STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 08/03/2022

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ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 7/24/22 through 8/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# EEAC11.	E 000		
F 000	INITIAL COMMENTS A recertification survey, complaint investigation and extended survey was conducted on 07/24/22-8/3/22 for Event # EEAC11. 1 of 13 allegations were substantiated. Intake #NC00186945 and NC00189771. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25(d)(1)(2) at tag F689 at a scope and severity (J) The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/21/22 and was removed on 7/28/22.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		8/22/22

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

Electronically Signed | 08/22/2022

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F 580	Continued From page 1	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews, the facility failed to immediately notify the family of a resident's change in condition for 1 of 1 residents reviewed for notifications (Resident #141). After the resident's knees buckled and she slid down during a mechanical lift transfer on 1/21/22, Nurse #8 assessed the resident for pain and swelling in her right leg. Nurse #8 obtained orders for x-rays but did not notify the family of Resident #141's right leg pain, swelling, and orders for x-rays. The family was notified on 1/22/22 by Nurse #10 when Resident #141 was transferred to the hospital. The Findings included: Resident #141 was admitted to the facility on 1/9/18. The annual Minimum Data Set (MDS) dated 9/14/21 revealed Resident #141 was moderately cognitively impaired. The facility investigation guide dated 1/28/22 indicated on 1/21/22 at 11:30 AM, NA #6 transferred Resident #141 using the mechanical lift. During the transfer, the resident's legs buckled, and the NA left the room to seek assistance. The NA returned with Housekeeper #1 and transferred the resident back to bed by lifting her off of the stand lift. There were no reports of pain from the resident when she was placed back in the bed. The NA went into the room around 1:30 PM to provide care to the resident. The resident complained of pain at that time and NA #6 notified the nurse of the resident's pain but didn't notify the nurse of the resident's leg slipping off of the lift platform. Nurse #8 assessed the resident to have right	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F580 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #141 is deceased therefore no corrective action was required. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected. On 08/03/2022, the Director of Nurses (DON) initiated an audit of 100% of resident falls from July 1, 2022 □ August 3, 2022 to identify if notification was completed to include immediate notification which includes; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident	

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knee swelling and notified the physician. She received orders to obtain x-rays.

An interview was conducted with Resident #141's family member on 7/24/22 at 1:47 PM. The family member stated Resident #141 broke her leg on Friday, 1/21/22. The family member was not notified until Saturday, 1/22/22 in the afternoon. The nurse at the facility informed the family member that Resident #141's leg was broken, and they were sending the resident to the emergency room (ER).

A progress note written by Nurse #8 dated 1/24/22 (noted to be a late entry for 1/21/22) revealed NA #6 informed Nurse #8 that Resident #141 had been complaining of right knee pain. Nurse #8 assessed Resident #141 and determined the resident's right foot was lying to the right side and her knee was swollen. Nurse #8 called the doctor and received orders for x-rays. There was no documentation of the family being notified of Resident #141's change of condition on 1/21/22.

During an interview with Nurse #8 on 07/28/22 at 11:58 AM, she stated she did not recall notifying the family of Resident #141's swelling, pain, and orders for x-rays.

A progress note written by Nurse #10 dated 1/22/22 at 4:12 PM revealed she notified the physician that x-rays could not be done until the morning due to inclement weather. The physician ordered the resident to be transferred to the hospital for evaluation. Nurse #10 notified the family of Resident #141's transfer to the ER. The resident left the facility at 3:45 PM.

which results in injury and has the potential for requiring physician intervention. The audit revealed that proper notification was completed in 34 of 34 falls.
3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education:
On 07/27/2022 the DON and Assistant Director of Nurses began in servicing of all Licensed Nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and Certified Nursing Assistants (CNA□s) (full time, part time, and prn including agency staff) on change in condition related to falls. Staff were educated on examples of change in conditions, what to do when a change in condition is identified, how to document a change in condition, and who to notify when there is a change in condition. This was completed 08/22/2022.

Falls will continue to be reviewed by the DON and Nurse Managers to include the Staff Development Coordinator (SDC) Nurse, and the Minimum Data Set (MDS) Nurse during clinical to ensure notifications were completed according to the policy. Additionally, on 08/22/2022, the DON initiated education titled Nurse Managers Fall Review Notification to the nurse managers that included education on falls and the notification process. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the

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F 580	Continued From page 4 The facility incident report dated 1/21/22 at 11:30 AM revealed the family was notified of Resident #141's transfer to the emergency room (ER) on 1/22/22 at 3:40 PM. On 7/26/22, attempts to interview Nurse #10 were unsuccessful. An interview was conducted with the Administrator on 07/28/22 at 1:50 PM. She stated the nurse should have immediately notified the family after assessing the resident to have pain and needing x-rays on 1/21/22.	F 580	change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/22/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that notification for falls have been completed timely using the F580 Quality Assurance Tool. Monitoring of 6 resident falls will be monitored to assure compliance with falls notification. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with notification process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/22/2022	

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F 684 SS=J	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, record review and staff and Physician interviews, the facility failed to have a nurse assess Resident #141 after the resident's knees buckled during a standing mechanical lift transfer and was assisted to the floor. Nurse Aide (NA) #6 and Housekeeper #1 transferred the resident back to bed without reporting the fall to the nurse. When Resident #141 complained of pain, later in the shift, she was assessed by the nurse, and x-rays were ordered. Sometime after the nurse assessed Resident #141 for pain, NA #6 reported the fall to the nurse. The resident was evaluated at the hospital on 1/22/22 and had a right femur fracture resulting in Resident #141 undergoing orthopedic surgery. This was for 1 of 2 residents reviewed for accidents (Resident #141). Immediate jeopardy began on 1/21/22 when the facility failed to ensure Resident #141 was assessed immediately after she slid down during a mechanical lift transfer. The NA left the resident to get help and the resident was moved without a nurse assessment. Immediate jeopardy was removed on 7/28/22 when the facility implemented an acceptable credible allegation of	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #141 was deceased on 03/15/2022 and is no longer a resident of the facility. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	8/22/22

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F 684	Continued From page 6 immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put in place are effective. The findings included: Resident #141 was admitted to the facility on 1/9/18. Diagnoses included dementia, right femur fracture, fracture around prosthetic right knee joint, and osteoarthritis. Resident #141's care plan dated 11/30/20, that was active on 1/21/22 for activities of daily living (ADLs) self-care performance deficit listed interventions of required two staff member assistance with all transfers and changes in ADL ability reported to the nurse as needed. The annual Minimum Data Set (MDS) dated 9/14/21 revealed Resident #141 was moderately cognitively impaired and required two-person extensive assistance for transfers. A progress note written by Nurse #8 dated 1/24/22 (noted to be a late entry for 1/21/22) revealed NA #6 informed Nurse #8 that Resident #141 had been complaining of right knee pain. Nurse #8 assessed Resident #141 and determined the resident's right foot was lying to the right side and her knee was swollen. Nurse #8 called the doctor and received orders for x-rays. The resident was administered pain medication. A progress note written by Nurse #10 dated 1/22/22 at 4:12 PM revealed she notified the	F 684	On 01/26/2022, the Director of Nurses, Rehab Manager, and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing the stand assist lift. This audit was completed on 01/26/2022. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer. This care plan update was completed on 01/28/2022. On 01/31/2022 the QA Nurse Consultant completed a review to ensure that no other resident had fallen from a lift and not been assessed immediately by the nurse for a change in condition. This audit reviewed all falls from January 11 - 24, 2022. There were no residents identified as having a fall during this audit. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 07/27/2022, the Director of Nurses began reeducating all staff in all departments (agency, full time, part time, and prn employees) on falls education. This education included the need for nursing assistants and other staff that witness a fall or lift event to notify the primary nurse immediately. Education also included that the nurse must assess	

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physician that x-rays could not be done until the morning due to inclement weather. The physician ordered the resident to be transferred to the hospital for evaluation. The resident left the facility at 3:45 PM.

