STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021

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E 000	Initial Comments An unannounced Recertification survey was conducted on 8/9/21 through 8/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# DLAN11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 8/9/21 through 8/12/21. A total of 11 allegations were investigated and all of them were unsubstantiated. Event ID# DLAN11.	F 000		
F 561 SS=B	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		8/16/21

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

Electronically Signed | 09/04/2021

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

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews, the facility failed to honor residents' preference for showers per week for 3 of 4 residents reviewed for choices (Residents #33, #53, and #58). The findings included: 1. Resident #33 was admitted to the facility on 2/28/19 with diagnosis which included muscle weakness and hypertension. The quarterly Minimum Data Set (MDS) dated 7/2/21 revealed Resident #33 was cognitively intact for daily decision making. Resident #33 was total dependent for bathing and required two people assist. Review of the shower schedule revealed Resident #33 was scheduled for showers on Mondays and Thursdays during 2nd shift. Resident #33's shower schedule for July 2021 further revealed on 7/1/21, 7/5/21, 7/8/21, 7/19/21, and 7/22/21 the resident did not receive a shower or a bath. The shower schedule further indicated on 7/12/21, 7/15/21, and 7/26/21 Resident #33 received a partial bath. An interview conducted with Resident #33 on 8/9/21 at 2:37 PM revealed staff have not been following her preferred shower days and she did	F 561	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. All residents that reside in the facility have the ability to be affected by the same deficient practice; therefore all residents or responsible parties have been contacted to determine residents choice and type/frequency of showers given. Measures that are put into place to ensure the same deficient practice does not reoccur again consist of: DON/LNHA have increased CNA PPD and hired two full time Certified Nursing Assistants designated to giving showers based on the frequency chosen by residents/RP. Shower schedule has also been updated to have all showers scheduled during the times in which the designated shower CNAs were present in	

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F 561	Continued From page 2 not have a choice of a shower or a bath. The resident further revealed she preferred showers, but nursing staff did not always give her a shower because they were short staffed. An interview conducted with the Nurse Aide (NA) #2 on 8/10/21 at 11:50 PM revealed in the month of July Resident #33 received baths instead of the resident's scheduled showers due to short staffing. NA #2 further revealed Resident #33 never refused and preferred showers. An interview conducted with Nurse Aide (NA) #3 on 8/12/21 at 11:46 AM revealed Resident #33 preferred showers and had never refused. NA #3 further revealed several residents received baths or partial baths instead of a preferred shower in July due to staffing issues. An interview conducted with the Director of Nursing (DON) on 8/12/21 at 12:20 PM revealed Resident #33 did prefer showers and expected Resident #33 to receive showers on the scheduled day. The DON further revealed she was not aware that resident received baths on the preferred schedule days. An interview conducted with the Administrator on 8/12/21 at 12:42 PM revealed he expected all residents to receive their preference of a shower or bath on the residents' scheduled days. 2. Resident #53 was admitted to the facility on 5/29/20 with diagnosis which included depression and muscle weakness. The quarterly Minimum Data Set (MDS) dated 7/29/21 revealed Resident #53 was cognitively intact for daily decision making. Resident #53	F 561	the facility. Showers will also be provided on weekends and given by CNAs working assignment during request. All refusals are also being followed up with by nursing department to ensure resident choice is honored. Education was given to all nursing department(i.e. all active CNA's and Nurses) by Staff Development Coordinator or Designee to ensure competency of shower, bed bath, nurse involvement on following up on resident refusals, and resident choice to have shower seven days a week if requested. Education completed as of 8/16/2021. Showers are to be audited at least five times a week to ensure showers were offered, given, or documented refusals/alternatives(i.e. bed bath). Showers/Bed Baths/Refusals will all be documented on EMAR, as well as on paper shower sheet that will be audited by DON or designee. Administration team to complete resident interviews with residents who have a BIMS of 11 or higher to the frequency below: 20 Resident Interviews per week x 4 weeks 10 Resident Interviews per week x 4 weeks 5 Resident Interviews per week x 4 weeks Completion date of 08/16/2021. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional	

