STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 COVID-19 focused survey was conducted on 6/13/2022 through 6/16/2022. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart B-Requirements for Long Term Care facilities. Event ID# J8ZZ11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 06/13/2022 through 06/16/2022. The facility was not in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The following intakes were investigated NC00183466, NC00182418, NC00189572, NC00189140, NC00186550 and NC00185954. Four of the 13 complaint allegations were substantiated resulting in deficiencies. Event ID# J8ZZ11.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to provide incontinent care for 1 of 1 dependent resident reviewed for activities of daily living (Resident #1). The findings included:	F 677	1. Resident #1 was provided incontinent care on 6/14/22 by NA #2. 2. An audit was conducted on 7/6/2022 of all incontinent residents to ensure incontinence care is being provided. This audit was completed by front line nurses.	7/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/09/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 677

Continued From page 1

Resident #1 was admitted to the facility on 8/24/18. Resident #1 readmitted on 6/6/22 with diagnoses which included pressure ulcer, chronic pain and neuromuscular dysfunction of bladder.

A review of Resident #1's Minimum Data Set (MDS) coded as a quarterly and dated 4/27/22 revealed Resident #1 was cognitively intact, and he required extensive assistance with bed mobility, toileting, was always incontinent of bowel and had an indwelling catheter.

A review of Resident #1's most current care plan last updated 5/4/22 revealed Resident #1 required maximum to total assist with bathing and toileting. Interventions included to provide incontinence care as needed.

An interview was conducted on 6/13/22 at 3:34PM with Resident #1 which revealed he frequently watched the clock and waited an hour or more to receive incontinence care. The Resident added the facility was very short staffed. He stated that they did not come unless he called and thought that they should check on him regularly.

During an observation of incontinent care on 6/14/22 at 10:44 AM, Nurse Aide (NA) #2 was observed washing resident's right upper arms and chest and then washed his genital area that was soiled with fecal matter. NA #2 continued to wash Resident #1's genital area multiple times as the fecal matter was dried on his scrotum. Resident #1 was turned on the right-side and his buttocks were noted with brownish dried fecal matter, the buttocks were cleansed of fecal matter.

F 677

3. Beginning on 6/17/22, all Licensed Nurses, Certified Nursing Aides, and Nurse Aids in Training will be in-serviced by the Administrator and/or Director of Nursing (DON) on the policy and procedure for incontinence care. To include effective incontinent care, timely incontinence care and toileting assistance. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education after 7/8/2022.

4. Effective 7/11/2022, The Director of Nursing/ Designee will monitor ADL to ensure that incontinent care is performed timely and effective by monitoring 12 resident weekly x 4 weeks, 8 residents weekly for 4 weeks, then 5 resident per week for 4 weeks. The Administrator will review the results of the weekly audit to ensure that incontinence care was provided timely and effectively.

5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

6. Person Responsible: Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE** **LENOIR, NC 28645**

(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 677	Continued From page 2	F 677	and Director of Nursing	

An interview was conducted with Resident #1 on 6/15/22 at 11:51 AM. Resident #1 indicated he had not received routine incontinence care. He stated he had not been offered incontinence care prior to breakfast on 6/14/22 and his bed bath was the first time anyone had checked him for incontinence that morning. He stated he could not feel when he had a bowel movement (BM) and when he smelled feces then he called staff for assistance. Resident stated he did not alert staff, as he was unaware he had a BM, however he felt staff should have checked. He stated the nursing staff did not check him for incontinence unless he notified them.

An interview was conducted with NA #2 on 6/14/22 at 11:20 AM, revealed she was a restorative NA and was not assigned to Resident #1. NA #2 stated she was only helping NA #3.

An interview conducted with Nurse Aide (NA) #3 on 6/16/22 at 9:37AM revealed on 6/14/22 she was assigned to care for Resident #1 on 7:00 AM- 3:00 PM shift. NA #3 stated prior to the bed bath she had not offered incontinence care to Resident #1 on the morning of 6/14/22. NA #3 further explained she had not entered the resident's room from the start of her shift at 7:00 AM until the bed bath was offered at close to 11:00 AM. The NA indicated that incontinence care and morning activities of daily living (ADL) care were not always completed due to lack of nurse aides. NA #3 further stated that there were too many dependent residents and not enough NAs to provide ADL care.

