STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 4/4/2022 through 4/7/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QMTM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/4/2022 through 4/7/2022. Event ID# QMTM11. Intake #NC00184732. 1 of the 4 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		4/29/22

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

Electronically Signed | 04/26/2022

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews the facility failed to provide incontinent care in a manner to maintain the resident's dignity for 1 (Resident #33) of 4 residents reviewed for dignity. Findings include: Resident # 33 was admitted to the facility on 10/31/2019 with multiple diagnosis including, Pneumonia, muscle weakness, fibromyalgia, urinary tract infection, and adult failure to thrive. A review of Resident #33's Minimum Data Set (MDS) dated 02/25/2022 revealed she was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15, she required extensive assist with 2 staff members for bed mobility, total dependence with 2 staff members for transfers, total dependence with 1 staff member for toilet	F 550	F550 The statements included 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. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 550	Continued From page 2 use and bathing, and extensive assist with 1 staff member for personal hygiene and dressing. She was coded incontinent for bowel and bladder. There was no coded rejection of care behaviors exhibited. On 04/04/2022 at 11:50 AM an interview was conducted with Resident #33. She stated that on 04/01/2022 she waited from 8PM to 11PM for her call light to be answered. She stated at 11:00 PM the NA # 3 came in and changed her. She stated she was saturated with urine and needed to be changed. She stated she knew it was 3 hours because she looked at her clock and timed it. On 04/06/22 at 09:47 AM an interview was conducted with Resident #33. She stated she waited an hour for the Nursing Assistant (NA) to answer her call light on 04/05/2022. She stated she put the call light on at 8:37pm. She stated after 45 minutes she threw a box of tissues at the door to get someone's attention. She stated Nurse #3 came in, asked her what she needed and turned the call light off. Resident # 33 told Nurse # 3 that she needed to be changed because she was wet and had a bowel movement. Nurse #3 then turned the call bell back on so the NA would come and assist her. NA #3 came in approximately 15 minutes later and changed her soiled brief. She stated she timed this occurrence by looking at her clock. She stated that she was saturated and had a bowel movement. She stated she felt like she needed to take a shower because she smelled like urine and that she was embarrassed about it. She stated she did not request a shower at that time. On 04/07/2022 at 8:10 PM an interview was conducted with NA # 3. She stated that she was	F 550	Resident #33 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #33 remains at the facility with no residual adverse effects. How the facility will identify other residents having the potential to be affected by the same deficient practice: All other incontinent residents in the facility have the potential to be affected. An audit was conducted on April 7, 2022 by Director of Nursing and Nursing Management team by interviewing and/or direct observation to determine if any additional residents did not received incontinent care timely. It was determined that no other residents were adversely affected by the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility policies related to incontinence care were reviewed by facility administration on April 20. 2022, and no updates were necessary. NA #3, and Nurse #3 were educated by Staff Development Coordinator on April 7, 2020, on the importance of answering call lights in a timely matter and if unable to fulfill resident's request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests.	

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F 550	Continued From page 3 assigned to Resident # 33 on 04/05/2022. She stated she changed Resident #33 and that she had a bowel movement. She stated she doesn't recall how long the call light was on. She stated she does her rounds every 2 hours and the nurse can answer call lights too. She stated she did not work on 04-01-2022. On 04/07/2022 at 9:26 AM an interview was conducted with Nurse #3 She stated she remembers resident # 33 complaining that it took 3 hours for someone to answer her call light on 04/01/2022 and an hour on 04/05/2022. She stated she answers call lights and helps the NAs when she can but it's hard to do when she's doing her med pass. She stated she went into the room two or three times herself between 8:00 PM to 11:00 PM on 4-1-22. She stated she went into resident # 33's room to give her roommate a breathing treatment, Resident # 33 did not say anything to her at that time. She stated she went into resident # 33's room two or three times, but she did not change the resident. She stated she was on her med pass and that she does not remember if Resident # 33 stated she needed to be changed. She stated she expects the NAs to answer the call lights within 5 minutes. She stated she remembered resident # 33 telling her that the NA came into the room to answer the call bell that was on for over an hour and changed Resident # 33's soiled brief. She stated she was on her med pass and that she did remember that Resident # 33 stated she needed to be changed so she turned the call light off then back on. On 04/07/2022 at 12:10 PM an interview with the Director of Nursing (DON) was conducted. The DON stated she was unaware of the wait times for these days. The DON stated her expectation	F 550	All staff will be educated regarding resident's rights/exercising of resident rights and importance of answering call lights timely and providing timely incontinence care. This will be completed by the Staff Development Coordinator and/or designee by April 29, 2021 This education will include the following: • The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. • A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. • The facility must protect and promote the rights of the resident. • The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. • The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. • Problems associated with incontinence and moisture, including skin breakdown	