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F 561	Continued From page 3 was total dependent for bathing and required two people assist. Review of the shower schedule revealed Resident #53 was scheduled for showers on Wednesdays and Saturdays during 1st shift. Resident #53's shower schedule for July 2021 further revealed the resident received a partial bath on scheduled shower days 7/3/21, 7/17/21, and 7/4/21. The shower schedule further indicated Resident #53 did not receive a shower or bath on 7/10/21 and 7/28/21. An interview conducted with Resident #53 on 8/11/21 at 11:06 AM revealed she was scheduled to get two showers per week, but usually only got one because there wasn't enough staff. Resident #53 revealed she looked forward to her showers and had never refused. An interview conducted with Nurse Aide (NA) #4 on 8/11/21 at 1:38 PM revealed Resident #53 preferred showers and did not recall the resident refusing. NA #4 further revealed during the month of July staffing was an issue and showers would be passed on to 2nd shift. An interview conducted with the Director of Nursing (DON) on 8/12/21 at 12:20 PM revealed Resident #53 did prefer showers and expected Resident #53 to receive showers on the scheduled day. The DON further revealed she was not aware that Resident #53 received baths on the preferred shower schedule days. An interview conducted with the Administrator on 8/12/21 at 12:42 PM revealed he expected all residents to receive their preference of a shower or bath on the residents' scheduled days.	F 561	Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

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F 561	Continued From page 4	F 561		

3. Resident #58 was admitted to the facility on 11/1/18 with diagnosis which included hypertension, depression, and muscle weakness.

The quarterly Minimum Data Set (MDS) dated 7/26/21 revealed Resident #58 was cognitively intact for daily decision making. Resident #58 was total dependent for bathing and required one person assist.

Review of the shower schedule revealed Resident #58 was scheduled for shower on Tuesdays and Fridays during 1st shift. Resident #58's shower schedule for June 2021 further revealed the resident received a partial bath on 6/1/21, 6/11/21, and 6/25/21. The shower schedule further indicated Resident #58 did not receive a shower or bath on 6/4/21, 6/8/21, 6/15/21, and 6/18/21.

An interview conducted with Resident #58 on 8/9/21 at 10:17 AM revealed she preferred a shower but often got a partial bath. The resident further revealed several scheduled shower days were missed due to staff being behind schedule.

An interview conducted with Nurse Aide (NA) #4 on 8/11/21 at 1:38 PM revealed Resident #58 preferred showers and could not recall the resident ever refusing. NA #4 further revealed scheduled showers were unable to be completed some days due to being short staffed.

An interview conducted with the Director of Nursing (DON) on 8/12/21 at 12:20 PM revealed Resident #58 did prefer showers and expected Resident #58 to receive showers on the scheduled day. The DON further revealed she

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F 561	Continued From page 5 was not aware that the resident received baths on the preferred shower schedule days. An interview conducted with the Administrator on 8/12/21 at 12:42 PM revealed he expected all residents to receive their preference of a shower or bath on the residents' scheduled days.	F 561		
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 reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment reviewed for the areas of hospice to reflect prognosis for 1 of 1 resident (Resident #29) reviewed for hospice and the number of falls for 1 of 3 residents (Resident #38) reviewed for falls. The findings included: 1. Resident #29 was admitted to the facility on 6/19/19 with diagnoses that included non-alcoholic steatohepatitis (an advanced form of non-alcoholic fatty liver disease) and hepatic failure. A review of a Hospice Certification Statement signed by the hospice physician on 6/23/21 indicated Resident #29 had a terminal illness with a life expectancy of six months or less for diagnosis of non-alcoholic steatohepatitis. The quarterly Minimum Data Set (MDS)	F 641	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. All residents that reside in the facility have the ability to be affected by this deficient practice. Audit was completed for three months prior to date deficient practice was noted, to ensure previous hospice referrals and falls were transmitted through MDS(Minimum Data Set). Education was given to MDS Nurse on transmission of accurate data through the	8/16/21

