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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on October 25 and 26, 2023.	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, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 residents sampled (#2) related to administration of a blood pressure medication and notifying the physician of a low blood pressure reading. The findings are: Review of Resident #2's current FL-2 dated 05/03/23 revealed a diagnosis of hypertension. Review of a signed physician's order dated 10/17/23 revealed there was an order for lisinopril 5mg (used to treat high blood pressure) daily. Review of the signed physician's order dated 10/19/23 revealed there was an order to hold lisinopril 5mg for blood pressure readings 110/70 or lower and to notify the Primary Care Provider (PCP). Observation of the medication administration of Resident #2' lisinopril 5mg on 10/26/23 at 8:40am revealed: -The MA administered Resident #2 lisinopril 5mg.	D 273		

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-The MA obtained Resident #2's blood pressure reading after administering lisinopril 5mg.
-Resident #2's blood pressure reading at 8:40am was 137/63.

Observation of Resident #2's blood pressure reading on 10/26/23 at 11:52am revealed a blood pressure reading of 125/62.

Review of Resident #2's vital sign summary page revealed:
-There was a blood pressure reading of 110/78 recorded on 10/19/23 at 9:14am.
-There was a blood pressure reading of 117/63 recorded on 10/20/23 at 8:41am.
-There was a blood pressure reading of 120/66 recorded on 10/21/23 at 9:32am.
-There was a blood pressure reading of 124/69 recorded on 10/22/23 at 10:08am.
-There was a blood pressure reading of 118/60 recorded on 10/23/23 at 10:52am
-There was a blood pressure reading of 115/65 recorded on 10/23/23 at 11:27am.
-There was a blood pressure reading of 126/70 recorded on 10/24/23 at 8:13am.

Review of Resident #2s October 2023 electronic medication administration record (eMAR) from 10/19/23 to 10/26/23 revealed:
-There was an entry for lisinopril 5mg daily, hold if blood pressure reading 110/70 or lower and call the PCP.
-There was documentation lisinopril 5mg was administered daily from 10/19/23 to 10/26/23.

Interview with a medication aide (MA) on 10/26/23 at 10:57am revealed:
-She had passed medications to Resident #2 when she worked as a MA.
-She had administered lisinopril 5mg to Resident

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#2.
-She checked Resident #2's blood pressure, either before or after Resident #2 took her medications.
-She was not aware Resident #2's lisinopril was to be held for a blood pressure reading of 110/70 or lower and to notify the PCP.

Interview with the nurse at Resident #2's PCP office on 10/26/23 at 11:32am revealed:
-Resident #2 was on lisinopril 5mg daily.
-Lisinopril was used to lower blood pressure.
-The PCP wanted to know when Resident #2's blood pressure dropped below 110/70 so he could adjust medications as needed.
-The PCP expected to be notified when Resident #2's blood pressure was 110/70 or below and for the lisinopril to be held.

Interview with the Resident Care Coordinator on 10/26/23 at 10:44am revealed:
-She administered lisinopril 5mg to Resident #2 this morning, then checked Resident #2's blood pressure.
-She checked Resident #2's blood pressure after she administered the lisinopril.
-Resident #2's blood pressure reading was 137/63.
-She did not know there was an order to hold Resident #2's lisinopril for blood pressure readings of 110/70 or lower.
-She did not see the instructions on the eMAR to hold the lisinopril and call the PCP.
-New orders were entered by the RCC and the Health Wellness Director (HWD).

Interview with the HWD on 10/26/23 at 11:45am revealed:
-The HWD and the RCC entered orders into the eMAR.

