| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE FOUNTAINS AT THE ALBEMARLE | 200 TRADE STREET TARBORO, NC 27886 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Recertification survey was conducted on 04/26/21 through 04/29/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IREQ11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 04/26/21 through 04/29/21. Event ID# IJEQ11.<br>1 of the 2 complaint allegations was substantiated but did not result in a deficiency. | F 000 | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not | F 582 | | 5/26/21 |

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

Electronically Signed | 05/19/2021

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| F 582 | Continued From page 1<br>covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form CMS 10055) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification review (Residents #19). | F 582 | Completion of ABN Notice for Resident #19 occurred on 04/27/21 and provided to resident RP. RP returned signed copy of ABN on 5/18/21.<br><br>Inservice with Social Worker, Business Office Manager, Business Office Assistant, and MDS nurse was held on 04/27/21 covering the need for providing a | |

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| F 582 | Continued From page 2<br>The findings included:<br><br>Resident #19 was admitted to the facility on 3/24/21 with diagnoses including diabetes mellitus.<br><br>Resident #19's Medicare Part A skilled services ended on 4/23/21. He remained in the facility.<br><br>Record review revealed that Resident #19 was not given the SNF ABN (form CMS 10055).<br><br>During an interview with the Administrator on 4/27/21 at 11:00 AM, she stated a SNF ABN (form CMS 10055) was not completed for Resident #19 because he did not receive skilled services after 4/23/21. She stated the Social Worker is responsible for completing the SNF ABN (form CMS 10055) if a resident received skilled services after Medicare Part A skilled services ended.<br><br>The Administrator stated on 4/27/21 at 3:59 PM the facility was unaware the SNF ABN (form CMS 10055) was required if a resident remaining in the facility did not continue to receive skilled services after Medicare part A coverage ended. She reported it is her expectation the facility follows the CMS Federal guidelines and provide the SNF ABN (form CMS 10055) to the resident or resident representative when required. | F 582 | Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare Part A if a resident received skilled services after Medicare Part A skilled services ends.<br><br>All residents remaining in facility that will still receive skilled services after Medicare Part A skilled services end will be audited by Business Office Manager or designee weekly x 4 weeks and monthly x 2 months to ensure SNF ABN is issued prior to discharge from Medicare Part A.<br><br>Findings of SNF ABN audits will be presented to the QAPI Committee monthly for three months with any changes to plan made as needed. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced | F 641 | | 5/26/21 |

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| F 641 | Continued From page 3<br>by:<br>Based on record review and staff interviews the facility failed to accurately code minimum data set (MDS) assessments for the use of antipsychotic medications (Resident #19), injection administration, insulin administration, and anticoagulant administration (Resident #23) for 2 of 14 minimum data set assessments reviewed.<br><br>Findings included:<br><br>1. Resident #19 was admitted to the facility on 3/24/21. His active diagnosis included major depressive disorder and dementia with behavioral disturbances.<br><br>A review of Resident #19's care plan dated 4/6/21 revealed he was care planned for medication management. The interventions included to monitor for adverse effects of medications, utilize the minimum amount of medications necessary, and consult pharmacist to review medications.<br><br>A review of Resident #19's orders revealed on 3/24/21 he was ordered Risperdal tablet 0.5 milligrams, give 0.5 milligrams by mouth two times a day related to major depressive disorder.<br><br>A review of Resident #19's MDS assessment dated 3/31/21 revealed he was assessed as severely cognitively impaired. No antipsychotic medications were noted as received.<br><br>During an interview on 4/28/21 at 9:17 AM MDS Nurse #1 stated Resident #19 was taking an antipsychotic medication and it should have been documented that he had received it on a routine basis. | F 641 | Modification of MDS dated 3/31/21 (Admission 5 Day Assessment) for Resident #19 was completed on 4/28/21 to code the resident as having received antipsychotic medications. This assessment with modification was transmitted on 4/29/21.<br><br>Modification of MDS 4/15/21 (Quarterly Assessment) for Resident #23 was completed on 4/28/21 to correctly code no injections, no insulin injections, and no anticoagulant for the 7 day lookback period. This assessment with modification was transmitted on 4/29/21.<br><br>100% audit of all residents most recent MDS assessment Section N will be conducted by DON and/or designee by 5/26/21 to ensure that assessments are accurate for Sections N.<br><br>Inservice with MDS nurse and DON by Administrator by 5/26/21 covering the need for accuracy in coding MDS assessments. Specific sections reviewed include Section N.<br><br>All MDS assessments (Section N) for residents will be audited by DON or designee weekly x 4 weeks and monthly x 2 months to ensure accuracy of assessments, with special attention to Sections N.<br><br>Findings of MDS assessment audits will be presented to the QAPI Committee by Administrator monthly for three months | |