An interview was conducted with the Director of Nursing (DON) on 6/15/22 at 3:45 PM. The DON indicated incontinence care was offered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 677	Continued From page 3 needed and every 2 hours. The DON revealed she expected the NA to do her rounds properly and checked on Resident #1 to ensure he was clean and dry.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to administer an abdominal wound treatment as ordered by the physician for 1 of 3 resident reviewed for wound care (Resident #1). The findings included: Resident #1 was admitted to the facility on 8/24/18. Resident #1 readmitted on 6/6/22 with diagnosis of pressure ulcer of sacral region stage 4, chronic pain and peripheral vascular disease. A review of Resident #1's Minimum Data Set (MDS) coded as a quarterly and dated 4/27/22 revealed Resident #1 was cognitively intact. Skin condition included a stage 3, a stage 4 and an unstageable pressure ulcer that were not present on admission.	F 684	1. Resident #1 received wound care per MD orders on 6/15/22. 2. An audit was conducted on 7/7/22 of all residents with wound care treatments to ensure treatments are being performed as ordered. This audit was completed by the Director of Nursing and Executive Director. 3. Beginning 6/17/22, all Licensed Nurses will be educated by the Director of Nursing and/or Wound Care Nurse on completing wound care treatments as ordered. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education after 7/8/22.	7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 684 Continued From page 4

A review of Resident #1's care plan updated 5/4/22 revealed Resident #1 was care planned for a potential for impaired skin integrity with interventions that included the staff to provide treatments as ordered.

A review of a nursing progress note dated 6/6/22 indicated Resident #1 was readmitted from the hospital and was noted to have wounds to his sacral area and his mid chest.

A review of the June 2022 Treatment Administration record (TAR) revealed the following orders:
6/9/22 and cleanse areas on the abdomen with wound cleanser; apply xeroform and cover with dry dressing daily.

Further review of the June 2022 TAR revealed the abdominal wound dressing order was signed as administered on 6/9/22 and 6/13/22; was not signed as administered on 6/11/22 and 6/12/22 and was indicated with a "N" for not administered on 6/10/22.

An interview with Resident #1 conducted on 6/14/22 at 8:47AM revealed he had not received any dressing changes to his wounds on the weekend of 6/11/22 and 6/12/22.

A telephone interview was conducted on 6/14/22 at 8:07 PM with Medication Aide #1 (Med Aide) who was assigned to Resident #1 on 6/11/22 and 6/12/22. Med Aide #1 reported that she only applied creams and did not do any wound care on her assignment. Med Aide #1 reported she asked Nurse #1 to complete the wound treatments on her patient assignment.

F 684

4. Effective 7/11/22, Director of Nursing or Unit Manager will conduct audits to monitor the completion of wound care per physician orders by randomly monitoring 5 wound treatments weekly x 4 weeks, 3 wound treatments weekly x 4 weeks, then 3 treatments monthly x 2 months. Director of Nursing, Unit manager or ADON will review TARS daily for completion of wound care treatment orders.

