STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		12/30/22

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

Electronically Signed | 12/15/2022

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide annual staff training on the facility's Emergency Preparedness (EP) Plan and failed to complete a yearly full-scale community-based exercise. Findings included: A review of the facility's EP Plan was conducted on 11-18-22 with the facility's Corporate Manager. During the review it was determined that the facility did not have documentation of staff completing the required annual EP training nor any documentation indicating when the last staff EP training was completed. The facility also did not have documentation of the required yearly full-scale community-based exercise. The facility's Corporate Manager was interviewed on 11-18-22 at 2:30pm. The Corporate Manager stated the facility was aware of the need for annual training and a community-based exercise and said the training and exercise had been completed but not documented. During an interview with the Administrator on 11-18-22 at 2:45pm, the Administrator explained she had only been in the facility a few months and did not have any knowledge of the staff training or the community-based exercise for EP.	E 001	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 22, 2022, facility leaders met with members of the Carrolton Facility Management team to revise the facility's Emergency Plan and to discuss the plan for annual education. The activation of the emergency plan (Hurricane Prep- occurring in September 2022) was documented and added to the facility Emergency Preparedness Binder. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Annual staff training on the facility Emergency Preparedness Plan will be completed the week of December 26, 2022. In accordance with facility policy# EP 27.1 Emergency Preparedness Training and Testing Program, stating the facility will complete testing exercises twice a year,	

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E 001	Continued From page 2	E 001	the facility has completed or will complete the following: • A mock disaster drill- Fire Drill was completed on November 30, 2022. • Active Shooter Drill- Carrolton Facility Management Vice President of Building and Properties will lead a facility-based functional exercise the week of December 26, 2022. The facility has also been in correspondence with the Director of Emergency Service for Martin County and is planning a full-scale community-based exercise. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Training schedules, and summaries from staff training and testing exercised will be reviewed by the facility's QAPI Committee. Concerns will be immediately addressed by the facility administrator and the QAPI Committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 30, 2022.	
F 000	INITIAL COMMENTS A recertification and complaint investigation	F 000		

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F 000	Continued From page 3 survey was conducted from 11/15/22 through 11/18/22. Event ID# 1E3O11. The following intakes were investigated NC00190414. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		12/23/22

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F 550	Continued From page 4 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to treat residents in a dignified manner by scolding a resident after the resident overturned a mop bucket for 1 of 3 residents reviewed for dignity (Resident #71). Findings included: Resident #71 was admitted to the facility on 11/19/20. His active diagnoses included aphasia, cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery, flaccid hemiplegia affecting right dominate side, difficulty in walking, occlusion and stenosis of left carotid artery, and major depressive disorder. Resident #71's minimum data set assessment dated 8/2/22 revealed he was assessed as moderately cognitively impaired and had no behaviors. His hearing was assessed as adequate with unclear speech. Resident #71 was sometimes understood and usually understood others. Resident #71's care plan dated 11/15/22 revealed he was care planned for a communication problem related to expressive aphasia. The interventions included to allow adequate time to respond, repeat as necessary, do not rush,	F 550	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 15, 2022, an investigation was immediately started by the administrator upon notification of verbal abuse allegation. 24-hour initial abuse allegation report was submitted to the Health Care Personnel Registry (HCPR) and the alleged employee (Housekeeper #1) was terminated on November 15, 2022. November 15, 20022, the Social Worker attempted to conduct an interview with resident #71 but the resident was unable to complete it. December 6, 2022, the facility administrator received correspondence from a NC DHHD Health Care Personnel Investigations Nurse Consultant stating that after carefully reviewing the reported allegation, the Department had determined that an investigation would not be conducted at this time. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of	

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F 550	Continued From page 5 request clarification from the resident to ensure understanding, face when speaking, make eye contact, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, and use alternative communication tools as needed. During observation on 11/15/22 at 11:36 AM a loud bang was heard on the hall. Resident #71 was observed in his wheelchair in the hallway with Housekeeper #1 standing in front of him, Housekeeper #1's janitor's cart was next to Housekeeper #1 on her left side (the resident's right side) and the mop water bucket from the janitor's cart was overturned in between Resident #71 and Housekeeper #1. The mop water was spilling out on the floor around Resident #71. Housekeeper #1 was standing approximately five feet away from Resident #71. Housekeeper #1 extended her arms out to her sides, leaned forward towards the resident in an aggressive manner, and yelled at Resident #71, "See what you did!? Are you happy now!?" Resident #71 attempted to back his wheelchair away from Housekeeper #1. Medication Aide #1 was observed to move towards the situation as Housekeeper #1 then turned and walked briskly off the hall stating in an elevated voice, "I'm done, I'm leaving! I'm not working anymore!" Medication Aide #1 was observed to attempt redirecting Resident #71 to his room. Resident #71 gestured to the floor when medication aide asked if he was okay and then he propelled his chair away from the staff member. During an interview on 11/15/22 at 11:40 AM Medication Aide #1 stated she saw Housekeeper #1 yell at Resident #71 "See what you did!? Are you happy now!? I'm done, I'm leaving." Medication Aide #1 stated this was not	F 550	the residents have the potential to be affected. November 17, 2022, the social worker conducted an interview with 100% of alert & oriented residents on abuse. No concerns were identified during the interviews. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: November 15 through 21, 2022, a series of mandatory in-services were conducted for all staff (including housekeeping) by the Director of Nursing (DON) on the Carrolton Facility Policy for Abuse, Neglect, and Exploitation. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning the week of December 12, 2022, alert & oriented residents to include resident # 71, will be interviewed by the Social Worker and/or designee for abuse. Non-alert and non-oriented residents will be observed for behavioral changes that may indicate treatment in an undignified manner. Interviews and observations will occur with the following schedule: • 3 residents per day for 2 weeks (including alert and oriented and non-alert and non-oriented residents), • 2 residents per week for 2 weeks (including alert and oriented and non-alert and non-oriented residents), • 2 residents per week for 4 weeks (including alert and oriented and non-	

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F 550	Continued From page 6 appropriate behavior for staff to resident interactions and she went to separate the two and speak with the resident to see what had happened and to ensure the resident was safe. She stated staff were trained to never raise their voice or speak in an accusatory manner to residents. She further stated staff had tried using a communication board several times with Resident #71, but he threw the communication boards away when staff brought them to his room. She concluded even though communication was difficult, staff should never speak in an accusatory tone with any resident. During an interview on 11/17/22 at 11:20 AM the Housekeeping Supervisor stated the language, tone, and raised voice used by Housekeeper #1 would not be tolerated among her staff as her staff was expected to treat residents with dignity and respect. She stated she also verbally speaks with each staff member and makes them aware she is available and all they need to do if something happens is walk away and get her for help and she would take care of it. During an interview on 11/17/22 at 4:01 PM the Director of Nursing stated based on the information reported to her by her staff who witnessed the incident, this was a dignity concern, and no resident should be spoken to in an undignified manner. Resident #71 refused to be interviewed by the surveyor. Housekeeper #1 was unavailable for interview.	F 550	alert and non-oriented residents). Any concerns identified during interviews will be immediately addressed by the DON/Administrator to include investigation and staff retraining. The DON will review the resident interview summaries provided by the social worker and concerns identified will be immediately addressed. The Administrator will present the findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 23, 2022.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3)	F 553		12/21/22

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F 553	Continued From page 7 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews the facility failed to invite 1 of 1 resident (Resident #389) reviewed for care plan meetings.	F 553	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 389 legal representative was	