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D 273	Continued From page 3 -She entered the order to hold the lisinopril and call the PCP if Resident #2's blood pressure was 110/70 or lower. -The order did show on the eMAR; the MAs have to click on the order to open the order so the entire order can be read. -The MAs should know how to click on the order so they can read the entire order. -The MAs should check Resident #2's blood pressure before administering the lisinopril. -The Resident #2's blood pressure reading is 110/70 or lower, the MAs should hold the lisinopril and call the PCP. Interview with the Executive Director (ED) on 10/26/23 at 12:45pm revealed: -She expected the PCP to be notified for blood pressure readings of 110/70 or lower and for the lisinopril to be held. -Resident #2's blood pressure could drop further if the medications were administered when a blood pressure was already low. -She expected the MAs to read the entire order when administering medications.	D 273		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.	D 297		

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This Rule is not met as evidenced by:
Based on observations, record reviews and staff interviews, the facility failed to ensure residents were served nutritionally adequate meals for 2 of 5 residents sampled (#3, #4)

The findings are:

1. Review of Resident #3's current FL-2 dated 02/28/23 revealed diagnoses of dementia with behavioral disturbance, major depression, hypertension, osteoporosis, chronic obstructive disease, and intervertebral disc disorder. Resident #3 had a diet order dated 07/25/23 for a texture modified, mechanical soft diet.

Review of the Menu at a Glance for the lunch meal on 10/25/23 revealed:
-There was a dessert of pecan pie, a fresh berry cup or reduced sugar custard pie to be served.

Observation of the lunch meal delivery service on 10/25/23 served at 12:10pm revealed no dessert item was served.

Review of the Menu at a Glance for the dinner meal on 10/25/23 included creamy carrot ginger soup.

Observation of the dinner meal delivery service on 10/25/23 at 5:10 to 6:00pm revealed there was no carrot ginger soup served to Resident #3.

Based on observations and record review, it was determined Resident #3 was not interviewable.

Refer to the interview with the lead cook on 10/26/23 at 8:55am.

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D 297	Continued From page 5 Refer to the interview with the Food Services Director on 10/26/23 at 9:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:15am. Refer to the interview with the Executive Director on 10/26/23 at 12:45pm. 2. Review of Resident #4's current FL-2 dated 05/29/23 revealed diagnoses of memory impairment, chronic deep vein thrombosis, hearing loss, and behavior changes. Review of a diet order dated 06/05/23 revealed Resident #4 was on a regular diet. Review of daily Menu at a Glance for the main meal on 10/25/23 revealed: -Oven roasted chicken quarters basted with tangy barbecue sauce should have been served. -A dessert of pecan pie, a fresh berry cup or reduced sugar custard pie should have been served. Review of the Daily Diet Modification Summary Report for the lunch meal on 10/25/23 included an 8 ounce portion of barbecue chicken. Observation of the lunch meal delivery service on 10/25/23 served at 12:10pm revealed: -Resident #4 was served a small chicken leg. -There was no dessert served. Observation of the dinner meal delivery service on 10/25/23 served from 5:10 - 6:00pm revealed Resident #4 did not receive carrot ginger soup.	D 297		

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D 297	Continued From page 6 Based on observations and record review, the resident was determined to be not interviewable. Refer to the interview with the Personal Care Aide (PCA) on 10/26/23 at 9:31am. Refer to the interview with the lead cook on 10/26/23 at 8:55am. Refer to the interview with the Food Services Director (FSD) on 10/26/23 at 9:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:15am. Refer to the interview with the Executive Director on 10/26/23 at 12:45pm. _____ Interview with a (PCA) on 10/26/23 at 9:31am revealed: -There was no dessert served on 10/25/23 at lunch. -He usually went back to the kitchen to get the dessert but yesterday they didn't have any. -There was no soup served on 10/25/23 at dinner. Interview with the lead cook on 10/26/23 at 8:55am revealed: -She used the Menu at a Glance for guidance of what to serve the residents. -She did not see chicken quarters listed on the menu. -She did not realize she was supposed to serve an 8-ounce portion of chicken. -She served chicken legs for the main meal on 10/25/23 at 12:10pm. -She did not always follow the diet menu. -A chicken leg was not an 8-ounce portion. -She had pound cake for dessert on 10/25/23 at	D 297		

