FOREST RIDGE
ASSISTED LIVING

November 13, 2020

Diana Spalding RN, BSN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation
2708 Mail Service Center
Raleigh, NC 27699-2708

RE:
Plan of Correction
Survey completed 10/01/2020
Facility License Number HAL-005-015

Ms. Spalding,

It was a pleasure to host your team on September 30, 2020 in your attention to a complaint investigation for Forest Ridge Assisted Living. Please find enclosed the Plan of Correction attached to the Statement of Deficiencies.

I hope that this meets your expectations as the plan of protection did on that day. We have continued to work with our local health department to determine their recommendations and guidance as we experience this unprecedented pandemic of COVID-19. We await your return visit and feel certain you can be satisfied of our compliance and continued partnership towards our residents' well-being.

Respectfully,

Amanda Calloway
Executive Director
Forest Ridge Assisted Living

151 VILLAGE PARK DRIVE • WEST JEFFERSON, NORTH CAROLINA 28694
PHONE (336) 846-1008 • FAX (336) 846-1147 • WWW.RIDGECARE.COM

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail Electronic Mail
7019 0700 0000 1710 6948

October 27, 2020

Mr. Jeff Dickerson, Executive Officer
Forest Ridge Assisted Living, LLC, Licensee
Forest Ridge
853 Old Winston Rd. Suite 118
Kernersville, NC 27284

Email: Amanda.calloway@ridgecare.com; jdickerson@ridgecare.com

Re: COVID-19 Focused Infection Control Survey and Complaint Investigation completed October 1, 2020 (ASPEN Event ID S2HF11)
Type B Violation

Facility:	**Forest Ridge**
Licensure Number:	**HAL-005-015**
County:	**Ashe**

Dear Ms. Calloway:

Thank you for the cooperation and courtesy extended during the survey completed October 1, 2020 by staff with the Adult Care Licensure Section. Based on the survey findings, 1 of 1 complaint allegations was substantiated resulting in deficiencies 10A NCAC 13F .0909 Residents' Rights. Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Type B Violation(s)

- Type B rule violation is cited for **10A 13F .0909 Residents' Rights** and **G.S. § 131D-21 Resident Rights.**
- Type B Violation(s) must be corrected within 45 days from the exit date of the survey, which is November 15, 2020.

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation, the Department shall assess the facility a civil penalty in the amount of up to $400.00 for each day that the violation continues beyond the time specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **November 17, 2020**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **November 17, 2020**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 704-594-0203. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Diana Spalding RN, BSN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies

cc: Ms.Jamie Shepherd, Supervisor, Ashe County DSS
Ms. Amanda Calloway, Administrator w/enclosures
Ms. Heather Bingham, Team Supervisor, West 2 Region, Adult Care Licensure Section

Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: **http://www2.ncdhhs.gov/dhsr/customerservice.html**
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

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	HAL005015	A. BUILDING: _____ B. WING _____	C 10/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 09/30/20, a desk review survey and a telephone exit on 10/01/20.	D 000	Community implemented a staffing pattern that allowed for the cohorting of residents to the best of our ability. Positive and negative staff teams were created that only interacted with those diagnosed as such. Medication carts were divided and arranged in a method to facilitate a positive resident cart and a negative resident cart. A plan of protection was enacted to reflect the recommendation of our local health department to try and cohort residents as practical. All staff have participated in reeducation for residents' rights and a detailed infection control training. To prevent this from occurring again, continued PPE Observations to ensure staff compliance with infection control measures and understanding of policies and procedures will occur. Community will continue monitoring for further guidance from LHD regarding Covid-19 and the recommendations around cohorting of residents during an outbreak.	
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: TYPE B VIOLATION Based on record reviews, observations, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to cohorting staff and residents after an outbreak dated 09/23/20 to reduce risk of transmission and infection. The findings are: Review of the Centers for Disease Control (CDC) guidelines for Preparing for COVID-19 in Nursing Homes and Infection Control for Nursing Homes dated 07/25/20 revealed the facility should identify a space in the facility that could be dedicated to the care for residents with confirmed COVID-19	D 338		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Cady — TITLE: Executive Director — (X6) DATE: 11/13/20

Reviewed and accepted by Diana Spalding RN, BSN on 11/06/20.