Hospital records dated 1/22/22 revealed Resident #141 presented with right thigh and hip pain that had been ongoing for two days. It was assessed to be constant pain that worsened with movement. Resident #141 denied trauma or fall and endorsed poor memory. An x-ray was performed and revealed right femur fracture. Resident #141 was transferred to another hospital for orthopedic surgery. The resident returned to the facility on 2/1/22.

The facility investigation guide dated 1/28/22 indicated on 1/21/22 at 11:30 AM NA #6 transferred Resident #141 using the mechanical lift. During the transfer, the resident's legs buckled, and the NA left to seek assistance. The NA returned with Housekeeper #1 and transferred the resident back to bed by lifting her off of the stand lift. There were no reports of pain from the resident when she was placed back in the bed. The NA went into the room around 1:30 PM to provide care to the resident. The resident complained of pain at that time and NA #6 notified the nurse of the resident's pain but didn't notify the nurse of the resident's leg slipping off of the lift platform. Nurse #8 assessed the resident and notified the physician.

An interview was conducted with NA #6 on 7/26/22 at 2:45 PM. NA #6 stated on 1/21/22 she was assisting Resident #141 from the bed to the wheelchair using the sit to stand lift without another person. During the transfer, Resident

for changes in condition. This education was completed on 08/22/2022.

On 7/27/2022 the Director of Nurses and Administrator reviewed all licensed nurses and certified nursing assistants (including agency, full time, part time, and prn employees) to validate that a skills validation for lift use had been completed within the past year. Employees who had not completed a lift skills validation in the last year had their lift skills validated by the Director of Nurses, Assistant Director of Nurse, and the Staff Development Coordinator on 08/22/2022. Any employee who was not able to complete the validation will not be allowed to work until they complete the training. The Director of Nursing will notify the staffing coordinator of any employee that cannot work until this is completed.

On 7/27/2022 the Director of Nurses and Administrator reviewed all staff in all departments (including agency, full time, part time, and prn employees) to validate that a skills validation for falls had been completed within the past year. Employees who had not completed a falls validation in the last year for falls to include immediate notification of the nurse with any falls, had their skills validated by the Director of Nurses, Assistant Director of Nurse, and the Staff Development Coordinator on 08/22/2022. Any employee who was not able to complete the validation will not be allowed to work until they complete the training. The Director of Nursing will notify the staffing

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F 684	Continued From page 8 #141 began sliding to the floor. NA #6 went to get another staff member to help her with the transfer and she returned with Housekeeper #1. NA #6 stated Resident #141 had slid down more by the time she returned with Housekeeper #1. NA #6 revealed she and Housekeeper #1 slid resident #141 all the way down to the floor then helped her from the floor to the bed. NA #6 explained Resident #141 did not appear to be in pain. NA #6 informed Nurse #8 when Resident #141 began to complain of pain while care was provided but did not immediately inform the nurse following the incident with the transfer. On 7/26/22 at 4:26 PM an interview was conducted with Housekeeper #1. He stated NA #6 came to get him to assist with Resident #141. When Housekeeper #1 and NA #6 arrived at the resident's room, Resident #141 was holding on to the lift, leaning against the bed with one knee bent, and close to the floor. They tried to lift Resident #141 but could not, so NA #6 lowered the resident to the floor. NA #6 and Housekeeper #1 assisted Resident #141 to the bed by picking her up. Housekeeper #1 stated the resident didn't yell or scream that she was in pain. He did not notify the nurse. An interview was conducted with Nurse #8 on 7/27/22 at 7:54 AM. Nurse #8 stated on 1/21/22 NA #6 informed the nurse Resident #141 was complaining of pain. She stated she was notified of the resident's pain sometime between 1:00 PM and 3:00 PM. Nurse #8 stated NA #6 did not tell her about the transfer incident at that time, but later NA #6 told Nurse #8 about the resident sliding down to the floor during the transfer. Nurse #8 assessed Resident #141 and stated the resident's foot was turned to the side and her	F 684	coordinator of any employee that cannot work until this is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that notification for falls have been completed timely using the F684 Quality Assurance Tool. Monitoring of 6 resident falls will be monitored to assure compliance with post fall processes to include notification of the nurse and skills validation of falls. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance with notification process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/22/22	

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knee was swollen. Nurse #8 revealed she called the physician, received orders for an x-ray, and gave the resident pain medications.

On 1/21/22 at 3:16 PM, the medication administration record (MAR) for Resident #141 revealed she received tramadol (pain medication) for a pain rating of "9" out of 10. The pain medication was assessed to be effective for the resident.

On 7/27/22 at 9:12 AM an interview was conducted with Physician #2. Physician #2 stated when the nurse called the on-call doctor on 1/21/22, she received orders for x-rays. The nurse didn't explain what happened to the resident when she called the doctor on 1/21/22.

An interview was conducted with the Director of Nursing (DON) on 7/28/22 at 11:35 AM. The DON stated nurses should be immediately notified after a fall or incident and before moving a resident. The nurse should have been told about Resident #141's transfer so an immediate assessment could be completed.

On 7/28/22 at 1:50 PM an interview was conducted with the Administrator. The Administrator stated NAs were expected to notify the nurse of any falls or incidents that occurred.

The Administrator and Nurse Consultant were verbally notified of Immediate Jeopardy for F684 on 7/27/22 at 11:33 AM.

The facility provided a credible allegation of Immediate Jeopardy removal that was accepted on 7/28/22:

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Removal Plan F684

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #141 was deceased on 03/15/2022 and is no longer a resident of the facility.

On 01/26/2022, the Director of Nurses, Rehab Manager, and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing the stand assist lift. This audit was completed on 01/26/2022. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer. This care plan update was completed on 01/28/2022.

On 01/31/2022 the QA Nurse Consultant completed a review to ensure that no other resident had fallen from a lift and not been assessed immediately by the nurse for a change in condition. This audit reviewed all falls from January 11 - 24, 2022. There were no residents identified as having a fall during this audit.

2. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 01/25/2022, the Director of Nurses began in servicing all staff in all departments (agency, full time, part time, and prn employees) on falls

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education. This education included the need for nursing assistants and other staff that witness a fall or lift event to notify the primary nurse immediately. Education also included that the nurse must assess for changes in condition. This education was completed on 02/01/2022.

On 7/27/2022 the Director of Nurses and Administrator reviewed all licensed nurses and certified nursing assistants (including agency, full time, part time, and prn employees) to validate that a skills validation for lift use had been completed within the past year. Employees who had not completed a lift skills validation in the last year had their lift skills validated by the Director of Nurses, Assistant Director of Nurse, and the Staff Development Coordinator on 7/27/2022. Any employee who was not able to complete the validation will not be allowed to work until they complete the training. The Director of Nursing will notify the staffing coordinator of any employee that cannot work until this is completed.