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F 553	Continued From page 8 Findings included: Resident #389 was admitted to the facility on 11-2-22. The admission Minimum Data Set (MDS) dated 11-9-22 revealed Resident #389 was moderately cognitively impaired. Review of Resident #389's medical record revealed a progress note dated 11-16-22 written by the facility's Social Worker (SW) stating an interdisciplinary care plan meeting was held that included activities, SW and a nursing assistant. The note indicated Resident #389's legal representative did not attend, and the care plan was reviewed and updated. During an interview with the SW on 11-17-22 at 11:25am, the SW stated she had not invited Resident #389 to her care plan meeting on 11-16-22. The SW explained She did not invite the resident because the resident was moderately cognitively impaired, and she does not invite a resident to care plan meeting unless the resident was cognitively intact. The SW further explained she had not mentioned or informed Resident #389 of the care plan meeting. Resident #389 was interviewed on 11-17-22 at 11:30am. Resident #389 was unaware a care plan meeting to discuss her care was held. She also stated she would have liked to have been informed about care plan meetings and would have attended if invited. A telephone interview occurred with Resident #389's legal representative on 11-17-22 at	F 553	invited by the facility social worker and attended care plan meeting on November 17, 2022. On December 14, 2022, the social worker was in-serviced by the administrator on the “Resident Rights” policy which emphasizes the resident’s right to participate in care plan meetings as well as ensure that all residents receive an invitation to attend. The social worker will be responsible for following up with the resident’s response to ensure an invitation was received timely prior to the scheduled care plan meeting. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. 3. Action taken/systems put into place to reduce the risk of future occurrence include: All newly hired social workers, Admissions Director (and other staff responsible for notifying residents of scheduled care plan meetings) will be provided the “Resident Rights” policy in-service during orientation which emphasizes the resident’s right to participate in care plan meetings as well as ensure that all residents receive an invitation to attend. The social worker will be responsible for following up with the resident to ensure an	

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F 553	Continued From page 9 11:40am. The legal representative stated he had not been informed by the facility or the SW of a care plan meeting on 11-16-22 for Resident #389. He stated he had not received a phone call or a letter informing him of the meeting. During a follow up interview with the SW on 11-17-22 at 11:55am, the SW stated she had mailed Resident #389's legal representative a letter on 11-9-22 informing him of the care plan meeting on 11-16-22. The Director of Nursing (DON) was interviewed on 11-17-22 at 11:58am. The DON explained a care plan meeting should involve nursing, nursing assistant, dietary, therapy, SW, activities, Administrator, DON, resident and the resident's legal representative. The DON also said every resident should be invited to a care plan meeting regardless of their cognitive status and if the resident was unable to come to the meeting, then the meeting should be moved to the resident. The Administrator was interviewed on 11-18-22 at 2:21pm. The Administrator explained she was aware of Resident #389 and her legal representative not attending the care plan meeting on 11-16-22 and that another care plan meeting was held with the legal representative later in the day on 11-17-22. She stated she expected residents and their legal representatives to be invited to the care plan meeting.	F 553	invitation was received timely prior to the scheduled care plan meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: 100% of scheduled care plan meetings, to include meeting with Resident #389, will be monitored by the Admissions Director weekly x 4 weeks, utilizing the Care Plan Participation Monitoring tool. 50% of scheduled care plan meetings, to include meeting with Resident #389, will be monitored by the Admissions Director monthly x 1 month, utilizing the Care Plan Participation Monitoring tool. The monitoring process will ensure residents receive an invitation to attend his/her scheduled care plan meeting with documentation of resident’s response. Any areas of concern identified during monitoring will be immediately addressed by the administrator including staff re-training, the social worker notifying the resident to confirm invitation was received timely and/or re-scheduling of care plan meetings as applicable. The Administrator will review and sign the Care Plan Participation Monitoring tool weekly x 4 weeks and monthly x 1 month to ensure all areas of concerns have been addressed. The Administrator and/or designee will	

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F 553	Continued From page 10	F 553	present the findings of the Care Plan Participation Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The Administrator and the Director of Nursing (DON) will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction. Corrective action completion date: December 21, 2022.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, staff and Physician interview the facility failed to assess 1 of 4 resident (Resident #45) to determine if self-administration of medication through a feeding tube was clinically appropriate. Findings included:	F 554	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #45 was assessed and determined to be clinically appropriate for self-administration of medications with supervision during the survey on November 16, 2022.	12/21/22

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F 554	Continued From page 11 Resident #45 was admitted to the facility on 9-26-17 with multiple diagnoses that included moderate protein-calorie malnutrition and gastrostomy status. Review of the Resident #45's Physician orders since admission revealed no Physician order for Resident #45 to self-administer medication. Review of Resident #45's medical record revealed no documentation of a "Medication Self-Administration Form", or documentation of education had been completed with Resident #45 to self-administer her own medication. Physician order dated 12-21-17 revealed an order for Resident #45 to have nothing by mouth (NPO). The quarterly Minimum Data Set (MDS) dated 9-22-22 revealed Resident #45 was cognitively intact and required extensive assistance with one person for eating. The MDS also revealed documentation the resident received enteral feedings. Resident #45's care plan dated 9-29-22 revealed a goal she would demonstrate adequate knowledge and technical ability to carry out task. The interventions included ask resident to verbalize understanding and demonstrate proper technique for administration of medications, observe self-administration of medication and document, reassess competency to self-administer medication on a consistent basis. An observation of medication administration occurred on 11-16-22 at 6:54am in conjunction with an interview with Nurse #2. Nurse #2	F 554	A physician's order was also obtained for the self-administration of medications by resident #45 on November 16, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who self-administer medications have the potential to be affected. There are currently no other residents who self-administer medications in the facility. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Policy # 2.13 Self-Administration of Medications was updated to reflect that the facility will use the Medication Self-Administration Safety Screen within the electronic medical record to assess and document the resident's clinical ability to self-administer medications. Nursing personnel (RNs, LPNs and Medication Aides) were in-serviced on December 19, 2022, by the Pharmacy Nurse Consultant and Director of Nursing. This in-service included the following topics: Administering Medications Hand Hygiene General Medication Administration Procedures Medication Monitoring Medication Allergies, Side Effects and Adverse Effects Six Rights of Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 554	Continued From page 12 confirmed Resident #45 was on enteral feedings and had received her medication through her feeding tube. Nurse #2 explained Resident #45 administered her own medication through her feeding tube. The Director of Nursing (DON) was interviewed on 11-16-22 at 9:13am. The DON confirmed Resident #45 self-administered her medication through her feeding tube. The DON said she did not know if the resident had been provided education or an assessment had been completed for the resident to self-administer medication. During an interview with Resident #45 conducted on 11-16-22 at 9:30am, Resident #45 stated she routinely administered her own medications to herself through her feeding tube. The Administrator was interviewed on 11-18-22 at 2:21pm. The Administrator discussed being made aware of the issue with Resident #45 self-administering her medications. She explained an order and an assessment had been completed on 11-16-22 once the issue had been brought to the staff's attention. The Administrator stated she did not know why an order and an assessment had not been completed previously because she was not employed at the facility at that time.	F 554	Administration Administering Solid Oral Medications Sublingual and Buccal Powdered Medications Topical Medications Patches Eye Medications Ear Medications Nose Drops and Nasal Sprays Inhaled Medications Self-Administration of Medications Medication Storage Storage and Security Facility Policy# 2.13- Self-Administration of Medications 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing will audit all residents who self-administer medications on a monthly, times three months to assure that: • Medication Self-Administration Safety Screens have been completed and • Physician orders have been obtained Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date:	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 554	Continued From page 13	F 554	December 21, 2022.	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff and residents, the facility failed to ensure residents who had perishable food items brought into the facility had a location	F 561	1. Immediate action(s) taken for the resident(s) found to have been affected include: The rights of all residents will be	12/30/22

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 561	Continued From page 14	F 561		

to store their food. This deficient practice affected 5 members of the Resident Council (Residents #22, #25, #35, #41, #55) and 1 of 3 residents reviewed for choices (Resident #56).

The findings included:

Review of the Resident Council Meeting Minutes dated 10/25/22 indicated this was an emergency meeting for the purpose of reviewing the memo titled "Food Safety and Resident Room Refrigerators". The minutes revealed that residents were informed that personal refrigerators would be removed. The memo read in part; "Perishable food could not be left with the resident as they had nowhere to store perishable food". The memo also stated that food could not be placed in one of the facility ' s refrigerators because all opened food must have an expiration date and the facility could not place food in their refrigerators that had been eaten from to ensure the safety, sanitary storage, handling, and consumption. The memo did not indicate that the facility would provide an alternative place for items that needed refrigeration to be stored.