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F 550	Continued From page 4 is for the call lights to be answered in a timely manner by all staff. She stated NA # 3 had worked on 04-01-2022.	F 550	• Preventing skin breakdown by providing timely incontinence care • Incontinent residents will be checked for incontinence every 2 hours at a minimum to determine the need for incontinence care. • The staff is to ensure someone is always present on the floor to meet resident's requests. If non-clinical staff should respond to call lights and are not able to meet the resident's needs or requests, they are to inform the nurse and /or certified nursing assistant immediately. Any staff out on leave or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and contracted staff will be educated during orientation by the Staff Development Coordinator/designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed to monitor incontinent residents to ensure that timely incontinence care has been provided as necessary to maintain resident's cleanliness and comfort and to determine if resident's right regarding incontinence care were being followed. The audit tool was initiated on April 20,2022 The Director of Nursing, Staff Development Coordinator and /or	

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F 550	Continued From page 5	F 550	designee will audit 5 incontinent residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on random days, shifts, and weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing. An audit tool was developed to monitor for call light answering times. Call light audit tool will be completed by Nursing Management team 2 x weekly x 4 weeks, then 1x weekly x 4 weeks then biweekly x 4 weeks. The results of these audits will determine the need for further monitoring. Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee Meeting by the Director of Nursing monthly x 3 months for review and further recommendations. Completion date: April 29, 2022	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and physician interview, the facility failed to maintain a	F 759	F759	4/29/22

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F 759	Continued From page 6 medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.7% for 2 of 26 residents observed for medication pass. (Resident #38 and #55). Findings included: Resident # 38 was admitted to the facility on 9/27/21 with diagnoses of esophageal reflux disease, and constipation. Review of the physician's orders dated 12/22/21 revealed Resident # 38 was ordered senna (laxative which contains only one active ingredient) 8.6 milligrams twice a day. During a medication administration observation on 04/07/22 at 08:45 AM, senna plus was administered to prevent constipation to Resident # 38. During an interview on 04/07/22 at 08:50 AM Nurse #3 revealed she had mistakenly given senna plus. 2. Resident # 55 was admitted to the facility on 11/19/21 with gastro-esophageal reflux disease and nausea. Record review of physician's orders dated 03/17/2022 administer metoclopramide 5 milligrams before meals (08:30 AM, 11:30 AM, and 04:30 PM). During a medication observation on 04/06/2022 at 9:25 AM Nurse #1 administered metoclopramide 5 milligrams (for nausea and vomiting).	F 759	The statements included 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. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: For Resident #38, the physician was immediately notified of the medication error with no changes in physician orders. The resident was monitored by nursing staff with no observed adverse effect. For Resident #55, the physician was immediately notified with orders changed to administer medication with meals per resident preference. The resident was monitored by nursing staff with no observed adverse effect. Resident #38 and Resident #55 remain at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice: All other residents in the facility have the potential to be affected. Nurse #1 was educated by the Director of Nursing on proper procedures for medication	

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F 759	Continued From page 7 During an interview on 04/06/22 at 09:25 AM Nurse #1 revealed that breakfast had been served and stated that Resident #55 preferred all her medication after her meals. She reported that Resident #55 had expressed in the past that the medication made her feel sick when taken on an empty stomach. An interview on 04/06/22 at 12:51 PM with the facility's Medical Director indicated that metoclopramide was prescribed for nausea and vomiting. When a resident refused to take medication before meals, the nurse can request an order to administer with meals. An interview on 04/06/22 at 02:39 PM with Nurse Supervisor #1 revealed that nurses were to inform the Medical Director if a resident does not want to take medications before meals and that the order should be changed.	F 759	administration on April 7 2022. A medication pass audit was completed by Staff Development Coordinator on Nurse #1 on April 7,2022 with a 0% medication error rate. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nursing staff and medication aides will be educated on proper procedures for medication administration to include the 5 Rights of Medication Administration. This will be completed by the Director of Nursing, Staff Development Coordinator or designee by April 29, 2022 Any licensed nursing staff or medication aide out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired licensed nursing staff or medication aide will be educated during orientation by the Staff Development Coordinator/designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To prevent this from recurring, beginning on 4/29/2022, the Director of Nursing and/or designee will audit 2 medication passes weekly for 4 weeks. These will include random shifts, including weekends. Audits will continue biweekly x 4 weeks, then monthly x 1 month.	

