standing at the medication cart on B hall on 08/24/20 at 11:27am revealed:
-The MA prepared medication for the resident.
-There was no redirection from the MA to the resident to wear a face mask/covering.
-The MA was not observed to offer or provide the resident a face mask/covering to wear.

Based on observation, interviews and record reviews it was determined the resident observed on 08/24/20 at 11:27am tested positive for COVID 19 on 08/28/20.

Observation of a second resident walking on the B hall on 08/24/20 at 11:30am revealed:
-The resident approached the entryway area while pulling a bulging black plastic bag where the Administrator was standing.
-The resident was not wearing a face mask/covering.
-The Administrator instructed the resident to take the bulging black plastic bag back to her room.
-The Administrator was not observed to redirect the resident to put on a face mask/covering.

Based on observation, interviews and record reviews it was determined the resident observed on 08/24/20 at 11:30am tested positive for COVID 19 on 08/28/20.

Observations on the C hall on 08/24/20 between 11:50am and 11:54am revealed:
-There were three residents in the hall who were not wearing a face mask/covering.
-A fourth resident entered the C hall who was not wearing a face mask/covering.

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D 338	Continued From page 17 -At 11:52am a resident exited a resident room into the hall and was not wearing a face mask/covering. -Another resident, not wearing a face mask/covering, entered the C hall and went into another resident room. -There were no staff observed on the C hall. Interview with a resident on 08/24/20 at 11:58am revealed: -The resident did not have or wear a face mask/covering. -The residents were provided a face mask/covering when they were going out of the facility for physician appointments. Observations on 08/24/20 at 11:59am revealed: -A staff person approached a resident who had exited the C hall. -The staff person greeted the resident with a hug. -The staff person was wearing a face mask and the resident was not wearing a face mask/covering. Observations of the facility dining room on 08/24/20 at 12:01pm revealed there were seven residents seated and one resident standing who were not wearing a face mask/covering. Observations of the patio smoking area located between the C and D halls on 08/24/20 at 11:47am revealed: -There were 16 residents in the smoking area. -The residents who were not smoking were not wearing a face mask/covering. Observation of the smoking area on 08/24/20 at 1:06pm revealed: -There were 4 residents in the fenced in area with no face masks/covering.	D 338		

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D 338	Continued From page 18 -There was no staff present in the smoking area. -Residents were observed lighting cigarettes using the lit cigarette of another resident. -Social distancing of at least 6 feet was not maintained by residents. Interview and observation of a resident in the smoking area on 08/24/20 at 1:06pm revealed he was not wearing a face mask/covering and complained of being "hoarse". Based on observation, interviews and record reviews it was determined the resident interviewed on 08/24/20 at 1:06pm tested positive for COVID 19 on 08/28/20. Interview with a medication aide (MA) on 08/24/20 at 12:23pm revealed: -She had not seen a policy related to COVID-19. -The facility had posted signs about wearing a face mask. -There was staff instructional information posted in the front office about COVID-19. Telephone interview with the MA on 08/25/20 at 10:53am revealed: -The residents did not wear face masks/coverings. -She did not know if it was a requirement for residents to wear face masks/coverings. -The facility residents who had tested positive for COVID-19 did not have a face mask/covering and stayed in their rooms. Telephone interview with a second MA on 08/25/20 at 11:26am revealed: -The residents only wore a face mask/covering when going out of the facility for physician appointments. -She had not been told the residents needed to	D 338		

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wear a face mask/covering in the facility when the residents were out of their rooms.

Telephone interview with the Resident Care Coordinator (RCC) on 08/26/20 at 9:14am revealed:
-The residents wore a face mask/covering if they had an appointment.
-The residents did not wear a face mask/covering inside the facility unless the resident had a "stomach virus or was throwing up".
-She watched television and watched the news to get information about COVID-19.

Telephone interview with the Administrator on 08/26/20 at 10:32am revealed:
-She received COVID-19 information via emails from their provider association.
-She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.
-She had not required residents to wear a face mask/covering.
-Resident were provided a face mask/covering when the resident went out of the facility for medical appointments and had been doing that prior to COVID-19.
-If a resident requested a face mask/covering, the resident was provided one.
-Staff were required to wear a face mask and she thought the facility was doing everything they should be doing to decrease exposure to COVID-19.

A telephone interview with a nurse for the facility's contracted hospice agency on 08/31/20 at 10:20am revealed that staff at the facility wore some type of face covering and residents did not while in the facility.