During a Resident Council meeting on 11/16/22 at 2:00 PM with Residents #35, #55, #22, #41, and #25, they stated their personal refrigerators in their rooms were removed and they were told that the facility could not be responsible for storing their food. The Residents stated they were only allowed to have nonperishable food. The Residents stated they were not made aware of an area for their personal food to be stored.

Resident #56 was admitted to the facility on 6/11/20 and her most recent Minimum Data Set assessment dated 10/10/22 indicated her

respected.

Resident #25 was discharge home from the facility on November 23, 2022.

Residents #35, #55, #22, and #41 received a memorandum the week of December 15, 2022, clarifying the policy that was distributed in November of 2022.

The facility social worker and dietary manager met with residents #35, #55 #22, and #41 the week of December 14, 2022, to review the memorandum and policy together.

The dietary manager met with residents #35, #55 #22, and #41 on Thursday, December 15, 2022, to review resident choices and special requests for snacks and meal options.

On December 20, 2022, after a conversation with the survey team, the Vice President of Buildings and Properties ordered a large refrigerator to be placed in the storage room across from the nurse's station for storing residents' perishable foods brought into the facility. We anticipate the arrival and installation of the refrigerator by December 23, 2022.

Facility policies will be updated to reflect the following:

- Perishable foods brought into the facility will be labeled and dated by nursing or activities staff and stored in the resident refrigerator,
- Nursing will be responsible for

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 561	Continued From page 15 cognition was intact. An interview was conducted with Resident #56 on 11/17/22 at 10:05 AM. The resident stated that her personal refrigerator in her room had been removed by the facility. Resident #56 stated she was concerned about not having anywhere to store food when her family brought meals from home. Resident #56 stated that she was not made aware of an area for personal food to be stored after the refrigerator was removed. An interview was conducted with Nursing Assistant (NA) #2 on 11/17/22 at 7:22PM. NA #2 stated that residents could receive food from the outside, but she was not aware of where the food was being kept since the resident ' s personal refrigerators were removed. An interview was conducted with NA #1 on 11/17/22 at 10:19 AM. NA #1 stated residents could receive food from the outside. NA #1 stated she had not been made aware of an alternative place for resident ' s personal food items to be refrigerated. NA #1 indicated she was unaware of any resident receiving perishable food from outside of the facility since the personal refrigerator policy had changed. An interview was conducted with the Assistant Director of Nursing (ADON) on 11/16/22 at 07:43 PM. The ADON stated that resident ' s personal refrigerators were recently removed but she was not aware of any area where she resident ' s personal food was to be stored. An interview was conducted with the Administrator on 11/17/22 at 2:45PM. The Administrator stated that the personal	F 561	checking and logging refrigerator temperatures daily to assure food safety. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of the residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All residents will be treated with dignity and respect. A memorandum will be delivered to all residents the week of December 25, 2022, clarifying the facility's policy on storing perishable foods brought into the facility. The same memorandum mentioned above will be mailed to all resident family members the week of December 25, 2022. Mandatory in-service education will be provided to all staff regarding the policy, procedures, and patient rights the week of December 25, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: A senior leader (DON, Administrator,	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 561	Continued From page 16 refrigerators had been removed due to electrical concerns. She stated that there was a refrigerator in the employee breakroom where residents could place their food. The Administrator reported that residents could ask the staff to get their food from the refrigerator in the breakroom and staff would bring the food out to them. When asked how the facility informed the residents of the change to their personal refrigerator protocol she indicated the residents were notified of the removal of their personal refrigerators by memo and at an in person meeting. She added that a letter was sent to the resident representatives by mail. When asked how residents, their representatives, and staff were made aware of the new protocol for where resident perishable food items previously stored in their personal refrigerators could be stored now, she was unable to provide an explanation.	F 561	Dietary Manager, Social Services Directors, or their designee.) will interview residents via weekly walking rounds to assure that residents understand the policy as related to perishable foods brought into the facility. Two residents per day will be interviewed for 4 weeks. Immediate correction to include re-education, will occur for residents found to misunderstand the facility policy related to perishable foods brought into the facility. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time as consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: 12/30/2022.	
F 567 SS=B	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a	F 567		12/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 567	Continued From page 17 resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review the facility failed to provide access to resident funds during the weekend for 2 of 2 residents reviewed for personal funds. (Resident #4, Resident #12) Findings included:	F 567	1. Immediate action(s) taken for the resident(s) found to have been affected include: Upon learning about the deficit practice, and prior to the departure of the survey team, a member of the corporate finance team placed cash for resident availability in a bank bag and placed it on a med cart	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 567	Continued From page 18 a. Resident #4 was admitted to the facility on 10/30/19. Resident #4's Minimum Data Set assessment dated 10/27/22 revealed she was assessed as cognitively intact. During an interview on 11/15/22 at 2:39 PM Resident #4 stated there was no way to get to her money on the weekends. She stated she would have to ask for her money on Friday or wait until Monday. b. Resident #12 was admitted to the facility on 7/15/21. Resident #12's Minimum Data Set assessment dated 10/19/22 revealed she was assessed as moderately cognitively impaired. During an interview on 11/15/22 at 2:08 PM Resident #12's visitor stated she did not think money was available on the weekend for resident accounts. She stated she had seen most residents needed to get money on Friday or wait until Monday and believed it was the same for Resident #12. During an interview on 11/16/22 at 12:18 PM Medication Aide #2 stated she did not think money was available on weekends but would ask a manager if she was asked by a resident for petty cash on the weekend. During an interview on 11/16/22 at 12:19 PM Medication Aide #3 stated she did not know if money was available on weekends, but she would ask the Activities Director.	F 567	so that the residents always have access. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. Letters regarding the updated process and procedures for accessing the cash were mailed to every responsible party on December 15, 2022. Letters were distributed directly to all alert and oriented patients alerting them of the updated process and cash availability on December 15, 2022.. A sign was placed on the business office door alerting residents of the cash availability on December 15, 2022. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All business office staff members will be in serviced about the regulation and process by which the facility would change practice to ensure compliance. All staff members will be in serviced by the business office manager, social worker, and administrator on the new process in mandatory staff meetings on Thursday, December 15, through December 21, 2022. Policy was updated to include the cash	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 567	Continued From page 19 During an interview on 11/16/22 at 12:22 PM the Activities Director stated petty cash was kept on a medication cart, but it no longer was something the facility did to the best of her knowledge. She concluded Receptionist #1 would know more because she used to put the money on the cart for the weekend. During an interview on 11/16/22 at 12:24 PM Receptionist #1 stated a long time ago they used to put money on a nurse's cart for petty cash for the weekends. She stated an old administrator told her to stop doing this, and to her knowledge, the residents needed to get money on Friday to have it on the weekend. During an interview on 11/17/22 at 4:15 PM the Director of Nursing stated money used to be kept on a locked medication cart for the weekend petty cash for residents. She stated when the business office manager left, this practice got missed and it had not been brought up to the administrations as a concern until yesterday. She concluded money should be available on weekends for residents. During an interview on 11/17/22 at 4:39 PM the Administrator stated money should be available to residents on the weekend who have accounts with the facility.	F 567	availability and residents were informed of the cash availability in a resident council meeting on Thursday, December 15, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The business office manager will balance the resident trust “cash fund” every business day to ensure that it balances, and that residents are utilizing the cash as needed. Audit results will be presented to the Administrator and Social Services Director daily. Audit results will be presented to the QAPI team monthly. Walking rounds by the Administrator and Social Worker will incorporate conversation with the residents about fund availability. These will occur a minimum of twice weekly. Weekend manager on duty rounds will be updated to include conversations with 5 residents about fund availability and /or problems associated with fund access. Immediate corrective action will follow. Resident council agendas will be updated to include Trust Fund Cash Availability to ensure on-going compliance. Corrective action completion date: December 21, 2022.	
F 574 SS=F	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi)	F 574		12/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 574	Continued From page 20	F 574		

§483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:
(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -
(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;
(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State