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D 297	Continued From page 7 lunch time but none of the staff came to get it. -The PCA's came to the kitchen to get dessert. -Dessert was part of the daily menu and should be served. -The menu should be followed to meet the nutritional needs of the residents. Interview with the FSD on 10/26/23 at 9:00am revealed: -Ginger carrot soup was on the menu for the dinner meal on 10/25/23. -He did not serve ginger carrot soup. -He planned to substitute with a beef vegetable soup but did not have any lids so did not think it was a good idea to serve soup. -Soup was part of the daily menu. Interview with the RCC on 10/26/23 at 11:15am revealed: -She did not realize there was no soup served for the dinner meal on 10/25/23. -If soup was on the menu, it should have been served. -Desserts should be prepared by the dietary staff and ready for the PCA's to pick up. -It was important the menu be followed so the residents received adequate nutrition. Interview with the ED on 10/26/23 at 12:45pm revealed: -She was unaware the menu for 10/25/23 for the lunch and dinner meals was not followed. -She expected the dietary staff to follow the menu to meet the resident's nutritional needs.	D 297		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 310		

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D 310	Continued From page 8 (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets as ordered for 2 of 3 sampled residents (#3, #5) who had an order for textured modified diet (#3, #5). The findings are: Review of the facility's regular menu for lunch dated 10/25/23 revealed an 8-ounce serving of bar-b-que chicken, ¾ cup of macaroni and cheese, ½ cup of steamed green beans, a dinner roll, and a dessert. Review of the facility's therapeutic diet menu on 10/25/23 for a texture modified diet revealed the tossed salad should be substituted with a 3/4 cup of tomato juice, the chicken should be deboned, the skin removed, ground, and serve with barbecue sauce, tender steamed green beans, and a dinner roll soft with butter. Review of the facility's regular menu for breakfast on 10/26/23 revealed 2 egg and cheese bites, 5 ounces of bacon strips, 1 ounce slice of wheat toast,1 tsp of margarine 5.5 ounces of fresh pineapple, half cup of cream of wheat or 1 cup of Cheerios, three quarter cup of orange juice, and 1 cup of milk. Review of the facility's therapeutic diet menu for breakfast on 10/26/23 for texture modified diet revealed serve egg and cheese bites, a ground sausage patty with one ounce of gravy, one	D 310		

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ounce slice of wheat bread served soft with butter, pureed fruit, and cereal served well moistened with milk.

1. Review of Resident #3's current FL-2 dated 02/28/23 revealed diagnoses included dementia with behavioral disturbances, major depressive disorder, hypertension, chronic obstructive pulmonary disease, and osteoporosis.

Review of Resident #3's diet order dated 07/25/23 revealed an order for a texture modified diet.

Review of the facility's therapeutic diet list posted in the kitchen dated 10/05/23 revealed Resident #3 was to be served a modified texture diet.

Observation of the lunch meal service on 10/25/23 between 12:10pm and 1:00pm revealed:
-Resident #3's meal tray was not marked.
-Resident #3 was served a tossed salad, chopped chicken, green beans, macaroni, a roll, and a cup of iced tea.
-Butter was not provided.
-Resident #3 ate 75% of the meal without difficulty.
-Resident #3 should not have been served a tossed salad.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:15am revealed:
-Resident #3 was on a modified texture diet because she had coughing episodes.
-She had witnessed one of Resident #3 coughing episodes.

Interview with the Health and Wellness Director (HWD) on 10/26/23 at 12:00pm revealed:
-Resident #3 was on a texture modified diet

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because she had coughing episodes.
-She was not aware of Resident #3 having any recent coughing episodes.

Refer to the interview with the Lead Cook on 10/26/23 at 08:55am.

Refer to the interview with the Food Services Director on 10/26/23 at 09:00am.