On 7/27/2022 the Director of Nurses and Administrator reviewed all staff in all departments (including agency, full time, part time, and prn employees) to validate that a skills validation for falls had been completed within the past year. Employees who had not completed a falls validation in the last year for falls to include immediate notification of the nurse with any falls, had their skills validated by the Director of Nurses, Assistant Director of Nurse, and the Staff Development Coordinator on 7/27/2022. Any employee who was not able to complete the validation will not be allowed to work until they complete the training. The Director of Nursing will notify the staffing coordinator of any employee that cannot work until this is completed.

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The Director of Nurses has ensured that all staff in all departments (agency, full time, part time, and prn employees) who does not complete the in-service training will not be allowed to work until the training is completed. Completed 07/27/2022.

This in-service was incorporated into the new employee facility orientation for all staff in all departments (agency, full time, part time, and prn employees). Completed 07/27/2022.

Date of IJ removal 7/28/2022

The credible allegation was validated on 7/28/22 when staff interviews revealed that they had received recent education on notifying the nurse when there was a fall or incident with a resident, not moving residents when they were found on the floor, reporting a change in resident condition, and assessment of residents. Interviews included staff from various departments and included agency staff. Staff expressed they would not move a resident observed on the floor and would contact the nurse immediately so the resident could be assessed. Nurses stated they should be notified of any falls or incidents so that they could assess the resident for injury. NAs stated mechanical lift transfers required two-persons. Facility documentation revealed staff were trained on the following topics: mechanical lifts, nurse notification and assessment, falls education, and change in condition. Attestations were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Agency staff received an in-service packet prior to working and this was verified by the facility trainers.

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F 684	Continued From page 13 Date of IJ removal 7/28/2022	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assure a diabetic resident's toenails were trimmed and podiatry services were arranged for 1 of 1 resident observed for foot care (Resident #9). Findings included: Resident #9 was admitted on 3/17/20 with diagnoses that included diabetes mellitus. Review of the quarterly minimum data set dated 5/12/22, revealed Resident # 9 's cognition was assessed as cognitively intact. The resident needed extensive assistance of one person to two persons physical assistance for Activities of Daily Living (ADL). There was no refusal of care. Review of the care plan updated 5/22/22,	F 687	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F687 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #9 obtained a corrective action on 08/02/2022 when he/she received foot care from the Podiatrist.	8/22/22

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revealed the resident was care planned for ADL self-care performance deficit due to disease process and impaired balance. The goals included the resident will improve her current level of functioning in bed mobility, transfers, eating, dressing, toilet use and personal hygiene and will receive staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff assistance with grooming and personal hygiene and encouraging resident to discuss feeling about self-care deficit.

Weekly skin assessment dated 5/6/22, 5/12/22, 5/18/22, 5/24/22, 5/30/22, 6/6/22, 6/13/22, 6/19/22, 6/25/22, 7/1/22, 7/7/22, 7/14/22, and 7/20/22 revealed no skin break down. There was no notation that the resident's toenails were long and needed toenail trimming or a podiatrist's care.

During an interview on 7/24/22 at 1:25 PM, Resident #9 stated she does not like long nails. Resident #9 further stated she had been requesting staff to cut her toenails, but they had not been doing so. Resident #9 indicated her toenails were long and had requested staff multiple times for a podiatric appointment and had not received one yet.

During an observation and interview on 7/25/22 at 11:30 AM Resident #9 was observed to be lying in bed. Observation of the resident's toes revealed the resident's right foot big toenail was thick and yellow color and was approximately inch and half long from the toe bed. The right foot 3rd, 4th and 5th toe (pinky toe) toenails were yellow and approximately one to one and half inch long from the nail bed. These toenails were curved inside towards the feet. The resident's left foot big

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

Beginning on 07/30/2022 the Director of Nurses (DON) initiated an audit of 100% of current residents for foot care. This audit consisted of direct observation of resident toenail condition, desired length, and inquiring to see if podiatry appointment had been requested. This audit was completed 08/12/2022.
Results: 42 of 87 residents required foot care or needed foot care, 25 of 42 were on 08/02/2022 by the podiatrist. The remaining 17 will be seen on 09/13/2022. The remaining 17 residents have been scheduled for an upcoming foot clinic. The physician has assessed the remaining 17 residents and agree that waiting until the upcoming foot clinic doesn□t pose any harm to the residents.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 08/04/2022, the DON and the Staff Development Coordinator (SDC) began education of all full time, part time, as needed (PRN) licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants including agency staff on foot care.
Staff were educated on recognizing and completing nail care if indicated during daily care. Staff were also educated that If a resident requires nail care, to please

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F 687	Continued From page 15	F 687		

toenail was thick and yellow in color and approximately one inch long. The 3rd toe was yellow and approximately an inch long from the nail bed. Resident #9 stated she had been asking the nurse aides, and nurses to cut her toenails and they indicated she needed to see a foot doctor. The resident further stated she had requested for a podiatrist appointment, and none had been set up so far. Nurse Aide #11 was in the room during the observation. During an interview with the Nurse Aide #11, she indicated she was not assigned to the resident. Nurse Aide #11 confirmed the resident's toenails were long and the nurse should have been notified about them. Nurse aide #11 stated when any resident requests a podiatric appointment then the assigned nurse was notified.

During an interview on 7/25/22 at 11:40 AM, Nurse Aide #8 stated she was assigned to the resident. Nurse Aide #8 indicated she had not observed the resident's toenails and the resident had not complained of any pain during ADL care. Nurse Aide #8 further indicated the resident had not complained to her about her toenails nor has she requested a podiatric appointment.

During an interview on 7/25/22 at 11:50 AM, Nurse #12 stated she was newly hire by the facility a few days ago and had not observed the resident's toenails. Nurse #12 further stated the resident nor nurse aides had requested for a podiatric appointment. Nurse stated, she could write on the communication sheet for the facility physician so that an appointment was set for the resident.

During an observation and interview with Resident #9 and the Director of Nursing (DON) follow up to ensure the nail care is provided. If the nail care can□t be provided in house, then the staff will need to notify the nurse or provider to ensure nail care is received. If nail care can□t be completed at the facility, then staff should take measures to seek alternative sources to ensure nail care is completed. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained.

Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/22/2022.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The DON or Designee will monitor compliance utilizing the F687 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months or until resolved. This monitoring will include direct observation of resident toe nails to ensure they are trimmed according to the resident□s preference. This will include auditing 6 residents on various halls, days, and shifts to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance

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F 687	Continued From page 16 on 7/25/22 at 12:30 PM, the resident reiterated to the DON that she had requested multiple staff to cut her toenails or place her on podiatric list. Resident indicated she had not seen a podiatrist for more than a year in this facility. While observing the resident's toes, DON confirmed that the resident's toenails should have been clipped a long time ago and should not have been waited for so long. DON stated the Podiatrist visited the facility every 3 months and the recent visit was in May. DON further stated that the resident was not on the podiatrist consult list on 5/24/22. DON stated the Nurse Aides were responsible to notify the assigned nurse, when the resident requests any podiatrist appointed or if the toenails needed trimming. The Nurse would then add the resident's name to the list of residents to be seen by the podiatrist. DON indicated that depending on the condition, the resident could be sent out for an outpatient podiatric appointment if needed. DON further indicated that the resident was on the list to see the podiatrist on 8/2/22. During an interview on 7/27/22 at 3:00 PM, Physician #1 stated that regular nail care should be provided especially for diabetic residents and the residents should be sent out for an outpatient podiatrist appointment if needed.	F 687	Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/22/2022	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		8/22/22

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F 689	Continued From page 17 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician interviews, the facility failed to safely transfer a resident with a mechanical lift. Resident #141 began to slide to the floor with her foot slipping off the platform. Nurse Aide (NA) #6 left the resident to get staff assistance and then Housekeeper #1 and NA #6 placed the resident back in bed without notifying the nurse. When Resident #141 complained of pain later in the shift, she was assessed by the nurse, and x-rays were ordered. The resident was evaluated at the hospital on 1/22/22 and had a right femur fracture resulting in Resident #141 undergoing orthopedic surgery. This was for 1 of 2 residents reviewed for accidents (Resident #141). Immediate jeopardy began on 1/21/22 when the facility failed to safely transfer a resident with a mechanical lift, left the resident unattended while getting help, and moved the resident without being assessed by the nurse. Immediate jeopardy was removed on 7/28/22 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put in place are effective. The findings included: Resident #141 was admitted to the facility on 1/9/18. Diagnoses included right femur fracture, fracture around prosthetic right knee joint, and	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #141 was deceased on 03/15/2022 and is no longer a resident of the facility. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 01/26/2022, the Director of Nurses, Rehab Manager, and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing the lift. This audit was completed on 01/26/2022. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it	

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F 689	Continued From page 18 osteoarthritis. Resident #141's care plan dated 11/30/20, that was active on 1/21/22 for activities of daily living (ADLs) self-care performance deficit listed an intervention of required two staff member assistance with all transfers. The annual Minimum Data Set (MDS) dated 9/14/21 revealed Resident #141 was moderately cognitively impaired and required two-person extensive assistance for transfers. The facility incident report dated 1/21/22 at 11:30 AM, revealed NA #6 informed Nurse #8 that Resident #141 was complaining of pain. The nurse assessed the resident to have swelling and pain in her right leg. The physician was notified, and orders were received for an x-ray. The resident was discharged to the emergency room (ER) on 1/22/22 for follow up after x-rays could not be completed. On 1/24/22 the Director of Nursing (DON) followed up with the investigation into the resident's knee pain. NA #6, who transferred the resident on 1/21/22, stated the resident's right leg buckled during transfer. The Resident did not fall on the floor. She was assisted back to bed where she remained until discharged to the hospital. The facility identified that NA #6 was not aware that this was considered an intercepted fall. The NA was educated on use of the lift. There were no changes in the days leading up to the resident's knee buckling. The resident had been seen by therapy who recommended that the sit to stand lift was the appropriate method for transfer. The facility investigation guide dated 1/28/22 indicated on 1/21/22 at 11:30 AM NA #6	F 689	included the required number of individuals to complete a safe transfer. This care plan update was completed on 01/28/2022. Since 1/28/2022, the Director of Nurses and the nurse management team has reviewed residents at the time of admission, quarterly and with significant changes to ensure that lift status and number of staff members needed for transfer was documented on the care plan for the resident. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 01/25/2022, the Director of Nurses began in servicing all licensed nurses and certified nursing assistants (full time, part time, and prn employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 02/01/2022. After 2/1/2022, this in servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift. Reeducation of the above was started on 07/27/2022. This education was completed 08/22/2022. Additionally, on 01/26/2022, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the	

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F 689	Continued From page 19 transferred Resident #141 using the mechanical lift. During the transfer, the resident's legs buckled and the NA left to seek assistance. NA #6 returned with Housekeeper #1 and transferred the resident back to bed by lifting her off of the sit to stand lift. There were no reports of pain from the resident when she was placed back in the bed. NA #6 went into the room around 1:30 PM to provide care to the resident. The resident complained of pain at that time and the NA notified Nurse #8 of the resident's pain but didn't notify the nurse of the resident's leg slipping off of the lift platform. The nurse assessed the resident and notified the physician. Hospital records dated 1/22/22 revealed Resident #141 presented with right thigh and hip pain that had been ongoing for two days. It was assessed to be constant pain that worsened with movement. Resident #141 denied trauma or fall and endorsed poor memory. An x-ray was performed and revealed right femur fracture. Resident #141 was transferred to another hospital for orthopedic surgery. An interview was conducted with NA #6 on 7/26/22 at 2:45 PM. NA #6 stated on 1/21/22 she was independently assisting Resident #141 from the bed to the wheelchair using the sit to stand lift. During the transfer, Resident #141 began sliding to the floor. NA #6 went to get another staff member to help her with the transfer and she returned with Housekeeper #1. NA #6 stated Resident #141 had slid down more by the time she returned with Housekeeper #1. NA #6 revealed she and Housekeeper #1 slid resident #141 all the way down to the floor then helped her from the floor to the bed. NA #6 stated one of the resident's feet was coming off the platform during	F 689	lift. This was completed on 02/11/2022. Competency was continued during the orientation process for new hires and as a part of the agency training. Agency staff are not allowed to use lifts until they have received training. They received education on this restriction at the beginning of their first shift in the facility. Once they are properly trained on lift use they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency staff member has been trained. On 01/31/2022, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed, on how to use the lift and if the correct number of caregivers were used to complete the transfer. These audits included actual observation of staff (including agency) carrying out transfers. There were no concerns identified from any of the audits that were completed. The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full time, part time, as needed and agency employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing accomplished this by: making sure that the written agency orientation packet is provided to the agency staff prior to their first shift in the facility. The facility leaves the packets near the time clock and will follow up by phone when needed to	

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F 689	Continued From page 20 the transfer and Resident #141's knees had given out. NA #6 explained she had used the lift by herself at times. She was aware Resident #141 needed a two-person transfer but NA #6 knew the resident well and believed she could safely transfer the resident on her own. NA #6 informed Nurse #8 when Resident #141 began to complain of pain but did not immediately inform the nurse following the incident with the transfer. On 7/26/22 at 4:26 PM an interview was conducted with Housekeeper #1. He stated NA #6 came to get him to assist with Resident #141. When Housekeeper #1 and NA #6 arrived at the resident's room, Resident #141 was holding on to the machine, leaned against the bed with one knee bent, and close to the floor. They tried to lift Resident #141 but could not, so NA #6 lowered the resident to the floor. NA #6 and Housekeeper #1 assisted Resident #141 to the bed. Housekeeper #1 indicated he was not trained on using mechanical lifts and he was helping NA #6 with Resident #141. Housekeeper #1 stated the resident didn't yell or scream that she was in pain. A progress note written by Nurse #8 dated 1/24/22 (noted to be a late entry for 1/21/22) revealed NA #6 informed Nurse #8 that Resident #141 had been complaining of right knee pain. Nurse #8 assessed Resident #141 and determined the resident's right foot was lying to the right side and her knee was swollen. Nurse #8 called the doctor and received orders for x-rays. The resident was administered pain medication. An interview was conducted with Nurse #8 on 7/27/22 at 7:54 AM. Nurse #8 stated on 1/21/22 NA #6 informed her Resident #141 was	F 689	ensure that the packet is reviewed. All employees must complete general orientation prior to working with residents. This training is included in the orientation process. This was completed 08/22/2022. This in-service was incorporated into the new employee facility orientation for all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees). This began on 1/31/2022. This was completed 08/22/2022. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/22/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance audits will be completed by the Director of Nurses or designee to monitor that staff are competent and understand the required amount of staff necessary to complete a transfer using the lift. This will be monitored using the F689 Quality	