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F 574	Continued From page 21 and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interviews with the Resident Council members and facility staff, the facility failed to post information and contact information about the State Survey Agency and the local ombudsman program. This occurred for 6 of 6 cognitively intact residents who regularly attended the Resident Council meetings (Residents #35, 55, 22, 41, 390, and 25). The findings included:	F 574	1. Immediate action(s) taken for the resident(s) found to have been affected include: Upon learning about the deficit practice the Administrator contacted the maintenance director to inquire about the location of information for Ombudsman and State Survey Agency. The framed information and contact information had been removed by maintenance for	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 574	Continued From page 22 A review of the Resident Council meeting minutes from 10/21 through 11/22 revealed the resident rights section did not contain information on the contact information for the state survey agency or the local ombudsman. During a group meeting on 11/16/22 at 2:00 PM with Residents # 35, 55, 22, 41, 390, and 25, they stated they regularly attended the Resident Council meeting. The Residents stated they did not know the number to contact the state survey agency. The residents stated they did not know who the Ombudsman was or how to contact the Ombudsman. The residents further revealed that they did not know who their current Ombudsman was, and the information had not been posted for almost a year. An observation and interview were conducted with the Social Worker on 11/16/22 at 3:03 PM. The Social Worker revealed that the information was usually kept posted on the wall near the nurse's station. The Social Worker stated that the information was not there, and she was not sure when it had been removed. A tour of the facility was conducted on 11/16/22 at 3:13 PM with the Administrator. There was no posting of the state survey agency and information in the facility. During the tour there was no posting of the Ombudsman's name and contact information. An interview was conducted with the Administrator on 11/16/22 at 4:02 PM. The Administrator stated she was not aware that the state survey information and ombudsman name and contact information were not available to the	F 574	purposes of painting the wall. The framed copies were located immediately and placed in their rightful location across from the nursing station. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. Letters were mailed to every responsible party on December 15, 2022, with a copy of contact information for the Ombudsman and State Survey Agency. Letters were distributed directly to all patients on December 15, 2022, providing them with copies of contact information for the Regional Ombudsman and State Survey Agency. This information is also provided during the admissions process. All residents, guests, and family members will consistently have access to the contact information postings on the information wall by the nursing station. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff members will be in serviced about the regulation and process by which the facility would change practice to ensure compliance. All staff members will be in serviced by the social worker, and administrator on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 574	Continued From page 23 residents.	F 574	the posting requirement in mandatory staff meetings on December 15 through December 21, 2022. This information is available and provided via every admission by the social worker. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Walking rounds by the Administrator and / or Social Worker will incorporate conversation with the residents about access to contact information for Ombudsman and State Survey Agency. These will occur a minimum of twice weekly with 5 residents. Weekend manager on duty rounds will be updated to include conversations with 5 residents about access to contact information for Ombudsman and State Survey Agency. . Immediate corrective action will follow. Resident council agendas will be updated to always include review of contact information for the Regional Ombudsman and the State Survey Agency to ensure on-going compliance. Audit results will be presented to the Administrator and Social Services Director daily. Audit results will be presented to the QAPI team monthly. Corrective action completion date: December 21, 2022.	

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F 576	Continued From page 24	F 576		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such	F 576		12/21/22

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F 576	Continued From page 25 access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to provide residents with access to the use of a telephone in a place where calls could be made without being overheard for 1 of 3 residents reviewed for privacy. (Resident #2). The findings included: Resident #2 was admitted to the facility on 7/9/12 with a readmission on 9/29/22. Review of the most recent Minimum Data Set (MDS) dated 10/4/22 revealed that Resident #2 was cognitively intact. An observation was conducted on 11/15/22 at 1:06 PM of Resident #2 on the telephone at the nurse's station. Resident #2 could be heard talking on the phone. An observation was conducted on 11/17/22 at 2:22 PM of Resident #2 on the telephone at the nurse's station. Resident #2 could be heard talking on the telephone. There were multiple staff and residents present around the nurse's station. An interview was conducted with Resident #2 on 11/18/22 at 2:40 PM. Resident #2 stated that he hated having to talk on the phone at the nurse's station. He stated that there was no privacy and staff sometimes asked him about things they	F 576	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility purchased two cell phones on Monday, December 12, 2022, that are solely accessible to the residents for communication in a private location. The phones will be in the possession of the Activity Director during the day and can be checked out from either nursing cart after facility business hours. A phone will be made available on the nursing cart every day at the end of the workday so that residents have access during the evening. The activity director will retrieve the phones in the morning for charging. The resident may choose to continue conversations utilizing the phone at the nursing station. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. Letters were mailed to every responsible party week of December 15, 2022, with an update on the facility phone availability. Letters were distributed directly to all patients week of December 15, 2022	

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F 576	Continued From page 26 heard him talk about on the phone. Resident #2 stated that the facility used to have cordless telephones for the residents to use. He stated that he could not recall the last time the cordless telephones were available for residents to use. Resident #2 reported he used the phone at the nurse's station several times a week. An interview was conducted with the Administrator on 11/18/22 at 2:45 PM. She stated that staff had looked for the cordless telephones and were unable to locate them. The Administrator further stated that the facility tried to accommodate the residents as best they could. The Administrator stated that she expected residents to have a private area to talk on the phone without being overheard.	F 576	providing them an update on phone availability, process, and location. This information will also be provided during the admissions process. All residents, guests, and family members will consistently have access to phones for ensuring private conversations at all times. Residents may continue to choose to utilize the phone at the nursing station if they choose, but phones will also be available that ensure privacy. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff members will be educated about the regulation and process by which the facility will change practice to ensure compliance. Staff members will be educated about the process for which patients may check out cellular phones and use the facility phones in a private location. All staff members will be in serviced by the social worker, and administrator on the posting requirement in mandatory staff meetings on Thursday, December 15 through December 21, 2022. This information will be added to the admissions information and shared with all new admits by the social worker. The administrator will present the policy and the check out requirements to the	

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F 576	Continued From page 27	F 576	resident council at the December meeting. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Walking rounds by the Administrator and Social Worker will incorporate conversation with the residents about fund availability. These will occur a minimum of twice weekly. Weekend manager on duty rounds will be updated to include conversations with 5 residents about fund availability and /or problems associated with phone privacy. Immediate corrective action will follow. Resident council agendas will be updated to always include review check on the phone usage and availability. Audit results will be presented to the Administrator and Social Services Director daily. Audit results will be presented to the QAPI team monthly. Corrective action completion date: December 21, 2022.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	F 577		12/21/22

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F 577	Continued From page 28 §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interviews with the Resident Council members and facility staff, the facility failed to inform residents of the location of the state inspection results. This occurred for 6 of 6 cognitively intact residents who regularly attended the Resident Council meetings. (Residents #35, 55, 22, 41, 390, and 25). The findings included: During a group meeting on 11/16/22 at 2:00 PM with Residents # 35, 55, 22, 41, 390, and 25, they stated the state inspection results were not made available for residents to read. The Residents stated they did not know the location of the state inspection results. An observation was conducted of the facility with the Administrator on 11/16/22 at 3:13 PM. The Administrator was unable to locate the state	F 577	1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility has determined that 100% of the residents have the potential to be affected. The facility will ensure that all residents are informed of the survey result notebook location (the facility lobby and across from the main nursing station). 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. Letters were mailed to every responsible party on December 15, 2022, with an	

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F 577	Continued From page 29 inspection results. During an interview with the Nursing Home Administrator on 11/16/22 at 3:15 PM, she stated that she was used to the survey inspection results being in a binder in the front lobby. The Administrator stated she was not aware that the state inspection results were not available to the residents.	F 577	update regarding where survey results can be located. Letters were distributed directly to all patients on December 15, 2022, providing them an update on where survey results are located. This information is also provided during the admissions process. All residents, guests, and family members will consistently have access to the survey results. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff members will be serviced about the regulation and process by which the facility would change practice to ensure compliance. Staff members will be educated about the availability of survey results. All staff members will be in serviced by the social worker, and administrator on the posting requirement in mandatory staff meetings on Thursday, December 15 through December 21, 2022. This information will be added to the admissions information and shared with all new admits by the social worker. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Walking rounds by the Administrator and	