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F 641	Continued From page 6 assessment dated 6/28/21 indicated a "No" to question J1400 which asked if Resident #29 had a condition or chronic disease that may result in a life expectancy of less than 6 months. An interview with the MDS nurse on 8/12/21 at 9:26 AM revealed she was responsible for coding Section J1400: Prognosis on Resident #29's quarterly MDS assessment dated 6/28/21. The MDS Nurse stated she did not code that Resident #29 had a life expectancy of less than 6 months because the Hospice Certification Statement was not available in the medical record when she completed the quarterly MDS assessment. An interview with the Director of Nursing (DON) on 8/12/21 at 12:08 PM revealed the MDS Nurse should have coded Resident #29's prognosis according to what the hospice physician had indicated in her Hospice Certification Statement. The DON stated if the hospice certification was not located in the medical record while the MDS nurse was completing Resident #29's assessment then she should have obtained the certification from hospice. 2. Resident #38 was admitted to the facility on 11/30/20 with diagnoses that included non-displaced mid-cervical fracture of right femur, muscle weakness, and repeated falls. A review of Resident #38's most recent quarterly Minimum Data Set Assessment dated 07/06/21 revealed the resident had moderately impaired cognition and required extensive assistance with bed mobility, transfer, locomotion on and off the unit, toilet use, and personal hygiene. Resident #38 was coded as not having had any falls since the prior assessment.	F 641	MDS. This education was provided by facilities regional MDS consultant on 08/16/2021. Audits were put into place for MDS to review with LNHA(Licensed Nursing Home Administrator) on all falls and hospice referrals being transmitted accurately in MDS. A double check process was implemented where each week the MDS coordinator will review look back period to determine that all falls and hospice referrals were transmitted in MDS. MDS/LNHA to review 100% of MDS transmissions for falls/hospice referrals for the first four weeks, 50% of MDS transmissions for falls/hospice referrals from weeks five through eight, and 25% of MDS transmissions for falls/hospice referrals from weeks nine through twelve. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance. Completion date is 08/16/2021.	

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F 641	Continued From page 7 Review of facility provided incident and accident logs revealed Resident #38 with two documented falls since her prior Minimum Data Set Assessment. One fall dated 05/16/21 and one fall dated 06/29/21. During an interview with MDS Coordinator on 08/12/21 at 9:26 AM she "missed" the documented falls on the incident report and should have coded Resident #38's assessment as having had falls since the previous assessment. During an interview with the Director of Nursing on 08/12/21 at 12:06 PM, she reported Resident #38's MDS assessment should have accurately reflected the two falls that occurred since the previous assessment.	F 641		
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. (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	F 657		9/9/21

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F 657	Continued From page 8 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, resident and staff interviews, the facility failed to revise Resident #4's care plan to reflect level of assistance required by the staff when repositioning in bed for 1 of 3 residents (Resident #4) reviewed for falls. The findings included: Resident #4 was admitted to the facility on 2/4/11 with diagnoses that included heart failure and generalized muscle weakness. An Event Report dated 12/5/20 indicated at approximately 1:45 AM, a nurse aide (NA) was in Resident #4's room providing personal care and when the NA rolled Resident #4 to change her brief, she was too close to the edge of the bed and Resident #4 rolled off the bed onto her knees on the floor. Resident #4 was assisted back to bed by two staff members and a mechanical lift. Immediate assessment showed a bruised area above Resident #4's left eye, small skin tear to right elbow and bruising to left knee and left shin. The quarterly Minimum Data Set (MDS) assessment dated 5/21/21 indicated Resident #4	F 657	//The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. All residents that currently reside in the facility have the ability to be affected by the deficient practice. Director of Rehab/Designee completed a 100% audit of all residents in the facility to ensure appropriate transfer intervention/bed mobility assistance was accurate in comparison to the residents Care Plan. The following were implemented to ensure this deficient practice does not reoccur: Education was given to all nursing	