5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

6. Person Responsible: Administrator and Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 684	Continued From page 5 A telephone interview was conducted with Nurse #1 on 6/14/22 at 8:09PM. She indicated the Charge Nurse was responsible for completing treatments when a Med Aide was assigned to a medication cart for a hall. Nurse #1 revealed on 6/11/22 and 6/12/22 there was no one assigned as the Charge Nurse. A telephone interview was conducted with Nurse #2 on 6/14/22 at 8:20PM. Nurse #2 stated she worked on 6/11/22 and did not assist the Med Aide with any treatments. An observation of wound care was conducted on 6/14/22 at 11:15 AM. The Assistant Director of Nursing (ADON) changed the dressing to the sacral wound per physician orders. There was no old dressing noted to the abdomen area and the ADON did not complete the treatment and dressing change per physician order. The edges of the abdominal wound were irregular, the area was approximately the size of a nickel, the center of the wound bed was yellow, the peri area was pink and there was no drainage or odor noted. An interview was conducted with the ADON on 6/15/22 at 11:40 AM. The ADON revealed she had not obtained a copy of the TAR or the Physician orders prior to doing the dressing change on 6/14/22. She indicated she was given the dressing change instructions on a slip of paper by the Director of Nursing (DON). The ADON stated she did not know there was a treatment to the abdomen and therefore did not administer a treatment to that area. She explained she typically would have verified the TAR and orders prior to administering the dressing change but did not because the DON asked her to do the treatment because the nurse	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 684	Continued From page 6 on the hall was too busy. A telephone interview was conducted with the Treatment Nurse on 6/16/22 at 10:24AM. She was not aware that Resident #1's treatments for 6/11/22 and 6/12/22 were not administered. She reported she performed the wound care for all residents on a regular basis however, when she was not there or assigned as a floor nurse, the hall nurse was responsible for the treatments on her hall. The Treatment Nurse stated when a Med Aide worked on the hall, the Med Aid applied creams and all other treatments were done by the assigned nurse on the hall. An interview was conducted on 6/15/22 at 3:45 PM with the Director of Nursing (DON). The DON revealed the Treatment Nurse was on vacation and when the wound nurse was not scheduled, the hall nurses were responsible for their own treatments. The DON indicated the ADON was responsible for verifying orders prior to administering treatments. An interview was conducted with the Administrator on 6/15/22 at 3:50PM, which revealed she had identified on 6/13/22 that no nurse completed the treatments for Resident #1 on 6/11/22 and 6/12/22 because he was assigned to a Med Aide. The Administrator indicated that a nurse should have completed the treatments on 6/11/22 and 6/12/22.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 686	Continued From page 7 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform pressure ulcer care as ordered by the physician for 2 of 3 residents reviewed for pressure ulcers (Resident #1 and Resident #7). Findings included: 1. Resident #1 was admitted to the facility on 8/24/18. Resident #1 readmitted on 6/6/22 with diagnosis of pressure ulcer of sacral region stage 4, chronic pain and peripheral vascular disease. A review of Resident #1's quarterly Minimum Data Set (MDS) dated 4/27/22 revealed Resident #1 was cognitively intact. Skin condition included a stage 3; a stage 4 and an unstageable pressure ulcer that were not present on admission. Resident #1 required extensive assistance with bed mobility, toileting, was incontinent of bowel and had an indwelling urinary catheter. A review of Resident #1's most current care plan last updated 5/4/22 revealed Resident #1 was care planned for a pressure ulcer to the sacrum with interventions that included staff to perform	F 686	1. Residents #1 and #7 received pressure ulcer care on 6/13/22. 2. An audit was conducted on 7/7/22 of all residents with pressure ulcers to ensure treatments are being performed as ordered. This audit was completed by the DON and/or Executive Director. 3. Beginning on 6/17/22, all Licensed Nurses will be in-serviced by the Administrator and/or DON on completing wound care treatments as ordered, completing documentation, and overseeing medication aides. Education also included job role of nurse while overseeing to include the completion of wound treatments as ordered. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education after 7/9/22. Staffing Coordinator was provided education on 6/15/22 regarding ensuring that a Licensed Nurse was assigned to oversee Medication Aide.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE** **LENOIR, NC 28645**

(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 686

Continued From page 8

wound care as ordered.

A review of Resident #1's weekly wound assessments indicated the right buttock Stage 3 pressure ulcer as resolved on 5/18/22; the right 4th toe unstageable wound was documented as unchanged on 5/25/22 and the sacral wound was documented as unchanged on 6/8/22.

A review of the Physician orders revealed an order dated 6/8/22 to cleanse sacral area with wound cleaner, apply calcium alginate with silver and gauze island with border daily.

A review of Resident #1's wound physician's evaluation and management summary dated 6/8/22 indicated a treatment plan for the sacral pressure ulcer of alginate calcium with silver and gauze island boarder dressing applied daily.

A review of Resident #1's Treatment Administration Record (TAR) revealed a physician's order dated 6/8/22 to cleanse sacral area with wound cleaner, apply calcium alginate with silver and gauze island with boarder daily at 2:30PM. Further review of the TAR revealed the sacral wound area treatment on 6/11/22 and 6/12/22 was not initialed as completed.

During an interview with Resident #1 on 6/13/22 at 3:34PM, Resident #1 stated the nursing staff had not provided him with wound care to his bottom. He reported he did not refuse care to his sacral area. Resident #1 added he had not received any wound care to his sacrum on 6/11/22 and 6/12/22.

An observation of wound care to Resident #1 was made on 6/14/22 at 11:15AM. The Assistant

F 686

4. Effective 7/11/22, the Director of Nursing or Executive Director will review assignments daily and on Friday for weekend coverage to ensure a nurse is assigned to oversee medication aides regarding performing treatments and other tasks. Director of Nursing, Unit Manager or wound Nurse will monitor wound care dressing changes per physician order by auditing wound treatment orders daily x 4 weeks, then weekly x 4 weeks, then bi-weekly monthly x 4 weeks.