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| F 641 | Continued From page 4 | F 641 | | |

During an interview on 4/28/21 at 9:21 AM the Director of Nursing stated Resident #19 had not stopped receiving his antipsychotic medication since admission on 3/24/21 and the MDS assessment dated 3/31/21 was incorrect.

2. Resident #23 was admitted to the facility on 1/26/21 with diagnoses that included diabetes mellitus and cerebral infarction (stroke).

A review of Resident #23's care plan dated 2/5/21 revealed she was care planned for unstable blood glucose due to diabetes mellitus. Interventions included evaluation of blood glucose level on Mondays, Wednesdays, and Fridays at 6:00 AM.

A review of Resident #23's physician orders dated 3/2/21 revealed an order for clopidogrel bisulfate (Plavix) 75 milligrams in the morning for cerebral infarction.

A review of Resident #23's Minimum Data Set (MDS) assessment dated 4/15/21, a quarterly assessment revealed she was assessed as receiving 3 injections, 3 insulin injections, and an anticoagulant 7 days of the 7-day lookback period.

Review of Resident #23's medication administration record revealed no injections, no insulin injections or anticoagulant administration during the 7-day lookback period.

During an interview with MDS Nurse #1 on 4/28/21 at 11:20 AM she revealed she coded the blood glucose evaluations during the 7-day lookback period as insulin injections. MDS Nurse #1 stated that she was unaware that clopidogrel bisulfate (Plavix) should not be coded as an anticoagulant.

with any changes to plan made as needed.

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| F 641 | Continued From page 5<br><br>An interview was conducted with the Director of Nursing on 4/28/21 at 12:34 PM who stated blood glucose evaluations should not be coded as insulin injections and clopidogrel bisulfate should not be coded as an anticoagulant. | F 641 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). | F 655 | | 5/26/21 |

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| F 655 | Continued From page 6<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 3 residents reviewed for baseline care plans (Resident #20, Resident #179).<br><br>Findings included:<br><br>1. Resident #20 was admitted to the facility on 3/30/21.<br><br>A review of Resident #20's minimum data set assessment dated 4/2/21 revealed the resident was assessed as severely cognitively impaired. Her active diagnoses included hypertension, obstructive uropathy, neurogenic bladder, diabetes mellitus, and hemiplegia.<br><br>A review of Resident #20's care plan history revealed her first care plan was initiated on 4/4/21.<br><br>During an interview on 4/28/21 at 11:39 AM MDS Nurse #1 stated Resident #20 did not have a | F 655 | Inservice with DON, ADON, SW, MDS by Administrator by 5/26/21 covering the need for completion of baseline care plans within 48 hours of admission.<br><br>All new admissions of residents will be audited by DON or designee weekly x 4 weeks and monthly x 2 months to ensure completion of baseline care plan within 48 hours of admission.<br><br>Findings of Baseline Care Plan audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed. | |

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| F 655 | Continued From page 7 | F 655 | | |

baseline care plan completed within 48 hours. Resident #20 was admitted on 3/30/21 and should have had a completed baseline care plan by 4/1/21 but she did not have an initial care plan until 4/4/21.

