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	HAL037001	A. BUILDING: _____ B. WING _____	R-C 05/05/2023

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GATES HOUSE	11 COMMERCE DRIVE GATESVILLE, NC 27938

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D 000	Initial Comments The Adult Care Licensure Section conductd a follow-up and complaint survey on 05/03/23 through 05/05/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide referral in a timely manner to meet the routine healthcare needs of 1 of 5 sampled residents (#3) related to a rash. The findings are: Review of Resident #3's current FL-2 dated 04/14/23 revealed: -Diagnoses included vascular dementia, hyperlipidemia, chronic obstructive pulmonary disease (COPD), hypertension, muscle weakness, and transient ischemic attack (TIA). -The resident's level of care was the special care unit. -There was an order for Baza Protect 12% topical, apply to perineum after each incontinent episode for skin protection as needed. Review of Resident #3's physician order dated 04/03/23 revealed: -There was an order to apply barrier cream to perineum area after each incontinent episode. -Resident #3 was admitted to hospice. Review of Resident #3's Resident Register	D 273		

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revealed an admission date of 02/28/23.

Review of Resident #3's progress notes dated 03/18/23 revealed resident had a severe rash on his inner thighs.

Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Baza Protect Cream (zinc oxide) 12%, apply to perineum area after each incontinent episode for skin protection as needed.
-There was no documentation the Baza Protect Cream 12% was administered from 04/05/23 through 04/28/23.

Review of Resident #3's May 2023 eMAR revealed:
-There was an entry for Baza Protect Cream (zinc oxide) 12%, apply to perineum area after each incontinent episode for skin protection as needed.
-There was no documentation the Baza Protect Cream 12% was administered from 05/01/23 through 05/03/23.

Observation of Resident #3's perineum area on 05/04/23 at 3:10pm revealed slightly reddish rash between the inner thighs.

Interview with Resident #3's responsible person (RP) on 05/04/23 at 3:15pm revealed:
-There were reddish "bumps" on the resident's inner thighs when she and a family member came to the facility to visit on 03/18/23.
-She informed the personal care aide (PCA) who notified the medication aide (MA) regarding the rash.
-The MA applied a cream to the area.

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Interview with Resident#3's family member on 05/05/23 at 8:05am revealed:
-She and and friend came to the facility with the RP on 03/18/23 to visit Resident #3.
-She noticed Resident #3 was "winching" and said his "private" hurt.
-She took Resident #3 to the bathroom and noticed he was saturated with urine and had reddish bumps or rash on his inner thighs.
-She notified the PCA.
-The PCA notified the MA who applied a cream to the area.
-The PCA said Resident #3 had a bath that day, but she did not notice the rash at that time.

Interview with the PCA on 05/05/23 at 10:15am revealed:
-She was the PCA on the special care unit (SCU)when Resident #3's family visited on 03/18/23.
-She noticed a reddish rash or bumps when she took Resident #3 to the bathroom.
-She did not remember seeing the rash before then or anyone reporting it to her.
-She notified the family and the MA.
-The MA came to the room and observed the rash and applied a cream to the area.
-She did not know if the MA reported it to anyone.

Interview with the MA on 05/05/23 at 9:43am revealed:
-She was the MA on the special care unit when Resident #3's family visited on 03/18/23.
-The PCA notified her of the rash on Resident #3's inner thighs.
-She came to the the room and observed the resident had a reddish rash or bumps on his inner thighs that was bleeding.
-She applied a "house stock" barrier cream to the area until the primary care provider (PCP) could

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be notified to see if something could be ordered.
-The resident commented " that eased it off."
-She notified the PCP via telemetric and the response was to monitor the area for spreading or getting worse until the PCP comes to the facility.
-The PCP usually came to the facility every other week.
-She did not know if Resident #3 was on the list to be seen by th PCP or if the PCP saw Resident #3 when she came to the facility on the next visit.