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F 689	Continued From page 21 complaining of pain. She stated she was notified of the resident's pain sometime between 1:00 PM and 3:00 PM. Nurse #8 assessed Resident #141 and stated the resident's foot was turned to the side and her knee was swollen. Nurse #8 revealed she called the physician, received orders for an x-ray, and gave the resident pain medications. Nurse #8 stated NA #6 did not tell her about the transfer incident at that time, but later NA #6 told Nurse #8 about the resident sliding down to the floor during the transfer. Nurse #8 stated had she known NA #6 was using the lift alone, she would have assisted the NA. Physician orders dated 1/21/22 at 4:15 PM revealed orders to obtain x-rays of the right femur and right knee. A progress note written by Nurse #10 dated 1/22/22 at 4:12 PM revealed she notified the physician that x-rays could not be done until the morning due to inclement weather. The physician ordered the resident to be transferred to the hospital for evaluation. The resident left the facility at 3:45 PM. On 7/26/22, attempts to interview Nurse #10 were unsuccessful. On 7/27/22 at 9:12 AM an interview was conducted with Physician #2. Physician #2 stated she was told by the previous DON Resident #141 was transferred by one person and that person left the resident in a room by herself. Physician #2 indicated Resident #141 should have been transferred with two staff. The documentation in the medical record for Resident #141 showed an obvious deformity due to fracture. When the nurse called the on-call doctor on 1/21/22, she	F 689	Assurance Tool. Monitoring of 6 staff via direct observation of questionnaire to assure compliance. Monitoring will be completed weekly x 5 weeks then monthly x 2 months or until resolved for compliance. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 08/22/2022	

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obtained orders for x-rays. Physician #2 was notified on 1/22/22 when x-rays could not be obtained. She gave an order to send Resident #141 to the ER for evaluation. The ER doctor informed the family Resident #141 had a fracture. Resident #141 underwent orthopedic surgery.

An interview was conducted with the current DON on 7/28/22 at 11:35 AM. The DON stated nurses should be immediately notified after a fall or incident and before moving a resident. The nurse should have been told about Resident #141's transfer so an immediate assessment could be completed. The DON indicated staff should always use two persons for lift transfers and should know a resident's transfer status. All staff were in-serviced on using lifts and reporting change of condition to nurses.

On 7/28/22 at 1:50 PM an interview was conducted with the Administrator. The Administrator stated NA's were expected to notify the nurse of any falls or incidents that occurred. Staff should be aware of a resident's transfer status and be trained on how to safely use lifts. Family and physician notification should be done immediately upon a resident's change in condition.

The Administrator and Nurse Consultant were verbally notified of Immediate Jeopardy for F689 on 7/27/22 at 11:33 AM.

The facility provided a credible allegation of Immediate Jeopardy removal with a correction date of 7/28/22:

Removal Plan F689

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1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #141 was deceased on 03/15/2022 and is no longer a resident of the facility.

On 01/26/2022, the Director of Nurses, Rehab Manager, and the Clinical Nurse Consultant began identification of residents that were potentially impacted by this practice. This audit was completed by reviewing current residents who were identified as requiring transfer utilizing the lift. This audit was completed on 01/26/2022. The Director of Nurses and the Clinical Nurse Consultant began updating the care plan to ensure it included the required number of individuals to complete a safe transfer. This care plan update was completed on 01/28/2022. Since 1/28/2022, the Director of Nurses and the nurse management team has reviewed residents at the time of admission, quarterly and with significant changes to ensure that lift status and number of staff needed for transfer was documented on the care plan for the resident.

2. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

On 01/25/2022, the Director of Nurses began in servicing all licensed nurses and certified nursing assistants (full time, part time, and prn employees) on Mechanical Lift Safety Education which included education on how to use the lift, how many caregivers are required to use the lift, and what to do if there is a problem with the lift. This was completed on 02/01/2022. After

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2/1/2022, this in servicing was incorporated into all new hire orientation for nurses, certified nursing assistants and agency staff that are allowed to use the lift.

Additionally, on 01/26/2022, the Director of Nurses began validation of competency of certified nursing assistants and nurses (agency and non-agency) on use of the lift. This was completed on 02/11/2022. Competency was continued during the orientation process for new hires and as a part of the agency training. Agency staff are not allowed to use lifts until they have received training. They received education on this restriction at the beginning of their first shift in the facility. Once they are properly trained on lift use they are allowed to use lifts according to facility policy. Supervisory staff are notified when an agency staff member has been trained.

On 01/31/2022, the Director of Nurses or a designee began weekly monitoring (which included facility staff and agency staff) to identify if training had been completed, on how to use the lift and if the correct number of caregivers were used to complete the transfer. These audits included actual observation of staff (including agency) carrying out transfers. There were no concerns identified from any of the audits that were completed.

The Director of Nurses has ensured that all licensed nurses and certified nursing assistants (full time, part time, as needed and agency employees who do not complete the in-service training will not be allowed to work until the training is completed. The Director of Nursing accomplished this by: making sure that the written agency orientation packet is provided to

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F 689	Continued From page 25	F 689		

the agency staff prior to their first shift in the facility. The facility leaves the packets near the time clock and will follow up by phone when needed to ensure that the packet is reviewed. All employees must complete general orientation prior to working with residents. This training is included in the orientation process. Completed 07/27/2022.

This in-service was incorporated into the new employee facility orientation for all licensed nurses and certified nursing assistants (full time, part time, prn and agency employees). This began on 1/31/2022 and still continues. Completed 07/27/2022.

Date of IJ removal 7/28/2022

On 7/24/22 at 10:54 AM, a two staff transfer observation and interview was conducted for a resident who was currently at the facility. NA #9 operated the lift and NA #5 assisted with the lift and transfer of the resident. NA #9 stated she had not been trained on the sit to stand lift at the facility. NA #5 revealed she received an in-service on the lift and transfer after the accident occurred.