During an interview on 4/28/21 at 12:03 PM the Director of Nursing stated baseline care plans should be completed within 48 hours of the resident's admission. Upon observing Resident #20's care plan history she concluded the resident's care plan was not initiated until 4/4/21.
2. Resident #179 was admitted to the facility on 4/19/21 with diagnoses that included a right hip fracture.

Review of Resident #179's medical record revealed no completed baseline care plan. Her comprehensive care plan was initiated on 4/24/21.

During an interview with the facility social worker on 4/27/21 at 4:49 PM she stated the baseline care plan should be completed within 48 hours.

An interview was completed with Minimum Data Set (MDS) Nurse #1 on 4/28/21 at 11:36 AM who stated she was unaware that a baseline care plan should have been initiated within 48 hours or that it was her responsibility until 4/24/21 when she was informed by her predecessor who was providing training.

During an interview on 4/28/21 at 12:03 PM the Director of Nursing stated baseline care plans should be completed within 48 hours of the resident's admission.

An interview was completed with the

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| F 655 | Continued From page 8<br>Administrator on 4/29/21 at 9:05 AM who stated the baseline care plan should have been completed with 48 hours of Resident #179's admission to the facility. | F 655 | | |
| F 712 SS=D | Physician Visits-Frequency/Timeliness/Alt NPP<br>CFR(s): 483.30(c)(1)-(4)<br><br>§483.30(c) Frequency of physician visits<br>§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.<br><br>§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.<br><br>§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to ensure physician visits were conducted every 30 days for the first 90 days of admission for 1 of 3 residents reviewed for timely physician visits (Resident #23).<br><br>The findings Included:<br><br>Resident #23 was admitted to the facility on | F 712 | Resident #23 was seen by her physician on 5/6/21.<br><br>Physician of Resident #23, Dr. Parker, was educated by Administrator on 4/29/21 as to the requirements of a resident being seen by their physician at least once every 30 days for the first 90 days after admission, and at least once every 60 | 5/26/21 |

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| F 712 | Continued From page 9<br>1/26/21 with diagnoses that included dementia and diabetes mellitus.<br><br>Review of Resident #23's medical record revealed she was seen by the Physician on 03/1/21. There was no other documentation that indicated she was seen by the physician.<br><br>An interview was conducted with the Administrator on 4/29/21 at 9:31 AM. She verified Resident #23 was seen by the physician on 3/1/21. She was unable to locate any additional physician progress notes for Resident #23. The Administrator stated the physician was required to see residents every 30 days of the first 90 days of admission and every 60 days thereafter. She stated Resident #23 was the only resident seen by Physician #2 in the facility as this was the Resident #23's responsible party's choice of physician. She further stated that Physician #2 does not utilize an extender to see residents in the facility.<br><br>A telephone interview was conducted with Physician #2 on 4/29/21 at 11:19 AM. He stated he was unaware that residents needed to be seen every 30 days of the first 90 days of their admission. Physician #2 stated he believed the requirement was that a resident be seen every 60 days. | F 712 | thereafter. Medical Records Clerk was also educated on 4/29/21 as to new assignment of auditing records to ensure the requirements of residents being seen by their physician and documentation of such visits being recorded in the resident□s medical record is completed in a timely manner to meet requirements of regulation.<br><br>Medical Records will conduct a 100% audit of all current residents by 5/26/21 to ensure all residents are in compliance with physician visit frequency and documentation.<br><br>All physician visits for residents will be audited by Medical Records or designee weekly x 4 weeks and monthly x 2 months to ensure compliance with frequency of visits and documentation.<br><br>Findings of Physician Visit audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed. | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. | F 756 | | 5/26/21 |

