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	HAL065019	A. BUILDING: _____ B. WING _____	R 01/13/2022

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BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up survey on 01/13/22.	D 000		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to submit completed accident and incident reports to the local Department of Social Services (DSS) for 3 of 3 sampled residents (#1, #2, and #3) who was involved in incidents resulting in the need for evaluation and treatment at the local emergency department. The findings are: Review of the facility's "Incident Report Policy" revealed: -An incident report must be completed in the event that a resident or visitor experienced an occurrence that was unusual, improper, or harmful. Incidents may include, but are not limited to, injuries, falls, theft, unexplained absence, sudden illness, and combative behavior. The resident's physician, family and responsible person and sponsoring agency, if	D 451		

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applicable, should be notified.
-Incidents or accidents resulting in death or requiring referral for emergency medical evaluation, hospitalization or medical treatment other than first aid shall be reported to the Department of Social Services (DSS). The completed electronic incident and accident report should be printed and submitted to the DSS by mail, fax, electronic mail, or in person within 48 hours of the initial discovery or knowledge by associates of the accident or incident.
-The policy was last revised October 2012.

The findings are:

1. Review of Resident #1's current FL-2 dated 08/02/21 revealed:
-Diagnoses included dementia and depression.
-The resident was constantly disoriented, ambulatory, and wandered.

a. Review of Resident #1's physician fax notification form dated 12/07/21 revealed:
-The resident was transferred to the local hospital emergency department (ED) for a psychological evaluation for hitting a staff member.
-The form was completed by the temporary Health and Wellness Director (HWD).

Review of a local hospital ED visit summary dated 12/07/21 revealed:
-Resident #1 was treated for dementia and a psychiatric evaluation completed.
-The resident was diagnosed with dementia without behavioral disturbance, unspecified dementia.

Review of Resident #1's Incident/Accident (I/A) reports revealed:
-There was no I/A report dated 12/07/21.

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-There was no documentation the facility had faxed an I/A report dated 12/07/21 for Resident #1 to the Adult Home Specialist (AHS) at the local Department of Social Services (DSS).

Interview with the local AHS on 01/13/22 at 12:30pm revealed:
-She monitored the facility and neither staff nor management informed her of Resident #1's incident dated 12/07/21.
-The facility did not notify her of Resident #1's 12/07/21 I/A.

Interview with the Administrator on 01/13/22 at 12:55pm revealed she was unable to locate Resident #1's I/A report dated 12/07/21.

Telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm revealed:
-She completed Resident #1's medical provider fax notification dated 12/07/21.
-The MA should have completed the I/A report because the MA was working at the time of Resident #1's incident on 12/07/21.
-She did not know why the MA did not complete the 12/07/21 /I/A report for Resident #1.

Request on 01/13/22 at 11:52am for Resident #1's I/A report dated 12/07/21 was not provided by survey exit.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

Refer to interview with the Administrator on 01/13/22 at 10:30am.

Refer to interview with a personal care aide

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(PCA) on 01/13/22 at 10:50am.

Refer to interview with a medication aide (MA) on 01/13/22 at 11:20am.

Refer to interview with the AHS on 01/13/22 at 12:30pm.

Refer to telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm.

Refer to the second interview with the Administrator on 01/13/22 at 3:00pm.

b. Review of Resident #1's Incident/Accident (I/A) report dated 01/04/22 revealed:
-The resident sustained an unwitnessed fall.
-The resident was transfer to the local Emergency Department (ED) for medication evaluation.
-There was no documentation the AHS was notified of Resident #1's I/A dated 01/04/22.

Review of Resident #1's facility progress notes dated 01/04/22 revealed:
-The resident was found on the floor in the family room holding the right side of her head and crying.
-The resident was transferred to the ED at 2:50pm by Emergency Medical Services (EMS).

Review of Resident #1's local hospital discharge medication list dated 01/07/22 revealed:
-The resident was admitted in the hospital from 01/04/22 - 01/07/22.
-The resident's diagnoses were not documented.