The credible allegation was validated on 7/28/22 when staff interviews revealed that they had received recent education on mechanical lifts, transfers, and falls. Interviews included staff from various departments and included agency staff. Additional observations of lift transfers revealed 2-staff were performing the procedure and had received the training. Facility documentation revealed staff were trained on the following topics: mechanical lift safety, falls education, and change in condition. Attestations were signed by

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F 689	Continued From page 26 trained staff for the verbal education that was provided. Staff indicated they were trained prior to working in the facility for their next shifts. Agency staff received an in-service packet prior to working and this was verified by the facility trainers. Date of IJ removal 7/28/2022	F 689		
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 interviews, the facility failed to: maintain the oven clean; maintain the reach-in freezer #1, walk-in refrigerator and walk in freezer clean; label and discard expired food from the reach-in refrigerator; place lids on cups filled with ice in the	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	8/22/22

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F 812	Continued From page 27 reach-in freezer #2. The roof of the reach-in freezer #2 had icicles that were touching the ice in the cups. Facility failed to discard a dented can the dry storage area. Facility failed to label and date food and nutritional supplements 2 of 2 nourishment refrigerators (station 1 and station 2 nourishment refrigerators). These practices had the potential to affect food being served to 84 of 88 residents. Findings included: 1. During an observation on 7/24/22 at 9:25 AM, the oven had a large volume of a greasy buildup, and dried food on the inside of the oven. The grease buildup was encrusted on doors and shelves where foods were being cooked. There was a large volume of dried grease buildup observed on the fronts of the oven and on the walls. During an interview on 7/24/22 at 9:28 AM, the Dietary Cook stated, the dietary aides were assigned to clean the oven in the beginning of the week and at the end of the week per the cleaning scheduled. The Cook indicated the oven would be cleaned tomorrow (7/25/22) which would be beginning of the week. 2. Observation of the reach-in freezer #1 on 7/24/22 at 9:32 AM, revealed an opened 20 fluid ounce (fl. oz) bottle containing blue colored liquid labelled "Gatorade" not dated. Observation also revealed a bag of frozen tater tots was opened and spilled on the floor of the freezer. During an interview on 7/24/22 at 9:32 AM, the Dietary Cook indicated she was unsure to whom the frozen blue colored "Gatorade" belonged.	F 812	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 7/24/2022. During initial walk through of the kitchen, it was noted dietary services had failed to properly maintain the cleanliness of the oven, reach-in freezer #1, walk-in refrigerator, and walk-in freezer; failed to label/discard expired food in reach-in freezer; failed to place lids on ice cups; failed to discard dented cans; and failed to maintain condition of reach in freezer. During observation of nourishment rooms 2 of 2 nourishment refrigerator/freezer were noted to have items without labels and dates. On 7/24/2022 the Dietary Cook discarded any improper labeled/dated and dented food items in the kitchen and nourishment fridges. Cleaning list was established to clean items cited; cleaning complete 7/26/2022. Maintenance defrosted and cleaned ice from walk in freezer 7/27/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be	

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F 812	Continued From page 28 She confirmed that this belonged to some staff. The Dietary Cook indicated the freezer contained food that was used on regular basis and needs to be cleaned. 3. Observation of the walk-in refrigerator on 7/24/22 at 9:35AM revealed on the top shelf of the refrigerator under the condenser was a tray containing 1) an opened clear plastic bag, with brown colored chopped food labeled "bacon bits - 6/22", 2) an opened clear plastic bag labeled "shredded swizz cheese - 5 pounds (lbs.)" and 3) an opened clear plastic bag containing multiple individual wrapped cheese slices. There was water in the tray and the three opened clear plastic bags were in the water. Observation of the refrigerator also revealed a stainless-steel container containing chopped tomatoes dated "7/19/22". The stainless-steel container had a plastic wrap that was only partially covering it. During an interview with the Dietary Cook on 7/24/22 at 9:37 AM, she indicated the water in the tray was the condensation water from the refrigerator. The Dietary Cook indicated the brown colored chopped food was bacon bits. The Dietary Cook stated, she was unsure if the bacon bits were removed from the freezer on 6/22/22 or placed in the refrigerator on that date. The Dietary Cook further stated meat products were stored in the refrigerator for 7 days before the food was discarded, and vegetables (chopped/ sliced) were stored for 3 days before they were discarded. 4. Observation of the walk-in freezer on 7/24/22 at 9:42 AM, revealed food stacked on the shelves were overloaded and did not allow proper circulation. There were two carts placed in the	F 812	affected by the alleged deficient practice. On 7/26/2022, the Dietitian Consultant completed a kitchen and nourishment walk through to ensure all food items were within their dates and dated properly. On 7/26/2022 maintenance director completed a walk-through of the kitchen to check all equipment was in working order. 3. Systemic changes In-service education was provided to all dietary staff full time, part time, and as needed staff on 8/12/2022. Topics included: " Storage and dating policies and regulations. " Proper cleaning and sanitation regulations. " Procedures for alerting PIC when equipment out of working order. " Inspections on shifts to observe all food are within their dates and tossed if out of date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. On 07/28/2022 the Director of Nurses began in servicing of all licensed nurses, Registered Nurses, Licensed Practical Nurses and medication aides (full time, part time, and prn including agency staff)	

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F 812	Continued From page 29 center of the freezer that were stacked with food in brown colored boxes. These boxes were wet and had ice on them. Multiple boxes on the shelves had ice on them. There was a plastic bag labelled "Broccoli 5 lbs." and an opened plastic bag containing multiple slices of frozen pizza on the top shelf which had freezer burn and ice crystals on them. Observation also revealed a bag of frozen mixed vegetables was opened and spilled on the shelves and on the floor of the freezer. During an interview on 7/24/22 at 9:45 AM, the Dietary Cook stated the freezer was recently serviced by maintenance as there was lot of ice and condensation. She indicated the freezer was overstocked and staff could not reach or clean the split food. 5. Observation of the reach-in refrigerator on 7/24/22 at 9:55 AM revealed 1) an opened clear plastic bag labelled "Ham - 7/12/22"; 2) an opened clear plastic bag labelled "Cheese- 7/19" and 3) an opened clear plastic bag with pink colored deli meat dated "6/3/22". During an interview on 7/24/22 at 9:55 AM, the Dietary Cook indicated the deli meat was bologna that was used for resident's sandwiches. The cook further indicated she was unsure if the date reflected the date the food was removed from the freezer or the use by date. The Dietary Cook stated that meat was generally stored for 7 days once removed from the freezer. 6. Observation of the reach-in freezer #2 on 7/24/22 at 9:47 AM revealed 3 trays containing approximately 22 cups filled with ice on each tray stacked one over the other on the top shelf and 3	F 812	on labeling and dating nourishments and discarding according to manufactures guidelines. 4. Quality Assurance monitoring procedure. The Dietitian Consultant or Interim Dietary Manager will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, within proper dates, and stored in clean and working equipment. DON, Administrator or designee will monitor nourishment refrigerators x 3 days a week for 4 weeks and then monthly x 3 months using a QA monitoring tool. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Compliance Date: 08/22/2022	

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trays containing approximately 22 cups filled with ice on each tray stacked one over the other on the second shelf. The cups on top tray, on both shelves were not covered. There were icicles on the roof ceiling of the freezer that were touching the ice in the cups on the top shelf.

During an interview on 7/24/22 at 9:47 AM, the Dietary Cook indicated that cups were filled with ice and were to be used for lunch. She indicated lids should be placed on cups to prevent any contamination. The Dietary Cook stated she unsure who filled the cups with ice and not placed lids on them.

7. During an observation of the dry storage on 7/24/22 at 10:00 AM, there was a dented can labeled Mandarin oranges - 6 lbs. and 10 oz. (ounce)" stored with other regular cans.

During an interview with the Dietary Cook on 7/24/22 at 10:00 AM, she stated the dented cans were no longer returned to the vender as the vender was not refunding the dented cans. The Dietary Cook stated dented cans were used as regular cans.

During a telephone interview on 7/26/22 at 11:00 AM, the dietitian stated the dented cans should be returned to the vendor and should not be used. The vendor would refund the facility of any dented cans. These cans should be stored separately in the dented can area.