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F 759	Continued From page 8	F 759	Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee meeting by the Director of Nursing monthly x 3 months for review and further recommendations. Completion date: April 29. 2022	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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. This REQUIREMENT is not met as evidenced by:	F 761		4/29/22

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F 761	Continued From page 9 Based observation and staff interview, the facility failed to discard expired medications in 1 of 1 medication room and failed to date and label medication in 1 of 2 medication carts on the 100 hall reviewed for medication storage. Findings included: a. An observation of the medication room, on 4/07/22 at 9:32 AM revealed 2 unopened bottles of Vitamin E 90 mg (200 IU) tablet - expiration date 1/22 1 opened bottle of low dose aspirin tablet - expiration 4/21. During an interview on 04/07/22 at 09:35 AM with the Treatment Nurse regarding the medication room, she stated that all nurses were responsible for checking the medication room for expired medication. The Medical Records Clerk ordered supplies and removed the expired medication. An interview on 04/07/22 at 10:08 AM with the Medical Records Clerk revealed she ordered the supplies and checked the medication room once a week for expired medications and threw away any expired medication from the medication room. She reported that expired medications should not be in the medication room. b. An observation of the 100-hall medication cart on 4/07/22 at 12:01 PM, revealed: 1 bottle of loperamide hydrochloric acid, anti-diarrheal medication, 2mg tablets - expired 3/2022 1 fluticasone propionate inhalation aerosol inhaler, used to treat asthma, 110mcg - loose in the medication cart drawer with no open date or resident name.	F 761	F761 The statements included 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. How corrective action will be accomplished for those observation areas found to have been affected by the deficient practice: Expired medication from the medication room, undated medication from Medication cart, and unlabeled medication were immediately removed and discarded by Samantha Arms, LPN on April 7, 2022 . No resident suffered any adverse effects from the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice: On April 07, 2022 an Audit was completed for all medication carts and medication rooms by the Nurse Management team to ensure that there were no expired, unlabeled, or undated medications in any medication cart or medication room. There were no additional expired,	

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F 761	Continued From page 10 During an interview on 04/07/22 at 10:22 AM, Nurse #2 reveled that the 100-hall medication cart was her assigned cart for the day. She reported that she was not sure who reviewed the medication cart for expired or unlabeled medications. Nurse # 2 reported that all medications needed to be labeled with a resident's name and dated. She expressed that since that the inhaler did not have a name or date, it needed to be thrown away. An interview on 04/07/22 at 10:42 AM with Nurse Supervisor #1 revealed that the pharmacist checked the medication room monthly. Nurses were responsible for removing expired medications from medication carts and the medication storage room. Nurses were instructed to notify supervisor for unmarked meds and to remove expired medications per facility protocol. An interview on 04/07/22 at 12:30 the Director of Nursing (DON) revealed that nurses should check medication carts nightly for unlabeled and expired medications. She reported that nurses should be reviewing expiration dates when administering medications.	F 761	unlabeled, and/or undated medications observed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Pharmacy will continue to complete monthly audits on medication storage in the medication rooms and medication carts to ensure that there are no expired, unlabeled, and/or undated medications. All licensed nurses will be educated on medication storage labeling and dating of all medications by Staff Development Coordinator. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the Staff Development Coordinator/Infection Preventionist or designee. Newly hired licensed nursing staff will be educated during orientation by the Staff Development Coordinator/Infection Preventionist or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed to monitor medication rooms and medication carts for expired, unlabeled, and/or undated medications. Starting April 20, 2022 Director of Nursing and/or designee will audit 100% of medication carts weekly x 4 weeks, then biweekly x 4 weeks then monthly x 1 month.	

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F 761	Continued From page 11	F 761	Medical records will audit medication room for expired medications weekly x 3 months. The results of these audits will determine the need for further monitoring. Results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing monthly x 3 months. If any issues or trends are identified, it will be addressed by the QAPI Committee, and the plan will be revised to ensure compliance. Completion date: April 29, 2022	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.	F 809		4/29/22