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| F 756 | Continued From page 10<br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to develop medication regimen review policies that address time frames for steps in the psychotropic medication regimen review process for 1 of 2 pharmacy policies reviewed. | F 756 | The facility will follow the contracted pharmacy (Pharmerica) policy "Section 8.1 Medication Monitoring Medication Regimen Review and Reporting" which is accurate to meet regulation to address | |

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| THE FOUNTAINS AT THE ALBEMARLE | 200 TRADE STREET TARBORO, NC 27886 |

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| F 756 | Continued From page 11<br><br>The findings included:<br><br>Review of a policy entitled "Skilled Nursing Drug Regimen Review" dated 10/30/19 revealed no time frames for the steps in the medication regimen review process.<br><br>Resident #26 was admitted to the facility on 4/4/18 with diagnoses that included anxiety.<br><br>Review of the "Recommendation Summary for DON and Medical Director" form completed for Resident #26, dated 2/19/21 revealed a recommendation for an evaluation of dosage of Lorazepam (a sedative) 0.25 milligrams (mg.)at bedtime and Sertraline (an antidepressant) 50 mg each day and to consider a dose reduction. A handwritten note written on the form revealed it was placed in the Medical Director's box on 4/8/21.<br><br>Review Resident #26's medical record revealed of an order dated 4/20/21 for Sertraline 25 mg. with instructions for 1.5 tablets to be given by the mouth in the evening.<br><br>An interview was conducted with the Assistant Director of Nursing (ADON) on 4/28/21 at 12:40 PM who stated she realized the February pharmacist's recommendations had not been received. She stated she contacted the pharmacist on 4/8/21 who resent the recommendations.<br><br>During an interview with the Administrator, the DON and the ADON on 4/28/21 at 12:45 PM the Administrator stated she had spoken with the pharmacist and the emailed recommendations | F 756 | time frames for steps in medication regimen review process.<br><br>The DON, ADON, and MDS nurse will be inserviced by Administrator on the contracted pharmacy (Pharmerica) policy "Section 8.1 Medication Monitoring Medication Regimen Review and Reporting" by 5/26/21.<br><br>Follow up of Skilled Nursing Drug Regimen Review will be audited by Administrator or designee monthly x 3 months to ensure compliance to policy.<br><br>Findings of audits will be presented to the QAPI Committee by Administrator monthly for<br>three months with any changes to plan made as needed. | |

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| F 756 | Continued From page 12<br>may have been blocked by their computer software. The DON stated she should have noticed the February recommendations from the pharmacist were not received. The Administrator stated there was no written policy that addressed the time frames for steps in the medication regimen review process. She indicated she was unaware the policy required time frames. | F 756 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by: | F 761 | | 5/26/21 |

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| F 761 | Continued From page 13<br>Based on observations and staff interviews the facility failed to keep an unattended skilled treatment cart locked for 1 of 1 treatment carts observed.<br><br>Findings included:<br><br>During observation on 4/26/21 at 2:04 PM the Skilled Treatment Cart was observed to be on the north hall unlocked and unattended. The lock was observed to be extended in the unlocked position. Three visitors were observed standing approximately five feet away from the unattended treatment cart. The Assistant Director of Nursing was inside a resident's room with the door closed and was not in sight of the treatment cart. The Assistant Director of Nursing returned to the treatment cart at 2:08 PM on 4/26/21. She was observed to open the drawers to the treatment cart and retrieve treatment supplies from the cart. She did not unlock the treatment cart before opening the drawer.<br><br>During an interview on 4/26/21 at 2:09 PM the Assistant Director of Nursing stated she left the treatment cart unlocked and she should have locked it.<br><br>During an interview on 4/27/21 at 7:59 AM the Director of Nursing stated it was facility policy that treatment carts were to be locked when out of view of staff. She concluded the Assistant Director of Nursing should have locked the treatment cart. | F 761 | Inservice with 100% of skilled nurses will be completed by DON by 5/26/21 covering treatment carts are to be locked at all times when unattended.<br><br>Treatment Carts will be audited by the DON or her designee weekly x 4 weeks and monthly x 2 months to ensure nurses are locking treatment carts when they are unattended.<br><br>Findings of Treatment Cart audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed. | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements. | F 812 | | 5/26/21 |