5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

6. Person Responsible: Administrator and Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 686	Continued From page 9	F 686		

Director of Nursing (ADON) administered wound care on Resident #1's sacral pressure ulcer. Observed Resident #1 was positioned on his right side for dressing change. The ADON remove the existing dressing from the pressure ulcer, the existing dressing was not dated. The existing dressing was observed with a moderate amount of drainage. The wound bed was observed with no slough noted. The wound edges were well defined. The area around the wound was red in color and noted with some maceration. The ADON cleansed the wound with wound cleaner and applied the calcium alginate with silver. The ADON then applied a border dressing to the area.

A telephone interview was conducted on 6/14/22 at 8:07PM with Medication Aide #1 (Med Aide) who was assigned to Resident #1 on 6/11/22 and 6/12/22. Med Aid #1 reported that she only applied creams and did not do any wound care on her assignment. Med Aide #1 reported she asked Nurse #1 to complete the wound treatments on her patient assignment.

A telephone interview was conducted with Nurse #1 on 6/14/22 at 8:09PM. Nurse #1 indicated when she worked with a Med Aide, she was uncertain of her responsibilities concerning wounds. She reported Med Aide #1 asked her to complete wound care on one of Med Aide #1's assigned residents. She indicated the Charge Nurse was responsible for completing the Med Aide treatments, which included pressure ulcer treatments. Nurse #1 revealed on 6/11/22 and 6/12/22 there was no one assigned as the Charge Nurse.

A telephone interview was conducted with Nurse #2 on 6/14/22 at 8:20PM. Nurse #2 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 686	Continued From page 10	F 686		

worked on 6/11/22 and did not assist the Med Aide with any treatments. She further reported that the delegated nurse was responsible for assisting the Med Aide with her notes, IVs and treatments. She added the Administrator was responsible for delegating which nurse assisted the Med Aide.

A telephone interview was conducted with the Treatment Nurse on 6/16/22 at 10:24AM. She was not aware that Resident #1's treatments for 6/11/22 and 6/12/22 were not administered. She reported she performed the wound care for all residents on a regular basis however, when she was not there or assigned as a floor nurse, the hall nurse was responsible for the treatments on her hall. The Treatment Nurse stated when a Med Aide worked on the hall, the Med Aid applied creams and all other treatments were done by the assigned nurse on the hall. She revealed Resident #1 had not refused his sacral treatments.

An interview was conducted with the Physician Assistant (PA) on 6/15/22 at 12:37. The PA revealed she expected wound care to be performed as ordered.

An interview was conducted with the Administrator on 6/15/22 at 3:50PM, which revealed she had identified on 6/13/22 that no nurse was assigned to the Med Aide on 6/11/22 and 6/12/22. The Administrator indicated that a Nurse should have completed Resident #1's treatment for the Med Aide on 6/11/22 and 6/12/22.

2. Resident #7 was admitted to the facility on 5/11/2022 with diagnoses of stroke, seizure, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 686	Continued From page 11 impaired mobility. A review of the admission Minimum Data Set (MDS) assessment dated 5/18/2022 revealed Resident #7 had severely impaired cognition, required extensive assistance with activities of daily living (ADLs) and was always incontinent of bowel and bladder. Skin condition included stage 3 pressure ulcers on admission. A review of the care plan dated 5/23/2022 revealed stage 3 pressure ulcers to left lateral knee, left lateral ankle, left lateral foot, right lateral ankle, right lateral foot, and right heel with interventions perform wound care as ordered. A review of Resident #7 weekly wound evaluation and management on 6/8/2022 revealed the left lateral knee stage 3 pressure ulcer as no change, the left lateral ankle stage 3 pressure ulcer as no change, the left lateral foot stage 3 pressure ulcer as no change, right lateral foot stage 3 pressure ulcer as improved, right lateral ankle stage 3 pressure ulcer as no change, and right heel stage 3 pressure ulcer as no change. A review of physician orders on 6/8/2022 revealed apply betadine to left lateral ankle and left lateral foot daily until 6/15/22. Further review of physician orders on 6/8/2022 revealed apply calcium alginate with silver and cover with bordered dressing to left lateral knee, right lateral foot, right lateral ankle, and right heel daily. Review of the treatment administration record (TAR) revealed a physician's order dated 6/8/2022 to clean and apply betadine daily to left lateral ankle and left lateral foot on 6/11/2022 and 6/12/2022 at 2:30 PM. Review of the TAR	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 686	Continued From page 12	F 686		

revealed the left lateral ankle and left lateral foot wound area treatment on 6/11/2022 and 6/12/2022 with no signatures.