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F 809	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to offer or deliver bedtime snacks to 2 (Resident # 33 and Resident # 40) of 2 residents reviewed for the delivery of snacks. Findings included: A. According to the Minimum Data Set (MDS) for Resident # 33 she was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. On 04/04/22 at 11:26 AM an interview was conducted with Resident # 33. She stated that bedtime snacks were not delivered or offered. During a second interview with Resident # 33 on 04/06/22 at 09:47 AM she stated that she never received, and she was not offered a snack on 04-05-2022. B. According to the Minimum Data Set (MDS) for Resident # 40 she was cognitively intact with a Brief Interview for Mental Status (BIMS) of 15. On 04/04/22 at 11:28 AM an interview was conducted with Resident # 40. She stated that bedtime snacks were not delivered or offered at any time. On 04/07/2022 at 8:10 PM an interview with Nursing Assistant (NA) # 3 was conducted. She stated that she was assigned to Resident #33 and Resident # 40 on 04/05/2022. She stated that she does pass the ice, but she does not pass or offer snacks unless the resident specifically asks for one. She stated she does not take the snack cart door-to-door because these are long term care residents, they ask if they want one.	F 809	F809 The statements included 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. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On April 7, 2022 NA#3 was educated on passing/offering snacks at bedtime. Resident #33 and resident #40 did not suffer any adverse effects from the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents in the facility were identified as having the potential to be impacted when evening snacks are not passed. Consumption bedtime snack report was reviewed by the Director of Nursing on April 7, 2022 and all bedtime snacks were	

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F 809	Continued From page 13 On 04/07/22 at 9:26 AM an interview with Nurse # 3 was conducted. She stated yes and no to the bedtime snacks being passed. The NAs know which residents usually ask for snacks, so they bring those residents the snacks. Some NAs take the cart door to door, and some don't. She expected the NAs to take the snack cart door to door and offer each resident a snack. If an agency NA is on the hall, she will educate them on the residents and she tells them to pass snacks. On 04/06/22 at 11:05 AM an interview was conducted with the Dietary Manager (DM). She stated dietary takes snacks out three times a day and the nursing staff pass them out. The snack times are 10:00 AM, 2:00 PM, and 8:00 PM. On 04/07/22 at 12:32 PM an interview was conducted with the Director of Nursing (DON). She stated that she was unaware the snacks were not being passed. She stated her expectation was for the staff to pass snacks at scheduled times.	F 809	documented as given. No additional resident suffered any adverse affect from the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Facility to educate all licensed nursing staff and certified nursing assistants on offering bedtime snacks to all residents. Inservice to be completed by Director of Nursing or Staff Development Coordinator by April 29, 2022. Any staff on leave or PRN status will be educated upon return to duty by the DON or SDC or designee. Any newly hired staff will be educated by SDC or designee during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed to monitor for residents being offered bedtime snacks. Interviews will be conducted by management team on 10 alert and oriented residents and documentation will be reviewed on 10 non alert and oriented residents to determine if residents are being offered bedtime snacks. This will occur 2x week x 4 weeks, then weekly x 4 weeks, then biweekly x 4 weeks. The Director of Nursing will bring the results of these audits to the Quality Assurance and Performance Improvement Committee meeting monthly	

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F 809	Continued From page 14	F 809	x 3 months for review and further recommendations. Completion date: April 29. 2022	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain water temperature during the wash cycle of the dishwasher according to manufacturer's instructions, failed to discard expired food and beverages, failed to cover, label, and date opened foods, failed to do hand hygiene and glove use between food preparation and sweeping the floor, and failed to keep ice machine clean.	F 812	F 812 The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected:	4/29/22

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F 812	Continued From page 15 The findings included: During the initial tour of the main kitchen on 04/04/2022 at 9:35 AM to 10:20 AM revealed the following: 1. On 04/04/22 at 9:35 AM it was observed that the water temperature during the wash cycle of the dishwasher that used chemical sanitation was 100 degrees Fahrenheit during the wash cycle. The machine is a single rack low temperature chemical dishwasher. Dishwasher instructions posted on wall above dishwasher. Temperature range 120-140 degrees Fahrenheit listed on the machine. Interview with Dietary Manager on 04/04/2022 at 9:36 AM revealed that the machine is a single rack low temperature chemical dishwasher. She stated per manufacturer instructions the water temperature is to be at 120 degrees Fahrenheit and the sanitizing chemical being used is bleach. She stated that the temperature was lower than expected. She stated that the sanitation concentration is tested 3 times a day. 2. Facility failed to cover, label, discard, and date foods. The following items were observed in refrigerators and dry storage available for use. A. In the walk-in refrigerator the following were seen: 1. One 128-ounce opened container of cole slaw dressing with no open date. 2. One box of muffins not covered and no opened date. 3. One package of Tortillas left open and no open date. B. In the reach in refrigerator #1:	F 812	All residents had the potential of being affected On 4/04/2022, the Dietary Manager immediately discarded any expired food and beverage and discarded any uncovered, unlabeled, undated foods. In addition, the ice machine was cleaned, and the Dietary Manager ensured that the water temperature during the wash cycle of the dishwasher was kept according to manufacturer's instruction. The cook was immediately educated on hand hygiene and PPE use procedures by the Dietary Manager. No resident was adversely affected by the alleged deficient practice. Systemic Changes: On 4/04/2022, Food Services District Manager in-serviced 100% of kitchen staff on procedures for properly storing, labeling, dating, and sealing foods; on handwashing procedures and PPE use; on coordination with laundry services to alternate times of using washing machine when dish machine is in use. A daily tracker will be completed to ensure the water temperatures are not pulling at the same time causing the hot water temps to decrease in the kitchen. On 4/04/2022, the Food Services District Manager educated the Dietary Manager and Assistant manager on procedures for	