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F 577	Continued From page 30	F 577	Social Worker will incorporate conversation with the residents about survey results. These will occur a minimum of twice weekly. Weekend manager on duty rounds will be updated to include conversations with 5 residents about survey result availability and location. Immediate corrective action will follow. Resident council agendas will be updated to always include a review / check in on the survey result location and availability. Audit results will be presented to the Administrator and Social Services Director daily. Audit results will be presented to the QAPI team monthly. Corrective action completion date: December 21, 2022.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		12/23/22

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F 584	Continued From page 31 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain resident walls and lighting fixtures in good repair. This occurred on 3 of 4 halls (Peele, Skilled and Sparks halls) reviewed for environment. Findings included: 1. Observation of Peele Hall revealed the following. a. Room 110 was observed on 11-15-22 at	F 584	1. Immediate action(s) taken for the resident(s) found to have been affected include: Room 110 □ the rusted, overhead light fixture was replaced, and the ceiling light fixture had a cover installed immediately following the survey exit. Paint scrapes on the wall were repaired the week of December 16, 2022. Room 54 □ holes on either side of the heating / air unit were repaired and painted the week of December 16, 2022.	

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F 584	Continued From page 32 10:30am. The room was observed to have rust on the over the bed light fixture, the ceiling light had a missing cover exposing the florescent light bulbs and there was paint scrapped off the wall exposing the plaster at the head of the resident's bed. A second observation of room 110 was completed on 11-18-22 at 10:15am with the Maintenance Director and the Environmental Manager. The second observation revealed rust on the over the bed light fixture, the ceiling light had a missing cover exposing the florescent light bulbs and there was paint scrapped off the wall exposing the plaster at the head of the resident's bed. The Environmental Manager was interviewed on 11-18-22 at 10:34am. The Environmental Manager stated she had not noticed the issue with the light fixture during her daily walk around rounds. She explained the housekeepers should be cleaning light fixtures if they are dirty during their daily cleaning of the room. The Maintenance Director was interviewed on 11-18-22 at 10:38am. The Maintenance Director stated he was unaware of the issues in room 110. He stated staff could report the issues through the facility's computer system, verbally or leaving a work order in his mailbox. 2. Observation of the Skilled Hall revealed the following. a. Room 54 was observed on 11-15-22 at 10:02am. The observation revealed 2 holes in the wall, one on each side of the heating/air unit with each hole measuring approximately 6 inches by 4 inches and paint was removed from the wall	F 584	Room 55 □ vinyl cove base in the bathroom was reattached, hole in the wall was repaired, and the bathroom was painted and the peeling paint on the cabinet was sanded and repaired the week of December 16, 2022. Holes in the wall on the SPARK hallway were repaired and new baseboard was installed and painted the week of December 16, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of the patients have the potential to be affected by holes in the wall and peeling vinyl cove base. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Thursday, December 15 through December 21, 2022, all staff (facility staff and contract staff), were educated by the facility administrator on the following items: • The importance of reporting maintenance concerns including, cracked, damaged, turned, or missed receptacle covers, holes in walls, peeling cove base, and stained ceiling tiles and integrity of light fixtures. • Reminding all facility staff members and contractors that the facility policy/procedure for sharing maintenance concerns - to post a ticket / maintenance work order via Point Click Care.	

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F 584	Continued From page 33 allowing the plaster to be exposed next to the resident's bed. During a second observation of room 54 on 11-18-22 at 10:18am with the Maintenance Director and the Environmental Manager, the observation revealed 2 holes in the wall, one on each side of the heating/air unit with each hole measuring approximately 6 inches by 4 inches and paint was removed from the wall allowing the plaster to be exposed next to the resident's bed. The Maintenance Director was interviewed on 11-18-22 at 10:38am. The Maintenance Director explained he made daily rounds of the facility but did not inspect resident rooms. He stated his daily rounds focused on safety violations and he was unaware of the issues in room 54. 3. Observation of the Sparks Hall revealed the following. a. The observation of the Sparks Hall occurred on 11-15-22 at 10:47am revealed the walls on either side of the hall at the bottom had several holes and the baseboards were peeling off allowing a resident to possibly obtain plaster or cut themselves if they were to grab a loose piece of baseboard. A second observation of the Sparks Hall occurred on 11-18-22 at 10:20am with the Maintenance Director and the Environmental Manager. The observation revealed the walls on either side of the hall at the bottom had several holes and the baseboards were peeling off. The Maintenance Director was interviewed on 11-18-22 at 10:38am. The Maintenance Director	F 584	A box was also placed in the business office for sharing work orders and concerns in written format. All staff facility members and contractors were educated on the policy, new work order box, and TELS system on Thursday, December 15 through December 21, 2022, by the facility administrator. All work orders (TELS and via the box) will be responded to in a reasonable amount of time (defined as 24 -48 hours). Newly hired staff will be educated by the Administrator/DON/Administrative nurses during orientation to the facility on: • Importance of reporting maintenance concerns including, cracked, damaged, turned, or missed receptacle covers, holes in walls, peeling cove base, and stained ceiling tiles and integrity of light fixtures. • Facility policy/procedure for sharing maintenance concerns - to post a ticket / maintenance work order via Point Click Care or to use the box for reporting work orders and concerns outside of the business office. Beginning the week of December 12, 2022, the maintenance director will make daily rounds throughout the facility, choosing five rooms per day for 6 weeks, to assess and identify: • holes in walls, • peeling cove base, and • stained ceiling tiles and integrity of light fixtures.	

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F 584	Continued From page 34 stated he had been aware of some of the issues on the Sparks Hall, but he stated there was not a plan to correct any of the issues. b. Room 55 was observed on 11-15-22 at 10:48am. The observation revealed the baseboards in the bathroom were peeling off the wall allowing a small hole in the wall and paint peeling off the dressers exposing wood. During a second observation of room 55 on 11-18-22 at 10:22am with the Maintenance Director and the Environmental Manager revealed the baseboards in the bathroom were peeling off the wall allowing a small hole in the wall and paint peeling off the dressers exposing wood. The Maintenance Director was interviewed on 11-18-22 at 10:38am. The maintenance Director stated he was unaware of the issues found in room 55. An interview with the facility's Corporate Manager occurred on 11-18-22 at 11:00am. The Corporate Manager discussed the facility had 52 rooms recently renovated and supplied a renovation worksheet for the 52 rooms dated 6-6-22. The Corporate Manager stated the facility had plans on moving the residents to the renovated area but had not completed the task. She also stated the facility did not have a time frame or written plan in place to complete the needed repairs. On 11-18-22 at 11:37am, the Corporate Manager provided a sheet of paper outlining a plan for continued renovations and when the residents would be moved to the new renovated area. She stated prior to the observations made with the	F 584	Rounds will be documented on an audit sheet and turned into the Administrator daily. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: 12/23/2022.	

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F 584	Continued From page 35 Maintenance Director and Environmental Manager on 11-18-22 there had not been a plan in place for further renovations. The Administrator was interviewed on 11-18-22 at 2:21pm. The Administrator discussed the building being old and repairs needed to be made but said the facility was in the process of doing upgrades.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		12/23/22

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F 657	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to revise the comprehensive care plan in the areas of pressure ulcers (Resident #67) and antianxiety medication (Resident #50). This was for 2 of 23 residents whose care plans were reviewed. Findings included: 1. Resident #67 was admitted to the facility on 6/25/20. A review of Resident #67's quarterly Minimum Data Set (MDS) assessment dated 7/15/22 revealed he was severely cognitively impaired. He was at risk for pressure ulcers. He had no unhealed pressure ulcers. A review of the comprehensive care plan for Resident #67 revealed a focus area initiated on 7/29/22 of suspected deep tissue injury to bilateral heels. The goal last revised on 11/16/22 was for Resident #67 to show signs of healing. An intervention was pressure relieving boots bilaterally. On 11/15/22 at 3:05 PM Resident #67 was observed in bed. He was not observed to be wearing pressure relieving boots. On 11/17/22 at 11:21 AM Resident #67 was observed in bed. He was not observed to be wearing pressure relieving boots. On 11/17/22 at 11:24 AM an interview with Medication Aide #1 indicated she was caring for Resident #67. She went on to say she was not	F 657	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 17, 2022, the MDS coordinator updated the care plan for Resident #67 and resident #50. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility's MDS team and Interdisciplinary Team attended an in-service presented by the Facility Nurse Consultant on December 16, 2022. The in-service covered the following topics: • F 657 Comprehensive Care plan regulations • Facility Policy and Practice 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Administrative nurses will complete an initial baseline audit of 100% of all care plans using the Comprehensive Care Plan Monitoring Tool December 16 through December 23, 2022, to assure that changes in status or modified interventions have been addressed and documented regarding the resident's care.	