Refer to the interview with the RCC on 10/26/23 at 11:15am.

Refer to the interview with the HWD on 10/26/23 at 12:00pm.

Refer to the interview with the Executive Director (ED) on 10/26/23 at 12:45pm.

2. Review of Resident #5's current FL-2 dated 08/15/23 revealed diagnoses included Alzheimer's Disease, anxiety disorder, major depression disorder, mood disturbance, hypothyroidism, and hypertension.

Review of Resident #5's signed physician order dated 10/20/23 revealed there was an order for a textured modified diet.

Review of the facility's therapeutic diet list posted in the kitchen dated 10/05/23 revealed Resident #5 was to be served a modified texture diet.

Observation of Resident #5's lunch meal on 10/25/23 at 12:27pm revealed:
-Resident #5 was served a bar-b-que chicken leg, a serving of macaroni and cheese, green beans, a roll, and a salad which consisted of spinach, chopped apples and pecan halves.
-Resident #5 should not have been served a

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tossed salad.
-The chicken should have been deboned, skin removed and served with barbecue sauce.
-Resident #5 was fed by the facility staff and consumed 50% of her meal.
-Resident #5 did not have any difficulty with the meal.

Observation of Resident #5's breakfast meal on 10/26/23 at 8:48am revealed:
-She was served two strips of bacon, scrambled eggs, pineapple chunks and grits or oatmeal.
-Resident #5 should have been served ground sausage patty with gravy, pureed fruit, and cereal well moistened in milk.
-Resident #5 was observed holding a strip of bacon in her hand, biting small pieces.
-No coughing noted during the meal.
-Resident #5 consumed 50% of her meal.
-The facility staff assisted in feeding Resident #5.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:25am revealed:
-Resident #5 was placed on a textured diet because she had problems swallowing one day last week.
-She had not noticed any coughing or difficulty swallowing since last week.

Interview with the Health Wellness Director (HWD) on 10/26/23 at 11:45am revealed Resident #5 could aspirate if served the incorrect texture.

Interview with the Executive Director (ED) on 10/26/23 at 12:45pm revealed Resident #5 could choke if fed the incorrect diet.

Refer to the interview with the Lead Cook on 10/26/23 at 08:55am.

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D 310	Continued From page 12 Refer to the interview with the Food Services Director on 10/26/23 at 09:00am. Refer to the interview with the RCC on 10/26/23 at 11:15am. Refer to the interview with the HWD on 10/26/23 at 12:00pm. Refer to the interview with the ED on 10/26/23 at 12:45pm. _____ Interview with the Lead Cook on 10/26/23 at 08:55am revealed: She knew the diets of all the residents. -She referred to the diet list for residents that required special diets. -She did not follow the therapeutic diet menu. -She put butter on the top of the rolls. -The chicken was to be served ground up for residents on a modified texture diet. -A tossed salad should not have been given to residents on a textured modified diet. Interview with the Food Services Director on 10/26/23 at 09:00am revealed: -The therapeutic diet menu was available but not posted in the kitchen. -The lead cook should follow the therapeutic diet menu. -Residents on a texture modified diet should not have been served a tossed salad. Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:15am revealed the personal care aides (PCA's) should be aware of which residents are on therapeutic diets. Interview with the Health and Wellness Director	D 310		

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(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 310	Continued From page 13 (HWD) on 10/26/23 at 12:00pm revealed: -Residents' meal trays should be marked with their room numbers. -The PCAs were expected to know which residents were on special diets and alert the kitchen if the diet served was incorrect. -It was important for residents to receive the correct diets to prevent complications. -The kitchen should identify each tray before it leaves the kitchen. Interview with the Executive Director (ED) on 10/26/23 at 12:45pm revealed: -She expected residents to receive the diet ordered by the physician. -Floor staff should be aware of residents' diets. -Her concerns if diets were not served as ordered were choking risks and other safety concerns.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents were treated with respect and dignity by not providing adequate furnishings for residents to eat in their rooms. The findings are: Observation of the breakfast meal on the D hall on 10/25/23 at 9:04am revealed: -A resident was seated on the side of her bed and	D 338		

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held her breakfast plate in her lap as she ate.
-There was no bedside table in the room .

