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ADULT CARE LICENSURE SECTION
RALEIGH

PRINTED: 01/28/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051-074	A. BUILDING: _____ B. WING _____	01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANDORA FAMILY CARE HOME II	101 W STEVENS ST SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and a COVID-19 focused Infection Control survey on January 5, 2021 - January 6, 2021 with an onsite visit on January 5, 2021 and a desk review survey and telephone exit on January 6, 2021.	C 000	10A NCAC 13G.0702 Tuberculosis Test and medical Examination a) Upon accepting a new resident referral from a facility, the administrator will request that the facility perform the 1st step of the 2 step TB test. The administrator will require of the facility to document the result of that 1st TB test to include the date of the test, the date the result was read, and the size of the induration	2/6/21
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, #3) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: 1. Review of Resident #1's current FL-2 dated 10/28/20 revealed diagnoses included brain injury, bipolar disorder, stroke, arthritis, COPD (chronic obstructive pulmonary disease), hypertension, pancreatitis, sleep apnea and bladder incontinence.	C 202		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE June Dean TITLE Administrator (X6) DATE 01/29/21

Reviewed and accepted 02/08/2021 - L Tate, R

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C 202	Continued From page 1 Review of Resident #1's Resident Register revealed he was admitted to the facility on 10/01/20. Review of Resident #1's record revealed there were no TB skin test available for review. Telephone interview with the Administrator on 01/05/21 at 1:06pm revealed: -Resident #1 was admitted from another facility. -She was not aware there was no documentation the TB skin test was administered for Resident #1. -She was responsible to ensure the TB skin test was administered upon admission. -The facility was responsible for ensuring TB skin test requirements were completed. Refer to interview with a medication aide (MA) on 01/05/21 at 1:04pm. 2. Review of Resident #2's current FL-2 dated 10/08/20 revealed diagnoses included schizoaffective disorder, bipolar type, hyperlipidemia, hypertension, urinary incontinence. Review of Resident #2's record revealed there were no TB skin test available for review. Telephone interview with the Administrator on 01/05/21 at 1:06pm revealed: -Resident #2 was admitted from a local hospital. -The result of the TB skin test was usually documented on the initial FL-2 sent from the hospital. -She always made sure the hospital administered the TB skin test. -She was not aware Resident #2 needed a TB	C 202	The administrator will request the document containing the 1st TB skin test results be faxed to the administrator before the resident's transfer to the family care home can be arranged. On receiving the TB test results, the administrator will ensure that the TB test results are documented to include the date of administration, the date and results of the test, to include the size of induration if any.	

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C 202	Continued From page 2 skin test. -She was not aware there was no documentation the TB skin test was administered for Resident #2. -She was responsible to ensure the TB skin test was administered upon admission. -The facility was responsible for ensuring TB skin test requirements were completed. Telephone interview with the Administrator on 01/06/21 at 10:55am revealed: -The local hospital medical records department had been contacted about the residents' TB skin test administered. -The hospital only had documentation for the TB skin test administered. -There was no documentation in the residents' hospital record for the TB skin test results. Refer to interview with a MA on 01/05/21 at 1:04pm. 3. Review of Resident #3's current FL-2 dated 10/13/20 revealed: -Diagnoses included schizophrenia and hyperlipidemia. -There was an admission date for Resident #3 of 09/22/20. Review of a hospital After Visit Summary dated 08/25/20 - 09/22/20 revealed: -There was documentation a TB skin test was placed on 08/31/20. -There was no documentation for the TB skin test results. Review of Resident #3's record revealed: -There was no tuberculosis (TB) screening form. -There was no further documentation for TB skin test administered. -There was no documentation for any TB skin	C 202	If the TB skin test is positive, the administrator will request a chest xray and symptom assessment by the resident's physician and its documentation of a negative chest x ray result before accepting the resident into the facility. If the 1st TB skin test is negative, the administrator will accept the new resident and within 24 hours of the resident's arrival into the facility, the administrator will schedule the resident	

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C 202	Continued From page 3 test results. Telephone interview with the Administrator on 01/05/21 at 1:06pm revealed: -Resident #3 had a TB skin test administered at the hospital before he was admitted to the facility. -The result of the TB skin test was usually documented on the initial FL-2 sent from the hospital. -She always made sure the hospital administered the TB skin test. -Information on the step one TB skin test for Resident #3 might be in the hospital discharge information. -She was responsible to ensure the TB skin testing was completed. -She could not recall if she knew the TB skin test administered to Resident #3 at the hospital had not been read. -There was no documentation for two-step TB skin testing for Resident #3. Interview with Resident #3 on 01/05/21 at 3:25pm revealed: -He was administered a TB skin test when he was in the hospital and "it was normal". -He had not had another TB skin test since his admission to the facility. Telephone interview with the Administrator on 01/06/21 at 10:55am revealed: -The local hospital medical records department had been contacted about the residents' TB skin test administered 08/25/20. -The hospital only had documentation for the TB skin test administered. -There was no documentation in the residents' hospital record for the TB skin test results. Refer to interview with a MA on 01/05/21 at	C 202	for a second TB skin test, 7-21 days from the date of the 1st TB skin test. The administrator will ensure the 2nd TB test is performed as scheduled, and read 48-72 hours from the day of administration. The administrator will also ensure the results of the 2nd TB test are recorded in the residents file to include date it was given, date it was read, the test result to include the size of induration if any.	

