STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 Recertification survey was conducted on 7/8/2019 through 7/10/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #NGJ611.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess a resident for cognitive pattern on the admission Minimum Data Set for 1 of 12 sampled residents reviewed (Resident #11). The findings included: Resident #11 was admitted to the facility on 4/10/19 with diagnoses of left ankle fracture, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, hypertension and diabetes mellitus. A review of the admission Minimum Data Set (MDS) assessment dated 4/17/19 indicated Resident #11 as "not assessed" on section C0500 of the Brief Interview for Mental Status (BIMS). Section C0700 indicated the resident was "not assessed" for Short- Term Memory OK and as "not assessed" for section C0800 Long-Term Memory OK. On 7/10/19 at 8:39 AM the Social Worker revealed she was responsible for completing	F 641	Northampton Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Northampton Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Northampton Nursing and Rehabilitation Center reserves the right to refute the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	8/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 641	Continued From page 1 sections C, D and Q on the MDS. She stated she was off the week Resident #11 was admitted to the facility. In an interview on 7/10/19 at 8:45 AM, the MDS Nurse stated Resident #11 was alert and oriented and had a BIMS of 13. She stated she had completed the MDS and the BIMs interview did not get done. The MDS Nurse stated that in the future when the social worker was off, either she or the Activity Director would need to complete the BIMS interview. In an interview on 7/10/19 at 8:47 AM the Administrator stated if the Social Worker was out she would expect the MDS Nurse would complete the required BIMS interview.	F 641	F 641 Resident # 11 no longer resides at the facility. A 100% audit of all residents' most current Minimum Data Set (MDS) assessments for section C0700 was reviewed by the Director of Nursing (DON) to ensure the residents' cognitive pattern were assessed on the MDS. This audit was completed on 7/19/19 and documented on a resident census sheet. There were no identified areas of concern. An in-service will be completed on 7/25/19 for the MDS nurse, Social Worker (SW) and DON by the MDS Consultant regarding the proper coding of MDS assessments as indicated in the Resident Assessment Instrument (RAI) manual with emphasis that (1) all MDS assessments are completed accurately and coded correctly to include cognitive pattern (2) when a member of the interdisciplinary team (social worker, dietary, or activities)is out, it is the responsibility of the MDS nurse to complete that section of the MDS. All newly hired MDS nurses and social workers will be provided the in-service during orientation by the DON. 10% of all current residents completed MDS assessments will be reviewed by the DON to ensure completion of and for accurate coding of the MDS assessments, including cognitive pattern	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 641	Continued From page 2	F 641	utilizing an MDS Accuracy QI Tool weekly for 8 weeks then monthly X 1 month. Any identified areas of concern will be immediately addressed by the DON to include additional training to the MDS nurse or SW and modifications to assessment as indicated. The Administrator will review and initial the MDS Accuracy QI Tool weekly for 8 weeks and then monthly X 1 month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QI Tool to the Executive QA Committee monthly X 3 months. The Executive QA Committee will meet monthly x 3 months to review the MDS Accuracy QI Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		8/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 657	Continued From page 3 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the care plan with splinting services for contracture management for 1 of 3 residents (Resident #20) reviewed for positioning/range of motion. The findings included: Resident #20 was admitted to the facility on 6/1/2018 with diagnoses to include dementia. An Occupational Therapy (OT) progress and discharge summary note dated 9/11/2018, included an analysis of Functional Outcome that read in part: Gains in passive range of motion (PROM) and splinting tolerance have decreased contracture risk. An H flex splint was ordered, and resident now tolerates 4 to 6 hours. Nursing education and training provided for splinting management. Pictures of donned splint on display for visual aid for staff.	F 657	F 657 Resident #20 Care Plan was reviewed and revised on 7/22/19 by the Minimum Data Set (MDS) nurse with oversite by the Director of Nursing (DON) to reflect splinting services for contracture management. A 100% audit of all care plans was initiated on 7/22/19 by the Director of Nursing (DON), including care plans for residents #20 and residents with splinting services to ensure that all areas of the care plan reflect the resident's individual needs. Any care plan with areas of concern will be updated by the MDS nurse by 8/5/19 with oversight from the Director of Nursing, to reflect the splinting needs of residents. An in-service will be completed by 8/7/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 657	Continued From page 4 A signed Physician order dated 9/11/2018 read: OT services completed. FMP (Functional Maintenance Program) established regarding right wrist splint. Her annual Minimum Data Set Assessment (MDS) dated 5/20/2019 revealed her cognition to be severely impaired. She required total assistance from staff for activities of daily living (ADL), and had functional limitation in range of motion for bilateral upper extremities and bilateral lower extremities. Her care plan last revised on 5/24/2019 included a focus of assistance for mobility related to contractures, with a goal of no worsening of lower extremity contractures. The interventions were as follows: 1) Dependent in Gerichair (reclining chair). 