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D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors and visitors wearing facemasks inside the facility. The findings are: Review of the current CDC guidelines for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 04/27/21 revealed: -All essential visitors should be screened for the	D 612		

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presence of fever and symptoms of the virus when entering the building.
-All visitors should wear a facemask or face covering and maintain social distancing of at least 6 feet between other residents and healthcare personnel while in the facility.
-If a resident is fully vaccinated, they may choose to have close contact with a visitor regardless of their vaccination status but a facemask should be worn at all times if the resident and visitor are not in the resident's room.
-A strong infection prevention and control program is critical to protect both residents and healthcare personnel.

Review of the NC DHHS guidelines for the prevention and spread of the Coronavirus Disease in LTC facilities dated 05/05/21 revealed:
-Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic included screening anyone entering a healthcare facility for signs and symptoms of COVID-19.
-All visitors and residents should wear a mask inside the facility if either person is not fully vaccinated.
-Establishing a process to ensure visitors entering the facility are assessed for symptoms of COVID-19.

Review of the facility's infection control policy dated revealed:
-The purpose of the policy was to prevent the spread of COVID-19 from one resident to another as well as employees.
-All employees should have a daily temperature checked.

Interview with a medication aide (MA) standing outside in front of the facility on 07/19/21 at

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11:15am revealed:
-The facility's first positive test result for COVID-19 was received on 07/12/21.
-Family members who visited the facility on 07/04/21 contacted the facility on 07/11/21 to let them know they had tested positive for COVID-19.
-The facility started testing residents and staff on 07/12/21.
-He completed infection control training in February 2021.
-The facility staff were required to wear facemasks, gloves, face shields, gowns, and shoe coverings since the outbreak started on 07/12/21.
-All visitors were supposed to have their temperature checked and complete a questionnaire by staff working in the facility when they entered the facility.
-All staff should complete the COVID-19 questionnaire and check temperature at the start of their shift.
-He has worked both in the facility and in a sister facility since the outbreak started on 07/12/21 but changed his PPE before entering the facility.

Observation of a maintenance staff outside the entrance of the facility on 07/19/21 at 12:18pm revealed:
-He stood approximately 6 feet away from the survey team and pulled his mask down below his lips onto his chin while speaking.
-He made sniffling and sniffling sounds several times while talking.

Interview with a maintenance staff on 07/19/21 at 12:15pm revealed:
-He tested positive for COVID-19 on 07/16/21.
-He had "allergy like symptoms" since being tested positive for COVID-19.

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-He was supposed to be working outside the facility since he tested positive, but he has been working inside to fix something in the laundry room.
-He always wore a facemask, gowns, faceshield, shoe covers, and gloves if he had to go in the facility.
-He removed the PPE after he left the facility and threw it away in the dumpster about 100 yards from the facility.
-He would hang his gown and shoe covers on a chair outside the entrance to the building during the work day in case he had to go back inside the facility.
-He did not remember being trained on how to put on and take off the PPE.
-He checked his temperature every morning when he got to work but he no longer wrote it down because "there was no need" in answering the same questions daily.

Observation of the maintenance staff on 07/19/21 at 12:50pm revealed he was inside the facility entering the laundry room wearing a mask, gown, gloves, and shoe covers.

Second interview with the maintenance staff on 07/19/21 at 12:50pm revealed:
-The Administrator told him he could go inside the facility if he wore personal protective equipment (PPE).
-He "feels fine" and his runny nose was not a symptom after testing positive for COVID-19 on 07/16/21.

Observation of the entry hallway on 07/19/21 at 12:35pm revealed:
-The entry opened to a hallway with several residents rooms.
-All resident rooms had their doors closed.

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D 612	Continued From page 4 -There was no sign or documentation on the outside of the residents rooms to designate which residents were positive for COVID-19. -There was one small plastic cart with drawers and wheels located about halfway down the hall containing gowns, gloves, masks, and foot coverings. Interview with a second MA on 07/19/21 at 12:43pm revealed: -Staff were required to take their temperature and complete a questionnaire before they started their shift. -Staff usually put on PPE outside of the facility before they entered. -Usually gowns were kept outside of the residents' rooms but most of the time the staff went to the soiled linen room to change PPE. -There were 12 of the 14 residents in the facility who tested positive for COVID-19. -She, a personal care aide (PCA), and the Activities Director tested positive for COVID-19 but had no symptoms of COVID-19 and continued to work in the facility. Review of the visitors screening log from 06/29/21 through 07/06/21 revealed there was no documentation the visitors were screened on 07/04/21 before they attended a birthday party for a resident. Telephone interview with the resident's legal guardian on 07/21/21 at 9:22am revealed: -She had a birthday party in the dining room of the facility for the resident on 07/04/21. -There were 10 family members who attended the birthday party along with several other residents. -Staff checked her temperature when she entered the facility on 07/04/21 but did not ask her	D 612		

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COVID-19 screening questions.
-She did not know if the other family members had their temperatures checked or screening questions asked because they arrived at a later time.
-None of the 10 family members or residents who attended the birthday party wore a face mask and the family members were not asked to wear a face mask by facility staff.
-She called the facility on 07/11/21 to inform the facility staff that a family member who attended the party had tested positive for COVID-19.