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Telephone interview with a home health nurse (HHN) on 08/31/20 at 3:35pm revealed:
-She was a nurse with a local home health agency and visited the facility 1 - 2 times a week.
-She had never seen a resident in the facility wearing a face mask/covering.
-She saw some staff wearing a face mask, and saw some staff not wearing a face mask.
-On 08/31/20, she stopped by the room where temperature screenings were done. A staff was in the room and was not wearing a mask.

c. Observation of the patio area located between the C and D halls on 08/24/20 at 11:47am revealed:
-There were four residents sitting around the end of a picnic table located in the yard.
-A resident was standing between two of the residents who were seated at the picnic table.
-The resident standing was observed within an arm distance of two of the seated residents at the table.
-The residents were not observed wearing face masks/coverings.

Interview with a medication aide (MA) on 08/24/20 at 12:23pm revealed:
-She did not go outside with all residents who smoked.
-She only went outside with residents who needed to be monitored when smoking.
-The COVID positive and COVID negative residents were separated.
-Any COVID positive residents who smoked did not smoke in the patio smoking area.
-Staff tried to tell residents to stay six feet apart, and that was hard to manage.

Telephone interview with the RCC on 08/26/20 at 9:14am revealed:

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-She watched television and watched the news to get information about COVID-19.
-She had to constantly remind the residents to stay six feet apart and the residents did not understand.
-There was a staff in the smoking area "off and on".

Telephone interview with the Administrator on 08/26/20 at 10:32am revealed:
-She received COVID-19 information via emails from their provider association.
-She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.
-The residents who had tested negative for COVID-19 were the only residents going out to smoke in the patio area.
-Some residents go out to smoke "at will".
-Staff checked on residents "intermittently" when residents were in the smoking area, but no staff was posted to go out and watch the residents.
-She could not ensure that residents who went out to smoke alone were social distancing.

d. Observations of the dining room on 08/24/20 at 11:31am revealed:
-There were round and square tables with two chairs placed at each table.
-The two chairs placed across from each other at the tables were positioned four to five feet apart.
-There were two residents seated in the dining room at different tables.

Observation of the dining room on 08/24/20 at 1:15pm revealed:
-At least 2 residents were sitting at each table at opposite sides who were not maintaining social distancing of at least 6 feet apart.
-There were 2 tables at which there were 3

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residents seated who were not maintaining social distancing of at least 6 feet apart..
-There were no residents wearing face masks/coverings.

Telephone interview with a medication aide (MA) on 08/25/20 at 10:53am revealed:
-The facility placed two residents at each table in the dining room who were not maintaining social distancing of at least 6 feet apart.
-The tables were placed six feet apart.

Telephone interview with a second MA on 08/25/20 at 11:26am revealed there were two non-COVID hall residents seated at each table in the dining rooms for meals who were not maintaining social distancing of at least 6 feet apart..

Telephone interview with the Administrator on 08/26/20 at 10:32am revealed:
-She received COVID-19 information via emails from their provider association.
-She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.
-She tried to keep residents six feet apart in the dining room by sitting two residents at each table.
-She changed the dining room seating to two residents per table when she got the state guidance that residents had to be separated.
-All information she had received indicated to wear a face mask, stay six feet apart, and wash hands.
-She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.

e. Observation on the A Hall on 08/24/20 at 12:30pm revealed:

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-Staff were wearing gowns, gloves, masks, face shields and shoe coverings when entering resident rooms to deliver meal and assist them with opening the packets of disposable eating utensils.
-Staff did not change any PPE between rooms.
-Staff was observed to change gowns prior to feeding a resident but did not perform any hand hygiene before donning a clean pair of gloves.

Observation of a personal care aide (PCA) on 08/24/20 at 12:50pm revealed:
-The PCA entered the D hall (COVID hall) through the closed double doors, wearing a face mask, face shield, and shoe covers.
-The PCA was carrying a bedspread in her hand.
-The PCA did not put on a gown or gloves.

Interview with the PCA on 08/24/20 at 12:59pm revealed:
-She knew she was supposed to put on gloves and a gown before entering the COVID hall.
-She did not put on a gown or gloves because she was going to "run in and out".

Observation of the PCA on 08/24/20 at 1:10pm revealed:
-She entered a resident room on one of the COVID positive halls.
-The resident was laying in the bed.
-She adjusted the bed pillow for the resident with her gloved hands as she asked the resident how he was doing.
-She left the resident room and prepared to open the door and enter another resident room without changing her gloves or gown.
-The PCA was prompted by the surveyor to change her gloves before entering the room.

Interview with the PCA on 08/24/20 at 1:14pm

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revealed she "normally" changed her gloves when leaving a resident's room and before entering another resident's room.

Telephone interview with a MA on 08/25/20 at 10:53am revealed:
-Residents on the COVID hall were always monitored and staff let them know they had to remain in their rooms.
-The double doors to the COVID hall were kept closed.
-The Administrator and Administrative Assistant would have the infection control policy in the front office.