Review of the TAR revealed a physician's order dated 6/8/2022 to apply calcium alginate with silver with gauze and border dressing daily to left lateral knee, right lateral foot, right lateral ankle, and right knee on 6/11/2022 and 6/12/2022 at 2:30 PM. Review of the TAR revealed the left lateral knee, right lateral foot, right lateral ankle, and right knee wound area treatment on 6/11/2022 and 6/12/2022 with no signatures.

A telephone interview was conducted on 6/14/2022 at 8:07 PM with Medication Aide #1 (Med Aide) who was assigned to Resident #7 on 6/11/2022 and 6/12/2022. Med Aide #1 reported that she only applies creams and does not do any wound care on her assignment. Med Aide #1 reported she asked Nurse #1 to complete wound treatments on her patient assignment.

A telephone interview was conducted with Nurse #1 on 6/14/2022 at 8:09 PM. She reported Med Aide #1 asked her to complete wound care on one of Med Aide #1 assigned residents. The Charge Nurse was responsible for completing the Med Aide's treatments that included pressure ulcer treatments. On 6/11/2022 and 6/12/2022 there was no one assigned as the Charge Nurse.

A telephone interview was conducted with Nurse #2 on 6/14/22 at 8:20 PM. Nurse #2 stated she worked on 6/11/2022 day shift and did not assist the Med Aid with any treatments. She further reported that the delegated nurse was responsible for assisting the Med Aide with her notes, IVs, and treatments. She added the

(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 686	Continued From page 13 Administrator was responsible for delegating which nurse assisted the Med Aide. An interview was conducted with the Physician Assistant (PA) on 6/15/2022 at 12:37 PM. The PA revealed she expected wound care to be performed as ordered. An interview conducted with the Administrator on 6/16/2022 at 8:40 AM revealed that Med Aides were scheduled on the assignment sheets but no assigned Nurse to provide oversight to the Med Aide. The Administrator explained that the scheduler did not think to provide oversight to the Med Aide to ensure that wound care would be provided. The Administrator further explained that she realized that wound care had not been done when she returned from vacation. The Administrator explained that she instructed the Director of Nursing to educate, monitor and audit throughout the weekend. The Administrator revealed that residents on 200 hall had no wounds that deteriorated but improved.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 690	Continued From page 14 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide catheter care for 1 of 1 resident reviewed for indwelling catheters. (Resident #1) Findings included: Resident #1 was readmitted to the facility on 6/6/22 with diagnosis of urinary tract infection (UTI), retention of urine and neuromuscular dysfunction of bladder. A review of Resident #1's most recent Minimum Data Set (MDS) coded as a quarterly and dated 4/27/22 indicated resident #1 was cognitively	F 690	1. Resident #1 received proper foley care on 6/17/2022. 2. An audit of all residents with foley catheters was performed on 7/6/22 by the Director of Nursing to observe for proper catheter care. No other concerns were observed and staff were re-educated regarding proper hand hygiene. 3. Beginning 6/17/22, all Licensed Nurses, Certified Nursing Aides and Nurse Aids in Training will be in-serviced by the Director of Nursing and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 690

Continued From page 15

intact and had an indwelling catheter.

A review of Resident #1's most current care plan last updated 5/4/22 revealed Resident #1 was care planned for risk of UTI's secondary to history of UTI's. The interventions included to observe standard precautions and provide catheter care per protocol.

A physician order dated 6/6/22 revealed to provide indwelling catheter care every shift.

Review of a physician progress note dated 6/8/22 read, Resident #1 with a chronic indwelling catheter was admitted to the hospital for catheter associated UTI. The assessment and plan read to continue with catheter care daily and change catheter tubing every 3 weeks.

An interview was conducted with Resident #1 on 6/13/22 at 3:34PM. Resident #1 indicated that the nursing staff failed to provide good catheter care.

During an observation of catheter care on 6/14/22 at 10:44AM, Nurse Aide (NA) #2 was observed washing Resident #1's right upper arms and chest. Nursing Assistant (NA) #2 with the same washcloth proceeded to wipe downward on the penis. NA #2 then wiped between the thigh and groin area. NA #2 failed to retract the foreskin of the penis and clean the urethra or the catheter tubing.

An interview was conducted with NA #2 on 6/14/22 at 11:20AM. NA #2 revealed with catheter care she was trained to clean around the penis and then clean the area around the catheter. NA #2 indicated she should have cleaned the entire penis and the catheter tubing.