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F 657	Continued From page 9 was moderately cognitively impaired and required extensive physical assistance with bed mobility by one person. Resident #4's care plan last reviewed on 6/10/21 indicated that Resident #4 was at risk for falls related to limited independent mobility. Interventions included the use of two employees when repositioning Resident #4 which was started on 12/6/20. An interview with Resident #4 on 8/9/21 at 11:56 AM revealed she had a fall several months ago when she rolled off the bed while a nurse aide was providing care to her. Resident #4 stated she fell to the floor and landed between her bed and her wheelchair. Resident #4 stated that she obtained a cut to her right elbow and her left foot got tangled on the bed sheet which pulled on her left hamstring. A second interview with Resident #4 on 8/11/21 at 9:22 AM revealed she was usually assisted by one nurse aide during care in the bed. Resident #4 stated she had been able to assist in turning to the side but had not been of much help recently since she had been sick. An interview with Nurse Aide (NA) #1 on 8/11/21 at 10:03 AM revealed she had just provided incontinence care to Resident #4 while in her bed by herself. NA #1 stated Resident #4 just needed one person assist and she was able to help when turning and repositioning in bed. NA #1 stated she stood on Resident #4's left side and was able to turn her from side to side with minimal assistance from Resident #4. An interview with the MDS nurse on 8/12/21 at	F 657	department(i.e. Active Nurses and CNAs) of where to find transfer status for each resident in EMAR, completed on 08/16/2021. Education also completed on documenting/reporting any changes needed to transfer/bed mobility status in EMAR, Report Sheets, or Change of Condition, education complete on 09/09/2021. Education was completed by DON or designee on 08/16/2021 and 09/09/2021. Therapy/Nursing Admin to bring to morning meeting at least five times a week any changes to transfer status for residents residing in this facility effective 08/17/2021. When a resident could need change in status of bed mobility/transfers it will be documented via EMAR, Report Sheets, or Change of Conditions. This information can be found on 24 Hour Report viewed on EMAR, as well as printed Report sheets. 12 Week Audit was implemented to ensure residents plan of care and modality intervention being used are matched for the following frequency: 20 residents reviewed/observed for weeks 1-4 to ensure bed mobility matches care plan, 10 residents reviewed/observed for weeks 5-8 to ensure bed mobility matches care plan, 5 residents reviewed/observed for weeks 9-12 to ensure bed mobility matches care plan. Completion date of 09/09/2021. The Administrator and Quality	

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F 657	Continued From page 10 9:26 AM revealed she was responsible for updating the care plans at least quarterly and every time there was a change in a resident's care. The MDS nurse stated she needed to update Resident #4's care plan because Resident #4 did not require two person staff assistance with personal care in bed. The MDS nurse stated Resident #4's level of assistance with turning and repositioning depended on her mood and if she was familiar with the nurse aide who was providing care to her. The MDS nurse also said she needed to re-evaluate Resident #4 and discuss her care at the falls committee so they could initiate a different intervention that would prevent the same fall incident in December from occurring again. The MDS nurse stated they held falls committee meetings monthly and were scheduled to have the next one in August. An interview with the Director of Nursing (DON) on 8/12/21 at 12:08 PM revealed Resident #4 did not require two-person assistance while being provided care in bed all the time. The DON stated the kind of assistance Resident #4 gave to staff depended on who the staff member was. She explained if Resident #4 was familiar with the nurse aide, she would let her take care of her by herself and would tell her not to get somebody else to help her. The DON further stated they needed to evaluate Resident #4 for bed mobility and update the care plan to initiate a more appropriate intervention to prevent further falls from her bed.	F 657	Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		8/16/21

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F 880	Continued From page 11	F 880		

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 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

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F 880	Continued From page 12 (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 observations, record reviews, and staff interviews, the facility failed to implement their infection control policies and procedures when 1 of 2 unvaccinated residents (Resident #135) was not placed on enhanced droplet contact precautions, two staff were observed not using all PPE and not changing PPE between rooms (Nurse #3 and Nurse Aide #5) and when 3 of 4 nurses (Nurse #1, Nurse #2 and Nurse #3) failed to clean and disinfect glucometers according to the manufacturer's recommendations after use on 2 of 3 residents (Resident #24 and Resident #17) reviewed for infection control. This occurred during a global pandemic.	F 880	1. The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

