STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086006	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE PLANTATION	515 W. KAPP STREET DOBSON, NC 27017

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey from August 30, 2022 to August 31, 2022.	{D 000}		
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 and interviews, 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 (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) by staff. The findings are:	D 612	Administrator in Charge, Care Coordinators, Supervisors and Owners will continue to remind and encourage staff they should keep their face mask up while in patient care areas and throughout the facility. Staff are required to screen daily. Staff daily screening upon arrival conducted prior to, during follow-up survey and continued, restricting their entrance to paitent care areas when failed screening. Restricting staff from working if they are symptomatic of respiratory illness. Facility continues to test weekly or twice a week per our County Community Transmission Levels. Administrator in Charge has contacted local health department CD nurse to clarify setting specific IPC guidance/recommendations to provide accurate updates for policy updates and staff, resident, visitor knowledge. 09/28/2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Hardy | TITLE: Administrator in Charge | (X6) DATE: 09/28/2022

Reviewed and acknowledged 09/29/22. Catherine Prater

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D 612	Continued From page 1 Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting face masks to cover a person's mouth and nose. -Cloth masks were not considered PPE and should not be worn by staff. Review of the facility's COVID-19 Pandemic Response Policy and Procedure revealed: -The purpose of the policy was to compile recommendations from the CDC and other Federal and State regulatory agencies. -The facility person responsible for communications with public health authorities and staff/visitor was the Administrator-In-Charge. -Personal protective equipment (PPE) would be continually ordered to ensure availability. -Instructions for suspected or confirmed COVID-19 precautions listed PPE as mask, gown and gloves. -An attachment to the policy regarding "COVID	D 612		

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Outbreak" read "You must report to work with your mask on." And "YOU MUST WEAR PPE DURING YOUR SHIFT AND APPROPRIATELY".

Observation on 08/30/22 at 9:05am revealed:
-There was a sign posted on the front entry door that read "Vaccinated and unvaccinated visitors should keep their masks on during visitation ...".
-There were 5 staff in the entry area not wearing masks and with no visible mask on their person.
-There were signs posted on doors in the entry area that called attention to all facility staff that read "YOU ARE REQUIRED TO WEAR A MASK THAT COVERS YOUR NOSE AND MOUTH".

Observation on 08/30/22 at 9:10am revealed:
-A male staff entered from a door on the left carrying a bedrail not wearing a mask and entered a door across the entry on the right.
-The door on the left of the entry area led to the Assisted Living (AL) hall.
-The door to the right led to the Special Care Unit (SCU).

Interview with the Administrator-In-Charge on 08/30/22 at 9:10am revealed:
-The staff from the county health department advised that facility staff could have relief from masks when they were in confined areas where residents did not congregate.
-She thought the entry area adjacent to the dining room and AL hall was a confined space.
-The staff that had carried furniture through the halls was maintenance staff and should have had a mask on.

Observation during the initial tour of the special care unit (SCU) on 08/30/22 at 9:43am revealed:
-Two staff were standing in Resident Room #103.
-The resident was observed in the bed sleeping

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and non-active.
-One staff (housekeeper) was standing towards the foot of the resident's bed near the door.
-The second staff (medication aide (MA)/personal care aide) was standing near the side of the resident's bed, less than 6 inches from the resident.
-The housekeeper had a surgical face mask on.
-The housekeeper's face mask had strings attached at each end.
-The strings were looped over both the housekeeper's ears.
-The face mask was pulled down off the housekeeper's nose and mouth and was under the housekeeper's chin.
-The MA had a surgical face mask on that had strings attached at both ends and looped over both the MA's ears.
-The MA's face mask did not cover her nose and mouth.
-The face mask was under the MA's chin.
-The MA and the housekeeper were both engaged in conversation.
-Both staff saw the surveyor and pulled their face mask up to cover their mouth and nose.

Interview with the housekeeper on 08/30/22 at 9:54am revealed:
-She was aware that a face mask should be worn at all times when in the presence of residents.
-When she was in Resident Room #103 she was aware the resident was present.
-She pulled her face mask down to catch her breath.
-Sometimes she could not breath when wearing a face mask because her sinuses were flared up.