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F 812	Continued From page 16 1. One chocolate shake with a throw away date of 3-27-22. C. Dry storage area: 1. One package of 24 count rolls with a package expiration date of 3-20-22 2. Five packages of 24 count rolls with a package expiration date of 3-30-22. 3. The ice machine had mold-like, black substance and pinkish slime-like substance on the lid and hinge. On 04/06/22 at 11:40 AM the Cook was observed sweeping the floor without wearing gloves. The Cook then donned gloves on, handled pots of cooking food, removed the gloves, and handled the pots of cooking food again without washing hands after the task. The Dietary Manager was interviewed on 04/06/22 at 2:34 PM in reference to food labeling and discarding foods/beverages on discard dates. She stated that it is everyone's responsibility for labeling food/beverages after opening and discarding foods/beverages on discard/expired dates. She stated she does daily checks. She stated per policy, opened foods are to be thrown away 7 days after opening. In reference to staff sweeping and not washing hands between handling and preparing foods, she stated she expected staff to wash their hands prior to handling the pots/food and prior to applying gloves. Regarding the dish machine, the sanitation concentration is tested 3 times a day. She stated the heat booster was not functioning properly, and a work order had been done. The kitchen shared the hot water heater with laundry and was currently alternating times of washing dishes and laundry to allow for proper washing	F 812	cleaning of ice machine. The Dietary Manager and Assist and Manager will rotate daily wipe down of the ice machine and will schedule monthly deep cleaning of the ice machine with maintenance which will be monitored and recorded on an ice machine tracker sheet. The Administrator educated the Maintenance Director on this schedule on 4/04/2022. In addition, the Dietary Manager and Assistant manager with do daily walk-throughs to ensure proper labeling, dating, and sealing of opened foods. Monitoring: An audit tool was developed for ensuring daily monitoring of opened and expired foods. This will be completed by the Dietary Manager and Assistant Manager daily. An audit tool was developed to monitor water temperatures of dish washing machine. This will be completed by the Dietary Manager or Assistant Manager daily. District Manager will monitor progress and compliance on visits weekly x 3 months. The results of these audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months by the Dietary Manager for compliance and recommendations.	

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F 812	Continued From page 17 and rinsing temperatures until the heat booster is repaired. Interview with the Administrator on 04/07/22 at 12:10 PM was conducted. The Administrator stated he expects the water temperature to be per policy regulations. He stated the heater booster is on schedule to be looked at today. Administrator stated it is dietary's responsibility to check the water temperature prior to using. Administrator stated his expectation is that dietary properly label and dispose of expired foods/beverages and to keep ice machine and other equipment clean. The Administrator stated his expectation is for all staff to wash their hands prior to handling foods.	F 812	Completed Date 4/29/2022	
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 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	F 880		4/29/22

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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
(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

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F 880	Continued From page 19 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 review, and staff interviews, the facility failed to: 1) Post the appropriate signage for Transmission Based Precautions (TBP) as recommended by the Center for Disease Control and Prevention (CDC) and as directed by the facility's policy for 3 of 5 newly admitted residents who were not up-to-date with all recommended COVID-19 vaccine doses or whose vaccination status was unknown (Resident #65, Resident #66, and Resident #67); and, 2) Implement the required precautions and don personal protective equipment (PPE) as indicated by the signage posted on the door for 1 of 5 residents (Resident #216) observed to be placed on TBP. These failures occurred during a global pandemic. The findings included: Review of CDC guidance titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" (updated February 2, 2022) included recommendations specific for nursing homes on managing new admissions and readmissions. The guidance read in part: "In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as	F 880	F880 The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected: Resident #65, #66, and #67 did not have “Special Droplet-Contact Isolation” signage on the room door. Appropriate signage was placed on resident #65, #66, and #67 room door on 4/4/2022 by the Staff Development Coordinator/Infection Preventionist (SDC/IP). Contract employee did not Don/Doff proper PPE on a resident on transmission based precautions. None of these residents suffered any adverse effect relating to the alleged deficient practice. All other residents with potential to be affected: On 4/4/2022, the Staff Development Coordinator (SDC) did an audit to ensure that all residents on transmission-based precautions had appropriate signage outside their room door. There were no	