DMS

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D 338	Continued From page 1 and identify Health Care Personal (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use. Review of the COVID-19 Long Term Care Infection Control Assessment and Response (ICAR) Tool for Long Term Care facilities (LTCF)s dated 08/20/20 revealed: -Cohort COVID-19 positive residents with dedicated staff in one area and COVID-19 negative residents with dedicated staff in a separate area. -This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of longterm care residents with COVID-19 do not demonstrate symptoms. Review of NCDHHS What to Expect: Response to New COVID-19 Cases or Outbreaks in Long Term Care Settings dated 09/04/20 revealed: -Follow NC DHHS and CDC guidance. -Your LHD will guide you on patient placement, cohorting of patients and staff, and environmental cleaning. -Check CDC guidance for the most up-to-date infection prevention recommendations for long-term care settings. -Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff (i.e. the same staff interact with symptomatic residents and residents who test positive for COVID-19 on an ongoing basis, and do not interact with uninfected residents). Review of the facility's COVID-19/Coronavirus Protocol dated 08/24/20 revealed there was no	D 338	Executive Director, Resident Care Consultant, Resident Care Director and Wellness Directors will all be responsible for continued monitoring for compliance. PPE observations will continue throughout the period of the active outbreak and then intermittently in the months following. Policy will be updated and reviewed as new guidance is provided from the CDC, DHHS or LHD. All re-education for staff and corrected practices will be completed by November 13, 2020.	

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D 338	Continued From page 2 protocol for cohorting, at the facility. Interview with the Administrator on 09/30/20 at 10:20am revealed: -The first reported positive staff COVID-19 case was on 09/23/20. -She contacted the local health department (LHD) on 09/23/20 and reported the first case of COVID-19 and followed the LHD guidance. -The guidance they were given did not include cohorting. -She contacted the LHD again on 09/25/20 with the second staff positive case of COVID-19 and then continued daily with telephone communication. Interview with a Memory Care Unit (MCU) medication aide (MA) on 09/30/20 at 10:39am revealed: -There was one resident in the MCU who tested positive for COVID-19 on 09/28/20. -She was the only MA who administered medications for residents in the MCU today 09/30/20, which included one COVID-19 positive resident and 17 COVID-19 negative residents. -There were approximately 19 residents on the AL side who tested positive for COVID-19 after 09/23/20. -On 09/28/20, she worked 7:00am - 3:00pm on the MCU and 3:00pm - 7:00pm on the Assisted Living (AL) as a MA and administered medications to, both residents who tested negative and those who tested positive for COVID-19 on the AL and MCU. -She was instructed by the Administrator to use personal protective equipment (PPE) when providing care for COVID-19 positive residents and directed residents to remain in their rooms. -After the COVID-19 outbreak on 09/23/20, she was not assigned to COVID negative or positive	D 338		

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D 338	Continued From page 3 residents and she administered medications to residents on both the MCU and AL sides. Interview with a MCU personal care aide (PCA) on 09/30/20 at 11:05am revealed: -He was assigned to work on the MCU only because there were more male residents on the MCU. -He provided care for all the residents on the MCU, including the COVID-19 positive resident. -He was not instructed to provide care only for either COVID-19 positive or negative residents. -Staff could be assigned by the Resident Care Director (RCD) to either AL or MCU and would be providing care for both COVID-19 positive and negative residents. -He was instructed by the Administrator to use PPE when providing care for COVID-19 positive residents and directed positives residents to remain in their rooms. Interview with a MCU Housekeeper on 09/30/20 at 11:26am revealed: -Since the outbreak on 09/25/20 she worked on both the AL and MCU. -Today, 09/30/20, she worked in the MCU and cleaned all 18 rooms on the MCU including the room of the resident who tested positive for COVID-19. -She wore PPE while cleaning the COVID-19 positive resident's room and discarded the gown, gloves and shoe covers before exiting the room. -She then proceeded to the next room on her list which was a COVID-19 negative room. Interview with the MCU Activities Director (AD) on 09/30/20 at 11:33am revealed: -On 09/29/20, the Regional Nurse instructed her to go to the AL side along with the AL AD and collect all the trash and laundry in the COVID-19	D 338		