Interview with the MA on 08/30/22 at 9:56am revealed:
-She was aware that she should wear a face

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mask when in the presence of a resident.
-She pulled her face mask down today because she had been moving furniture around and she could not breathe.
-She pulled the face mask down to get her breath.
-The facility had provided training on the proper way to wear PPE.

Interview with the Special Care Unit Coordinator (SCUC) on 08/30/22 at 10:01am revealed:
-She was not aware staff were taking off their face masks off when in the room with residents.
-Staff had been trained and made aware they needed to wear a surgical face mask when a resident was present.
-There were postings and flyers displayed to remind staff to wear PPE.

Observation of the facility on 08/30/22 at various times between 9:55am and 4:15pm revealed:
-At 9:55am, residents from the AL hall went through the front entry area into the dining room for snacks and hydration.
-There was a total of 10 residents present in the dining room.
-At 10:29am, 2 staff led 14 residents from the SCU through the front entry into the dining room for snacks and hydration.
-At 11:15am, 2 residents entered the open dining room doors from the front entry area to access the patio area through a door on the left of the dining room.
-At 11:15am, a kitchen staff was setting up tables for lunch with her mask below her nose.
-At 3:30pm, a resident was sitting in a chair in the facility's entry area.

Interview with the resident by the facility's entry area on 08/30/22 at 3:30pm revealed:

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-She sat by the entry area most mornings and afternoons.
-She liked to people watch before and after she returned from her day program.
-She entered from the AL hall door to go to the dining room for snacks and meals or to sit in the entry any time she wanted.
-She was unsure if staff wore masks while she was in the entry area.

Observation on 08/31/22 at various times from 7:15am to 11:00am revealed:
-At 7:15am, there was 1 resident sitting by the front entrance door and 1 resident laying on the couch in the entry area.
-At 7:35am, a staff was assisting residents on the SCU while wearing her mask below her top lip.
-At 8:10am, a staff walked through the hall beside the SCU door without a face mask into the entry area and retrieved a face mask from a table by the front door.
At 11:00am, 2 residents were sitting on the couch in the front entry way by the dining room.

Interview with a medication aide (MA) on 08/31/22 at 10:25am revealed:
-All staff were to wear masks when at work.
-She wore her mask all the time when she worked.
-Residents frequently sat in the front entrance and had to go through the hall for meals and snacks.

Interview with a second resident on 08/31/22 at 10:50am revealed:
-Facility staff did not usually wear face masks.
-He could not remember how long it had been since staff wore face masks, but it had been a long time.
-He noticed staff had been wearing face masks

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for the past couple of days.

Interview with a third resident on 08/31/22 at 11:20am revealed:
-Staff did not wear their masks, only a couple staff wore masks all the time.
-The rest of the staff did not wear masks until yesterday (08/30/22) when one of them came down the hall and said, "state was here, put your masks on."
-She thought all the staff were supposed to wear face masks at work.

Interview with a housekeeper on 08/31/22 at 11:27am revealed:
-It was the facility's policy that all staff wear face masks when in the facility.
-She had not been told that staff could remove their face masks at the front entrance area while residents were not around.

Interview with the Maintenance Supervisor on 08/31/22 at 12:23pm revealed:
-All staff, including maintenance staff, were to have face masks on when they entered the facility to work.
-He was never told the front entry was an area where he could take his face mask off.
-He did not know why his maintenance staff did not have his face mask on yesterday morning (08/30/22) but he should have had a face mask on.

Telephone interview with a representative from the local county health department on 08/31/22 at 10:10am revealed:
-They refer all facilities to CDC for infection control and prevention of spreading COVID-19.
-The CDC guidelines were that all health care personnel (HCP) were to wear face masks in the

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D 612	Continued From page 7 facility at all times when in areas where staff may encounter residents. -She did not recommend to the management that the front entry was a confined area that was safe for staff to remove face masks. Interview with the Administrator on 08/30/22 at 3:45pm revealed: -It was facility policy that staff were to wear face masks while working in the facility around residents. -Staff knew to cover their nose and mouth with face masks when they were around residents. -She could not follow each staff around every day to ensure they kept their face masks on. -She thought the front entry was considered a confined area where staff could remove their face masks because residents did not frequent the area. -It was human error that she told staff that the front entry was a confined area in which they could remove their face masks.	D 612		