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F 880	Continued From page 20 described in the testing section above; COVID-19 vaccination should also be offered." Review of a facility policy on SARS-CoV-2 (Effective February 10, 2022) addressed Managing and Evaluating Residents. This policy read in part: "New Admissions / Readmissions --COVID-19 status and vaccination status will be determined prior to admitting the resident ... Up to Date: means a person has received all recommended COVID-19 vaccines, including ay booster dose(s) when eligible... --All residents who are NOT up to date with all recommended COVID-19 vaccine doses AND are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon readmission, and should be tested as described in the testing section; COVID-19 vaccination should also be offered ..." 1-a) Resident #65 was admitted to the facility on 3/30/22 and resided on the 600 Hall. Resident #65's medical record revealed she refused COVID-19 vaccination due to "conscientious objection" on 3/31/22 after admission to the facility. A review of the facility's record of the COVID-19 vaccination status of its residents (dated 4/4/22) indicated Resident #65's status as, "Quarantine." An initial tour of the 600 Hall was conducted on 4/4/22 at 9:43 AM. An observation revealed three residents' rooms (Resident #63, Resident #69, and Resident #216) had signage to indicate the resident was on Transmission Based Precautions (TBP). Each of these three rooms also had a cart	F 880	additional residents identified as having been adversely affected by the alleged deficient practice. All new admissions for the past 14 days were reviewed and placed in quarantine, if not up to date with vaccination status. All of these residents had appropriate signage on their room door. On 4/4/2022 one to one education was provided by the Staff Development Coordinator for COTA (Certified Occupational Therapist Assistant) Student regarding proper donning of PPE per facility infection control policies and procedures. This education included techniques to Don and Doff PPE, disposing of PPE when leaving a resident room and prior to entry to other resident rooms. Systemic changes The facility policies related to infection control practices were reviewed by the administration on April 20, 2022 and no revisions and/or updates were needed All Facility staff will be educated that all residents on transmission-based precautions must have appropriate signage outside the resident door as well as following PPE use guidelines for residents on transmission based precautions. This education was initiated by the Director of Nursing on April 22,2022 and will be completed by DON and/or SDC by 4/29/2022. Any licensed nurse out on leave or PRN status will be	

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F 880	Continued From page 21 containing Personal Protective Equipment (PPE) placed next to the doorway. An observation conducted on 4/4/22 at 9:48 AM of the 600 Hall revealed there was no signage placed on or near Resident #65's doorway to indicate this resident was on TBP. However, a cart containing PPE was placed in the hallway next to Resident #65's door. An interview was conducted on 4/4/22 at 9:55 AM with Nurse #1. Nurse #1 was assigned to care for residents on the 600 hall. When asked, Nurse #1 reported she thought there were three - 600 Hall residents currently on TBP (Resident #63, Resident #69, and Resident #216). Upon further inquiry as to why a fourth PPE cart was on the 600 hallway, the nurse stated she was not sure what type of TBP precautions were in effect for Resident #65 but didn't think it was COVID-19 related. An observation and interview was conducted with the Assistant Director of Nursing (ADON) on 4/4/22 at 10:02 AM as he was changing the residents' TBP signage and placement of PPE carts on the 600 Hall. During the interview, the ADON reported he also assumed responsibilities as the facility's Infection Preventionist. At that time, the signage of TBP and placement of PPE carts for newly admitted residents on the 600 Hall were discussed. The ADON reported Resident #65 needed to be on TBP and to have a PPE cart placed next to her door. When asked who was responsible for posting a TBP sign and placing a PPE cart next to the resident's room, the ADON stated, "During the week, I do." The ADON reported the quarantine status of a late Friday or weekend admission sometimes needed to be	F 880	educated by the SDC and/or DON prior to returning to their assignment. Any newly hired personnel will be educated by the SDC during orientation. Monitoring: On April 20,2022 the Quality Assurance and Performance Improvement (QAPI) Committee, consisting of the Director of Nursing, Staff Development Coordinator/Infection Preventionist, Administrator, and Administrative Staff initiated an audit tool to observe for continued compliance with the plan of correction. The audit tool consists of the following: • Staff performing donning of PPE appropriately after exiting room and prior to entering another residents room. • Appropriate transmission-based precautions signage outside the residents door Facility will observe 3 employees weekly to include each shift and weekends for one month to ensure proper donning of PPE, then 3 employees bi-weekly for one month and then 5 employees monthly for one month. The Director of Nursing and/or Staff Development Coordinator/Infection Preventionist and Administrative RN will continue to audit on going.	