Review of Resident #1's facility record revealed there was no documentation the facility had faxed an I/A report dated 01/04/22 for the resident to

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D 451	Continued From page 4 the AHS. Interview with the AHS on 01/13/22 at 12:30pm revealed she monitored the facility and neither staff nor management informed her of the fall and hospitalization for Resident #1 dated 01/04/22. Telephone interview with the local hospital's Social Worker on 01/13/22 at 12:40pm revealed: -Resident #1 was admitted to the hospital from 01/04/22 - 01/07/22. -The resident's diagnoses were not provided. Telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm revealed: -She did not know why the 01/04/22 I/A report was not sent to the AHS. -She did not think she was working on 01/04/22. -It would have been the responsibility of the Administrator to send the 01/04/22 I/A report to the county if she was not working on that date. Interview with the Administrator on 01/13/22 at 3:00pm revealed: -She located the email the HWD sent to the AHS for Resident #1's incident dated 01/04/22. -The HWD scanned incident reports into a system then would fax the reports to the AHS using the scanner. -There was no way to determine if the AHS received the incident reports. Review of an email provided by the Administrator on 01/13/22 at 3:00pm revealed: -The sending email address was from a "donotreply.com" email. -There was an attachment titled "facility named incident". -The email was dated 01/06/22.	D 451		

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-The email was to the AHS, Administrator, and temporary HWD.
-The body of the email contained direction to open the attached document.
-There was documentation the email was sent using a multifunctional printer.
-There was no confirmation report the email was received by the AHS.

Review of the attached document for the email dated 01/06/22 revealed:
-The document was typed and titled "County Incident Report".
-There was documentation Resident #1 was found on the floor on 01/04/22 at 1:15pm.
-The resident had altered mental status.
-The resident was transferred to the local hospital for a medical evaluation.

Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.

Refer to interview with the Administrator on 01/13/22 at 10:30am.

Refer to interview with a personal care aide (PCA) on 01/13/22 at 10:50am.

Refer to interview with a medication aide (MA) on 01/13/22 at 11:20am.

Refer to interview with AHS on 01/13/22 at 12:30pm.

Refer to telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm.

Refer to the second interview with the

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D 451	Continued From page 6 Administrator on 01/13/22 at 3:00pm. 2. Review of Resident #2's current FL-2 dated 12/13/21 revealed: -Diagnoses included dementia with lewy bodies, dementia with behavioral disturbances, and hypertension. -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #2's local hospital discharge summary dated 01/06/22 revealed: -The resident was admitted to the hospital from 01/04/22 to 01/06/22. -The resident's primary diagnoses was a fall. -The resident was transported to the emergency department where a Trauma 1 Activation was initiated (Emergency care for trauma patients such as head injuries sustained from a traumatic accidents). -The resident was initially seen and evaluated by the Trauma Surgery Service. -The resident had dried blood around her mouth and bilateral nares. -The resident was admitted to the hospital. -The resident's condition continued to decline. -The resident was transferred to the hospice care center. -There was no medical diagnoses documented. Review of Resident #2's Incident/Accident (I/A) Report dated 01/04/22 revealed: -The resident sustained an unwitnessed fall around 7:35am. -The resident sustained scrapes/abrasion, swelling, redness, and was bleeding from the nose and lip. -The resident injured her nose and mouth. -Staff provided first aide. -The resident did not require transfer to the local	D 451		

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hospital for a medical evaluation.
-There was no documentation the AHS was notified of Resident #2's accident dated 01/04/22.

Interview with the AHS on 01/13/22 at 12:30pm revealed she monitored the facility and neither staff nor management informed her of Resident #2's accident dated 01/04/22.

Refer to interview with the Administrator on 01/13/22 at 10:30am.

Refer to interview with a personal care aide (PCA) on 01/13/22 at 10:50am.

Refer to interview with a medication aide (MA) on 01/13/22 at 11:20am.

Refer to interview with the AHS on 01/13/22 at 12:30pm

Refer to telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm.

Refer to the second interview with the Administrator on 01/13/22 at 3:00pm.