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F 880	Continued From page 13 The findings included: The Centers for Disease Control and Prevention (CDC) guideline entitled "Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccinations," updated on 04/27/21 under section 5 Use of Personal Protective Equipment: "Recommendations for use of personal protective equipment by health care personnel remain unchanged." The Centers for Disease Control and Prevention (CDC) guideline entitled, "Interim Infection Control and Prevention Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, "updated on 02/23/21 indicated in part: "The PPE (personal protective equipment) recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: 1. Respirator - Put on N95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or re-use. Perform hand hygiene after removing the respirator or facemask. 2. Eye protection - Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply.	F 880	All unvaccinated residents have the ability to be affected by this deficient practice. Education was provided to Administration Department as well as all active nurses to ensure that everyone is aware of requiring proof of COVID 19 vaccination prior to resident admitting to green units (Area where vaccinated residents and residents who have been in the facility for at least 14 days). All unvaccinated residents are to be placed on enhanced droplet precautions in designated facility area until 14 day window has passed. Education was provided by Telina Glover, RN; Harriet Smith, RN; Diana Samad, LPN; Education was completed on 08/16/2021. All residents currently residing in the facility that have been admitted within the last 14 days have been reviewed to ensure necessary precautions are in place. Audits to be completed by Admissions Director, LNHA, or designee of the following: 100% of new admissions will be reviewed within 24 hours of admission during weeks 1-4 to ensure resident is in appropriate location as well as precautions are in place. 50% of new admissions will be reviewed within 24 hours of admission during weeks 5-8 to ensure resident is in appropriate location as well as precautions are in place. 25% of new admissions will be reviewed within 24 hours of admission during weeks 9-12 to ensure resident is in appropriate location as well as precautions are in place. This will ensure vaccination status matches destination in facility, as well as necessary precautions are in place.	

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F 880	Continued From page 14 Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to the manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or re-use. A review of the facility's Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed COVID-19 revised on 05/26/20 indicated the following statements: "Prevention of infection to include educating staff and ensuring that they adhere to proper techniques and procedures; and following established general and disease-specific guidelines such as those of the Centers for Disease Control and Prevention (CDC). "Hand hygiene must be done before entering and leaving resident room. "Do hand hygiene before and after entering the room. Clean gloves need to be put on before entering each room and should be removed when leaving each room with hand hygiene completed after leaving the room. "When gloves are used, they must be used only once and discarded into appropriate receptacles located in the room in which the procedure was performed. "Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.	F 880	Completion date of 08/16/2021. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance. 2. The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. All residents that require a glucometer to be used during blood sugar checks have the ability to affected by this deficient practice. Education was provided by Telina Glover, RN; Harriet Smith, RN; Diana Samad, LPN; to all active Nurses and active Medication Aides to ensure appropriate disinfectant wipes are used, and appropriate cleaning procedure takes place after each use as described in	

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F 880	Continued From page 15 "Residents will be on enhanced droplet contact isolation for 14 days after admission/readmission and 300 hall rooms are designated for all new admissions and return from hospital residents. If direct care is provided you should wear a KN95 or higher respirator, goggles or face shield, isolation gown and gloves when entering the room. 1. Resident #135 was admitted to the facility on 08/03/21 to a private room on the 300 hall. Upon entry to the facility on 08/09/21, the Director of Nursing (DON) and Administrator indicated the 300 hall was the quarantine hallway for new admissions that were vaccinated in the front of the hall and unvaccinated in the back of the 300 hall (behind the barrier). Upon entry on 08/09/21, there was one resident behind the barrier on enhanced droplet contact precautions. An observation on 08/09/21 at 10:01 AM of Resident #135 revealed her in her room with the door open. There was a sign on the door demonstrating how to don and doff personal protective equipment (PPE). There was no PPE on the outside of her room or on the door of her room in a caddy. There was no sign on the resident's door that indicated she was on enhanced droplet contact precautions. The resident was sitting up on her bed and scratching her legs and arms and stated she was very nervous. Review of Resident #135's medical record revealed the resident had not received the COVID-19 vaccines. A continuous observation on 08/09/21 from 10:15	F 880	manual of glucometers ordered. Education was also given to Central Supply personnel on which disinfectant wipes can be used on medication carts. All education was completed as of 08/16/2021. 100% audit was completed of all residents required blood sugar checks to ensure individual glucometer was in possession of each residents room. Audits to be conducted consist of: 20 nurse observations from week 1-4, 10 nurse observations from week 5-8, 5 nurse observations from week 9-12. Observations consist of ensuring each resident has personal glucometer in resident room, hand hygiene was performed, gloves were used, and appropriate cleaning procedure took place. Completion date of 08/16/2021. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

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AM to 10:30 AM revealed Nurse Aide (NA) #5 going into Resident #135's room to provide care. NA #5 went into the room with a KN95 mask and goggles on and supplies for care in her arms. NA #2 came out of the room at 10:30 AM with her mask and goggles on, sanitized her hands and proceeded into another resident's room with the call light on.