Telephone interview with the Administrator on 08/25/20 at 3:17pm revealed:
-The only visitors in the facility "now" were nurses and physicians.
-She received COVID-19 information via emails from their provider association.
-She had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.
-She had not received any information from the local health department (LHD) related to COVID-19.
-All contacts she had with the LHD had been by telephone and she only had "scribbled notes" on those phone calls.
-She had provided information to the staff on COVID-19 via posted notes at the time clock and she gathered a few staff together "at a time" every day.
-She reminded staff every day about steps to prevent transmission and spread of COVID-19.
-She started providing those reminders when "the state closed everything down."

Telephone interview with the Resident Care

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Coordinator (RCC) on 08/26/20 at 9:14am revealed the Administrator got information from the Center for Disease Control (CDC) and passed it on to her and the Administrative Assistant.

Telephone interview with the local health department communicable disease nurse on 09/02/20 at 11:28am revealed:
-The LHD had called the facility "multiple times" for follow up and monitoring of symptoms on those residents who had tested positive for COVID-19.
-The facility got guidance and recommendations on COVID-19 prevention and transmission from the CDC and DHHS.

Telephone interview with the Administrator on 08/26/20 at 10:32am revealed she had not received any information on transmission prevention and monitoring for COVID-19 from the local health department.

Telephone interview with the Administrative Assistant on 08/31/20 at 9:20am revealed:
-Five of the staff retested for COVID-19 on 08/28/20 had tested positive.
-There were 29 additonal residents (from the last test date of 08/24/20) who tested positive for COVID-19 on 08/28/20.

2. Confidential resident interview revealed:
-A named staff was "more of a danger".
-The staff said to the resident "hit me, hit me, hit me".
-The staff had "attacked" the resident twice within minutes apart.
-The staff got in the resident's face and came toward the resident "in a speedy way".
-The staff had placed hands around the resident's

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arm and "tried to shove" the resident.
-The resident told a family member about the incident.
-The resident "thought" the Administrator knew about the incident because the resident thought she had been told by the resident.
-Another staff (named) had to "break it up".
-The resident told another resident (named) about the incident.

Confidential interview with a second resident revealed:
-A staff member was "ugly, rude".
-There was one staff a couple of residents called "satan".
-The staff person "grabs people, threatens them, curse words back and forth, says hit me, hit me".
-The staff person "jerks"[ed] residents around and grabbed them by the arm pushing them to go where she wanted them to go.
-The staff had said to him "hit me, hit me".
-The staff was loud.
- "The way she talks to people, you do anything out of line you gonna go to jail".

Confidential interview with a family member revealed:
-She remembered the resident telling her about a "confrontation" with a named staff not long ago.
-Seemed like it was a couple months ago.
-The named staff "put her hands on [resident] and shoved [resident] and pushed [resident] back".
-The resident was afraid of getting in trouble.
-The named staff kept telling the resident to hit the staff.
-If the resident called the family member and told the family member something, it really was bothering the resident, "it's kind of threatening and intimidating" to the resident and "enticing" the resident to show anger and pick a fight with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL033005	A. BUILDING: _____ B. WING _____	C 09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ROCKY MOUNT	1650 COKEY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 27 resident. The named staff was not available for interview. _____ The facility failed to implement and maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) for screening visitors and staff, social distancing, communal dining, and use of personal protective equipment (PPE), for infection prevention and transmission of coronavirus (COVID-19)during the COVID-19 pandemic in which over 30 residents residing in the facility were diagnosed with COVID-19 on 08/14/20 and additional COVID-19 testing on 08/28/20 revealed 47 residents tested positive for COVID-19. The facility's failure placed the residents at increased risk for contracting and transmitting COVID-19, resulting in substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/27/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 4, 2020.	D 338		
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.	D914		

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D914	Continued From page 28 This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure residents were free from neglect as related to resident rights and abuse and neglect. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance for screening, personal protective equipment (PPE)/masks, social distancing with smokers, social distancing in the dining room, and infection control measures, established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) and were implemented and maintained to provide protection of residents in a facility with known residents with positive test results for coronavirus (COVID-19) during a global coronavirus pandemic, and to ensure residents were free of physical abuse regarding allegations of being grabbed and shoved by a staff, and verbal abuse regarding the way staff talked to residents. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Right (Type A2 Violation)].	D914		
D919	G.S. 131D-21(9) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 9. To have access at any reasonable hour to a telephone where he or she may speak privately. This Rule is not met as evidenced by: Based on virtual observations and interviews, the facility failed to ensure each resident had access to the use of a telephone at a reasonable hour.	D919		

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D919	Continued From page 29 The findings are: Based on interviews and virtual observations, the facility failed to ensure residents who had tested positive for Coronavirus (COVID-19) and were quarantined due to their diagnosis had access to a telephone to make and receive calls. [Refer to D324 10A NCAC 13F .0906(d)(1) Other Resident Care and Services (Type B Violation)].	D919		