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F 880	Continued From page 22 corrected when he came in on Monday. A follow-up interview was conducted on 4/7/22 at 9:34 AM with the ADON. During the interview, he reported the failure to post TBP signage on the weekend was due to a failure of communication between the Admissions staff and nursing. The ADON stated he typically knew about resident admissions ahead of time and would put a TBP order into the electronic medical record for a resident who was either unvaccinated against COVID-19 or whose vaccination status was unknown. An interview was conducted on 4/7/22 at 10:39 AM with the facility's Director of Nursing (DON). During the interview, the DON stated her expectation would be to have a better procedure in place to facilitate communication between Admissions and nursing staff with regards to a newly admitted resident's vaccination status and the need for initiation of TBP. 1-b) Resident #66 was admitted to the facility on 4/1/22 and resided on the 600 Hall. Resident #66's medical record revealed she refused COVID-19 vaccination on 4/4/22 after admission to the facility due to "conscientious objection." A review of the facility's record of the COVID-19 vaccination status of its residents (dated 4/4/22) indicated Resident #66's status as, "Quarantine." An initial tour of the 600 Hall was conducted on 4/4/22 at 9:49 AM. An observation revealed three residents' rooms (Resident #63, Resident #69, and Resident #216) had signage to indicate the	F 880	The Quarantine/Isolation Unit will have an audit conducted three times a week to ensure that appropriate signage is on resident room door. In addition a follow up audit will be conducted at random upon notification of any new COVID + and/or suspected resident. This audit will be conducted 3 times a week for one month and then weekly for one month and then monthly for one month by SDC/DON or designee. QAPI Findings of the audit tools will be reported by the Director of Nursing and/or Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for review times three months for review and further recommendations. Date of completion: April 29,2022	

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	345439	A. BUILDING _____ B. WING _____	C 04/07/2022

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resident was on Transmission Based Precautions (TBP). Each of these three rooms also had a cart containing Personal Protective Equipment (PPE) placed next to the doorway.

An observation conducted on 4/4/22 at 9:48 AM of the 600 Hall revealed there was no signage placed on or near Resident #66's doorway to indicate this resident was on TBP.

An interview was conducted on 4/4/22 at 9:55 AM with Nurse #1. Nurse #1 was assigned to care for residents on the 600 hall. When asked, Nurse #1 reported she thought there were three - 600 Hall residents currently on TBP (Resident #63, Resident #69, and Resident #216).

An observation and interview was conducted with the Assistant Director of Nursing (ADON) on 4/4/22 at 10:02 AM as he was changing the residents' TBP signage and placement of PPE carts on the 600 Hall. During the interview, the ADON reported he also assumed responsibilities as the facility's Infection Preventionist. At that time, the signage of TBP and placement of PPE carts for newly admitted residents on the 600 Hall were discussed. The ADON reported Resident #66 needed to be on TBP and to have a PPE cart placed next to her door. When asked who was responsible for posting a TBP sign and placing a PPE cart next to the resident's room, the ADON stated, "During the week, I do." The ADON reported the quarantine status of a late Friday or weekend admission sometimes needed to be corrected when he came in on Monday.

A follow-up interview was conducted on 4/7/22 at 9:34 AM with the ADON. During the interview, he reported the failure to post TBP signage on the

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weekend was due to a failure of communication between the Admissions staff and nursing. The ADON stated he typically knew about resident admissions ahead of time and would put a TBP order into the electronic medical record for a resident who was either unvaccinated against COVID-19 or whose vaccination status was unknown.

An interview was conducted on 4/7/22 at 10:39 AM with the facility's Director of Nursing (DON). During the interview, the DON stated her expectation would be to have a better procedure in place to facilitate communication between Admissions and nursing staff with regards to a newly admitted resident's vaccination status and the need for initiation of TBP.

1-c) Resident #67 was admitted to the facility on 4/2/22 and resided on the 600 Hall.

Resident #67's medical record revealed she refused COVID-19 vaccination due to "conscientious objection" on 4/4/22 after admission to the facility.

A review of the facility's record of the COVID-19 vaccination status of its residents (dated 4/4/22) indicated Resident #67's status as, "Quarantine."

An initial tour of the 600 Hall was conducted on 4/4/22 at 9:49 AM. An observation revealed three residents' rooms (Resident #63, Resident #69, and Resident #216) had signage to indicate the resident was on Transmission Based Precautions (TBP). Each of these three rooms also had a cart containing Personal Protective Equipment (PPE) placed next to the doorway.

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An observation conducted on 4/4/22 at 9:48 AM of the 600 Hall revealed there was no signage placed on or near Resident #67's doorway to indicate this resident was on TBP.