2) functional maintenance plan: wedge cushion to be placed under knees and pillows on side or between as needed for pressure relief. The care plan did not address a focus or interventions for the upper extremity contracture. The care guide portion of the care plan did not address a splint to the right hand. On 7/9/2019 at 11:46 AM an interview was conducted with Rehabilitation (Rehab) Manager who stated Resident #20 tolerated a right wrist extension splint for 6 hours per day in September of 2018. The Rehab Manager stated the right wrist splint was ordered for continued use after Resident #20 was discharged from OT services and the placement of the splint was turned over to the facility's restorative department. On 7/9/2019 at 2:26 PM, an interview was conducted with the Occupational Therapist who stated she ordered the hand splint for Resident	F 657	by the MDS Consultant and DON with the interdisciplinary care plan team members and hall nurses: Minimum Data Set (MDS)nurse, Dietary Manager (DM), Social Worker (SW), Staff Facilitator, Quality Improvement nurse, Activities Director and 100% of the nurses on the requirements for completing comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed. An audit will be completed of 10% of all resident's care plans that requires splinting services to include care plans for resident #20 weekly X 8 weeks then monthly X 1 month by the Director of Nursing to ensure that the care plans accurately reflects the residents utilizing the Splinting QI Audit Tool. The interdisciplinary care plan team members or hall nurses will be retrained and the care plan will be revised immediately by the DON for any identified areas of concern. The Administrator will review and initial the Splinting QI Audit Tool weekly X 8 weeks then monthly X 1 month for compliance and to ensure all areas of concern have been addressed. The DON will present the findings of the Splinting QI Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Splinting QI Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 657	Continued From page 5 #20 in 9/2018 and wrote a functional maintenance program (FMP) for use of the splint. The Occupational Therapist stated she trained staff on the use of the splint and put up the pictures of the splint as a visual reminder for staff. The Rehab Manager joined the interview and stated she was unable to find documentation on the in-service and did not know who would have been in-serviced. The Occupational Therapist then stated she was not sure if an in-service had been done, but the pictures in the room would probably have been the in-service. The Occupational Therapist stated she had not seen Resident #20 for a while, and she did not know if staff were putting the splint on her wrist as she had advised, but she would've expected staff to put the splint on for 4 to 6 hours per day. On 7/9/2019 at 2:39 PM, an interview was conducted with the MDS nurse who stated she oversaw the restorative program. She stated the therapy staff sent communication via the electronic medical record (EMR) for restorative plans when a resident was discharged from therapy and was to be followed by restorative. She stated she had never received communication from OT via the EMR regarding a splint for Resident #20's hand. The MDS nurse stated the only time she knew Resident #20 had a hand splint was while she was actively receiving OT care, and stated she did not know of any FMP for the hand splint. The MDS nurse stated she did not know of a Physician order for the splint and was not aware of the pictures of the splint above the resident's bed. The MDS nurse stated she initiated and updated care plans for the residents, and further stated a wrist splint was not addressed in a care plan for Resident #20 because staff was not putting a wrist splint on	F 657	frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 657	Continued From page 6 her. On 7/9/2019 at 3:32 PM an interview was conducted with the Director of Nursing (DON) who stated she expected better communication between therapy staff and the MDS nurse, so the wrist splint care would have been carried out and the care plan updated for providing the care.