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C 202	Continued From page 4 1:04pm. Interview with a MA on 01/05/21 at 1:04pm revealed the Administrator was responsible for ensuring resident TB skin testing was completed prior to admission.	C 202	The administrator will perform a monthly follow up on all new residents to ensure TB skin tests ave done and documented.	2/6/21
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 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 published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health	C 612	10A NCAC 13G. 1701 (c) Infection Prevention and control program c) The facility has implemented an infection control and prevention plan to ensure twe safety of staff, residents and visitors. The facility (staff on site) is conducting daily screenings of staff, residents and essential visitors.	1/14/21

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C 612	Continued From page 5 and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding visitor screening, resident screening and social distancing of residents. Review of the CDC's Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities, last updated 05/29/20, revealed: -Screen all visitors and staff for the presence of fever and symptoms consistent with COVID-19 before starting each shift, when they enter the building. -Ensure all residents have been asked at least daily about fever and symptoms consistent with COVID-19. -Post signage at all entrances and leave notices for contract service providers at all residences that provide information about current visitation policies or restrictions. -Post signage at all entrances that remind visitors and personnel not to enter the building if they have fever or symptoms consistent with COVID-19. -Instead of communal dining, consider delivering meals to rooms, creating a "grab n' go" option for residents, or staggering mealtimes to accommodate social distancing while dining. -Schedule group activities in a staggered fashion to limit number of residents participating and allow them to remain at least 6 feet apart from each other. -Remind residents to remain at least 6 feet apart from others when they are outside their room. Review of the NC DHHS Guidance for Smaller Residential Settings Regarding Visitation, Communal Dining, Group and Outside Activities,	C 612	Only essential visitors are allowed at the facility at this time and this includes staff, state / county inspectors, general contractors and maintenance staff. There is posted sinage on all entrance doors of the facility. posted to notify visitors of the visitation restrictions and the screening of visitors of symptoms of illness, known exposure to covid-19 and ensuring the presence of all visitors wearing a face covering.	1/14/21

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C 612	Continued From page 6 last updated 06/26/20, revealed: -The facility must have a plan that include procedures for conducting daily screening for temperature check, presence of symptoms, and known exposure to COVID-19 of all residents and staff, particularly those returning from extended visits or time outside of the home. -Screen visitors for symptoms of illness, known exposure to COVID-19, and presence of a face covering. -During communal dining ensure 6 feet of space between each individual. Review of the NC DHHS COVID-19 Long-Term Care Infection Control Assessment and Response (ICAR) Tool, last updated 09/20, revealed: -Actively screen all residents at least daily for fever and respiratory symptoms; immediately isolate anyone who is symptomatic. -Enforce social distancing among residents. 1. Observation of the entrance door of the facility on 01/05/21 at 9:15am revealed there was no signage posted for visitors regarding screening of visitors. Observation on 01/05/21 at 9:18am revealed the medication aide (MA) invited the surveyors into the facility without performing any COVID-19 screening. Observation on 01/05/21 at 3:15pm revealed: -A resident opened the door and invited the surveyors into the facility. -The Administrator joined the surveyors in the dining room area. -The Administrator and staff did not perform any COVID-19 screening for the surveyors.	C 612	The facility has implemented a visitor log that is used to screen all the visitors visiting the facility. The staff on duty will ensure the visitor has a face covering, then proceed to check the visitor's temperature, then ask them COVID-19 screening questions of symptoms of fever, cough, cold or shortness of breath. Also ask if the visitor has traveled in the last 21 days or been exposed to COVID-19.	1/14/21

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C 612	Continued From page 7 Telephone interview with a MA on 01/05/21 at 1:58pm revealed: -The facility only allowed visits for emergency needs such as facility maintenance. -Before visitors entered the facility, they were asked symptom screening questions and their temperatures were checked. -They did not document the results of the screening for visitors. -She did not remember to screen the surveyors when they were entering the facility. Video conference interview with the Administrator on 01/05/21 at 11:10am revealed: -The facility was only allowing essential visitors such as the plumber for maintenance needs. -Resident's family and friends were using video conferencing to visit with the residents, as the facility was not allowing family visitation. -The staff would check the visitor's temperature before entering and ask them COVID-19 screening questions, including signs and symptoms. -She asked visitors if they had symptoms of COVID-19 including fever, cough, or cold symptoms. -She asked visitors if they had traveled or been exposed to COVID-19. -Visitors were asked to use hand sanitizer upon entrance to the facility. -She did not document the visitor screenings. -Residents doctor appointments were conducted mostly via video conference. Second interview with the Administrator on 01/05/21 at 3:35pm revealed: -She nor the staff screened the surveyors upon entry to the facility because she "assumed" the surveyors would not be out surveying if they had COVID-19.	C 612	If the visitor passes the screening, then the staff would ask them to sanitize their hands using an approved gel sanitizer. The visitor would then sign their name on the facility visitor's log. The administrator is responsible for maintaining the visitor log, weekly. Any visitor with positive symptoms or questions of recent travel with exposure will not be allowed into the facility.	