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| F 812 | Continued From page 14<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to discard 3 of 3 opened container of pasta salad by the expiration date and failed to allow steam pans to dry prior to stacking during 1 of 3 kitchen observations. These practices had the potential to affect food served to residents.<br><br>The findings included:<br><br>1. On 4/26/21 at 10:40 AM an observation of the walk-in cooler revealed 3 opened containers of pasta salad. The use by date stamped on the containers of pasta salad was 4/12/21.<br><br>During an interview with the dietary manager on 4/26/21 at 10:40 AM he stated the items were beyond the expiration date and should be discarded. | F 812 | The opened containers of pasta salad that were past their expiration date were discarded immediately on 4/26/21. The steam pans found to be stacked and not dry were immediately rewashed on 4/26/21 and allowed to dry appropriately before stacking.<br><br>Inservice with 100% of dining associates covering the importance of dating/labeling food and discarding food appropriately by the expiration date will be completed by Assistant Dining Director 5/26/21.<br><br>Inservice with 100% of dishwashers covering the importance of allowing dishes to dry prior to stacking will be completed by Assistant Dining Director 5/26/21 | |

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| F 812 | Continued From page 15<br>During an interview with the dietary manager on 4/29/21 at 11:05 AM he said he monitored the items in the refrigerators 2 times per week when conducting inventory. He stated the pasta salad was used last week and he just missed discarding the containers prior to the expiration date.<br><br>2. During an observation on 4/26/21 at 11:10 AM the storage rack for the steam pans was observed to have steam pans stacked together. As the dietary manager removed one of the steam pans it was noted the interior of the top pan and the bottom of the lower pan it was stacked on were wet. The manager removed pans from 2 other stacks of pans on the same rack and noted these pans were also wet between the pans. The dietary manager then instructed kitchen employee #1, who was washing pans at the dish washer machine, that the pans should not be stacked together wet and he needed to let them dry completely prior to stacking them on the storage rack.<br><br>During an interview with the dietary manager on 4/26/21 at 11:10 he stated the pans should be air dried prior to stacking. | F 812 | The walk-in cooler will be audited by the Assistant Dining Director or designee weekly x 4 weeks and monthly x 2 months to ensure compliance with food being properly dated/labeled and discarded by the expiration date.<br><br>Dishes will be audited by the Assistant Dining Director or designee weekly x 4 weeks and monthly x 2 months to ensure compliance with dishes being allowed to dry properly prior to stacking.<br><br>Findings of Walk-In Cooler audits and Dish audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed. | |
| F 813 SS=D | Personal Food Policy<br>CFR(s): 483.60(i)(3)<br><br>§483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews with residents' families and staff the facility failed to | F 813 | The Admissions Information Sheet for skilled nursing will be revised | 5/26/21 |

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| F 813 | Continued From page 16<br>have a policy regarding outside food brought into residents by family or visitors to ensure the safe storage, handling and reheating of foods for consumption for 1 (resident #22) of 2 resident's families interviewed.<br><br>The findings included:<br><br>A review of the facility policy titled Resident Food Storage dated 1/15/19 revealed the procedure to ensure all foods were stored under sanitary and safe conditions listed:<br><br>1. Foods brought in from home or from an outside source for a resident residing in a licensed area of the community will be:<br>a. Covered<br>b. Dated with the date the food was brought into the community; and<br>c. Labeled with the resident ' s name and room number.<br><br>The family member for resident #22 was interviewed on 4/27/21 at 12:30 PM. The family member stated they brought foods for the resident and was aware the resident's name, the date and the room number needed to be on the food items. The family member was not aware of how the food items should be reheated. The family member stated he was not aware of a policy for food handling.<br><br>During an interview with the dietary manager on 4/29/21 at 11:15 AM he stated the current policy did not address how long the food items could be stored or how to reheat the food items. He added reheated foods needed to be heated to 165 degrees Fahrenheit. | F 813 | 100% of skilled nursing associates (nurses and CNAs) were inserviced by DON on revised Admissions Information Sheet by 5/26/21.<br><br>All current residents and families will be provided education and a copy of the new Admission Information Sheet by 5/26/21.<br><br>All new admissions and families will receive education on the community□'s Admission Information Sheet.<br><br>Random audits of skilled nursing associates (nurses and CNAs) will be conducted by DON or designee to ensure knowledge of the revised Admissions Information Sheet weekly x 4 weeks and monthly x 2 months.<br><br>Findings of Admission Sheet Information Audit will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed. | |