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F 657	Continued From page 37 aware of Resident #67 needing to wear pressure relieving boots. She stated she did not have access to care plans. She went on to say Resident #67 had some pressure relieving boots in his closet, but normally the nurse would let her know if she needed to put these on a resident. On 11/17/22 at 11:31 AM an interview with Nurse #2 indicated she was caring for Resident #67 that day. She stated this was her first day back to work in a couple of weeks. She went on to say if a resident needed to wear pressure relieving boots it would be listed on the Treatment Administration Record (TAR). She further indicated Resident #67 did not have pressure relieving boots listed on his TAR. Nurse #2 stated she had not had a chance to review any residents' care plans that day and did not know if Resident #67 had pressure relieving boots on his care plan. She went on to say she knew Resident #67 used pressure relieving boots at one time but she did not think he still needed them. On 11/17/22 at 2:27 PM an interview with the Treatment Nurse revealed she was familiar with Resident #67. She stated at one time she initiated pressure relieving boots as an intervention because he developed deep tissue injuries on his heels. She stated Resident #67 was doing much better, was up and walking, and the deep tissue injuries were healed as of 9/14/22. She went on to say Resident #67 no longer needed pressure relieving boots. She further indicated the MDS Nurse would be the person to remove them from Resident #67's care plan. On 11/17/22 at 2:36 PM an interview with MDS Nurse #1 indicated Resident #67's last interdisciplinary team (IDT) meeting was on	F 657	Subsequent audits will be conducted by the Director of Nursing or designee who will review a random sample of care plans one (1) time per week for one (1) month and every other week for (1) month using the Comprehensive Care Plan Monitoring Tool to assure the review and revision of care plans. Results will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Findings of this audit will be discussed with the resident council. Corrective action completion date: December 23, 2022.	

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F 657	Continued From page 38	F 657		

11/2/22. She stated she should have removed the pressure relieving boots from Resident #67's care plan at that time as he no longer needed them but they had not been. She went on to say this had been an oversight on her part.

On 11/18/22 at 3:18 PM an interview with the Director of Nursing (DON) indicated resident care plans should be accurate and should be revised to reflect their status.

2. Resident #50 was admitted to the facility on 2/15/22 with a diagnosis of anxiety disorder.

A review of Resident #50's quarterly Minimum Data Set (MDS) assessment dated 8/19/22 revealed she was severely cognitively impaired. She did not receive any antianxiety medications in the 7 day look back period of this assessment.

A review of Resident #50's medical record revealed a physician's order dated 2/16/22 for lorazepam 0.5 milligram (mg) tablet every 8 hours as needed for anxiousness. It further revealed this order was discontinued on 2/28/22 due to ineffectiveness. There were no additional orders for lorazepam found in Resident #50's medical record.

A review of Resident #50's comprehensive care plan last revised on 8/24/22 revealed a focus area initiated on 2/16/22 of antianxiety medication (lorazepam).

On 11/17/22 at 2:44 PM an interview with MDS Nurse #1 indicated she would have been responsible for removing the antianxiety medication focus area for lorazepam from Resident #50's care plan after the 8/24/22

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F 657	Continued From page 39 interdisciplinary team (IDT) meeting as Resident #50 was no longer taking that medication. She stated this was just an oversight on her part. On 11/18/22 at 3:18 PM an interview with the Director of Nursing (DON) indicated resident care plans should be accurate and should be revised to reflect their status.	F 657		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and Physician interview, the facility failed to initiate new treatment orders for pressure ulcer treatment and perform pressure ulcer treatment as ordered by the Physician for 1 of 4 resident (Resident #25) reviewed for pressure ulcers. Findings included: Resident #25 was admitted to the facility on 7-14-22 with multiple diagnoses that included	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected include: The Treatment Nurse was counseled by the Chief Clinical Officer on November 17, 2022, regarding the importance of obtaining and documenting physician orders and performing treatments as ordered by the physician. Resident #25 discharged home from the	12/15/22

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F 686	Continued From page 40 pressure ulcer of buttock and hip unstageable. The quarterly Minimum Data Set (MDS) dated 10-19-22 revealed Resident #25 was cognitively intact and was documented for her pressure ulcers. Resident #25's care plan dated 10-21-22 revealed a goal that her pressure ulcer would show signs of healing and remain free from infection. The interventions for the goal were administer medications as ordered, administer treatments as ordered. Physician order from the wound care clinic dated 10-28-22 revealed an order for Resident #25 to have her right hip wound cleaned with soap and water, then apply Prisma (wound treatment) to wound bed and cover with foam dressing. There was no indication this order had been received or processed by facility staff. A review of Resident #25's Treatment Administration Record (TAR) for the months of October and November 2022 revealed the order from the wound care clinic dated 10-28-22 was not documented on the TAR. Resident #25's TAR for the month of October and November 2022 revealed the resident was receiving the following pressure ulcer treatment to her right hip; clean right hip with Dakin's (antiseptic cleaner) 0.5% and apply Dakin's moist gauze daily. Resident #25 was interviewed on 11-15-22 at 12:31pm. The resident discussed having a pressure ulcer on her right hip and stated it had been there for a "long time". Resident #25	F 686	facility on November 23, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% residents with pressure ulcers have the potential to be affected. A review of all current residents with pressure ulcers was completed by the Director of Nursing and Treatment Nurse to assure appropriate orders were in place. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel (RNs, LPNs, including the Treatment Nurse) were in-serviced on the week of December 5, 2022, by the Director of Nursing. This in-service included Facility policy # 8.3 Pressure Injury Prevention and Management. The Treatment nurse was in-serviced by the Director of Nursing on December 15, 2022, regarding the following items: " Initiating new treatment orders as written by the physician, " Performing pressure ulcer and any other treatments as ordered by the physician, " Completing weekly wound assessments and documenting them timely in the electronic medical record, " Utilizing staff for assistance with treatments as needed, " Proper hand hygiene,	

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F 686	Continued From page 41 explained she went to the wound care clinic monthly and saw their wound care physician. She stated the facility Treatment Nurse provided the pressure ulcer treatments once a day. An observation of Resident #25's right hip pressure ulcer care with the facility's Treatment Nurse occurred on 11-15-22 at 3:37pm. Resident #25's wound bed was beefy red with pink edges and minimal drainage. There were no signs or symptoms of an infection present. The Treatment Nurse cleaned the pressure ulcer with normal saline, applied calcium alginate with silver then covered with a foam dressing. The Treatment Nurse was interviewed on 11-16-22 at 12:20pm. The Treatment Nurse initially stated she was unaware of the Physician order from the wound clinic for Prisma and the pressure ulcer to be cleaned with soap and water but then stated the facility had not been able to receive Prisma for the past 2 months, so she had been using calcium alginate with silver for Resident #25's right hip pressure ulcer since 10-28-22. She also explained she had been using an antiseptic cleanser until 11-14-22 when she changed to the normal saline cleanser. The Treatment Nurse stated she was unaware she had to write an order if she was substituting a treatment. She also stated she had not discussed the change in treatment with the wound care clinic and added she had discussed the change in treatment with the facility Physician. An attempt was made to contact the wound care clinic Physician on 11-16-22 at 2:00pm. A message was left for a return call. A telephone interview occurred with the facility	F 686	" Notifying the Director of Nursing if ordered treatment supplies are not readily available, " Completing and documenting all coordination with providers to include wound clinics, consulting physicians, and the facility Medical Director 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning week of December 15, 2022, the Director of Nursing or designee will observe the Treatment Nurse performing treatments for residents with pressure ulcers. The DON will review all orders form facility providers as well as consulting MDs to assure that treatments orders are initiated and preformed as ordered. Treatment observations will occur at the following frequency: " 5 residents a week for 2 weeks, " 2 residents a week for 4 weeks Carrolton Facility Management Facility Nurse Consultant or Chief Clinical Officer will monitor results of the weekly treatment observations for 6 weeks. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for	