Observation of the lunch meal on the D hall on 10/25/23 at 12:10pm revealed:
-A resident was seated on the side of her bed and held her breakfast plate in her lap as she ate.
-There was no bedside table in the room.

Observation of the lunch meal on the A hall on 10/25/23 at 12:34pm revealed:
-A resident was seated in a chair holding her breakfast plate on her lap while eating.
-There was no bedside table in the room.
-A second resident was seated in a chair next to her bed with her breakfast tray sitting on her bed while eating.
-There was no bedside table in the room.

Observation of the dinner meal on the A hall on 10/25/23 at 5:18pm revealed:
-A resident was seated in a chair holding her breakfast plate on her lap while eating.
-There was no bedside table in the room.
-A second resident was seated in a chair next to her bed with her breakfast tray sitting on her bed while eating.
-There was no bedside table in the room.

Observation of the breakfast meal on the A hall on 10/26/23 at 8:42am revealed:
-A resident was seated in a chair holding her breakfast plate on her lap while eating.
-There was no bedside table in the room.
-A second resident was seated in a chair holding her breakfast tray in one hand while eating.
-There was no bedside table in the room.

Interview with a personal care assistant (PCA) on the D hall on 10/26/23 at 10:50am revealed:

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-He did not know why all the residents did not have bedside tables in their rooms.
-He put the meal trays on their nightstand or dresser if there was no bedside table.
-He did not know if there were any bedside tables elsewhere in the facility, he had never asked.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:25am revealed:
-The residents have been eating in their rooms for 2 weeks.
-The facility staff had placed tables in residents' rooms who needed tables to hold their meal.
-She did not know some residents were holding their plates in their laps and unable to reach their drink.
-The PCA should have asked for a table if the resident did not have one in their room for meals.
-No one asked her for a table for any resident for their meals.

Interview with the Health Wellness Director (HWD) on 10/26/23 at 11:45am revealed:
-Bedside tables should be provided by the resident's family.
-If the resident was on Hospice, a bedside table should be provided by the agency.
-If a resident needed something, the facility staff should let the HWD know what is needed.
-She did not realize residents were holding their meals in their laps when eating.

Interview with the Executive Director (ED) on 10/26/23 at 12:45pm revealed:
-Some families brought bedside tables in for their family members.
-We provided tables to others.
-There were bedside tables in the facility for the residents to use.
-The staff needed to ask for bedside tables for

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D 338	Continued From page 16 the residents who did not have them.	D 338		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.	D 610		

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This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control and Prevention (CDC) were implemented related to Personal Protection Equipment (PPE) during a COVID 19 outbreak.

The findings are:

Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During Covid-19, updated 05/08/23, (2) Recommended infection prevention and control practices when caring for a patient with a suspected or confirmed Covid -2 infection "healthcare personnel who enter a room of a patient with confirmed Covid infection should use N95 mask, gown, gloves, and eye protection".

Review of documentation provided by the facility on 10/25/23, four residents tested positive for Covid-19 on 10/21/23.

Interview with the Executive Director (ED) on 10/25/23 at 09:40am revealed:
-There were currently 4 residents that were positive for Covid-19 and in quarantine.
-The facility followed the CDC guidelines for infection control guidance.
-Staff were required to wear full PPE prior to entering a resident room that was in quarantine

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for Covid-19.
-Full PPE consisted of an N95 mask, gloves, gown, and a face shield.