Interview with the hospice aide on 05/04/23 at 3:45pm revealed:
-She was Resident #3's hospice aide.
-She had been coming to the facility, Monday through Friday, for a about a month.
-She saw Resident #3 on yesterday, 05/03/23.
-The area between the inner thighs was still reddish.
-She gave him a bed bath and applied barrier ointment and yeast powder to the area.
-She instructed the MAs and the PCAs to apply the cream when they provided incontinent care.
-Sometimes he could tell you when he needed incontinent care.

Interview with the memory care coordinator (MCC) on 05/05/23 at 12:30pm revealed:
-Resident #3's rash was not reported to her when it was observed by family members who were visiting on 03/18/23.
-She did not know why the PCA did not notice the rash when giving Resident #3 a bath.
-She expected the rash to be reported to her, the primary care provider (PCP) or hospice in a timely manner.
-She expected there not to be a delay in getting the barrier cream order.

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D 273	Continued From page 4 Interview with the Administrator on 05/05/23 at 1:45pm revealed -She did not recall there being an issue with Resident #3 having a rash. -She expected the PCA to report the rash to the MA and the MCC to ensure treatment was ordered in a timely manner. Attempted interview with Resident #3's PCP on 05/04/23 at 10:00am was unsuccessful. Based on observations, record reviews and interviews, it was determined that Resident #3 was not interviewable.	D 273		
D 619	10A NCAC 13F .1802 (b) Reporting & Notification of a Suspected or C 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (b) The facility shall provide the residents and their representative(s) and staff with an initial notice within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its initial notification to residents and their representative(s), shall: (1) not disclose any personally identifiable information of the residents or staff; (2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change; and (3) provide information to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.	D 619		

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to notify the responsible person of 1 of 5 sampled residents (#3) of positive COVID-19 cases in the facility resulting in a communicable disease outbreak.

The findings are:

Review of COVID-19 Infection Prevention Guidance for Long-Term Care Facilities from North Carolina Department of Health and Human Services (NCDHHS) dated 12/30/22 revealed:
-The facility should utilize signage to advise of infection prevention strategies.
-During an outbreak investigation visitors should be made aware by the facility of the potential risk of visiting during an outbreak investigation, visitors should wear face coverings or masks during visits, visits should ideally occur in the resident's room, visitors should only go to and from the resident's room and/or designated visiting areas, and visitors should physically distance themselves from other residents and staff when possible.

Review of Resident #3's current FL-2 dated 04/14/23 revealed:
-Diagnoses included vascular dementia, hyperlipidemia, chronic obstructive pulmonary disease (COPD), hypertension, muscle weakness, and transient ischemic attack (TIA).
-The resident's level of care was the special care unit.

Review of Resident #3's Resident Register revealed an admission date of 02/28/23.

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D 619	Continued From page 6 Review of Resident #3's Accident/Incident (A/I) Report dated 03/19/23 revealed: -The resident was observed laying in bed shaking. -The resident had a temperature of 101.5 degrees Fahrenheit. -The emergency medical service (EMS) was called and the resident was transported to the emergency room (ER). -The resident's discharge diagnosis was COVID-19. -The primary care provider (PCP), the Administrator, the local department of social services (DSS), and the responsible person (RP) were notified that Resident #3 was sent to the ER. Review of Resident #3's progress notes dated 03/19/23 revealed: -The resident was sent to the ER due to a change in condition. -The primary care provider (PCP) and RP were notified. -An A/I report was completed. Review of Resident #3's hospital admission report dated 03/22/23 revealed: -The resident was admitted to the hospital on 03/19/23 and discharged back to the facility on 03/22/23. -The diagnosis was pneumonia due to COVID-19. Interview with Resident #3's responsible person (RP) on 05/04/23 at 3:15pm revealed: -She was not notified that there were COVID-19 cases in the facility around 03/10/23. -She and another family member visited Resident #3 on 03/18/23, the day before he was sent to the ER on 03/19/23 and diagnosed with COVID-19.	D 619		

