STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	C 02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 02/06//2021 to 02/08/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 9YEF11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 02/06/2021. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event #9YEF11 3 of the 8 complaint allegation were substantiated.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide pain medication according to physician's order for 1 of 1 resident reviewed for pain management. (Resident#2) Findings included:	F 697	100% Medication pass audit of all nurses and med aides. Nurses and med aides in-serviced starting on 2/17/2021 by the Director of Nursing. Topic included: Medication Administration Policy. Education was completed for all	2/22/21

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

Electronically Signed | 02/26/2021

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F 697	Continued From page 1 The facilities policy for medication administration dated 12/2020 read, in part: Medications must be administered in accordance with the orders, including any required time frame ...The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Resident #2 was admitted 12/30/2020 with diagnosis including Chronic Pain Syndrome, Acute Respiratory Failure, unspecified whether with hypoxia or hypercapnia, Unspecified Diastolic (congestive) heart failure, Anxiety Disorder and Muscle Weakness. The admissions Minimum Data Set (MDS) dated 01/21/2021 had Resident#2 coded as cognitively intact needing extensive assistance with toilet use, personal hygiene, limited assistance with bed mobility, transfer and dressing, and supervision with eating. Resident #2 had experienced pain 4 out 5 times during the last look back period. The December 2020 and January 2021 Medication Administration Record (MAR) did not have the following medications documented as administered: Gabapentin 100 MG capsule for Diabetic Neuropathy, three times a day, January 6th, Oxycodone-Acetaminophen-Schedule II, 10-325 MG tablet for pain, every eight hours, three times a day, and for a pain assessment every shift was missed for second shift on December 30th, first shift on January 2nd, 3rd and 4th, second shift on January 21st, first shift January 22nd, 23rd, 24th, 25th, and 26th. January 25th also missed second shift documentation.	F 697	nursing staff on or before 2/21/2021 by the Director of Nursing. Nurses or med aides will not work after 2/21/2021 without completing education. The administrative nursing team will review the missed MARS administration report during the clinical meetings to identify medication documentation error. Nurses and Med Aides with medication documentation error will receive a Medication Error Report. All newly hired nurses and med aides will receive the same Medication Administration Policy education and have a Medication Pass Audit completed during the orientation process beginning 2/21/2021; the education will be completed by the Director of Nursing or nurse educator. The Medication Pass Audit will be completed by the unit manager or Quality Assurance nurse. The Director of Nursing or Nurse educator has ownership to ensure compliance to ensure education is provided prior to direct patient care. The Quality Assurance nurse, unit managers and DON will perform weekly Medication Pass Audits of 4 Nurses or Med Aides x 4 weeks beginning 2/22/2021 through 03/12/2021 and then 4 Nurses or Med Aides monthly x 2 months through 5/2021. Results of the Medication Pass Audits will be reported to the Quality Assurance Committee by the Quality Assurance nurse during the monthly meetings; any trends will be noted and immediate	

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F 697	Continued From page 2 During a telephone interview with Nurse #2 on 02/08/2021 at 1:57 PM, Nurse #2 stated there were documentation errors but did give medications on the days the MAR wasn't signed, and the MAR was supposed to be signed after every medication administration. Nurse #2 also stated she realized she didn't sign the MAR the next day but the matrix will not let her go back in to fix it and she did not put a note in the system because the unit was very busy on those days. Nurse #2 further stated Resident #2 never complained of pain when she worked with him. During a telephone interview with the Physician Assistant (PA) on 02/08/2021 at 3:41 PM, the PA stated there should be documentation for all medication administrations to assure medications were administered and he expected the medication orders to followed. The PA also stated the pain assessments were needed because Resident #2 had chronic pain and was on medication to control his pain prior to being admitted to the facility and he wanted to make sure his pain medication regimen was controlling his pain. During a telephone interview with the Administrator on 02/08/2021 at 3:56 PM, the Administrator stated documentation for medications should be documented and Physician orders should be followed as prescribed.	F 697	correction implemented to ensure compliance. The Administrator is responsible for implementing the acceptable plan of correction. The results of the monitoring will be maintained in a binder clearly labeled within the Director of Nursing's office. The Director of Nursing will ensure compliance in the absence of the Nursing Home Administrator. The Nursing Home Administrator will have ownership to ensure audits stay up to date and compliance.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		2/21/21