Review of the staff screening log from 07/14/21 to 07/19/21 revealed there was no questionnaire and temperature check completed for the Activities Director and a maintenance worker that was observed working in the facility.

Observation of the Activities Director on 07/19/21 at 12:53pm revealed:
-She exited a resident's room who tested positive for COVID-19 wearing a mask, gown, gloves, and shoe covers and walked down the hallway entering the dining room wearing the same PPE.
-She did not remove the dirty PPE before entering the dining room.
-She exited the dining room carrying a styrofoam cup and entered the residents room again saying "here's you some water".
-She exited the COVID-19 positive resident's room, walked down the hallway to the soiled utility room and removed the gown and gloves placing them into a trash receptacle.

Interview with the Activities Director on 07/19/21 at 1:27pm and 1:40pm revealed:
-Today (07/19/21) was her first day working with the residents.
-She "just knew" almost everyone in the building

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had tested positive for COVID-19.
-She did not remember having any training on infection control.
-She checked her temperature before each shift but she was not filling out the screening questionnaire.
-She had been told to fill out the questionnaire when she entered the facility.
-She was not sure why she was not filling out the questionnaire.
-She usually wore the same mask all day unless it became soiled.
-She did not know she was supposed to remove the dirty PPE after exiting the COVID-19 positive room before she went into the dining room because the residents did not go into the dining room.

Observation of the maintenance staff on 07/19/21 at 1:56pm revealed he exited the facility and did not remove his PPE.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 07/20/21 at 2:01pm revealed:
-She was responsible for providing infection control training to the facility staff.
-The last time she completed an in person infection control training was in November or December 2020.
-She provided some training in the hallways to the staff while she was in the facility on 07/12/21 when testing was started.
-She reviewed the correct way the PPE should be worn and how to take it on and off.
-All visitors and staff should be screened by completing a questionnaire and getting their temperature checked prior to entering the facility.

Telephone interview with the Resident Care

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D 612	Continued From page 7 Coordinator (RCC) on 07/20/21 at 5:00pm revealed: -A resident had a birthday party at the facility on 07/04/21. -It was the policy of the facility to screen all visitors with a temperature check and screening questions asked before entrance into the facility and wear a face mask. -The resident's family member called on 07/11/21 and reported that a family member who attended the birthday party tested positive for COVID-19. -The facility started testing all residents and staff on the morning of 07/12/21. -She did not know the visitors to the facilty on 07/04/21 did not complete the screening process and was not sure why screening was not completed. -Staff should be self screening before they start their work shift, including completing the questionnaire and checking their temperature. -She needed to put signs on the resident's door so everyone knew who had tested positive for COVID-19. -The Nurse Practitioner or the Nurse Consultant from the facility's contracted pharmacy was responsible for completing the Infection Control training. Telephone interview with the Administrator on 07/20/21 at 4:07pm revealed: -Once the first resident tested positive for COVID-19 on the morning of 07/12/21, all staff were required to wear gowns, facemasks, shoe coverings, and faceshields. -They had originally put plastic carts with PPE outside every resident's room that had tested positive for COVID-19. -Currently, there were more residents that had tested positive for COVID-19 than they had plastic containers.	D 612		

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D 612	Continued From page 8 -All staff should be completing the questionnaire and temperature checks before starting their shifts. -He did not know that some staff were not completing the screening process. -The staff should know how to put PPE on and take it off because staff should be trained when hired. -The facility has quarterly infection control meetings. -He knew the Activities Director had not been trained in infection control. _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NCDHHS) for infection prevention and transmission during the COVID-19 pandemic related to screening of staff and visitors and visitors wearing face masks inside the facility during an outbreak of COVID-19. The facility's failure to follow the guidance related to infection prevention for COVID-19 was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 05, 2021.	D 612		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND	D 618		

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D 618	Continued From page 9 NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to report suspected or confirmed cases of COVID-19 to the local health department (LHD) immediately upon finding out the residents had been exposed to a visitor who tested positive for COVID-19. The findings are: Review of the current CDC guideline for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 03/29/21 revealed the local health department (LHD) should be notified immediately of a suspected or confirmed case of COVID-19. Review of the NC DHHS guidelines for the best practices in prevention for LTC facilities dated 02/10/21 revealed residents and families should be informed about the COVID-19 situation in the local community and the actions the facility is taking to protect them.	D 618		

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Interview with a medication aide (MA) on 07/19/21 at 11:15am revealed:
-The facility had their first positive test for COVID-19 on 07/12/21.
-A family member that had visited the facility on 07/04/21 contacted the facility on 07/11/21 to let them know they had tested positive for COVID-19.
-The facility started testing residents and staff on 07/12/21.
-The Administrator and the Resident Care Coordinator (RCC) was responsible for contacting the LHD.
-He thought the Administrator and the RCC had contacted the LHD.