Observation of B-hall on 10/25/23 at 10:05am revealed:
-There was a 3-drawer plastic bin outside of room B4.
-There were gloves, masks, and shoe coverings available for facility staff to use.
-There were no gowns and no face shields in the bin.
-There was a 3-drawer plastic bin outside of room B7.
-There were gloves, masks, and gowns available for facility staff to use.
-There were no face shields or shoe coverings available to the staff.

Observation on 10/25/23 at 09:50am of the C hall revealed:
-Room #1 and Room #6 had closed doors with signs on both rooms that read, "see staff prior to entering the room".
-A plastic cart in the middle of both rooms contained gloves, gowns, and booties inside.
-There were no face shields available inside of the cart for usage.

Observation of the lunch meal delivery on C hall on 10/25/23 at 12:15pm revealed:
-A personal care aide (PCA) entered Room #6 to deliver her lunch.
-He was wearing a mask.
-He donned gloves and a gown to enter the room to deliver the lunch meal.
-He did not don a face shield before he entered the room.

Observation of the lunch meal delivery on C hall

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D 610	Continued From page 19 on 10/25/23 at 12:18pm revealed: -A PCA entered Room #6 to deliver her lunch. -He was wearing a mask. -He donned gloves and a gown to enter the room to deliver the lunch meal. -He did not don a face shield before he entered the room. Interview with the ED on 10/26/23 at 9:40am and 12:45pm revealed: -Staff were required to wear full PPE for 5 days. -The residents in rooms C1 and C6 tested positive for Covid-19 on 10/21/23 and were on isolation. -Full PPE consisted of mask, gloves, face shield and gown. -There was an adequate supply of PPE available. -Each staff member should have a face shield with their name on it. -She expected staff to wear full PPE when they entered rooms C1 and C6. Interview with a PCA on 10/26/23 at 10:00am revealed: -The residents in Room C1 and C6 were on isolation because they tested positive for Covid-19. -He knew he was to wear full PPE which included a gown, gloves, mask and a face shield. -He did not recall if there were face shields available for him to wear to deliver lunch on 10/25/23. -He did not wear a face shield or eye protection to enter Room C1 or C6 to deliver the lunch trays. Interview with infectious disease nurse at the local Health Department on 10/26/23 at 9:32am revealed: -She was in contact with the facility frequently since the COVID outbreak on 10/16/23.	D 610		

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-She spoke with the ED or the Health Wellness Director (HWD) when she called.
-The facility staff were instructed to wear gowns, mask, gloves and goggles when providing care to a resident who tested positive for COVID, for the first 5 days.
-After day 5, the facility staff only needed to wear a mask.

Interview with the Resident Care Coordinator (RCC) on 10/26/23 at 11:15am revealed:
-The residents in rooms C1 and C6 tested positive for Covid-19 and were on isolation.
-Staff were required to wear full PPE when they entered rooms C1 and C6.
-Full PPE included a gown, gloves, mask and a face shield.
-She made spot checks to make sure staff wore the correct PPE.
-She reminded staff frequently about the correct usage of PPE.
-Face shields were available for staff usage.
-She and the HWD were responsible for filling up the PPE carts.

Interview with the HWD on 10/26/23 on 12:00pm revealed:
-The residents in rooms C1 and C6 tested positive for Covid-19 on 10/21/23 and were on isolation.
-PPE carts were available outside the residents' rooms.
-She was responsible to set up the PPE cart when a resident was initially placed on precautions.
-The RCC and floor staff were expected to keep the PPE carts full and notify her if more supplies were needed.
-She was notified today that the carts needed to be filled and she filled them.

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D 610	Continued From page 21 -She placed face shields inside the carts. -Staff were expected to wear full PPE when they entered rooms C1 and C6 to help decrease the spread of Covid. -Full PPE included a gown, gloves, face shield and mask. Interview with the ED on 10/26/23 at 12:45pm revealed: -The facility staff was expected to wear gowns, gloves, masks, and face shields when the entered a resident's room who had tested positive for COVID for the first 5 days.	D 610		