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D 619	Continued From page 7 -Resident #3 was not feeling well the day they visited him on 03/18/23. -She did not recall seeing any signage on the entrance door informing visitors of positive COVID-19 cases in the facility. -She did not recall any staff at the facility informing her that there were positive COVID-19 cases in the facility. -She should have been notified that COVID-19 cases were in the facility. Interview with Resident #3's family member on 05/05/23 at 4:30pm revealed: -The RP was not notified that there was COVID-19 cases in the facility. -She and a friend visited Resident #3 with the RP on 03/18/23, the day before he went to the hospital on 03/19/23 and was diagnosed with COVID-19. -Resident #3 was not feeling well on the day of their visit on 03/18/23. -She did not recall seeing any signage informing visitors that the facility had positive COVID-19 cases. -She did not recall any staff informing them that the facility had positive COVID-19 cases in the facility -Had she known there were COVID-19 cases in the facility, she would have worn a mask or decided not to visit that day. -Not knowing there were COVID-19 cases in the facility exposed her and others she came in contact with after leaving the facility to COVID-19. -She and the RP did not know there were positive COVID-19 cases in the facility until they went to the hospital on 03/19/23 and the physician informed them that Resident #3 had COVID-19 and it would be best for them not to visit the resident at that time. -A staff person from the facilty called them after	D 619		

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D 619	Continued From page 8 Resident #3 was diagnosed with COVID-19 and asked them if they knew Resident #3 was in the hospital, and informed them there had been positive cases in the facility. Telephone interview with a Registered Nurse (RN) with a regional infection prevention support team on 05/05/23 at 11:06am revealed: -She spoke with the Administrator by telephone on 03/10/23 regarding the COVID-19 outbreak in the facility. -She provided guidance on prevention guidelines to prevent the spread of COVID-19 by telephone and email on 03/10/23. -She provided the Administrator with an attachment in an email on 030/10/23 of COVID-19 Infection Prevention Guidelines for Long-Term Care Facilities from the North Carolina Department of Health and Human Services (NCDHHS). -She highlighted portions of the document to reinforce with the Administrator guidelines the facility needed to implement and follow during the COVID-19 outbreak. -She instructed the Administrator to post signage per the NCDHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities at the facility to ensure staff, residents, and visitors were aware of the COVID-19 outbreak. -She expected the facility to post signage of the COVID-19 outbreak because visitors needed to be aware of the facility's outbreak status and wear face masks to prevent the spread of COVID-19. -She instructed the Administrator that the facility needed to contact the RP for all residents to notify them that the facility has an outbreak of COVID-19. -The Administrator was expected to notify all RPs of the COVID-19 outbreak to protect the	D 619		

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community from potential exposure to COVID-19; once anyone walked into the facility, they were exposed to COVID-19.

Interview with the memory care coordinator (MCC) on 05/03/23 at 4:00pm and 05/05/23 at 12:30pm revealed:.
-A team worked on notifying residents' families around 03/10/23 to inform them of positive COVID-19 cases in the building.
-She notified Resident #3's RP to inform her of positive COVID-19 cases.
-She could not document the call in the resident's progress notes because she had not been issued a code yet to access the facility's computer system.
-She could not provide any documentation that she called Resident #3's RP.

Interview with the Administrator on 05/03/23 at 3:45pm and 05/05/23 at 1:45pm revealed:
-Several residents were tested for COVID-19 around 03/10/23 due to symptoms and were found to be positive.
-The local health department was notified regarding the positive cases.
-The facility followed the Infection Prevention Guidance of Long Term Care facilities and the local health department.
-The local health department sent signage to the facility to post at the entrance of the facility to inform visitors that COVID-19 was in the facility.
-The signage was posted on the front door of the facility.
-She and members of the management team contacted family members to inform them that the facility had positive cases for COVID-19.
-Family notifications were documented in the residents' progress notes.
-The MCC notified Resident #3's RP regarding

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D 619	Continued From page 10 positive COVID-19 cases in the facility. -The MCC could not document notification in Resident #3's progress notes because she recently came from another facility and had not been issued a code yet to access the facility's computer system. Based on observation, record review, and interviews, it was determined that Resident #3 was not interviewable.	D 619		