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D 338	Continued From page 4 rooms. -She was instructed to take the trash out and the AL AD was instructed to wash the laundry. -Since the COVID-19 outbreak on 09/23/20, the staff would work both in AL and MCU. -There was no instruction or assignment from the Administrator to only care for a set of residents either positive or negative or to stay on the MCU or AL. Observation of the AL on 09/30/20 at 11:55am revealed: -A housekeeper exited a resident's room who tested positive for COVID-19. -She pushed her cleaning cart down the hall. -She entered the room of a resident who tested negative for COVID-19. Observation on the Assisted Living (AL) hall on 09/30/20 between 10:35am to 12:00pm revealed: -The AL hall intersected the main hall that began at the entrance to the building and ended at the rear of the building. -There were eighteen COVID-19 positive residents, and twenty-one COVID-19 negative residents residing on the AL hall. -The COVID-19 negative residents' rooms were not cohorted away from the COVID-19 positive residents' rooms. -A MA, and three PCAs were observed redirecting COVID-19 positive residents in the hallway back into their rooms located next to COVID-19 negative residents' rooms. -The COVID-19 positive residents were not wearing masks when they attempted to exit their rooms and used hallway rails to assist themselves with ambulation. -Staff was not wearing gowns, gloves, eye protection, or shoe coverings when assisting or redirecting COVID-19 positive residents back into	D 338		

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D 338	Continued From page 5 their rooms. -The staff did not prompt the residents attempting to leave their rooms to put on a face mask. -The hallway rails were not cleaned and disinfected after positive COVID-19 residents touched them. Interview with a personal care aide (PCA) on 09/30/20 at 10:30am revealed: -She was assigned to provide personal care assistance to all the AL residents. -She provided care for all the COVID-19 negative residents and all the COVID-19 positive residents. -She was not assigned to care for only COVID-19 negative or COVID-19 positive residents. -She was instructed by the RCC to use personal protective equipment (PPE) when providing care for COVID-19 positive residents, and direct residents to remain in their rooms. Interview with a medication aide (MA) on 09/30/20 at 11:02am revealed: -She was assigned to administer medications and assist with personal care for all the AL residents. -She was not assigned to only the COVID-19 negative or COVID-19 positive residents on the AL side of the facility. Interview with the Resident Care Coordinator (RCC) on 09/30/20 at 11:56am revealed: -She was responsible for educating and auditing the staff on infection prevention measures. -The positive COVID-19 residents were moved away from the negative COVID-19 residents. -The staff was assigned to provide care to all the residents. -The staff was not separated to provide care for only negative or positive COVID-19 residents. -The staff was not instructed to provided care to	D 338		

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D 338	Continued From page 6 negative COVID-19 residents and then positive COVID-19 residents because all the residents required care at different times. -She was told by the Administrator to educate and re-enforce keeping positive COVID-19 residents isolated from negative COVID-19 residents. -She and the Regional Director of Clinical Services educated the staff on symptoms of COVID-19, and proper putting on and taking off PPE. Interview with the Regional Director of Clinical Services on 09/30/20 at 12:10pm revealed: -She provided resources and education on infection control for COVID-19 to the staff at the facility. -The residents with COVID-19 positive results were being isolated and moved away from COVID-19 negative residents. -The staff was assigned to all the residents on the AL or SCU. -The staff assignment was not separated to assign staff to COVID-19 positive or COVID-19 negative residents. -The staff was to put on PPE prior to entering a COVID-19 positive resident's room, take off PPE, and use hand sanitizer or wash their hands when exiting a COVID-19 positive resident's room. -The Administrator spoke to the LHD daily on the telephone. -The Administrator told her the LHD did not instruct her to assign separate staff to COVID-19 positive and COVID-19 negative residents. Interview with the Clinical Director of the LHD on 09/30/20 at 3:54pm revealed: -As of 09/30/20 nine staff and twenty residents tested positive for COVID-19. -She spoke to the Administrator daily since the outbreak was reported on 09/23/20.	D 338		

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D 338	Continued From page 7 -On 09/23/20, the Administrator informed her one staff member and three residents tested positive for COVID-19. -On 09/23/20, the Administrator informed her the three positive residents were placed in isolation. -She offered guidance on importance of cohorting the negative residents away from the positive residents. -The Administrator said she would do the best she could. -She was under the "impression" that the Administrator understood cohorting meant to assign separate staff to work with COVID-19 positive residents. -She did not provide a written communication on the LHD guidance to the Administrator. Interview with the Administrator on 09/30/20 at 5:10pm revealed: -She spoke to the LHD daily on the telephone since the outbreak began on 09/23/20. -She informed the LHD all the positive residents were placed on isolation and moved together away from the negative residents. -She was told to do the best she could do to keep residents who wandered out of their rooms in their room. -She was not told to cohort staff. Interview with the Chief Operating Officer (COO) on 09/30/20 at 4:30pm revealed: -The Administrator informed him of the COVID-19 outbreak on 09/23/20. -He and the Administrator received the education and guidance from NC DHHS regarding COVID-19. -The latest guidance from NC DHHS was dated 09/04/20 and addressed cohorting and notification to the LHD. -He did not have communication with the LHD but	D 338		