F 690

Executive Director on the policy and procedure for catheter care. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education after 7/8/22.

4. Effective 7/11/22, the DON and/or Unit Manager will perform audits for residents with foley catheters for proper catheter care, 3 residents 3 times weekly for 4 weeks, 2 residents 3 times weekly for 4 weeks, then 3 residents weekly for 4 weeks.

5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance

6. Person Responsible: Administrator and Director of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 690	Continued From page 16 An interview conducted with the Physician Assistant (PA) on 6/15/22 at 12:37PM revealed she expected residents with a history of UTI's and at risk for infection, would receive proper peri care and catheter care. The PA indicated catheter care included cleansing around the urethral opening and the catheter tubing as well as monitoring for infection. An interview was conducted with the Director of Nursing (DON) on 6/15/22 at 3:30PM. The DON indicated that catheter care was done every shift and included pulling back the foreskin on a male and cleaning the entire shaft of the penis and around the urethral opening. She revealed as a part of catheter care the catheter tubing should be cleansed. The DON revealed the facility had no specific education on catheter care. She indicated the staff should know how to properly clean an indwelling catheter.	F 690		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 725	Continued From page 17	F 725		

by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in delayed incontinence care. This affected one resident (Resident #1).

The findings included:

This tag is cross referred to:

F677- Based on observations, record review, staff and resident interviews, the facility failed to provide incontinent care for 1 of 1 dependent resident reviewed for activities of daily living (Resident #1).

An interview conducted with Nurse Aide (NA) #4 on 6/13/22 at 2:42PM. NA #4 indicated there was not enough nurse aides on the schedule, making it "impossible" to provide bed baths and showers. NA #4 explained that most residents required 2 nurse aides for assistance but there was not always two nurse aides assigned to a hall during the morning and evening shift making it a

1. Facility failed to provide sufficient nursing staffing, as evidenced by incontinence care not being provided (Resident #1). Resident #1 was provided incontinent care on 6/14/22 by NA #2.

2. An audit was conducted of the last 10 days by the Executive Director to ensure staffing was adequate for resident census. This audit was completed on 7/1/22.

3. Administrator educated Director of Nursing on the requirement to properly staff the facility based upon facility census. This education was completed by 7/5/22.

Beginning 6/17/22, all Licensed Nurses, Certified Nursing Aides and Nurse Aids in Training will be in-serviced by the Director of Nursing or Executive Director on effective and timely incontinent care. All newly hired employees will receive the education in new hire orientation. No