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F 760	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure 1 of 1 resident (Resident #2) was free of medication errors when medications were not documented as being administered. Findings included: The facilities policy for Medication Administration dated 12/2020 read in part: Medications must be administered in accordance with the orders, including any required time frame ...The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Resident #2 was admitted 12/30/2020 with diagnosis including Chronic Pain Syndrome, Acute Respiratory Failure, Unspecified Diastolic (congestive) heart failure, Anxiety Disorder and Muscle Weakness. The admissions Minimum Data Set (MDS) dated 01/21/2021 had Resident#2 coded as cognitively intact needing extensive assistance with toilet use, personal hygiene, limited assistance with bed mobility, transfer and dressing, and supervision with eating. Resident #2 had experienced pain 4 out 5 times during the last look back period. The care plan dated 01/04/2021 had focuses of needed assistance with activities of daily living (ADL) related to (R/T) impaired mobility, at risk for skin breakdown R/T impaired bed mobility, at risk for pain R/T acute/chronic illnesses, at risk for alteration of skin integrity R/T fragile skin.	F 760	100% Medication pass audit of all nurses and med aides. Nurses and med aides in-serviced starting on 2/17/2021 by the Director of Nursing. Topic included: Medication Administration Policy. Education was completed for all nursing staff on or before 2/21/2021 by the Director of Nursing. Nurses or med aides will not work after 2/21/2021 without completing education. The administrative nursing team will review MARS during the clinical meetings to identify medication documentation error. Nurses and Med Aides with medication documentation error will receive a Medication Error Report. All newly hired nurses and med aides will receive the same Medication Administration Policy education and have a Medication Pass Audit completed during the orientation process beginning 2/21/2021; the education will be completed by the Director of Nursing or nurse educator. The Medication Pass Audit will be completed by the unit manager or Quality Assurance nurse. The Director of Nursing or Nurse educator has ownership to ensure compliance to ensure education is provided prior to direct patient care. The Quality Assurance nurse, unit managers and DON will perform weekly Medication Pass Audits of 4 Nurses or Med Aides x 4 weeks beginning 2/22/2021 through 03/12/2021 and then 4 Nurses or Med Aides monthly x 2 months through 5/2021.	

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F 760	Continued From page 4 The December 2020 and January 2021 Medication Administration Record (MAR) did not have the following medications documented as administered: December 30th, Furosemide 40 MG tablet, twice a day, January 1st, Furosemide 40 MG tablet, twice a day, January 25th, Furosemide 40 MG tablet, twice a day, January 1st, Gabapentin 100 MG capsule, three times a day, January 6th, Oxycodone-Acetaminophen-Schedule II, 10-325 MG tablet, every eight hours, three times a day, and for a pain assessment every shift was missed for second shift on December 30th, first shift on January 2nd, 3rd and 4th, second shift on January 21st, first shift January 22nd, 23rd, 24th, 25th, and 26th. January 25th also missed second shift documentation. During a telephone interview with Nurse #2 on 02/08/2021 at 1:57 PM, Nurse #2 stated there were documentation errors but did give medications on the days the MAR wasn't signed, and the MAR was supposed to be signed after every medication administration. Nurse #2 also stated after both days of missed documentation, she realized she didn't sign the MAR but the matrix would not let her go back in to correct it and she did not put a note in Resident #2's chart because the unit was very busy on those days. During a telephone interview with Med Aid#1 on 02/08/2021 at 2:54 PM, Med Aide #1 stated Resident #2 never had c/o pain. The Med Aides are supposed to report any complaints from the residents to the nurses and the pain assessments are completed by the nurses. During a telephone interview with Nurse #4 on 02/08/2021 at 3:49 PM, Nurse #4 stated all	F 760	Results of the Medication Pass Audits will be reported to the Quality Assurance Committee by the Quality Assurance nurse during the monthly meetings; any trends will be noted and immediate correction implemented to ensure compliance. The Administrator is responsible for implementing the acceptable plan of correction. The results of the monitoring will be maintained in a binder clearly labeled within the Director of Nursing's office. The Director of Nursing will ensure compliance in the absence of the Nursing Home Administrator. The Nursing Home Administrator will have ownership to ensure audits stay up to date and compliance.	

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F 760	Continued From page 5 medications are to be signed as they are administered and the pain assessments are to be completed by the nurses. During a telephone interview with the Physician Assistant (PA) on 02/08/2021 at 3:41 PM, the PA stated there should be documentation for all medication administrations to assure medications were administered and he expected the medication orders to followed. The PA also stated the pain assessments were needed because Resident #2 had chronic pain and was on medication to control his pain prior to being admitted to the facility and he wanted to make sure his pain medication regimen was controlling his pain. During a telephone interview with the Administrator on 02/08/2021 at 3:56 PM, the Administrator stated medications should be documented and Physician orders should be followed as prescribed.	F 760		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, a test tray, resident and staff interviews the facility failed to	F 804	On 2/8/21, A 100% use of plate warmer was put in place to be used with every	2/13/21