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| F 813 | Continued From page 17<br>During an interview the Administrator on 4/29/21 at 12:30 PM she stated the current policy was provided by the corporate office. She added it did not address the length of time the foods items could be stored or how to ensure the food items were reheated to maintain food safety. | F 813 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other | F 880 | | 5/26/21 |

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| F 880 | Continued From page 18<br>persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews, the facility failed to implement quarantine precautions for a new unvaccinated | F 880 | Resident #179 was placed on isolation with the correct signage on 4/28/21. The correct PPE (N95, eye protection, gloves, | |

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| F 880 | Continued From page 19 | F 880 | | |

resident and failed to have correct signage for 1 of 1 resident (Resident #179). They also failed to use safe infection control techniques during wound care for 1 of 1 wound care observations (Resident #19).

The findings included:

The Centers for Disease Control and Prevention (CDC) guideline entitled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" last updated on 3/29/21 contained the following statements:

Create a Plan for Managing New Admissions and Readmissions

In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.

Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents as described in CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.

Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

Guidance addressing placement, duration, and

gown) were placed outside of the resident□s room available for associates.

100% of skilled nursing associates were inserviced beginning on 4/28/21 to be complete by 5/26/21, covering sign requirements for quarantine to include PPE required and following CDC guidelines for quarantine to include wearing PPE for staff and restrictions for residents on quarantine. Training will be provided by DON (Infection Preventionist) or designee with an attestation of completion.

All new admission or readmissions will be audited by DON or designee weekly x 4 weeks and monthly x 2 months to ensure CDC guidance regarding proper signage and PPE are in use.

100% of skilled nursing associates will be inserviced to be complete by 5/26/21, regarding proper glove use during wound care. Training will be provided by ADON (Infection Preventionist) or designee with an attestation of completion.

Wound care observations will be completed by ADON or designee weekly x 4 weeks and monthly x 2 months to ensure proper glove use during wound care.

Findings of Infection Prevention audits and Wound Care audits will be presented to the QAPI Committee by Administrator monthly for three months with any changes to plan made as needed.

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| F 880 | Continued From page 20<br>recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection.<br><br>Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection<br>Residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure.<br>HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.<br>CDC PPE optimization strategies include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a well-fitting facemask when NIOSH-approved N95 or equivalent or higher-level respirators are not available).<br><br>1 A. Resident #179 was admitted to the facility on 4/19/21.<br><br>A review of Resident #179's medical record revealed she had not received the COVID19 vaccine.<br><br>During an observation on 4/26/21 at 1:22 PM Nurse Aide (NA) #2 was observed going in Resident #179's room with no personal protective equipment other than a mask. There was a blue sign with a drawing of a house observed next to Resident #179's door. There was no writing on | F 880 | Additional Infection Control Training, to include proper PPE use during wound care, will be conducted on 5/21/21 by Regional Prevention Support Team Coordinator with attestation of completion.<br><br>A Root Cause Analysis (RCA) will be completed on 5/20/21, which will be done with assistance from the Infection Preventiontist, Quality Assurance and Performance Improvement (QAPI) Committee and Governing Body.<br><br>This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community | |