Telephone interview with the Director of Nursing (DON) from the LHD on 07/20/21 at 12:24pm revealed:
-She was notified on 07/12/21 around 4:00pm by a local adult day care program that a resident was picked up early by family because the facility had a resident who tested positive for COVID-19.
-The facility had not called to report the COVID-19 positive test result to the LHD.
-She called the RCC around 4:15pm and was told the facility had not called to report the COVID-19 positive test result because they had been testing all the staff and residents.
-She gave verbal guidance over the telephone to the RCC and suggested to test all the sister facilities because staff was shared between the facilities.
-The Administrator reported 2 staff members had tested positive for COVID-19 on 07/12/21.
-She emailed guidance which included to test all staff and residents for COVID-19, send the test results to the LHD, send a total count of residents and staff at the facility and the sister facilities, and test all residents and staff at 3, 5, 7, and 10 days

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or with the presence of any symptoms of COVID-19.
-The Administrator told her he could not test staff at all facilities because there were 165 plus members.
-The Administrator told her one resident had a birthday party on 07/04/21 with family members who had attended while not wearing face masks and a family member tested positive for COVID-19 after the party.
-She emailed the Administrator on 07/13/21 at 4:52pm to allow asymptomatic employees who tested positive for COVID-19 to work while wearing face masks, gowns, gloves, shoe covers, and goggles but only with residents who tested positive for COVID-19, and symptomatic employees who tested positive for COVID-19 should not work.
-Guidance regarding COVID-19 and outbreaks of COVID-19 were sent via email to the facility at the beginning of the pandemic and again "months ago".

Telephone interview with the Public Health Director at the LHD on 07/20/21 at 1:11pm revealed:
-The Administrator was informed on 07/11/20 by a resident's family member of a suspected COVID-19 exposure at the facility on 07/04/21 and did not call to notify the LHD immediately per state regulations.
-The DON at the LHD gave verbal instructions on guidance for a COVID-19 outbreak on 07/12/21 to the RCC and followed up with two emails sent to the RCC and Administrator.
-The DON at the LHD had a difficult time getting the information requested from the facility regarding the COVID-19 testing completed with the results.
-She did not know why the Administrator did not

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report the suspected COVID-19 exposure to the LHD immediately.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 07/20/21 at 2:01pm revealed:
-The Administrator was responsible for contacting the LHD regarding a suspected or confirmed case of COVID-19.
-The facility had tested all staff and residents beginning in the morning on 07/12/21.
-The testing was completed around 12:00pm.
-It was more important to take care of the residents and complete the COVID-19 testing before contacting the LHD.
-She knew the LHD thought the facility did not contact them soon enough.

Telephone interview with the RCC on 07/20/21 at 5:00pm revealed:
-The facility had started testing the residents and staff for COVID-19 at 8:30am on 07/12/21.
-A nurse from the LHD had called between 11:00am and 11:30am while they were testing wanting a list of everyone who was tested and the results.
-She faxed the information to the LHD around 3:00pm on 07/12/21.
-She did not contact the LHD before testing because they did not know they had a positive test.

Telephone interview with the Administrator on 07/20/21 at 4:07pm revealed:
-He knew he needed to call the LHD and let them know if the facility had a resident that had tested positive for COVID-19.
-The facility was contacted on 07/11/21 that a recent visitor had tested positive for COVID-19.
-All the staff and residents were tested during the

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D 618	Continued From page 13 morning on 07/12/21. -The staff was focusing on getting the residents tested as soon as possible. -They did not know they had a resident that had COVID-19 until the morning of 07/12/21. -He or the RCC was responsible for contacting the LHD. -The LHD had called the RCC while the residents were being tested requesting some paperwork that needed to be completed. -The RCC sent the requested documentation to the LHD after all the testing was completed. -The facility had contacted the LHD as quickly as possible. -He had received no guidance from the LHD related to COVID-19. _____ The facility failed to follow the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) guidelines for notification of the local health department (LHD) of a suspected or confirmed COVID-19 diagnoses. The facility's failure resulted in the facility not receiving time sensitive guidance from the LHD on measures for preventing and decreasing transmission and infection which resulted in a COVID-19 outbreak. The facility's failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2021.	D 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044039	A. BUILDING: _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 14	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection prevention and control program and the reporting and notification of a suspected or confirmed communicable disease outbreak. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff and visitors and visitors wearing facemasks during an outbreak of COVID-19. [Refer to Tag 0612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to report suspected or confirmed cases of COVID-19 to the local health	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 15 department (LHD) immediately upon finding out the residents had been exposed to a visitor who tested positive for COVID-19. [Refer to Tag 0618, 10A NCAC 13F .1802(a) Report and Notification of a Outbreak (Type B Violation)].	D912		