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C 612	Continued From page 8 -If visitors came to the facility, the visitors were usually screened. -There was no documentation kept of the visitor screenings performed at the facility. Refer to the telephone interview with the local health department's (LHD) Environmental Health Specialist on 01/05/21 at 1:12pm. Refer to the video conference interview with the Administrator on 01/05/21 at 11:10am. 2. Telephone interview with a resident on 01/05/21 at 2:06pm revealed: -Staff did not check his temperature daily. -Staff asked him how he was feeling in the morning. -Staff did not ask him about COVID-19 signs or symptoms daily. Telephone interview with a medication aide (MA) on 01/05/21 at 1:58pm revealed: -She asked the residents how they were feeling every morning. -She did not take the residents temperatures daily. -She did not ask the residents about COVID-19 signs and symptoms daily. -If residents reported signs or symptoms of COVID-19 she would isolate the resident immediately, take the resident's temperature, and assess the resident for signs and symptoms. -She was educated by the Administrator on the signs and symptoms of COVID-19 and the process for reporting the signs and symptoms when she started training in September of 2020. Video conference interview with the Administrator on 01/05/21 at 11:10am revealed: -Staff did not take the resident's temperatures	C 612	The facility has also implemented a log and screening procedures for all staff and residents. The administrator will monitor the logs weekly and maintain them. The staff on duty is required to check their daily temperature every morning before assuming the daily duties. staff will also perform a self screening of signs and symptoms of COVID-19 and document on their log. Any positive screen will immediately be reported to the administrator who will then ask the staff to isolate and	1/14/21

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C 612	Continued From page 9 daily. -Staff did not ask the residents about COVID-19 signs and symptoms daily. -Staff would monitor the residents for signs and symptoms of COVID-19 and if signs or symptoms were noted they would then take their temperatures and complete the screening. -Residents did not leave the facility except for medical appointments that required them to be in person. -Primary care providers conducted telemedicine visits with the residents when able. Refer to the telephone interview with the local health department's Environmental Health Specialist on 01/05/21 at 1:12pm. Refer to the video conference interview with the Administrator on 01/05/21 at 11:10am. 3. Observation via video conference on 01/05/21 at 11:31am revealed: -The dining room table sat 6 people. -The seats at the table were not 6 feet apart in distance. Telephone interview with a resident on 01/05/21 at 2:06pm revealed all 6 of the residents would sit at the dining table to eat meals. Telephone interview with a medication aide (MA) on 01/05/21 at 1:58pm revealed: -All six of the residents ate at the dining room table together for meals. -There was not six feet of space in between the residents at the table during meals. Video conference interview with the Administrator on 01/05/21 at 11:10am revealed: -The facility conducted communal dining with all 6	C 612	quarantine in their room. The administrator will then proceed to find a replacement staff to allow the positive staff to leave for testing and isolation outside of the facility. The staff will also conduct daily symptom screening and temperatures of all the residents before assuming the day's activities Any resident with a positive screening will immediately be isolated in the facility if feasible or transferred to an outside facility to quarantine.	

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C 612	Continued From page 10 of the residents at the table during meals. -The residents were not seated 6 feet apart during meals. Refer to the telephone interview with the local health department's (LHD) Environmental Health Specialist on 01/05/21 at 1:12pm. Refer to the video conference interview with the Administrator on 01/05/21 at 11:10am. Telephone interview with the LHD Environmental Health Specialist on 01/05/21 at 1:12pm revealed: -Guidance was given to the Family Care Homes in the county on a case by case basis. -She sent out an email a few weeks ago to all of the residential care homes in the county that provided a link to the NC DHHS Long Term Care Outbreak Toolkit Instructions. -She included in her email that residential cares are unique and not specifically addressed in the guidance, but that the information can be applied in their home. -The facility was on the email list to receive the guidance that was sent by the LHD. Video conference interview with the Administrator on 01/05/21 at 11:10am revealed: -The facility did not have a COVID-19 specific policy and procedure that they were using. -She used the guidance provided by North Carolina Department of Health and Human Services (NC DHHS) related to COVID-19. -She received the email updates from NC DHHS related to COVID-19 guidance. -She did receive the guidance sent by the local health department (LHD) that was sent to the Adult Care Homes.	C 612	The administrator will be notified of a positive screen immediately. The administrator will then notify the residents physician and the county health department within 12 hours of notification. Dining and group activities at the facility will be practiced safely with social distancing. Only 3 residents are allowed to eat or interact at the dinning table at a time, with 6 feet between them. The dining area is disinfected before the other 3 residents are allowed at the table.	2/6/21 1/6/21