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 725	Continued From page 18 challenge to find assistance. An interview was conducted with NA #5 on 6/13/22 at 2:58 PM revealed call outs were frequent and resulted in an increase in workload preventing nurse aides from providing incontinence care as often as they should. An interview was conducted with NA #6 on 6/15/22 at 3:06PM. NA #6 indicated residents did not receive timely incontinence care, because the facility did not have enough nurse aides to provide the care. An interview was conducted on 6/15/22 at 3:45PM. Nurse #3 stated she at times she provided patient care, as well as her assigned nursing duties to ensure residents received care. An interview was conducted with the Scheduler (who was also a NA) on 6/16/22 at 9:48AM, revealed the Administrator determined the staffing needs by the census. She indicated when staff called out, she adjusted the patient assignment with the staff that were already on the schedule, or she assigned herself and she worked that assignment. She added the nurses and restorative NAs were expected to assist with patient care. An interview was conducted on 6/16/2022 at 12:25 PM with the Administrator indicated they were short of Nurse Aides. The facility had concerns that patient care was not completed. They had been working to increase staffing. The Administrator added the facility needed to hire 5 to 8 NAs.	F 725	employee will be allowed to work without the education after 7/8/22. 4. Beginning 7/11/22, Administrator and/or DON will monitor daily staffing schedule 5 times per week x 12 weeks. Administrator and/or DON will conduct daily labor meeting (Mon-Fri) to ensure staffing numbers are adequate to meet resident needs daily. Administrator will enlist the assistance from outside staffing agencies to supplement facility staff if needed. Administrator will work with Human Resources and Regional Director to ensure ads are current and recruiting process is being followed. Administrator will review applicant through advertising platform JassHR for timely response and interview scheduling. The facility is also hosting job fairs monthly and participating in any local in-person and virtual job fairs being held. 5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 6. Person Responsible: Administrator and Director of Nursing	
F 867 SS=D	QAPI/QAA Improvement Activities	F 867		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 867	Continued From page 19 CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place after the last recertification survey which ended 7/9/2021 for their failure to provide activities of daily living (ADL) care for dependent residents, sufficient nursing staffing, and infection control practices. These areas were recited again during the follow up survey and complaint investigation completed 9/8/2021. The continued failure of the facility during three federal surveys shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to: F677- Based on observations, record review, staff and resident interviews, the facility failed to provide incontinent care for 1 of 1 dependent resident reviewed for ADL Care for dependent residents (Resident #1). During the recertification survey completed 7/9/2021, the facility failed to provide showers as scheduled to 7 of 14 residents reviewed for	F 867	Effective 6/16/2022 resident #1 incontinence care were completed as needed by nursing staff. As of 6/17/2022 staff have been provided education on proper hand hygiene as per facility policy. Review of Prior Quality Assurance plan should have been continued longer. Quality Assurance plan will continue for 12 months to ensure continued compliance for infection control, staffing, and ADL care. On 7/7/2022 the Regional Director of Operations educated the administrator on facility policy and procedure in regard to reviewing any improvement plans to ensure procedures and monitoring are in place. Administrator will monitor all active performance improvement plans monthly x3 months to ensure all improvement plans are being implemented and monitored for improvement. Administrator will review Infection control, staffing and ADL care plans for 12 months for continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 867	Continued From page 20 assistance with activities of daily living. During the complaint investigation and follow up survey completed 9/8/2021, the facility failed to provide showers or bed baths for 1 of 3 dependent residents reviewed for ADL Care for dependent residents. F725- Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff for 1 of 1 resident (Resident #1) resulting in delayed incontinence care. During the recertification survey completed 7/9/2021, the facility failed to provide sufficient nursing staff, resulting in missed showers for dependent residents and incontinence care not being provided for 10 of 10 residents reviewed for staffing. During the complaint investigation and follow up survey completed 9/8/2021, the facility failed to provide sufficient nursing staff resulting in missed showers for 1 of 3 dependent resident reviewed for staffing. F880- Based on observation, staff interviews, and record review, the facility failed to ensure 3 of 4 nursing staff performed hand hygiene after removing gloves during a dressing change and Activities of Daily Living (ADL) care for 1 of 1 resident (Resident #1). During the recertification survey completed 7/9/2021, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment	F 867	Administrator will report findings to Quality Assurance Performance Improvement committee for any needed improvement monthly x 6 months. Infection control and wound plans will be reviewed for 12 months to ensure compliance. Completion Date: July 15, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 867	Continued From page 21 (PPE) when 1 of 2 staff members failed to wear an N95 mask, eye protection, gown and gloves prior to entering the room of 1 of 1 resident on enhanced droplet isolation. Staff also failed to disinfect a glucometer after use on 1 of 3 residents reviewed for infection control. During the complaint investigation and follow up survey completed 9/8/2021, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 1 staff member failed to wear eye protection prior to entering the room of 1 of 3 residents on enhanced droplet isolation. An interview on 6/16/2022 at 12:25 PM with the Administrator indicated staffing and the inability to complete resident care had continued to be a problem. The Administrator stated that the census was kept to 70-80 residents and one hall closure was due to lack of staffing. The staff and department heads would help, and bonuses were offered to staff that stayed to work the next shift. The Administrator revealed that the facility had a recruitment event to increase staffing and five agencies were consulted to staff the facility. The Administrator indicated the facility needed five to eight additional Nurse Aides (NA) to manage resident care. The Administrator voiced that nursing staff should have washed their hands prior to donning clean gloves and prior to exiting the resident's room. Staff would need continued education and monitoring related to handwashing and infection control practices.