STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 and the Cherokee County Department of Social Services conducted a complaint investation 10/26/21 - 10/28/21. The Cherokee County Department of Social Services initiated the complaint investigation on 09/23/21.	C 000		
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: TYPE A1 VIOLATION	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 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 staff not wearing masks or screening of visitors to the facility and the Administrator not isolating according to CDC guidelines when diagnosed with COVID-19, resulting in hospitalizations for 2 of 4 residents (#1 and #2). The findings are: Review of the NCDHHS guidance for the prevention and spread of COVID-19 in long term care (LTC) facilities upated September 2020 revealed: -All visitors to the facility should be screened for signs and symptoms of COVID-19 prior to entering the facility. -Implement universal facemask use by staff, residents, and visitors. Review of CDC guidelines for the prevention and spread of COVID-19 in long-term care (LTC) facilities updated 11/20/20 revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Personnel should be screened for fever and symptoms of COVID-19 before starting each shift. -Screen residents daily for fever and symptoms of COVID-19. -Staff should wear a facemask at all times while they are in the facility.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 2 Review of the Division of Health Service Regulation (DHSR) report dated 03/16/21 revealed: -An annual survey for the facility was completed on this day. -The facility was issued a citation in infection control related to not screening visitors for signs and symptoms of COVID-19 prior to entering the facility and staff not wearing masks. -Staff and residents did not wear facemasks in the facility because the Administrator "knew" they had not been exposed to the virus. -The Administrator did not screen the residents for signs and symptoms of COVID-19 because she "knew" the residents. -The Administrator did not require facility staff to be screened because she "knew" they had not been exposed to the virus. -The Administrator observed the residents every day and she "knew" them; therefore, it was not necessary to follow the COVID-19 guidance from the CDC and the NCDHHS. Review of the CDC guidelines for quarantine, isolation and the prevention and spread of COVID-19 and Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 dated 09/10/21 revealed: -Personnel and visitors should always wear a face mask in the facility. -All visitors should be screened for the presence of fever and symptoms on the virus when entering the building. - Quarantine if you have been in close contact (within 6 feet of someone for a cumulative total of 15 minutes or more over a 24-hour period) with someone who has COVID-19, unless you have been fully vaccinated.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 3 - Isolation is used to separate people infected with COVID-19 from those who are not infected. People who are in isolation should stay at home until it is safe for them to be around others. At home, anyone sick or infected should separate from others, stay in a specific "sick room" or area, and use a separate bathroom (if available). -Individuals who have been isolated due to being infected with COVID-19 can be around other individuals after 10 days since symptoms first appeared and 24 hours with no fever without the use of fever-reducing medication and other symptoms of COVID-19 are improving. Review of a NCDHHS COVID-19 email update dated 08/06/21 to Family Care Home Providers (FCHP) revealed if your test comes back positive, you should isolate based on current CDC isolation guidelines for people with COVID-19. Telephone interview with the Administrator on 09/23/21 at 12:20pm revealed: -She disagreed with having to wear a mask in her own home. -Neither she nor her staff wore masks while working in the facility prior to her testing positive for COVID-19 on 09/13/21. - After testing positive, she remained in her personal living quarters for 4 days before she went back around any residents. -The facility currently had two residents who had been diagnosed with COVID-19. Interview with the Administrator on 10/26/21 at 10:10am revealed: - She began feeling feverish on 9/12/21 but she did not check her tempterature. - She checked her temperature on 9/13/21 with a reading of 102 degrees Farhenheit. - She took an "at-home" COVID-19 test on	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 4	C 612		

9/13/21 and the results were positive.
- Her physician instructed her to quarantine for 7 days.
-Staff were not wearing masks prior to 09/13/21.
-She continued to disagree with wearing a mask in her own home.

Telephone interview with Resident #1's family member on 09/23/21 at 11:15am revealed:
-He visited monthly over the past year.
-Staff and residents were not wearing masks during any of these visits.
-His temperature was not checked upon entering the facility and no COVID-19 screening questions were asked.
-The family member always wore a mask inside the facility.
-The most recent visit to the facility was the week of 09/13/21 and staff were not wearing masks, his temperature was not taken, and staff did not ask him any COVID-19 screening questions.
-His family member was sent to the hospital on 09/16/21 and was diagnosed with COVID-19.

Telephone interview on 09/23/21 at 11:55am with a family member of a resident revealed:
-She was in the facility at least monthly.
-Her most recent visit to the facility was the first week in September 2021.
-She did not see any staff wearing masks over the last year.
-Staff did not take her temperature.
-Staff did not ask her any COVID-19 screening questions.
-There were often small children in the facility, who were relatives of the owner, and they never wore masks.
-A family member of the SIC/MA who had also tested positive for COVID-19 provided care for the children

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 5	C 612		

-After her family member was in the hospital, they found out Administrator had tested positive for COVID-19.
-The Supervisor-in-Charge/Medication Aide (SIC/MA) was never seen wearing a mask in the facility.