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F 804	Continued From page 6 serve palatable food according to their preferred temperature for 2 out of 2 residents (Resident #3 and Resident #4) sampled for palatable food. Findings included: The meal policy revised July 2017 in part read: Hot foods shall be held at a temperature of 136 degrees or above until served ..... Nursing and Dietary Services will establish procedures such that delivery of food to serving areas accommodates this requirement. A lunch meal pass and test tray on 02/06/2021 was observed on Unit 2B at 12:10 PM with the Dietary Supervisor (DS). The cart arrived on the hall with ten trays. Nurse #1 walked to the cart and removed a tray and walked away with the cart door open. Two Nursing Assistants then came and passed the remaining trays out and left two trays, one being the test tray. The DS took the tray out of the cart at 12:22 PM and stated her thermometer was calibrated and proceeded to test the lunch. The menu consisted of: meatloaf, potatoes and mixed vegetables. The meatloaf was 122 degrees, the potatoes were 130 degrees and the mixed vegetables were 124 degrees. During an interview with Resident #3 on 02/06/2021 at 12:33 PM, Resident #3 stated his lunch was warm and would like to have hot food. Resident #3 also stated the temperature has gotten better in the last couple of weeks because his food used to be cold most of the time. Resident #3 further stated he also received cold breakfasts and doesn't ask to reheat it because once it is cold it would not taste right after it is reheated.	F 804	meal to ensure that the food remain the proper temperature. In-service training was completed on 2/8/21 for the dietary department to ensure proper use of the plate warmer and to include correct temperature holdings for food. Monitoring of Hot and Cold food items upon preparation, during holding process, and upon plating to ensure both safe and palatable temperatures are maintained. Measures put in place to ensure the alleged deficient practice will not recur: The Dietary Supervisor will monitor the temperatures 5 times a week for 2 weeks; then 2 times a week for 3 weeks; then 1 time a week for 2 weeks ; followed by monthly checks. Reports will be presented to the QAPI committee by the Administrator or Director of Nursing. The QAPI meeting is attended by the Administrator, DON, MDS, Therapy, HIM and the Dietary Supervisor and quarterly by the Medical Director and Pharmacist. Education was given to staff ensuring the proper way of passing trays and making sure the door on food cart remain close after removal of each tray. Education was completed on 2/13/21 for all staff. In-Service training records, temperature logs, and test tray observation results to be reported to QAPI committee by the Administrator to review and ensure effectiveness and sustained compliance.	

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F 804	Continued From page 7	F 804		

During an interview with Resident #4 on 02/06/2021 at 12:37 PM, Resident #4 stated his lunch was not hot, it was warm, and his breakfasts are also cold. Resident #4 also stated he would like to give them a list of his likes and don't likes and have them follow the list.

During an interview with Nurse #1 on 02/06/2021 at 12:13 PM, Nurse #1 stated she didn't know why she left the cart door open and she was just helping the Nursing Assistants. Nurse #1 also stated she did have complaints of cold food from the residents and she would ask if they wanted it heated up but has not reported it to anyone.

During an interview with Nursing Assistant (NA) #1 on 02/06/2021 at 12:51 PM, NA #1 stated she had had complaints of cold food. She asked residents if they wanted their food heated and she would get it warmed for them. NA #1 also stated she has reported it to the Nurses and Dietary Supervisor.

During an interview with NA #2 on 02/06/2021 at 12:53 PM, NA #2 stated she had received complaints of cold food and she would warm it up if they wanted. NA #2 also stated she had not reported it to the nurse because it happened frequently.

During an interview with the DS on 02/08/2021 at 1:29 PM, the DS stated she has not had any complaints of cold food. The DS also stated the hot temperatures are supposed to be 136 degrees when served to residents.

During an interview with the Administrator on 02/08/2021 at 3:56 PM, the Administrator stated she expected the temperature of meals to be

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F 804	Continued From page 8 served according to facility policy.	F 804		
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 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	F 880		2/13/21

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F 880	Continued From page 9 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. §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 observation, record review and staff interviews, the facility failed to implement their policies and procedures related to personal protective equipment (PPE) and hand hygiene when entering and exiting resident rooms for 2 of 5 sampled residents (Resident #1 and Resident #2) who resided on the facility ' s quarantine hallway and were on enhanced droplet isolation	F 880	1. Nurse Aide (NA #1) was immediately reeducated on hand hygiene with the use of hand sanitizer or soap and water before and after entering an isolation precaution setting once notified by surveyor of behavior. This education was completed by the DON/IP on 2/6/2021. 2. The Director of Nursing completed a	