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| F 880 | Continued From page 21<br>the sign. There was no indication if the resident was on quarantine or what personal protective equipment (PPE) was to be utilized for this resident. There was a PPE cart next to the door with gowns and gloves available.<br>Nurse #2 was observed going in Resident #179's room with no personal protective equipment except for a surgical mask.<br><br>An interview was conducted with Nurse #2 on 4/26/21 at 1:26 PM who stated a gown nor gloves were necessary as she administered a pain medication to Resident #179.<br><br>An interview was conducted with NA #2 on 4/26/21 at 1:29 PM who stated the sign by Resident #179's door indicated she was under quarantine precautions and she should have donned a gown and gloves prior to entering the room.<br><br>During an observation on 4/26/21 at 3:05 PM Resident #179 was observed in the facility beauty shop. She was not wearing a mask.<br><br>An observation was conducted on 4/26/21 at 5:00 PM and Resident #179 was observed sitting outside the entrance to the facility. She was not wearing a mask.<br><br>During an interview with Resident #179 on 4/27/21 at 10:40 AM she stated she refuses to wear a mask. She stated she frequently exits her room to visit other residents and attends activities. Resident #179 reported nursing staff members do not don gowns and gloves to enter her room. She further stated she had not been instructed to remain in her room. | F 880 | or affiliated companies. | |

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| THE FOUNTAINS AT THE ALBEMARLE | 200 TRADE STREET TARBORO, NC 27886 |

| (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 |
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An interview was conducted with the Director of Nursing (DON) on 4/27/21 at 3:14 PM who stated staff should don gowns and gloves to enter a quarantined resident's room. She stated Nurse #2 should have donned a gown and gloves to administer medication to Resident #179. The DON stated if a resident is outside their room, they should be encouraged to wear a mask. She further indicated Resident #179 should not be outside of her room as she was to be quarantined for 14 days as a new admission who was unvaccinated.

An observation was conducted on 4/27/21 at 3:29 PM. Resident #179 was observed talking with other residents unmasked.

Review of a progress note dated 4/27/21 revealed Resident #179 was taken outside by Recreational Therapist #1. The note further indicated Resident #179 took herself outside during a poetry reading activity.

An interview was conducted with Recreational Therapist #1 who stated she did not don a gown or gloves when she worked with Resident #179 on 4/27/21. She further stated she had observed Resident #179 spending time with other residents unmasked. Recreational Therapist #1 indicated she was unaware Resident #179 should have remained in her room.

1 B. A review of the county positivity rate dated 4/19/21 revealed the positivity rate for the county was 10.8%.

During observation of Resident #179's room on 4/26/21 at 10:25 AM there was a blue sign with a drawing of a house on the sign posted next to the resident's room. There was no writing on the sign

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and no indication if the resident was on quarantine. There was a personal protective equipment (PPE) cart next to the door with gowns and gloves available. There was no writing on the sign and no indication of what PPE was to be utilized for this resident.

During an interview on 4/26/21 at 10:50 AM Nurse Aide #1 stated residents with the blue sign that depicted a house hung next to resident doors was for newly admitted residents on 14-day quarantine due to COVID19. Staff were to wear gloves, a gown, and surgical mask when caring for the residents.

During an interview on 4/26/21 at 10:53 AM Nurse #1 stated the blue signage was used for residents who were newly admitted and on 14-day quarantine due to COVID19 precautions. She further stated those were the signs that were used and not the signs with the directions for personal protective equipment requirement and use. She concluded staff were to wear at least a surgical mask, gowns, and gloves to care for the resident.

During observation on 4/27/21 at 8:22 AM Resident #179's room still had the same blue sign with no instructions next to the door.