3. Review of Resident #3's current FL-2 dated 02/03/21 revealed:
-Diagnoses included dementia, hypertension, atrial fibrillation, constipation, and anxiety.
-The resident was constantly disoriented.
-The resident was used a wheelchair.

Review of an electronic progress note dated 12/17/21 at 6:53pm revealed:
-Resident #3 was found on the floor lying on her back with her back arched around 5:15pm.
-The resident complained of pain in abdomen

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area.
-The resident was assessed by the temporary health and wellness director (HWD).
-The primary care provider (PCP) was notified and advised to send the resident to the local hospital emergency department (ED) for evaluation.
-The resident's note was completed by a medication aide (MA).

Review of the local hospital report dated 12/17/21 revealed:
-Resident #3's admission diagnosis to the ED was an unwitnessed fall.
-Resident #3's discharge diagnoses included a fall, pulmonary nodule, compression fractures of Throacic 7 and Thoracic 12 vertebra.

Review of the facility's Incident/Accident (I/A) report dated 12/17/21 for Resident #3 revealed:
-The approximate time of the incident was 5:00pm.
-The location of incident was in the residents' room.
-The nature of the incident was an unwitnessed fall.
-The type of injury was documented as complaints of abdominal pain.
-There was no documentation of notification to the local department of social services (DSS).

Review of the facility's county incident report for Resident #3 dated 12/17/21 revealed:
-The incident occurred at 5:15pm.
-The resident was observed on the floor at bedside.
-The nature of the injury was documented as complaints of abdominal pain, T7 and T12 fractures of "indeterminate" age.
-The follow up care was documented as the

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resident was transferred to the ED for evaluation, had a CT scan and x-rays
-There was documentation Resident #3 was diagnosed with inoperable fractures of unkown causes.
-The responsible party was notified on 12/18/21 at 11:35 (did not indicate am or pm).
-There was no documentation the primary care provider was notified.
-There was no documentation the county DSS was notified.
-The county incident report was completed by the temporary HWD on 12/18/21.

Interview with the AHS on 01/13/22 at 12:30pm revealed:
-She monitored the facility and neither staff nor management informed her of Resident #3's accident.
-She had not received an incident report dated 12/17/21 for Resident #3.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

Refer to interview with the Administrator on 01/13/22 at 10:30am.

Refer to interview with a personal care aide (PCA) on 01/13/22 at 10:50am.

Refer to interview with a medication aide (MA) on 01/13/22 at 11:20am.

Refer to interview with the AHS on 01/13/22 at 12:30pm.

Refer to telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22

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D 451	Continued From page 10 at 1:47pm. Refer to the second interview with the Administrator on 01/13/22 at 3:00pm. _____ Interview with the Administrator on 01/13/22 at 10:30am revealed: -The temporary Health and Wellness Director (HWD) had the original Incident/Accident (I/A) reports with her to enter in the electronic system. -The HWD was out of town. -The temporary HWD was a Registered Nurse. -The HWD would send the Administrator, today (01/13/22), the I/A reports she had with her. -Who ever witnessed a resident incident would report to the medication aide (MA). -It was the responsibility of the MA to complete the I/A reports. -After completion, the MA would submit the handwritten I/A report to the HWD. -The HWD transfered the handwritten information in the electronic I/A report system. -Once entered, the hard copy of the I/A report would be destroyed. -It was the responsibility of the HWD or Administrator to submit the I/A reports to the local Adult Home Specialist (AHS). -The Administrator emailed the electronic I/A reports to the AHS. -The HWD would transcribe information from the handwritten I/A reports to a I/A form she developed to fax to the AHS, (County Incident Report). -Sometimes the MAs faxed the I/A reports to the AHS. -The MAs gavethe fax confirmation to the Administrator once faxed. -If an I/A occurred on the weekend, the I/A report would not be sent to the AHS until the following business day.	D 451		

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-I/A reports for residents who required more than first aid were to be sent to the county AHS.
-Examples were falls with head injuries, falls without head injuries but with complaints of pain, and resident death.
-The Administrator and HWD asked the MAs if there were I/A reports that had been completed during daily meetings.
-She expected I/A reports to be sent to the AHS within 48 hours of I/A.
-There was no process in place to ensure the HWD faxed the I/A reports to the AHS.
-The Administrator trusted the HWD would perform her duties as expected.