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 23 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure 3 of 4 nursing staff, Nurse Aide (NA) #1; NA #2 and the Assistant Director of Nursing (ADON), performed hand hygiene after removing gloves during a dressing change and Activities of Daily Living (ADL) care for Resident #1. Findings included: The facility policy entitled, "Hand Hygiene" was	F 880	On 7/7/22, current facility staff working in isolation areas, providing incontinent care and wound care were visually observed by the Executive Director (ED) and Director of Nursing (DON) for proper hand sanitation including hand washing before exiting isolation areas, during incontinent care and before/during wound care. The NA #1 and NA #2 were re-educated by the Nursing Home Administrator on 7/5/2022 on the proper procedure for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 24 revised July 2021. The procedure section, step 7, indicated staff were to perform hand hygiene according to the Centers for Disease Control (CDC) guidelines. The steps included: b. before and after touching the resident or the resident's surroundings; f. after removing gloves; h. before and after performing any invasive procedure (i.e., dressing change) i. before and after entering isolation precaution settings and j. before and after performing resident care. 1a. A continuous observation was made on 6/14/22 at 11:15 AM of the Assistant Director of Nursing (ADON). The ADON entered the room with mask, gown and donned gloves. The ADON removed a sacral wound dressing that was soiled with a moderate amount of drainage. She removed gloves without washing or disinfecting her hands and continued to don new gloves. The ADON then finished her wound care to the sacral wound, doffed gloves and exited the room to obtain treatment supplies for the resident's left thigh wound, without washing hands. At 11:30 AM the ADON was observed outside the resident's room with wound care supplies in hand. No hand washing was observed. The ADON then donned gown and gloves and re-entered Resident #1's room. The ADON administered wound care to the left thigh. The left thigh wound was noted to be bleeding with bright redness noted to the circular wound bed. The ADON cleansed the wound and discarded the visibly reddened soiled gauze. She removed her gloves and did not wash her hands. The ADON donned new gloves and finished the dressing change. The ADON completed the wound care to the left thigh and removed her gown, gloves and mask. The ADON exited the room without washing her hands. The ADON walked to the nurse's station, retrieved a mask	F 880	hand hygiene upon changing gloves during incontinent care and upon leaving an isolation room. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) was re-educated and competency checks on hand hygiene and wound care was performed by the Regional Nurse Consultant on 7/7/22 to include proper hand hygiene during care tasks. The ED started re-education to the current facility staff on hand sanitation using the CMS recommended “Clean Hands” YouTube video in addition to facility procedures for hand hygiene, performing wound care and incontinent care. The Director of Nursing will continue the education which will be completed on 7/8/2022. This education will be a part of new staff orientation. The ED and DON will complete Module 7: Hand Hygiene of the CDC Infection Prevention training thru CDC TRAIN to improve their ability to train staff on proper hand hygiene and monitor adherence to performance of proper hand hygiene. Training will be completed by 7/8/22. On 7/11/2022, Administrator will implement more surveillance rounds to ensure the staff is complying with hand hygiene procedures with assigning members of the facility leadership to perform hand hygiene observations during weekly ambassador rounds for a total of 9 staff members weekly. The DON and/or ADON will perform hand	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(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 25 and put the mask on Resident #8's face. The ADON then walked to the medication room and washed her hands. An interview was conducted with the ADON on 6/15/22 at 11:20 AM. The ADON stated she was not aware the policy indicated the need for hand hygiene prior to administering wound care. The ADON indicated she should have washed her hands after removing her gloves, prior to leaving the resident's room and prior to placing a mask on the face of Resident #8. 1b. An observation of incontinent care was made on 6/14/22 at 10:44 AM. Nurse Aide (NA) #2 was observed washing Resident #1's right upper arms and chest. NA # 2 then washed Resident #1's penis and scrotum, which was noted with fecal matter. The soiled washcloth was given to NA #3 who placed it in a bag. NA #2 entered the bathroom, removed her gloves, and donned new gloves. NA # 2 did not wash her hands. Resident #1 was turned on the right-side and his buttocks were noted with brownish fecal matter. NA #1 washed between resident's buttocks. Fecal matter was observed on the washcloth. NA #1 proceeded with soiled washcloth to wipe Resident #1's lower back and then his upper back with the soiled washcloth. NA #1 then handed the washcloth to NA #3, who placed it in a bag. NA #1 removed her gown, gloves and exited the room. NA #1 did not wash her hands. An interview was conducted with NA #2 on 6/14/22 at 11:20 AM. NA # 2 revealed she should have washed her hands between glove changes. An interview was conducted with NA #1 on 6/14/22 at 2:48 PM. NA #1 indicated she should	F 880	hygiene audits during wound care and ADL care randomly on 5 employees weekly x 4 weeks, 3 employees weekly time 4 weeks then 5 employees monthly x 1 month. Administrator will report findings to Quality Assurance Performance Improvement committee for any needed improvement monthly x 6 months. Infection control and wound plans will be reviewed for 12 months to ensure compliance. Completion date: 7/12/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	C 06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE LENOIR, NC 28645**

(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 26 have washed her hands prior to leaving the room. An interview was conducted with the Administrator on 6/16/22 at 9:26 AM. The Administrator indicated the nursing staff should have washed their hands prior to donning clean gloves and prior to exiting the resident's room.	F 880		