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D 338	Continued From page 8 it was the responsibility of the Administrator to inform the LHD regarding a COVID-19 outbreak and follow their guidance. -The facility was following the current recommendations from NC DHHS which was to follow the LHD recommendations and that did not include to cohort staff. -The Administrator did try to cohort the COVID-19 positive residents on the AL as recommended and informed the LHD they would "do their best" and no further recommendations were given. -The facility did not have the capability to cohort staff due to staffing issues with COVID-19. -The Administrator did not inform the LHD of any issues with staffing because they handle that on the regional level. -The facility could not cohort residents because the lack of staff and did the "best" they could and "tried" to keep them all together. -The facility had exhausted the as needed (PRN) staffing pools and to a staffing agency with his 18 facilities. -All of the positive COVID-19 residents were not kept on the same hall. -There were 2 COVID-19 residents located on the AL 100 hall, 17 COVID-19 residents located on the AL 200 hall and 1 COVID-19 resident located on the MCU 100 hall. -The facility had a policy related to COVID-19 but it did not contain cohorting because that was something they did not have an issue with until this outbreak. -The staff were not assigned to a set of residents or AL or MCU. Telephone interview with the Communicable Disease Nurse at the LHD on 09/30/20 at 4:16pm revealed: -The Administrator called her on 09/23/20 regarding a staff member who tested positive for	D 338		

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D 338	Continued From page 9 COVID-19. -She gave the Administrator the current recommendation which included cohorting of staff and residents. -She asked the Administrator if they could separate the COVID-19 positives and negative residents. -The Administrator told her they would "do their best" to place the positive COVID-19 residents on one hall. -She informed the Administrator if cohorting of residents was not possible immediately, it was important to make sure they cohort staff. -She instructed the Administrator to use the same staff to take care of the COVID-19 positive residents and not to use those staff to provide care for any other residents that were negative for COVID-19. -She was not informed by the Administrator of any issues related to staffing concerns. -She did not know if the facility had a "COVID-19 hall" or not. -She expected the facility to cohort the residents and staff in order to prevent the spread of COVID-19 through sharing staff with positive and negative COVID-19 residents. Telephone interview with the Clinical Director of the LHD on 10/01/20 at 1:19pm revealed: -She expected the facility to cohort the staff to limit the potential exposure that might occur while providing care for COVID-19 residents and control the spread of COVID-19. -The Administrator did not inform her of any staffing issues. -If the facility cohorted the staff, then it would decrease the chance of cross contamination that goes with staff providing care for positive and negative COVID-19 residents.	D 338		

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FOREST RIDGE	151 VILLAGE PARK DRIVE WEST JEFFERSON, NC 28694

(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 10 Telephone interview with the Administrator on 10/01/20 at 3:54pm revealed: -She received and read all of the documentation supplied by NC DHHS which included cohorting. -She did not include cohorting in the facility's policy and procedure for COVID-19 because up until this outbreak they had not had a reason to cohort. -The company has 18 other facilities which have had many positive COVID-19 outbreaks but they were not told to cohort by the LHD. -She was given the recommendation by NC DHHS in reference to cohorting staff and when she revised her COVID-19 policy and procedure on 08/24/20, she did not include cohorting of staff or residents because up until this outbreak they had not had a reason to cohort. -She described cohorting of residents as, "keeping all of the positive" COVID-19 residents together and assign staff to provide care for the positive COVID-19 residents and do not use that staff to provide care for negative COVID-19 residents. -She read all of the information or guidance she received form NC DHHS, and the CDC that was posted online or sent by the State in an email, and understood what cohorting meant in regards to residents and staff but she did not implement cohorting because it was not recommended by the LHD. The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL005015	A. BUILDING: _____ B. WING _____	C 10/01/2020

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D 338	Continued From page 11 COVID-19 related to not cohorting staff. The lack of cohorting in accordance with the guidance led to to the inability to control the spread of COVID-19 and this increased opportunity for disease transmission. The failure was detrimental to the health and safety of the 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 09/30/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15 , 2020.	D 338		
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 observation, interview, and record review, the facility failed to ensure all residents were free from neglect related to Resident Rights. The findings are: The facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), local health department (LHD), and the North Carolina Department of	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 12 Health and Human Services (NC DHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic for reducing the risk of transmission and infection of COVID-19 related to not cohorting staff. The lack of cohorting in accordance with the guidance led to to the inability to control the spread of COVID-19 and this increased opportunity for disease transmission. The failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D912		