Interview with a personal care aide (PCA) on 01/13/22 at 10:50am revealed:
-The PCAs would report I/As to the MAs.
-The MAs completed the I/A reports.

Interview with a MA on 01/13/21 at 11:20am revealed:
-She completed I/A reports when she worked as a MA even if she did not witness the incident.
-The PCA informed the MA of the incident and what they witnessed.
-She called the family and let the facility nurse know about the incident.
-The resident was sent out to ED if needed for evaluation.
-The MA completed the written I/A report and place it under the temporary HWD's office door..
-The MA was not aware what happened regarding the I/A report once she placed it under the HWD's office door.
-The HWD was responsible for notifying DSS of resident incidents.
-The only time the MA would send an I/A report to DSS would be for an elopement.
-The MAs were trained on the procedure for

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D 451	Continued From page 12 reporting I/A reports by the previous HWD Telephone interview with the temporary HWD on 01/13/22 at 1:47pm revealed: -Reportable I/As to the AHS consisted of resident to resident altercations, elopements, falls with death, or I/As which required transfer to the hospital for medical evaluation. -The MA was expected to document the I/A and place the report under the HWD office door. -Any I/A reports completed while she was off was not sent to the AHS until her next day working. -The MA was still expected to place the I/A reports under her office door during her days off. -Any reportable I/A reports were given to the Administrator by the MA if the HWD was not working. -But, it was the responsibility of the HWD to send the I/A reports to the AHS. -When the HWD was not available, it was the responsibility of the Administrator to send the I/A reports to the AHS. -She did not remember the required timeframe she or the Administrator were to submit I/A reports to the AHS. -Since 11/08/21, it was the HWD's responsibility to transcribe the original I/A report completed by the MA into the electronic system, then file the original handwritten copy in the facility's legal file. -She did not know why the electronic version of the I/A report was not sent to the AHS. -The Administrator should have a copy of the I/A reports she emailed to the AHS because she always included the Administrator in the emails. -She expected the section on the I/A report which indicated when the I/A report was sent to DSS to be completed by the staff who sent the I/A report. Second interview with the Administrator on 01/13/22 at 3:00pm revealed:	D 451		

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D 451	Continued From page 13 -The HWD scanned incident reports into a system then would fax to the AHS using the scanner. -There was no way to determine if the AHS received the incident reports by the HWD when emailing via the scanner. -The Administrator thought using the scanner to email incident reports to the AHS may not be the best method.	D 451		
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: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection for special care	D 612		

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unit residents during the global coronavirus (COVID-19) pandemic as related to screening visitors and disinfection of high traffic areas by staff to reduce the risk of transmission and infection.

The findings are:

Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Long-Term Care Facilities dated 09/10/21 revealed:
-The guidance referred to Interim Infection Control Recommendations for Healthcare Personnel during the COVID-19 Pandemic.
-Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work.
-Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
-Healthcare personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

Review of the NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/21 revealed:
-All visitors should be screened for signs and

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symptoms prior to entering the facility.
-DHHS continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.
-Facilities should continue to screen all who enter for visitation. Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine should not enter the facility.

Review of the facility's COVID-19 guidelines revised 12/22/21 revealed:
-The facility was to follow State, local, and/or authorities having jurisdiction guidance when the facility had positive cases of COVID-19.
-Housekeeping should be scheduled for resident rooms and common areas to included high touch surfaces such as light switches, handrails, grab bars, and refrigerator handles in staff and resident areas to keep COVID-19 out of the community.
-When the facility had positive cases of COVID-19 increase cleaning frequencies and clean for infection prevention and illness outbreak.
-All staff were to wear PPE with any potential contact or interaction with a COVID-19 positive resident.
-The type of PPE was not specified.
-An isolation cart and trash container were to be kept outside the COVID-19 positive resident's room for disposing of the face mask after exiting the room.
-Wearing full PPE, wipe the door, door handle in hallway and enter the room.
-Wipe inside door and door handle when entering the room and closing the door.
-In preparation for exiting the room, remove gown and gloves and place in the trash and use hand