During an observation and interview on 7/27/22 at 1:00 PM, the dietitian observed the dented can on the rack containing canned food and stated the dented can should be removed from the rack and returned to the vendor. She reiterated dented

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F 812	Continued From page 31	F 812		

cans should not be stored on the rack or used. The can needed to be stored separately and returned to the vendor

8. Review of the manufacturer's recommendations for nutritional supplement Med Pass 2.0 read, in part "MED PASS products can safely remain on a medication cart as long as it is kept at refrigerated temperature range (34 - 40 degrees F). Cover, label and refrigerate opened containers of MED PASS products and discard after 4 days as long as the product has been kept at proper refrigerated temperature range. If product is not kept refrigerated, discard after 4 hours."

On 7/24/22 at 10:10 AM, an observation of the nourishment refrigerator #1 (station 2), revealed the refrigerator contained 1) one - 46 fluid ounces (fl. oz.) orange juice bottle, 2) one- 60 fl. oz bottles cranberry juice bottles and 3) three - 32 fl. oz nutrition supplement " Med Pass 2.0", that were opened. There was no label indicating the open date or use by date on the beverages and nutritional supplement.

During an interview on 7/24/22 at 10:10 AM, Nurse #7 stated the nutrition supplement "Med pass 2.0" was used during medication administration. Nurse #7 further stated all the Med Pass (nutritional supplement) should be dated when opened and discarded after 24 hours. Any juices like orange juice and cranberry juice that are used during medication administration should be labelled and discarded within 24 - 48 hours. Any applesauce or pudding opened during medication administration should be discarded once medication administration was completed and should not be refrigerated.

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	345311	A. BUILDING _____ B. WING _____	C 08/03/2022

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(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 812	Continued From page 32 On 7/24/22 at 10:15 AM, an observation of the nourishment refrigerator #2 (station 1) revealed 1) one - 46 fl. oz. orange juice bottle that was opened, 2) two- 60 fl. oz cranberry juice bottles that were half emptied and 3) four - 32 fl. oz nutritional supplements "Med Pass 2.0", that were opened. There was no label indicating the open date or use by date on them. During an interview on 7/27/22 at 10: 00 AM, the Director of Nursing (DON) stated all nurses should label any products (Juices or nutritional supplements) when opened during medication administration with an open date. These products should be placed in the refrigerator after use and discarded within 24 hours of opening.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities 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 observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification survey in May 2019, June 2021 and subsequently recited in July 2022 on the current recertification and complaint survey.	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	8/22/22

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F 867	Continued From page 33 The recited deficiencies were in the area of Store/Prepare/Serve -Sanitary (F812) This deficiency was recited in the current recertification survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: This tag was cross referenced to: F812 -Store/Prepare/Serve- Sanitary Based on observations, record review and interviews, the facility failed to: maintain the oven clean; maintain the reach-in freezer #1, walk-in refrigerator and walk in freezer clean; label and discard expired food from the reach-in refrigerator; place lids on cups filled with ice in the reach-in freezer #2. The roof of the reach-in freezer #2 had icicles that were touching the ice in the cups. Facility failed to discard a dented can the dry storage area. Facility failed to label and date food and nutritional supplements 2 of 2 nourishment refrigerators (station 1 and station 2 nourishment refrigerators). These practices had the potential to affect food being served to 84 of 88 residents. During the previous recertification survey on 6/10/21, the facility failed to label and date food and nutrition supplements in 2 of 2 nourishment refrigerators reviewed for food storage (station 1 and station 2 nourishment refrigerators). The facility was also cited during the 5/23/19 recertification survey for failure to maintain and clean the stove, oven, and areas under the dishwashing machine in the kitchen.	F 867	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 08.03.2022, the Clinical Nurse Consultant educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Infection Prevention and Control (F880). These deficiencies were cited again on the current recertification survey completed on 8.03.2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Storage/Prepare/Serve-Sanitary (F812). Corrective action has been taken for the identified concerns in the areas of: Infection Prevention and Control (F880). The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 08.04.2022 to review the deficiencies from the July 24 □ August 3, 2022 annual recertification survey and reviewed the citations. On 08.03.2022, the Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance	

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F 867	Continued From page 34 During an interview on 7/28/22 at 4:34 PM, the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern based on family grievances, staff identified concerns or areas that need improvement, 2) A root cause analysis was completed, 3) Based on the root cause analysis the QA committee develops a plan, audits tools, and monitors that plan and 4) the outcome was discussed in the QAA meeting. The Administrator indicated when problem areas were identified the quality assurance and performance improvement (QAPI) plan was laid out. Individual staff should report progress or lack of progress and reason for the lack of progress. The root cause should be analyzed, and all effort should be made to resolve this issue. The team should continuously monitor until the deficient area concerns have been resolved. The recited deficiencies were in the area of implementation of the infection control policies and procedures (F880) This deficiency was cited during the infection control survey in January 2021 and recited in the current recertification survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. Findings included: This tag was cross referenced to: F880 - Infection Prevention and Control Based on observations, record review, and staff	F 867	Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Infection Prevention and Control (F880). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 08.04.2022, the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Infection Prevention and Control (F880). The administrator will continue monthly QAPI meetings to review compliance with F812 and F880 as well as any new areas of non-compliance. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to	

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F 867	Continued From page 35 interviews, the facility failed to implement the infection control policies and procedures for special droplet contact precautions when 2 staff members (Nurse Aide #7 and Nurse Aide#8) failed to wear the required Personal Protective Equipment (PPE) when entering Resident #30 ' s room and Resident #193's room for 2 of 2 residents reviewed for infection control practices. During the previous infection control survey on 1/25/21, the staff failed to implement the guidelines regarding use of personal protective equipment (PPE) during COVID-19 when two staff members did not wear the full PPE required (Social Worker #1 and Housekeeper #1) while providing services in the resident's room for 1of 6 sampled residents who were on Enhanced Droplet Precautions (Resident #10). This failure occurred during the COVID-19 pandemic.	F 867	work until training has been completed by 08/22/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 08/22/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		8/22/22

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F 880	Continued From page 36	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(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