An interview was conducted on 4/4/22 at 9:55 AM with Nurse #1. Nurse #1 was assigned to care for residents on the 600 hall. When asked, Nurse #1 reported she thought there were three - 600 Hall residents currently on TBP (Resident #63, Resident #69, and Resident #216).

An observation and interview was conducted with the Assistant Director of Nursing (ADON) on 4/4/22 at 10:02 AM as he was changing the residents' TBP signage and placement of PPE carts on the 600 Hall. During the interview, the ADON reported he also assumed responsibilities as the facility's Infection Preventionist. At that time, the signage of TBP and placement of PPE carts for newly admitted residents on the 600 Hall were discussed. The ADON reported Resident #67 needed to be on TBP. He was observed as he moved the PPE cart located next to Resident #69's room to Resident #67's doorway, stating Resident #69 was also admitted over the weekend but was fully vaccinated and did not need to be on TBP. When asked who was responsible for posting a TBP sign and placing a PPE cart next to the resident ' s room, the ADON stated, "During the week, I do." The ADON reported the quarantine status of a late Friday or weekend admission sometimes needed to be corrected when he came in on Monday.

A follow-up interview was conducted on 4/7/22 at 9:34 AM with the ADON. During the interview, he reported the failure to post TBP signage on the weekend was due to a failure of communication

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between the Admissions staff and nursing. The ADON stated he typically knew about resident admissions ahead of time and would put a TBP order into the electronic medical record for a resident who was either unvaccinated against COVID-19 or whose vaccination status was unknown.

An interview was conducted on 4/7/22 at 10:39 AM with the facility's Director of Nursing (DON). During the interview, the DON stated her expectation would be to have a better procedure in place to facilitate communication between Admissions and nursing staff with regards to a newly admitted resident's vaccination status and the need for initiation of TBP.

2) Resident #216 was admitted to the facility on 3/28/22 and resided on the 600 Hall.

Resident #216's medical record revealed she refused COVID-19 vaccination due to "conscientious objection" on 3/28/22 (after admission to the facility).

A review of the facility's record of the COVID-19 vaccination status of its residents (dated 4/4/22) indicated Resident #216 ' s status as, "Quarantine."

An initial tour of the 600 Hall was conducted on 4/4/22 at 9:49 AM. An observation revealed Resident #216's room had signage posted on her door to indicate the resident was on Transmission Based Precautions (TBP). A cart containing Personal Protective Equipment (PPE) was placed in the hallway next to her door.

An observation conducted on 4/4/22 at 12:14 PM

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revealed a TBP sign continued to be posted on Resident #216's door and a cart containing PPE was placed next to her door. At that time, a Certified Occupational Therapy Assistant (COTA) student (COTA Student #1) was observed to enter Resident #216's room without donning a gown. He closed the door behind him. Review of the TBP signage for Special Droplet Contact Precautions posted on the door listed the required PPE to be donned prior to entering the room included a gown, an N95 or higher level respirator, protective eyewear, and gloves.

A continuous observation of the resident's doorway revealed COTA Student #1 exited the resident's room on 4/4/22 at 12:42 PM. Upon his exit, he was observed to be wearing an N95 mask, eye protection and gloves (no gown). The therapist removed his gloves, then went back into the resident's room. Without wearing gloves or a gown, the therapist was observed from the hallway as he picked up the resident's call light and placed it next to her. He again exited the room.

During an interview conducted on 4/4/22 at 12:45 PM, COTA Student #1 identified himself as a Certified Occupational Therapy Assistant student. When asked what PPE he was required to wear upon entering Resident #216's room, the student acknowledged he needed to wear an N95 mask, gown, gloves, and goggles. The student stated he realized he didn't have on a gown only after he had already started the therapy with Resident #216. When asked if he had received orientation at this facility regarding the PPE required to enter a room on TBP, the student said "yes." However, he reported he received so much information that he forgot about the PPE.

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F 880	Continued From page 28 An interview was conducted on 4/5/22 at 10:40 AM with the Assistant Director of Nursing (ADON) on 4/4/22 at 10:02 AM. The ADON also assumed responsibilities as the facility's Infection Preventionist. During the interview, the ADON reported COTA Student #1 would be expected to follow the PPE requirements posted for a resident on TBP. An interview was conducted on 4/7/22 at 10:39 AM with the facility's Director of Nursing (DON). During the interview, the DON stated she would expect COTA Student #1 to observe the TBP signage and wear appropriate PPE when entering a resident's room. The DON reported the facility may need to put a plan into place to ensure a student received more extensive education on Day 1 with the Infection Preventionist prior to assuming resident care duties.	F 880		