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sanitizer. Face shield and mask remain on.
-Wipe door and door handle, exit room. Use hand sanitizer.
-In hallway, use hand sanitizer and shut door, wipe door, door handle. Use hand sanitizer.
-Remove face shield, clean and set aside to dry. Use hand sanitizer.
-Get new mask ready to put on, use hand sanitizer.
-Remove mask and place in trash bag, use hand sanitizer.
-Put on new mask, use hand sanitizer.
-Wipe down area, use hand sanitizer.

Review of the facility's current census report dated 01/13/22 revealed the current census was 23.

Review of the facility's current COVID-19 positive report dated 01/13/22 revealed:
-There were three residents in the facility who were diagnosed with COVID-19.
-There were two staff who were diagnosed with COVID-19.

1. Observation of the facility on 01/13/22 at 7:30am revealed:
-The front door was opened by the housekeeper.
-The surveyors were allowed entrance into the facility by the housekeeper.
-There was a table against the right wall inside of the facility.
-On the table was a binder titled "Associate/3rd Party Provider, Family, and Visitor Screening"
-There was a thermometer on right wall to the right of the table.
-The housekeeper did not assess surveyor's temperature or perform COVID-19 screening questions upon entrance to the facility.
-A personal care aide (PCA) approached

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surveyors standing at the inside entrance of the facility.
-The PCA asked surveyors if they wanted to be tested for COVID-19 once in the facility.
-The surveyors declined a COVID-19 test.
-The PCA did not prompt surveyors to perform COVID-19 screening or assess temperatures.
-A medication aide (MA) approached surveyors at the inside entrance of the facility.
-The MA directed surveyors to the facility library.
-Surveyors prompted the MA regarding COVID-19 screening procedures.
-The MA directed surveyors to obtain temperatures and complete the visitor log book after prompting.
-The MA did not confirm temperatures of surveyors after temperature self-assessment.
-The MA did not review the visitor log book after surveyors answered COVID-19 screening questions.

Review of the facility's visitor log book on 01/13/22 at 7:34am revealed:
-Visitor log book was titled "Associate/3rd Party Provider, Family, and Visitor Screening.
-The book contained COVID-19 screening log sheets, which was to be completed for each visitor.
-The COVID-19 screening log sheets had columns to document date, time in, name, have you experienced any of the COVID-19 symptoms in the past 48 hours; have you had any of the following (prolonged close contact within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24 hour period with someone with COVID-19 in the prior 14 day or otherwise met the criteria for quarantine; a recent diagnosis of COVID-19 or suspected positive COVID-19 (confirmed positive test or diagnosed with COVID-19 by a healthcare professional); if

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you answered yes to any question, notify the Administrator for entry/reentry decision and refer to healthcare professional; outcome if access to community allowed; and additional information (for essential healthcare providers, include employer's name, phone number, and address).
-There was no column to document temperature.

Interview with the housekeeper on 01/13/22 at 2:24pm revealed:
-She knew visitors were to self-screen or be prompted to self-screen for COVID-19 on entrance to the facility.
-She did not screen the surveyors or prompt the surveyors to self-screen for COVID-19 because she thought the surveyors would want to speak to the MA first.

Interview with the PCA on 01/13/22 at 1:30pm revealed:
-Visitors to the facility were to obtain their temperature using the wall thermometer and document their name and time entered in the visitor sign in log on entrance to the facility.
-There were no COVID-19 screening questions to be asked by staff when visitors entered the facility.
-It was the responsibility of the MA to review the visitor sign in log to be certain the visitor did not have signs or symptoms of COVID-19 when visitors completed the visitor log book.

Telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm revealed:
-She expected any staff who allowed visitors in the facility to screen the visitors for COVID-19 signs and symptoms and prompt for a temperature.
-The staff were also responsible to ensure visitors

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wore face masks, did not have a temperature, and answered the COVID-19 questions on the visitor sign in log.
-Staff were to contact the Administrator or HWD if visitors answered yes to the COVID-19 questions documented in the visitor sign in log before allowing additional entry in the facility.
-Anyone who answered yes to the signs and symptoms of COVID-19 were not supposed to be in the facility because of the possibility of contaminating residents and staff.

Interview with the Administrator on 01/13/22 at 12:55pm revealed:
-It was expected any staff allowing visitors entrance in the facility to screen them for COVID-19 signs and symptoms and prompt for temperature self-assessment.
-She expected staff who allowed any visitors entrance to the facility to prompt them to complete the sign in log which contained questions regarding signs and symptoms of COVID-19 and to obtain a temperature using the wall thermometer.
-She expected the staff who allowed visitors entrance in the facility to ensure any visitors who answered "yes" to the COVID-19 signs and symptoms questions not be allowed additional entrance in the facility.
-She last trained the housekeeper in June 2021 regarding screening visitors for COVID-19.
-The housekeeper had not had additional training in screening visitors for COVID-19 since June 2021.
-The housekeeper, PCA, and MA should have prompted the surveyors to sign in, complete the COVID-19 screening questions, and obtain a temperature on entrance to the facility this morning, 01/13/22.
-All three staff should have reviewed the sign in

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D 612	Continued From page 20 log and COVID-19 screening questions after the surveyors completed the log. 2. Observations of the facility on 01/13/22 at various times from 7:45am to 3:00pm revealed no observations of the housekeeper cleaning handrails, light switches, or doorknobs throughout the facility. Interview with the housekeeper on 01/13/22 at 2:24pm revealed: -She worked Monday through Friday from 7:30am to 2:30pm or 3:30pm. -She was responsible for cleaning the building. -Upon arrival to work she vacuumed the common areas, cleaned management offices and common bathrooms. -Around lunchtime, she would clean that days assigned hallway to consist of vacuuming, wiping the handrails, and cleaning rooms of residents who were not diagnosed with COVID-19. -She rotated hallway each day: Monday- Hall A; Tuesday- Hall B; Wednesday- Hall C; Thursday- Hall D; and Friday she focused cleaning he common areas. -The care staff assigned to each hall were responsible for cleaning the cleaning on Saturday and Sunday. -She was not responsible for cleaning rooms of COVID-19 positive residents. -She thought one of the personal care aides (PCAs) was responsible to clean the COVID-19 positive resident rooms. -Due to COVID-19, she wiped down the handrails, light switches, and doorknobs one time a day, which was usually in the morning. -She had not been instructed by management to wipe down the handrails, light switches, and doorknobs more than once a day due to the COVID-19 pandemic.	D 612		

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D 612	Continued From page 21 Telephone interview with the temporary Health and Wellness Director (HWD) on 01/13/22 at 1:47pm revealed she did not know the expectations of facility cleaning regarding COVID-19. Interview with the MA on 01/13/21 at 2:32pm revealed: -She would only clean the medication cart area at the end of her shift. -She frequently wiped down the medication cart with an antibacterial wipe throughout her shift and at the end. -The PCAs would wipe down their assigned halls at the end of their shift. -It was the responsibility of the PCA assigned to the COVID-19 positive residents to clean their room. -She did not know who was responsible to ensure the PCAs wiped down their assigned halls or COVID-19 positive resident rooms. Interview with a PCA on 01/13/22 at 2:50pm revealed: -She was called in to provide personal care today, 01/13/22, because of a staff call out. -She was performing personal care today, 01/13/22, then the Administrator pulled her to disinfect the facility. -She was instructed by the Administrator to disinfect the handrails and door handles. -It was the responsibility of night staff to disinfect the common areas. Interview with the Administrator on 01/13/22 at 3:00pm revealed: -She expected the housekeeper to disinfect the facility's high traffic areas three times a day. -She did not know the housekeeper was not	D 612		

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D 612	Continued From page 22 disinfecting high traffic areas only once a day.	D 612		