STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	**95 LOCUST STREET CONNELLY SPG, NC 28612**

(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) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 9/22/20 through 9/24/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# MR8J11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 9/22/20 through 9/24/20. 4 of the 8 complaint allegations were substantiated resulting in a deficiency. Event ID #MR8J11.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		10/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/15/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

(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) COMPLETION DATE
F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

(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) COMPLETION DATE
F 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include procedures for outdoor visitation screening in their COVID-19 policy and failed to screen visitors prior to an outdoor resident visitation for 1 of 6 residents (Resident #6) reviewed for infection control. These failures occurred during the COVID-19 pandemic. The findings included: A review of the facility's COVID-19 policy entitled "Visitation Policy" updated on 7/24/20 did not include screening for outdoor resident visitation. The facility's Visitor Screening Log for 8/28/20 indicated one visitor had been screened upon entry to the facility on 8/28/20 at 2:50 PM to go to room 502 which was not Resident #6's room. The visitor signed out at 3:13 PM. On 9/23/20 at 10:59 AM, a phone interview was conducted with the facility's Director of Marketing (DM) who stated the facility had an outdoor visitation for Resident #6 with her family members on 8/28/20. The DM could not say how many people were present at the visitation, but she emphasized that there were not a lot of people who gathered to visit with Resident #6. She stated that nobody touched Resident #6 and all the people present wore masks. The DM said all the visitors including Resident #6's family members were not screened because none of them entered the facility. The DM stated she	F 880	1. All visitation for residents, outdoor and indoor, will require residents to be COVID free, have proper PPE in place as well as require visitors to follow all visitation requirements and screening process laid forth in the latest guidance on visitation, communal dining and indoor activities for larger residential settings. 2. Facility will require all future visits to adhere to the same guidance and has inserviced all staff on the latest secretarial guidance. All visitors will be screened prior to any/all visitation. This information will be available to future visitors and staff as well, with the expectation that it is followed, or visitation will not be allowed. 3. Re-education for all staff will be conducted to ensure all staff are aware of the changes. Visitation will be scheduled and all parties educated on the expectations of visitation before the visit occurs. 4. Root Cause Analysis (RCA) was completed by Regional Clinical Manager on 10/14/2020. Findings from RCA were 1)failed to screen visitors for outside visit, 2)staff did not alert the visitors to remain at least 6 feet apart, and 3) Facility didn't treat this as a compassionate visit (State viewed as outdoor compassionate visit)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	95 LOCUST STREET CONNELLY SPG, NC 28612

(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) COMPLETION DATE
F 880	Continued From page 3 spoke with Resident #6's family members and educated them prior to the event not to come if they were sick. On 9/22/20 at 1:37 PM, an interview was conducted with the Director of Nursing (DON) who was also responsible for Infection Control. The DON stated she was present when Resident #6 had outdoor visitation from family members on 8/28/20. Resident #6 and all her visitors wore masks. The DON stated all the visitors did not get screened because they did not go into the building. None of Resident #6's visitors had their temperatures checked before the visitation. She counted at least five visitors stood outside while visiting Resident #6. She knew that the Administrator had asked Resident #6's family members not to come if they had been sick or if they had been around other people who were sick before the visit. The DON also confirmed that the visitor who had been screened on 8/28/20 was not one of Resident #6's visitors. On 9/22/20 at 2:57 PM, an interview conducted with the Administrator confirmed the facility had an outdoor visitation for Resident #6 on 8/28/20. All visitors wore masks and stayed outside of the 6-feet marked area. The Administrator could not say how many visitors came because she was not present during the entire visit. She stated some visitors came out of their cars, waved to Resident #6, handed Resident #6's family member a card and left. She said there were no more than five people who stood outside at one time. The Administrator stated they did not check the temperatures of all visitors because nobody went inside the building but she had asked Resident #6's family member not to come and told other family members not to come if they had	F 880	so screening would be the same. 5. Training was completed with Department heads, receptionist, activities, and wellness coordinator on Visitation and Screening. CMS QSO-20-39-NH was used for the training, this was completed by Regional Clinical Mangaer on 10/14//20 and 10/16/20. 6. Administrator or Director of Nursing will ensure adherence to the new guidance with monitored daily visitation and will review visitation weekly to ensure all new protocols are followed. 7. Corrective action to be completed by 10/16/2020. 8. Administrator will bring findings to QAPI meeting monthly x 3 months for further recommendations and oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	C 09/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHABILITATION	**95 LOCUST STREET CONNELLY SPG, NC 28612**

(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) COMPLETION DATE
F 880	Continued From page 4 been sick or if they had been around anyone who had been sick. On 9/24/20 at 2:06 PM, a follow-up interview with the Administrator revealed that the reason why they did not think about screening the visitors prior to the outdoor visitation for Resident #6 on 8/28/20 was that they had planned for none of the visitors to be within 6 feet of Resident #6. The Administrator also stated that the facility policy did not specify screening for outdoor visitation as well and she had thought that they did the right thing at that time and followed the safety precautions to prevent transmission of COVID-19.	F 880		