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow a Physician order to provide splinting service for contracture management for 1 of 3 residents (Resident #20) reviewed for positioning/range of motion. The findings included: Resident #20 was admitted to the facility on 6/1/2018 with diagnosis to include dementia. An Occupational Therapy (OT) progress and discharge summary note dated 9/11/2018, included an analysis of Functional Outcome that read in part: Gains in passive range of motion (PROM) and splinting tolerance have decreased contracture risk. An H flex splint was ordered, and resident now tolerates 4 to 6 hours. Nursing education and training provided for splinting	F 658	F 658 Resident #20 was referred to therapy on 7/9/19 by the Minimum Data Set (MDS) nurse for contracture management. A clarification order was written on 7/22/19 by the treatment nurse to discontinue the splint until therapy evaluation. The pictures of the splinted hand/wrist in resident #20 room was removed on 7/9/19 by the Director of Nursing (DON). A 100% of all residents to include resident #20 physician orders from 9/11/18 to 7/22/19 will be reviewed by 8/7/19 by the Director of Nursing and Medical Records. This audit is to identify residents with orders for splinting. All residents identified with orders for splinting will be observed	8/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 658	Continued From page 7 management. Pictures of donned splint on display for visual aid for staff. A signed Physician order dated 9/11/2018 read: "OT services completed. FMP (Functional Maintenance Program) established regarding right wrist splint". The order did not include a signature of the nurse receiving the order. Review of the annual Minimum Data Set Assessment (MDS) dated 5/20/2019 revealed Resident #20's cognition to be severely impaired. She required total assistance from staff for activities of daily living (ADL), and had functional limitation in range of motion for bilateral upper extremities and bilateral lower extremities. Her care plan last revised on 5/24/2019 included a focus of assistance for mobility related to contractures, with a goal of no worsening of lower extremity contractures. The interventions were as follows: 1) Dependent in Gerichair (reclining chair). 2) functional maintenance plan: wedge cushion to be placed under knees and pillows on side or between as needed for pressure relief. The care plan did not address a focus or have interventions for the upper extremity contracture. The care guide portion of the care plan did not address a splint to the right hand. Review of the July 2019 Medication Administration Record/Treatment Administration Record MAR/TAR for Resident #20 revealed no order for a splint to the right hand. On 7/8/2019 at 10:09 AM an observation was conducted of Resident #20 as she lay in her bed in her room. Her right hand was visible on top of the sheet, with no splinting device to her hand or	F 658	by the Quality Improvement nurse by 8/7/19 to ensure the splints were provided to the resident per the physician's order. Therapy referrals and order clarification were completed by the DON for any identified areas of concern during the audit. An in-service will be completed by 8/7/19 by the Director of Nursing (DON) with 100% of all nursing assistants (NA) to include NA #1, restorative aides, medication aides and nurses to include Nurse #1 regarding ensuring residents are provided splints per physician's order and resident care guide. All newly hired nursing assistants, restorative aides, medication aides, and nurses will receive the in-service during orientation by the Staff Facilitator. An audit will be completed of 10% of physician's orders for residents that require splint services and observations of the resident to include resident #20 to ensure the splint is being provided per order. This audit will be completed weekly X 8 weeks then monthly X 1 month by the Quality Improvement nurse utilizing the QI Splinting Audit Tool. The nursing assistant and/or nurse will be retrained and the splint will be immediately provided during the audit by the Quality Improvement nurse for any identified areas of concern. The Director of Nursing will review and initial the QI Splinting Audit Tool weekly X 8 weeks then monthly X 1 month for compliance and to ensure all areas of concern have been addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 658	Continued From page 8 wrist. Two large pictures of a splint to an area that covered the hand and wrist were taped above her bed. On 7/8/2019 at 12:09 PM an observation was conducted of Resident #20 as she lay in her bed in her room. Her right hand was visible on top of the sheet, with no splinting device to her hand or wrist. The two large pictures of a splinted hand/wrist remained taped above her bed. On 7/8/2019 at 3:35 PM an observation was conducted of Resident #20 as she lay in her bed in her room. Her right hand was visible on top of the sheet, with no splinting device to her hand or wrist. The two large pictures of a splinted wrist/hand remained taped above her bed. On 7/9/2019 at 9:22 AM an observation was conducted of Resident #20 as she lay in her bed in her room. Her right hand was visible on top of the sheet, with no splinting device to her hand or wrist. Two large pictures of a splinted wrist/hand were taped above her bed. On 7/9/2019 at 9:48 AM an observation was conducted of daily morning care provided to Resident #20 with nursing assistant (NA) #1. The NA stated Resident #20 was alert at times but confused and very contracted with her extremities. The NA stated Resident #20 had boots for her feet and was positioned with pillows under and between her knees. The NA stated she did not know anything about a splint for the resident's wrist. On 7/9/2019 at 11:41 AM an observation was conducted of Resident #20 as she lay in her bed	F 658	The DON will present the findings of the QI Splinting Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the QI Splinting Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 658	Continued From page 9	F 658		