Another continuous observation on 08/09/21 from 1:30 PM to 1:39 PM revealed Nurse #3 going into Resident #135's room with a medication cup with his KN95 mask and goggles on to administer pain medication to the resident. Nurse #3 was observed coming out of Resident #135's room at 1:39 PM and sanitized his hands and proceeded to the medication cart with his KN95 mask and goggles on.

An interview on 08/09/21 at 1:45 PM with NA #5 revealed the residents on the front of the 300 hall were vaccinated and only required staff to wear a KN95 mask, goggles and gloves for care. NA #5 stated the residents in the back of the hall behind the barrier required all PPE because they were unvaccinated. NA #5 further stated there was currently only 1 unvaccinated resident behind the barrier on the 300 hall.

An interview on 08/09/21 at 2:00 PM with Nurse #3 revealed there was resident behind the barrier on the 300 hall. Nurse #3 further indicated the resident was on enhanced contact droplet precautions for COVID-19. Nurse #3 stated the resident behind the barrier on enhanced precautions which required N95 mask, goggles, gown and gloves when providing care. He further stated all PPE had to be donned when entering and all PPE doffed when leaving the room and

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new mask applied and goggles cleaned and disinfected. Nurse #3 explained while working on the front of the hall the same mask and goggles could be worn in each room since the residents were all vaccinated.

On 08/10/21 at 1:32 PM Resident #135 was not in her room and had been moved to a room behind the barrier.

An interview on 08/10/21 at 2:02 PM with Nurse #3 revealed Resident #135 had been moved earlier in the day behind the barrier by the DON and housekeeping but stated he was not sure why the resident had been moved unless it was due to her vaccine status. Nurse #3 indicated Resident #135 had not been on enhanced droplet contact precautions but had been placed on enhanced droplet contact precautions today with PPE placed in a caddy on her door.

An interview on 08/10/21 at 2:30 PM with NA #5 who had been assigned to Resident #135 revealed she was assigned to the resident both yesterday and today. NA #5 further revealed the resident had not been on enhanced droplet contact precautions and there had not been any PPE outside her door or in a caddy on her door. NA #5 indicated the only sign she had seen on the door was a sign for donning and doffing PPE which was on everybody's door on the 300 hall. NA #5 further indicated Resident #135 had been placed on enhanced droplet contact precautions today and PPE placed in a caddy on her door.

An interview on 08/12/21 at 11:42 AM with the DON who was also serving as the Infection Preventionist (IP) revealed Resident #135 had not had her vaccines and should have been admitted

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to a room behind the barrier on the 300 hall instead of the room she was admitted to. The DON stated she discovered on Tuesday 08/10/21 there was not a sign for enhanced droplet contact precautions on the resident's door and witnessed staff not using the appropriate PPE. The DON further stated she made the decision to move the resident behind the barrier so staff would know they had to wear all appropriate PPE into her room when providing care. She indicated she thought she could isolate the resident in place on the 300 hall, but when she discovered staff not using the appropriate PPE, she moved the resident behind the barrier to ensure proper use of PPE.

An interview on 08/12/21 at 1:03 PM with the Administrator revealed he would have expected Resident #135 to have been admitted behind the barrier on the 300 hall and placed on enhanced droplet contact precautions on admission since she was not vaccinated against COVID-19.

2. A review of the facility's policy entitled, "Policy and Procedure: Cleaning and Disinfecting Glucometers" indicated:
*Glucometers must be disinfected after every use if used for multiple residents.

A review of the facility's glucometer manufacturer's instructions entitled, "Ark Care Technical Brief," revised on 9/2019 indicated the following statements regarding how to clean and disinfect the meter and how often:
*The meter should be cleaned and disinfected after use on each patient.
*Only wipes with EPA (Environmental Protection Agency) registration numbers listed have been validated for use in cleaning and disinfecting the

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meter. Wipes with EPA registration numbers not listed should not be used to clean and disinfect the glucometer.
*To ensure compliance ARKRAY recommends that blood glucose meters be cleaned and disinfected after each use.

a. An observation was made on 8/10/21 at 4:33 PM of Nurse #1 while she checked Resident #24's blood sugar. Nurse #1 obtained a glucometer from the top drawer of the medication cart along with a single-use lancet, a test strip, and an alcohol prep pad. Nurse #1 wiped the glucometer with a disinfectant wipe prior to going into Resident #24's room. Nurse #1 put gloves on and wiped Resident #24's left third finger with an alcohol prep pad prior to sticking it with a lancet. Nurse #1 wiped off the first drop of blood with a tissue paper, placed the second drop of blood into the strip that was inserted in a glucometer and obtained the blood sugar reading. Nurse #1 went back to the medication cart, placed the glucometer on top of the medication cart and discarded the used lancet in a sharp's container. She pulled out a disinfectant wipe out of the canister and wiped the front and back of the glucometer for about ten seconds and placed the glucometer in the top drawer of the medication cart.