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F 880	Continued From page 37 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement the infection control policies and procedures for special droplet contact precautions when 2 staff members (Nurse Aide #7 and Nurse Aide#8) failed to wear the required Personal Protective Equipment (PPE) when entering Resident #30's room and Resident #193's room for 2 of 2 residents reviewed for infection control practices. The findings included: Record review revealed the policy entitled "Infection Prevention and Control Program/COVID-19 Program", revised in June 2022, indicated that residents with/or suspected to have COVID-19 should be placed on Special Droplet Contact Precautions (formally cold	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 880	Continued From page 38 enhanced precaution). Staff should wear appropriate PPE, including a respirator (or facemask if pre-approved by infection control) at all times when in the room. The record review revealed the CDC interim policy "Interim Infection Prevention and Control Recommendation for Healthcare Personnel During the COVID-19 Pandemic", updated in February 2022, indicated that employees, who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection, should use a NIOSH- approved N95 or equivalent or higher-level respirator, gloves, gown, and eye protection. On 7/26/22 at 12:05 PM, during the observation on 500 hall, there was "Special Droplet Contact Precautions" signage posted outside the rooms' doors where Residents #30 and #193 resided. The signage instructed the staff to clean their hands before entering and when leaving a room, wear a gown when entering a room and remove it before leaving, wear an N95 or higher-level respirator before entering the room and remove after exiting, the protective eyewear (face shield or goggles) and wear gloves when entering the room and remove before leaving. The PPE was available on 500 hall near the residents ' rooms. 1a. On 7/26/22 at 12:10 PM, during the observation of lunch distribution on 500 hall, Nurse Aide #7 entered the room of Resident #30 with the meal tray. Nurse Aide #7 did not don a gown or gloves prior to entering the room. On 7/26/22 at 12:15 PM, during an interview, Nurse Aide #7 indicated that she observed the plastic bin with PPE near the room of Resident	F 880	Resident #193 was not affected by the deficient practice. Resident #193 remained on isolation precautions throughout quarantine period. They remained on Special Droplet Contract Precautions through the 10th day. Isolation precautions were removed and there were no complications identified. Resident #30 was not affected by the deficient practice. Resident #30 remained on isolation precautions throughout quarantine period. They remained on droplet precautions through the 10th day. Isolation precautions were removed and there were no complications identified. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 07/29/2022, The Assistant Director Nurses who is also an Infection Preventionist completed a review to ensure appropriate isolation signs for Special Droplet Contract Precautions were on the doors of all residents who were currently on Special Droplet Contract Precautions. The result of the review completed by the Assistant Director Nurses revealed that 4 of 4 residents who were on Special Droplet Contract Precautions had an isolation sign on their door. Director of Nurses completed an audit of resident records and direct observation to identify residents on Special Droplet Contract Precautions. The results of the audit by Director of Nurses revealed that 4 of 4 residents were on Special Droplet Contract Precautions and	

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F 880	Continued From page 39 #30, did not pay attention to the droplet precaution signage and did not put on PPE prior to entering the room. Nurse Aide #7 stated she worked in the facility for three weeks and did not know Resident #30 was on droplet precaution. She reported she received training in infection control, including isolation precaution and PPE, at orientation. Nurse Aide #7 was aware that PPE was required to enter the room with the signage of droplet precaution. b. On 7/26/22 at 12:20 PM, during the observation of lunch distribution on 500 hall, Nurse Aide #8 entered the room of Resident #193 with the meal tray. Nurse Aide #8 did not don a gown or gloves prior to entering the room. On 7/26/22 at 12:25 PM, during an interview, Nurse Aide #8 indicated that she observed the plastic bin with PPE near the room of Resident #193 and signage of droplet precaution on the door but forgot to put on PPE prior to entering the room. Nurse Aide #8 stated she received regular in-service on infection control, including PPE training. She knew that PPE was required to enter the room with the signage of droplet precaution. On 7/26/22 at 12:30 PM, during an interview, Nurse #9, assigned for 500 hall, confirmed that PPE was required to enter the rooms with droplet precaution signage on the door. Nurse #9 indicated that if she would have seen the staff entering the rooms of Residents #30 and #193 without PPE, she would stop and re-educate them. On 7/27/22 at 9:15 AM, during an interview, the Director of Nursing (DON) indicated that Residents #30 and 193 had physician ' s orders	F 880	these residents would be affected the alleged deficient practice. On 07/29/2022, The Assistant Director Nurses who is also an Infection Preventionist audited rooms of residents who required Special Droplet Contact Precautions to observe staff compliance with adherence to wearing the appropriate personal protective equipment in resident rooms when entering and exiting resident rooms. Results revealed compliance with current facility personal protective equipment policy. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 07/29/2022, The Director of Nursing (DON) and Assistant Director Nurses began education with all staff including (full time, part time, and prn including agency staff) Registered nurses, Licensed practical nurses, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary staff on CDC Use of Personal Protective Equipment when caring for residents with confirmed or suspected COVID19. This included reviewing a video with demonstration of donning and doffing of PPE. This was completed on 08/22/2022. Beginning on 08/06/2022, the	

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F 880	Continued From page 40 for droplet isolation precaution as newly admitted residents, and special droplet contact precautions signage was posted on the doors to the rooms. DON expected the staff to wear the appropriate PPE for special droplet contact precautions prior to entering the room with signage of isolation precaution. On 7/27/22 at 9:45 AM, during an interview, Infection Control Nurse indicated that the staff should follow the signage that was posted on residents ' rooms' doors. Infection Control Nurse continued that the facility provided mandatory infection control in-service every year and more often for the guidelines update. She stated before entering the room, the staff should have read the signage on the doors for Residents #30 and #193. The signage explained that the resident was on quarantine, which required the staff to wear appropriate PPE. On 7/27/22 at 11:05 AM, during an interview, the Administrator indicated that staff should follow the posted isolation precaution signage on Resident #30 and Resident #193 ' s doors and put on an appropriate PPE prior to entering their rooms.	F 880	Administrator initiated Infection control rounds to be completed weekly to monitor compliance with PPE utilization. These audits will be completed monthly and discussed in the monthly Quality Assurance Performance Improvement (QAPI) meeting. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning on 08/22/2022 the Administrator or designee will observe and monitor PPE compliance and utilization using Infection Control Monitoring Focused Rounds: Special Droplet Contact Precautions QA screening tool for F880 Infection Prevention and Control weekly x 5 weeks then monthly x 2 months to ensure compliance with the facility infection control policy. This monitoring will include 5 observations on various days, halls and shifts to ensure compliance. Quality Assurance (QA) Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored	

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F 880	Continued From page 41	F 880	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 08/22/2022 Directed Plan of Correction Compliance Date: 08/18/2022 Root Cause Analysis: A root cause analysis was completed on 08/18/2022 by the: DON, Administrator, Staff Development Coordinator, Minimum Data Set Nurse (MDS), Therapy Director, Social Worker, Certified Nurse□s Assistant (CNA), Housekeeper and Registered Nurse and was reviewed by the Performance Improvement (QAPI) committee on 08/22/2022. Root cause analysis (RCA) was identified to be unintentional adherence to policy related to equipment location and misinterpretation of policy. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process. The root cause analysis was incorporated into the plan of correction/intervention plan.	

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F 880	Continued From page 42	F 880		

Attestation Statement
I am the Director of Nurses/Infection Preventionist. I have provided education on Infection Prevention and Control for F-tag 880 at Roxboro Healthcare and Rehab Center between the dates of July 24, 2022 □ August 22, 2022.

Topics included:
" Appropriate PPE Utilization
" Adherence to Special Droplet Contact Precautions
" Donning and Doffing the required PPE before providing care of services to a resident on Special Droplet Contact Precautions

Education sessions were attended by each staff member.
Inservice of education dates and times include:
August 4, 2022: 7am □ 4:30pm
August 5, 2022: 7am □ 4:30pm
August 7, 2022: 7am □ 5:00pm

August 9, 2022: 7am □ 5:30pm
August 10, 2022: 4:15pm □ 4:30pm
August 15, 2022: 2pm □ 4pm
August 16, 2022: 12pm □ 3:30pm

This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(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 43	F 880	change has been sustained. Any staff identified above who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/22/2022. Printed Name: _Lynnell Royal_____ Signature: _Lynnell Royal_____ Credentials: _RN, DON_____ Date: _08/22/2022_____	