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F 686	Continued From page 42 Physician on 11-17-22 at 3:35pm. The facility Physician stated he did not remember the Treatment Nurse discussing a change in Resident #25's wound care treatment. He stated the Treatment Nurse had the discretion to substitute products but that he would expect an order to be written. The Director of Nursing (DON) was interviewed on 11-17-22 at 3:46pm. The DON stated she was unaware of the wound care clinic's order for Resident #25 written on 10-28-22 and was not aware the order had not been transcribed onto the TAR. The DON said she would expect the Treatment Nurse to follow the Physician orders and if there had to be a change, the change would be discussed with the Physician and an order written. During an interview with the Administrator on 11-18-22 at 2:21pm, the Administrator stated she expected staff to follow up with the wound care clinic and any changes be discussed with the Physician and an order written.	F 686	comment and suggestions. Corrective action completion date: December 15, 2022. Pressure Injury Prevention and Management Policy Date Implemented: 10/1/2020 Date Reviewed/ Revised: Policy #8.3 Policy:This facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. Definitions: “Pressure Ulcer/Injury” refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. “Avoidable” means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident’s clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Policy Explanation and Compliance Guidelines: 1. There are multiple terms used to describe this type of skin damage, including pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed	

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F 686	Continued From page 43	F 686		

sore. For purposes of this policy, pressure injury, as the current standard terminology, will be used.

2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate.

3. Assessment of Pressure Injury Risk
a. Licensed nurses will conduct a pressure injury risk assessment in the electronic medical record on all residents upon admission/re-admission, weekly x four weeks, then monthly or whenever the resident's condition changes significantly.
b. The tool will be used in conjunction with other risk factors not captured by the risk assessment tool. Examples of risk factors include, but are not limited to:
i. Impaired/decreased mobility and decreased functional ability:
ii. Co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
iii. Drugs such as steroids that may affect healing;
iv. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency;
v. Exposure of skin to urinary and fecal incontinence;

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F 686	Continued From page 44	F 686	vi. Under nutrition, malnutrition, and hydration deficits; and vii. The presence of a previously healed pressure injury. c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse and documented in the electronic medical record. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task. f. Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed. 4.Interventions for Prevention and to Promote Healing a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. b. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g.,	

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F 686	Continued From page 45	F 686	moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). c. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: i.Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); ii. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; iii. Provide appropriate, pressure-redistributing, support surfaces; iv. Maintain or improve nutrition and hydration status, where feasible. d. Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present. i. Pressure injuries will be differentiated from non-pressure injuries, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Treatment decisions will be based on the characteristics of the wound,including the stage, size, amount of exudate, and presence of pain,infection, or non-viable tissue. e. The goals and preferences of the resident and/or authorized representative will be included in the plan of care.	

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F 686	Continued From page 46	F 686	f. Interventions will be documented in the care plan and communicated to all relevant staff. g. Compliance with interventions will be documented in the weekly summary charting. 5. Monitoring a. The RN Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. iii. Any complications (such as infection, development of a sinus tract, etc.) as needed. c. A Focused Incident Review will be performed on each pressure injury that develops in the facility. Findings will be reported in the monthly QAA Committee Meeting. d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified. 6. Modifications of Interventions a. Any changes to the facility's pressure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 686	Continued From page 47	F 686	injury prevention and management processes will be communicated to relevant staff in a timely manner. b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: i.Changes in resident's degree of risk for developing a pressure injury. ii.New onset or recurrent pressure injury development. iii.Lack of progression towards healing. iv.Resident non-compliance. v.Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.	
F 689 SS=D	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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility failed to provide a hazard free environment by leaving an electrical outlet uncovered with exposed wires for 1 of 6 residents reviewed for accidents (Resident #4). Findings included:	F 689	1. Immediate action(s) taken for the resident(s) found to have been affected include: The one outlet cover in the room of patient # 4 was turned back to it's proper position prior to the survey exit. The maintenance director assessed the outlet and determined there was no	12/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 689	Continued From page 48 Resident #4 was admitted to the facility on 10/30/19. Resident #4's minimum data set assessment dated 10/27/22 revealed she was assessed as cognitively intact. During observation of Resident #4's room on 11/15/22 at 2:43 PM an electrical outlet cover was observed ajar, and electrical wires were observed uncovered in Resident #4's room under the room's air-conditioning unit. During an interview on 11/15/22 at 2:45 PM Resident #4 stated it did not bother her that the outlet was uncovered but understood it could be a safety issue for someone else. During observation on 11/16/22 at 2:50 PM the electrical outlet was observed to still have exposed electrical wiring and the cover was still ajar. During an interview on 11/16/22 at 2:54 PM Medication Aide #2 stated she was Resident #4's Medication Aide for that day. She stated if staff had concerns with a resident's room needing repairs to avoid being a hazard, they would report the issue to the Maintenance Director via his electronic work order tracking system. She concluded she did not notice the outlet wires were uncovered. During an interview on 11/16/22 at 2:55 PM the Director of Nursing stated the outlet should not have been uncovered and it should have been reported to maintenance	F 689	hazardous condition present. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with exposed outlet receptacles have the potential to be affected. A tour of the facility during the survey revealed no other covers out of place. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: During the survey, a tour of the facility was conducted by the maintenance director to ensure that no other receptacles needed attention. The corporate VP of Property toured the facility on Tues, December 13, 2022 to assessing outlet covers. The maintenance director accompanied him. No cracked receptacles or loose wires were identified. All staff were educated on the importance of reporting cracked, damaged, turned, or missed receptacle covers. The facility policy was reviewed, and all staff members were reminded that the facility policy for sharing maintenance concerns is to post a ticket / maintenance work order via Point Click Care. A box was also placed in the business office for sharing work orders and concerns in written format. All staff members were educated on the	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 689	Continued From page 49 During an interview on 11/16/22 at 3:02 PM the Maintenance Director stated when staff identified issues with a resident's room that required his attention, they enter it into his electronic work order tracking system. Resident #4's room outlet was not in the system, and he was not aware of any concerns with Resident #4's outlet not being covered. He concluded it appeared a screw was missing on the cover. During an interview on 11/18/22 at 2:25 PM the Administrator stated the electrical outlet should have been covered and was a hazard to the residents.	F 689	policy, new work order box, and TELS system on Thursday, December 15 through December 21, 2022. All work orders (TELS and via the box) will be responded to in a reasonable amount of time (defined as 24 -48 hours). 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The maintenance director will make daily rounds throughout the facility, choosing five rooms per day to check every outlet cover and identify other maintenance concerns. Rounds will be documented on an audit sheet and turned into the Administrator daily. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: 12-21-22.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		12/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 761	Continued From page 50	F 761		

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews the facility failed to keep medications locked while unattended for 1 of 1 treatment carts observed and failed to refrigerate insulin for 1 of 3 medications carts observed (Treatment Cart #1, Medication Cart #1).

Findings included:

During observation on 11/15/22 at 10:49 AM Treatment Cart #1 was observed unattended in the main entry hallway with a housekeeper next to the unlocked cart. At 11:50 AM a therapist was observed passing the unlocked treatment cart.

1. Immediate action(s) taken for the resident(s) found to have been affected include:
The Treatment Nurse was counseled by the Director of Nursing on November 15, 2022, regarding the importance of locking the treatment cart when unattended.

Nurse #5 was counseled by the Director of Nursing on November 15, 2022, regarding the importance of keeping unopened insulin refrigerated until used. The unrefrigerated insulin was discarded.