After review of the instructions at the back of the germicidal surface wipes canister, an interview with Nurse #1 on 8/10/21 at 5:06 PM revealed that she did not know she was supposed to let the glucometer stay wet for two minutes. She added that the germicidal surface wipes were new, and she was not used to using this kind of disinfectant wipe.

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F 880	Continued From page 20 b. An observation was made on 8/11/21 at 5:12 AM of Nurse #2 while she checked Resident #24's blood sugar. Nurse #2 went into Resident #24's room and searched for Resident #24's glucometer at the bedside but did not find one. Nurse #2 stated she saw the box where the glucometer had been originally packaged in but did not see the glucometer in the room. Nurse #2 went back to the medication cart and obtained a glucometer from the top drawer of the medication cart and other supplies used to check Resident #24's blood sugar and then entered her room. Nurse #2 cleaned Resident #24's left third finger with an alcohol prep pad and stuck it with a lancet. She placed a drop of blood into a strip that was inserted in the glucometer and obtained Resident #24's blood sugar reading. Nurse #1 walked back to the medication cart, disposed of her gloves and other supplies used, wrapped the glucometer in two disinfectant wipes and left it on top of the medication cart. Nurse #1 did not wipe the glucometer before wrapping it with germicidal surface wipes. An interview with Nurse #2 on 8/11/21 at 5:18 AM revealed she had been told to wrap the glucometer in disinfectant wipes and let it sit for at least two minutes. Nurse #2 stated the germicidal surface wipes were the only disinfectant wipes available in the medication cart and thought it was acceptable to use them on the glucometer. Nurse #2 shared some residents kept their glucometers at the bedside, but the nurses kept extra glucometers in the medication carts which were not assigned to a particular resident. Nurse #2 also stated that she had not used the glucometer that was on the medication cart on another resident prior to using it on Resident #24.	F 880		

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c. An observation was made on 8/11/21 at 8:07 AM of Nurse #3 while he checked Resident #17's blood sugar. Nurse #3 obtained Resident #17's glucometer which was in a plastic bag at the bedside. After wiping Resident #17's right second finger with an alcohol prep pad, Nurse #3 stuck it with a single-use lancet and placed a drop of blood into a test strip that was inserted in the glucometer. After the blood sugar reading registered, Nurse #3 pulled out the test strip and placed the glucometer back into the plastic bag and left it at the bedside. Nurse #3 did not clean or disinfect the glucometer.

An interview with Nurse #3 on 8/11/21 at 8:17 AM revealed he had been told that glucometers that were kept in the room did not need to be cleaned after each use but were only supposed to be cleaned weekly. Nurse #3 did not know who was assigned to clean and disinfect the assigned glucometers and stated they did not have a schedule about the weekly cleaning and disinfecting of glucometers.

An interview on 8/12/21 at 12:03 PM with the Director of Nursing (DON) who was also the facility's infection preventionist revealed glucometers were assigned to each resident and were stored in their rooms. The glucometers that were assigned for an individual resident were supposed to be only cleaned if they were visibly soiled and did not require disinfection each time. The extra glucometers that they kept in the medication carts were not assigned to specific residents and were supposed to be cleaned and disinfected after every use with any of the approved disinfectant wipes from the glucometer's manufacturer. The DON confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE HEALTH AND REHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 that the germicidal surface wipes were not listed in the list of approved disinfectants and should not be used to disinfect the glucometers used at the facility because they had not been validated. The DON added that the approved germicidal disposable wipes were available in some of the medication carts and was not sure why some medication carts had the other germicidal surface wipes that were not approved to be used on the glucometers. An interview with the Administrator on 8/12/21 at 12:53 PM revealed the nurses should have followed the glucometer's manufacturer's guidelines and used an EPA-registered wipe that was approved to be used to disinfect the glucometers after use.	F 880		