in her room. Her right hand was visible on top of the sheet, with no splinting device to her hand or wrist. The two pictures of a splinted hand/wrist remained taped above her bed.

On 7/9/2019 at 2:48 PM, an interview was conducted with the Medication Aid (MA) #1 who stated Resident #20 had a splint to her hand, but it was a long time ago, and she could not speculate on how long ago it was. The MA stated the restorative aide (RA) would have been putting it on and documenting the time it was on under the restorative program.

On 7/9/2019 at 3:04 PM, an interview was conducted with Nurse #1 who stated Resident #20 was under the Restorative program for her splints and positioning. The nurse stated the floor NA would be expected to continue with positioning during the day. The nurse stated she did not know why OT would give Resident #20 splints as she did not like to wear them, and therapy had not informed staff of any continued splinting needed.

On 7/9/2019 at 11:46 AM an interview was conducted with Rehabilitation (Rehab) Manager who stated Resident #20 tolerated a right wrist extension splint for 6 hours per day in September of 2018. The Rehab Manager stated the right wrist splint was ordered for continued use after Resident #20 was discharged from OT services and the placement of the splint was turned over to the facility's restorative department.

On 7/9/2019 at 2:26 PM, an interview was conducted with the Occupational Therapist who stated she ordered the hand splint for Resident #20 in 9/2018 and wrote a functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 658	Continued From page 10	F 658		

maintenance program (FMP) for use of the splint. The Occupational Therapist stated she trained staff on the use of the splint and put up the pictures of the splint as a visual reminder for staff. The Rehab Manager joined the interview and stated she was unable to find documentation on the in-service and did not know who would have been in-serviced. The Occupational Therapist then stated she was not sure if an in-service had been done, but the pictures in the room would probably have been the in-service. The OT stated she had not seen Resident #20 for a while, and she did not know if staff was putting the splint on her wrist as she had advised, but she would've expected staff to put the splint on for 4 to 6 hours per day.

On 7/9/2019 at 2:20 PM, an interview was conducted with the Restorative Aide (RA) #1 who stated Resident #20 was not on the restorative program and could not remember if she had ever been on the restorative program. The RA stated she did not know about a splint to the right wrist.

On 7/9/2019 at 2:39 PM, an interview was conducted with the MDS nurse who stated she oversaw the restorative program. She stated the therapy staff sent communication via the electronic medical record (EMR) for restorative plans when a resident was discharged from therapy and was to be followed by restorative. She stated she had never received communication from OT via the EMR regarding a splint for Resident #20's hand. The MDS nurse stated the only time she knew Resident #20 had a hand splint was while she was actively receiving OT care and stated she did not know of any FMP for the hand splint. She further stated she did not know of a Physician order for the splint and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 658	Continued From page 11 not aware of the pictures of the splint above the resident's bed. On 7/9/2019 at 3:20 PM an interview was conducted with the Director of Nursing (DON) who stated usually the FMP was initiated by therapy and carried out by the floor NAs. The DON stated RAs were not expected to provide care for the FMP. The DON stated she could not remember of an in-service to staff on the hand splint for Resident #20 and did not remember an FMP ever initiated for the hand splint. The DON stated she did not know why a nurse had not signed and transcribed the order to the MAR/TAR when the Physician had signed it. The DON further stated she expected therapy staff to communicate with staff within guidelines that were already established and expected staff to follow orders for care when a resident had a change of therapy.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 812	Continued From page 12 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the steam table under shelf for one of one steam tables observed. The findings included: Review of the Dietary Policy Manual (Version 8-20-13) under Cleaning Assignments indicated staff were to "Clean and straighten steam table pan rack" and "clean and polish steam table" weekly. During an observation on 7/9/19 at 11:59 AM the 6 well steam table was observed. The 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 7/ 10/19 at 9:31 AM the 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles. On 7/10/19 at 2:47 PM the 6 foot underside of the steam table shelf was observed to be covered with dark dried food particles and was sticky to touch. In an interview on 7/10/19 at 3:41 PM the Dietary Manager stated that staff did clean the steam table weekly and must have missed the underside of the shelf. She indicated that staff would clean it that evening.	F 812	F 812 The 6 foot steam table under shelf was cleaned on 7/10/19 by the Dietary Manager. 100% audit of all kitchen equipment to include stem table under shelves will be completed by 8/7/19 by the Dietary Manager. The Dietary Manager or designee will immediately clean any kitchen equipment with areas of concern during the audit. 100% in-service will be completed by 8/7/19 for all Dietary aides, Cooks, and Dietary Manager Assistant by the Dietary Manager regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the procedure and schedule for checking and cleaning kitchen equipment. All newly hired dietary employees to include dietary aides and cooks will be in-serviced regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the procedure and schedule for checking and cleaning kitchen equipment during orientation by the Dietary Manager. The Dietary aide and Cook will check kitchen equipment for cleanliness and ensure in a sanitary condition daily, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 812	Continued From page 13 In an interview with the Director of Nursing on 7/10/19 at 4:25 PM stated she would expect staff to clean the steam table and underside of the shelf.	F 812	prevent cross contamination to include steam table under shelves. The Dietary Manager will audit kitchen equipment to include steam table under shelves for cleanliness and sanitation utilizing a Kitchen Equipment Sanitation Tool weekly X 8 weeks then monthly X 1 month. The Administrator will review and initial the Kitchen Equipment Sanitation Tool weekly X 8 weeks then monthly X 1 month for completion and to ensure all areas of concern that were identified were addressed to include work orders. The Administrator will present the findings of the Kitchen Equipment Sanitation Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Kitchen Equipment Sanitation Tools to determine trends and /or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	