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F 880	Continued From page 10 precautions. These failures occurred during COVID-19 pandemic. The findings included: Record review of facility policy and procedure titled "Personal Protective Equipment for COVID-19 or Suspected COVID-19 Residents" revised April 2020 revealed personnel were to use hand sanitizer or soap and water before and after entering isolation precaution setting. It further revealed staff were to wear full personal protective equipment when working with individuals with known or suspected COVID-19. On 02/06/21 at 12:30 PM, an observation was made of Nurse Aide (NA) #1 entering Resident #2 ' s room that was located on the facility ' s 100 hall quarantine unit. She picked up a meal tray and she was not wearing gloves and a gown. NA# 1 was observed to exit the room after picking up the lunch tray and did not perform hand hygiene. Droplet precaution signage was observed posted beside the door to Resident #2 ' s room which specified staff were required to wash hands when entering and leaving room, wear mask. If contact with secretions likely, they were to use gown, gloves and facial shields. On 02/06/21 at 12:32 PM, NA #1 was observed entering Resident # 1 ' s room after exiting Resident #2 ' s room. Resident #1 ' s room was also located on the facility ' s 100 hall quarantine unit. NA #1 did not don a gown and gloves or wash her hands before entering Resident # 1 ' s room. She picked up Resident #1 ' s tray. NA # 1 also did not wash her hands or use a hand sanitizer after she exited the resident's room. Enhanced Droplet precaution signage was	F 880	100% audit of all rooms who were to be isolated to ensure proper signage was present and PPE carts were stocked accordingly on 2/6/2021. There were no findings of inadequate PPE or no/wrong signage. 3. Entire Facility audit was performed to ensure all employees were following the facility□s policy and procedure titled Personal Protective Equipment for covid-19 or suspected covid-19 residents. This was completed on 2/8/2021 by the Director of Nursing. 4. Education was provided to all full time, part time, and prn staff licensed and non-licensed by the Director of Nursing to ensure that they understood the facility□s policy and procedure for Personal Protective Equipment for Covid-19 or suspected Covid-19 to include hand hygiene with the use of hand sanitizer or soap and water before and after entering an isolation precaution setting, and that full Personal Protective Equipment is to be worn when working with individuals with known or suspected Covid-19. The Enhanced Droplet Precaution sign was reviewed in the in-service so that staff were reminded of the education once they saw the sign on the resident□s door. Education was completed on 2/13/2021. 5. The facility has partnered with Alliant Quality for Quality Improvement Initiative QII for infection control NC9076 we are focused on Hand Hygiene and PPE donning and doffing. Alliant Quality will review improvements the facility will make after this survey, assess the facility□s current infection control practices and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	C 02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE GREEN HEALTH AND REHABILITATION	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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F 880	Continued From page 11 observed posted beside the door to Resident #1 ' s room which specified staff were required to wash hands when entering and leaving room, wear mask. If contact with secretions likely, they were to use gown, gloves and facial shields. During an interview on 02/06/21 at 12:35 PM, NA #1 revealed she had been trained regarding infection control practices, hand hygiene and use of PPE when entering isolation rooms. She indicated she was aware that she should have performed hand hygiene and don PPE according to the signage posted but missed to do it when she entered and exited Resident #1's and Resident # 2 ' s rooms. An interview with Nurse #1 on 02/06/21 at 12:40 PM revealed Resident #1 and Resident # 2 were on 14 days isolation. Nurse #1 indicated residents placed on isolation had a signage and PPE supplies outside their doors for staff to utilize prior to entering the room. He indicated nursing staff had been trained on hand hygiene and the use of PPE when caring for residents in isolation to prevent infection transmission. He indicated he always donned PPE prior to entering the room and performed hand hygiene when entering and exiting residents' rooms. An interview with Director of Nursing (DON) on 02/06/21 at 1:45 PM revealed she was also the Infection Prevention Nurse (IPN). She indicated all staff had been trained regarding infection control practices, policies and procedures including enhanced droplet precaution requirements. She stated staff were to perform hand hygiene before and after every resident encounter as well as don PPE as per signage on the resident's door. She indicated Resident #1	F 880	determine how to sustain best practices for the health and safety of the facilities residents and staff through quality improvement efforts. This partnership began on 2/12/2021. 6. For Monitoring purposes, the Director of Nursing, Quality Assurance Nurse or nurse supervisor will witness 6 staff members weekly for 6 weeks x 3 months, donning/doffing PPE and hand hygiene with the use of hand sanitizer or soap and water before and after entering an isolation precaution setting. The Director of Nursing, Quality Assurance Nurse or nurse supervisor will ensure proper PPE is worn and proper hand hygiene is performed when entering/exiting an isolation precaution setting. Audits will be reviewed by the facility QAPI committee during routine meeting to determine if further monitoring is necessary.	

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F 880	Continued From page 12 and Resident #2 were on 14 days isolation after being admitted to the facility from the hospital. The residents had an enhanced droplet isolation signage as well as PPE supply outside their doors that staff were required to use prior to entering the rooms. An interview with the Administrator on 02/08/21 at 10:25 AM revealed all staff were to perform hand hygiene and don PPE as per signage on the door prior to entering the room of residents on isolation	F 880		