During an interview on 4/27/21 at 3:31 PM the Assistant Director of Nursing stated she and the Director of nursing split infection control duties. She further stated she was responsible for the placement of signage. She stated the use of the blue sign with the house to indicate quarantine for new admissions was in place prior to her starting work here in November. She further stated in her time there was never a discussion about the need

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for the signage to indicate the type of precautions the residents were on and what PPE needed to be used to enter the room. She further stated she was aware signage for residents on isolation precautions were to indicate what kind of isolation they were on and what PPE was needed to enter the room and had not had a discussion with staff for the reason the signs did not have this for Resident #179.

During an interview on 4/27/21 at 3:38 PM the Director of Nursing stated the decision to use blue signs with the house depicted on the sign came from the corporate office. She further stated they implemented the use of these signs for new admission residents who needed to be quarantined for observation due to the COVID19 pandemic. She stated the staff were educated as to what the sign meant, however they had not been utilizing signage which had writing on it what the isolation precautions were or what personal protective equipment was needed to enter, and she was not aware that this was needed.

During an interview on 4/27/21 at 4:08 PM the Administrator stated Resident #179 was not vaccinated for COVID19 and was admitted on 4/19/21. The blue signs were placed in order to ensure the staff knew the resident was on quarantine. She further stated she was aware if a resident was placed on isolation precautions, they were required to place signage that explained what precautions the resident was on and what personal protective equipment was to be used. She further stated she did not believe residents who were on quarantine due to being a new admission were required to have such signs because they were not on specific isolation precautions such as droplet precautions.

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During an interview on 4/28/21 at 8:48 AM the Administrator stated the facility policy for newly admitted residents was to follow the CDC guidance for long term care facilities.

2. Resident #19 was admitted to the facility on 3/24/21.

A review of resident #19's minimum data set assessment dated 3/31/21 revealed he was assessed as severely cognitively impaired. He did not have a pressure ulcer and his active diagnoses included hypertension, diabetes, hyponatremia, and Alzheimer's disease.

A review of a nursing note dated 4/23/21 revealed the nurse was called to resident room by a nurse aide and observed an open area to Resident #19's left buttocks which was 2 centimeters long by 2 centimeters wide. Resident #19 had no complaints of pain and no drainage was observed. The physician was made aware and the family and Director of Nursing were made aware.

A review of the current physician order for Resident #19 dated 4/26/21 revealed he was ordered to have the wound to his left buttocks cleansed with normal saline, apply Xerofoam, and cover with a border dressing daily.

During an interview on 4/28/21 at 3:19 PM the Director of Nursing stated the hall nurse had informed her Resident #19's old dressing had come off and the Director of Nursing was going to perform the dressing change on Resident #19.

During wound care observation on 4/28/21 at

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| F 880 | Continued From page 26<br>3:21 PM the Director of Nursing was observed to perform wound care on Resident #19. She was observed to wash her hands and then place clean gloves on. She then had the resident turn on his side and she unfastened the residents brief and the inside of the resident's brief was observed to be scantly soiled with feces. The Director of Nursing pressed the brief down with her gloved right hand to reveal the wound on the left buttock. The glove to the Director of Nursing's right hand was not visibly soiled after coming in contact with the scantly soiled brief. The wound had healthy pink tissue. The prior dressing was not present upon the wound. The Director of Nursing did not change gloves or perform hand hygiene. She then placed normal saline on a gauze and used her gloved right hand to pick up the gauze with normal saline and cleanse the wound bed. She discarded the gauze and used her gloved right hand to pick up the Xerofoam and place it on the wound bed. The Director of Nursing then covered the wound with a border dressing. At this point the Director of Nursing removed her gloves and performed hand hygiene.<br><br>During an interview on 4/28/21 at 3:28 PM the Director of Nursing stated because the dressing had come off and she did not remove a dirty dressing she did not remember to remove her gloves following pressing the soiled brief down on the resident and then cleansing and applying the Xerofoam to the wound. She concluded she should have changed gloves between removing the brief and cleansing and applying the new dressing. | F 880 | | |