Telephone interview with the Director of Nursing (DON) from the local Health Department on 10/28/21 at 9:10am revealed:
-The Health Department was notified from the local hospital on 09/15/21 that a resident who resided in the facility (Resident #1) had been hospitalized with COVID-19.
-The Health Department was notified from the local hospital on 09/17/21 that a second resident who resided in the facility (Resident #2) had been hospitalized with COVID-19.
-The Health Department was not initially aware Resident #1 and Resident #2 were from the same facility.
-The facility did not contact the local Health Department to report a staff member tested positive for COVID-19 on 09/13/21 or that two residents had been transferred to the hospital with COVID-19 symptoms on 09/14/21 and 09/16/21.

1. Review of Resident #1's current FL-2 dated 09/06/21 revealed:
-Diagnoses included high blood pressure, diabetes, anxiety, and chronic obstructive pulmonary disease (COPD).
-There was an order for oxygen 2 liters per minute via nasal canula as needed (not constant).
-There was an order for Ventolin HFA 2 puffs every 4 hours as needed for shortness of breath. (Ventolin is a medication which is inhaled to treat wheezing and shortness of breath).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 6 Review of Resident #1's Care Plan dated 09/06/21 revealed: -She sometimes used a walker for ambulation. -She only required stand by assistance for transfers. -She was on oxygen 2 liter per minute as needed. Review of Resident #1's Medication Administration Record for September 2021 revealed: -There was an entry for oxygen 2 liter per minute as needed and there was no documentation of oxygen having been administered. -There was an entry for Ventolin HFA 2 puffs every 4 hours as needed for shortness of breath and there was no documentation of it having been administered. Review of a Progress note from Resident #1's Primary Care Provider on 09/16/21 revealed: -Resident #1 was on the side of the bed in a tripod position (a position whereby a person sits while leaning forward with their arms on their knees in efforts to relieve respiratory distress). -The resident was shivering with substernal retractions (a sign of respiratory distress when the breathing muscles are inefficient, still working to breathe, but the lack of air pressure causes the skin to pull inward between the ribs). -The resident could not speak in full sentences. -Her respiratory rate was 28 breaths per minute (Normal range is 12-20). -For three days the resident had been on oxygen 2 liters per minute, so the practitioner increased the oxygen to 4 liters per minute. -The increase of oxygen decreased the respirations to 22 breaths per minute, but the resident still presented with labored breathing. -The resident had a productive cough, "needed a nebulizer treatment" and a fever of 99.2 º	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 7	C 612		

Fahrenheit (F).
-The decision was made to send Resident #1 to the hospital.
-Resident #1 verbalized she was scared and asked if she was going to die.

Review of Resident #1's hospital history and physical dated 09/16/21 revealed:
-Her chest x-ray showed low lung volume.
-She tested positive for COVID-19.
-Her temperature was 100.3ºF.
-A venturi mask was placed (a mask considered to be a high-flow oxygen therapy device designed to deliver a fixed concentration of oxygen).
-Diagnoses included acute on chronic hypoxic respiratory failure (respiratory failure due to low amounts of oxygen) secondary to bilateral COVID pneumonia and acute kidney injury secondary to dehydration.

Review of Resident #1's hospital progress note dated 09/19/21 revealed Resident #1 became unresponsive and with low blood pressure.

Review of Resident #1's hospital discharge summary dated 09/24/21 revealed:
-Discharge diagnoses included respiratory failure secondary to COVID-19 pneumonia and COPD exacerbation.
-Resident #1 was admitted to the care of hospice and discharged back to the facility on 09/24/21.

Interview with the Administrator on 10/26/21 at 10:10am revealed Resident #1 was admitted to the hospital with COVID-19 symptoms on 09/16/21 and died at the facility on 09/25/21.

2. Review of Resident #2's current FL-2 dated 10/22/20 revealed diagnoses included high blood pressure, diabetes and cardiac failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 8 Record review revealed no documentation regarding Resident #2's condition prior to her hospitalization on 09/14/21. Review of hospital records for Resident #2 dated 09/14/21 revealed: -Resident #2's admission diagnoses on 09/14/21 included "wet, gurgly breath sounds", back pain and altered mental status. -Resident #2 tested positive for COVID-19 on 09/15/21. -Resident #2's discharge diagnoses on 09/19/21 included acute heart failure secondary to COVID pneumonia. _____ The facility failed to follow recommendations and guidance from the Centers for Disease Control and Prevention and the North Carolina Department of Health and Human Services regarding screening visitors for temperature and symptoms and staff wearing masks during the global coronavirus (COVID-19) pandemic resulting in Resident #2 developing symptoms of COVID-19 and hospitalized on 09/14/21 and tested positive for COVID-19 on 09/15/21, followed by Resident #1 developing symptoms of COVID-19 and hospitalized on and diagnosed with respiratory failure secondary to COVID-19 pneumonia, discharged back to the facility on 09/24/21 and died on 9/25/21. This failure resulted in serious neglect and physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/11/21 for this violation.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL020011	A. BUILDING: _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND N FAMILY CARE HOME	142 GRASSY KNOB ROAD ANDREWS, NC 28901

(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 612	Continued From page 9 CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 11/27/21.	C 612		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents were free of neglect related to infection control. The findings are: 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 staff not wearing masks or screening of visitors to the facility and the Administrator not isolating according to CDC guidelines when diagnosed with COVID-19, resulting in hospitalizations for 2 of 4 residents (#1 and #2). [Refer to Tag 612, 10A NCAC 13 G .1701 (c) Infection Control Prevention Program (Type A1 Violation)].	C 914		