2. Identification of other residents having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 761	Continued From page 51 During an interview on 11/15/22 at 10:51 AM the Treatment Nurse stated treatment carts were to be locked when left unattended due to the medications in the cart. She further stated she remembered something she forgot and left the cart in the entrance hallway unlocked and forgot to lock it and should have locked it. During observation with the Treatment Nurse on 11/15/22 at 10:52 AM the treatment cart was observed to contain items including barrier film normal saline, vitamin A&D ointment barrier spray, Minerin cream, bacitracin ointment, Iodoform packing strips, antifungal powder, Thera Antifungal body powder, silver alginate bandages, Povidone-Iodine USP swab sticks, Neosporin, Nystatin cream USP, Mupirocin Ointment, Ketoconazole cream, Santyl cream, med honey, and hydrocortisone cream. During an interview on 11/17/22 at 4:13 PM the Director of Nursing stated treatment carts were to be locked when unattended. 2. Observation of a medication cart located on "Peele Hall" occurred on 11-15-22 at 2:30pm. Nurse #5 was present during the examination of the medication cart. The observation revealed Humalog (insulin) 100 (milligrams)mg/ (milliliter)ml multi-vial that was unopened in the top drawer of the medication cart. The multi-vial had a label to refrigerate until opened. Nurse #5 was interviewed on 11-15-22 at 2:37pm. The nurse stated she was unaware how often the medication carts were checked for expired or unopened medication and was unaware the unopened multi-vial insulin needed to be refrigerated.	F 761	the potential to be affected was accomplished by: The facility has determined that 100% residents have the potential to be affected, including all residents that receive insulin and any that may encounter an unlocked treatment or medication cart. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing personnel (RNs, LPNs and Medication Aides) were in-serviced on December 14-19, 2022, by the Pharmacy Nurse Consultant, Consulting Pharmacist and Director of Nursing. The in-services included the following information: Medication Administration Medication Storage Medication Carts Security Glucometers Inhalers Insulin Medication Disposal Facility Policies (NC SNF Pharmacy Policy and Procedure Manual) Medication Storage, Insulin Storage and Medication Storage-Key Authorization 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The ADON and administrative nurses will complete weekly random medication storage audits using the Medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 761	Continued From page 52 The Director of Nursing (DON) was interviewed on 11-15-22 at 2:42pm. The Don explained the hall nurse, Unit Manager or Pharmacist should be checking the medication carts every week. She stated she expected the nurses to be checking the insulins for the date the insulin was opened and the expiration date prior to using. The DON also said if there was an insulin unopened, the insulin needed to stay in the refrigerator until it was needed. During an interview with the Administrator on 11-18-22 at 2:21pm, the Administrator stated the Humalog should have remained in the refrigerator until it was needed. She explained the facility provided training to the nurses on medication storage but was unaware if Nurse #5 had the training.	F 761	Storage/Observation Weekly Inspection tool weekly for 12 weeks (December 6, 2022, through February 24, 2022. The ADON and administrative nurses will also complete weekly random medication administration audits using the Medication Pass Worksheet tool weekly for 12 weeks (December 6, 2022, through February 24, 2022. Medication Storage/Observation Weekly Inspection and Medication Pass Worksheet tools will be reviewed weekly by the Director of Nursing for 12 weeks. Additional Medication Storage audits will be completed by consulting pharmacy team members in December, January, and February. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 20, 2022	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		12/12/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 812	Continued From page 53 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 and staff interviews the facility failed to have a barrier between a nurse aide's (Nurse Aide #1) bare hands and ready to eat food for 1 of 4 dining observations. This practice had the potential to affect food served to a resident. Findings included: During observation on 11/16/22 at 7:34 AM Nurse Aide #1 was observed providing a meal tray to a resident in their room. She was observed to move the tray over the bed, adjust the height of the tray, and then remove the heat top off the tray. She then held the resident's piece of toast with her bare hand as she spread jelly on the toast. During an interview on 11/16/22 at 7:41 AM Nurse Aide #1 stated she knew not to touch resident	F 812	1. Immediate action(s) taken for the resident(s) found to have been affected include: Nursing assistant #1 promptly discarded of the toast as soon as the surveyor brought it to her attention. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of the residents are at risk. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing assistant #1 serving food to the resident was immediately reeducated	

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	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 812	Continued From page 54 food and to hand sanitize following touching resident items, but she was moving fast and did not realize it. During an interview on 11/16/22 at 7:45 AM the Director of Nursing stated staff were not to touch resident food with bare hands and the nurse aide should not have touched the toast. She concluded staff had been educated on this.	F 812	about “safe handling” of resident’s food. All staff were educated on November 30, 2022 (by the Director of Nursing) on the proper technique for serving patient meals. Inservice included hand sanitizing and utilization of fork and knife to maneuver and protect resident food items. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Meal observations will be monitored daily by the DON, Unit Manager, Activity Staff, and /or designee. • Five residents per week will be observed during meal time to ensure that proper food safety measures are in place for six weeks and thereafter as deemed appropriate. • Audit tool, “meal observation” will be utilized for the monitoring. Audit records will be reviewed by the /Quality Assurance Committee until such time as consistent substantial compliance has been achieved. Corrective action completion date: December 12, 2022	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867		12/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF WILLIAMSTON	119 GATLING STREET WILLIAMSTON, NC 27892

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F 867	Continued From page 55	F 867		

monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/18/2022

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F 867	Continued From page 56	F 867		

systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 57 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's Quality Assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the survey 11/22/19 and 6/10/21 in order to achieve and sustain compliance. This was for 5 recited deficiencies on a recertification	F 867	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 18, 2022, through December 15,2022, Carrolton Facility Management team members held a series of meetings with the facility administrative team and	

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F 867	Continued From page 58 survey on 11/18/22. The deficiencies were in the areas of dignity, the right to forms of communication in private, care plan timing and revision, storage of drugs and biologicals, and sanitary food service. The continued failure during these federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F550 - Based on observation, staff interviews, and record review the facility failed to treat residents in a dignified manner by scolding a resident after the resident overturned a mop bucket for 1 of 3 residents reviewed for dignity (Resident #71). During the recertification and complaint investigation survey of 6/10/21 the facility was cited for failing to treat residents in a dignified manner as evidenced by staff standing while providing assistance with eating and failing to prevent staff from making inappropriate verbal statements to residents. During the recertification and complaint investigation survey of 11/22/19 the facility was cited for failing to treat a resident with dignity and respect by labelling a resident who required assistance with meals as a "feeder" and providing a meal tray to a resident 20 minutes prior to the rest of the residents eating in the dining room. F576 - Based on staff and resident interviews and record review the facility failed to provide access to resident funds during the weekend for 2 of 2	F 867	contractors to discuss survey findings and develop the respective plans of correction. These meetings included but were not limited to: " November 18, 2022- meeting with facility administrative team to discuss survey findings " November 22, 2022- meeting to revise the Facility Emergency Plan " November 30, 2022- meeting with facility Administrator/DON to discuss survey follow up and monitoring " December 5, 2022, and December 6, 2022- meetings to discuss 2567 Summary of Findings " December 12, 2022, to complete RCA and discuss DPOC " December 13, 2022- meeting with all Carrolton Facility Administrators and DONs to discuss recent survey findings, corrective actions, monitoring and evaluation practices. " December 14, 2022, and December 15, 2022, to finalize plan of correction and discuss upcoming Resident Council and QAPI meetings. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 867	Continued From page 59 residents reviewed for personal funds. (Resident #4, Resident #12) During the recertification and complaint investigation survey of 11/22/19 the facility was cited for failing to deliver mail to residents on Saturdays. F657 - Based on observations, record review and staff interviews the facility failed to revise the comprehensive care plan in the areas of pressure ulcers (Resident #67) and antianxiety medication (Resident #50). This was for 2 of 23 residents whose care plans were reviewed. During the recertification and complaint investigation survey of 6/10/21 the facility was cited for failing to update a care plan for siderails. During the recertification and complaint investigation survey of 11/22/19 the facility was cited for failing to review and/or revise the care plan to reflect the individual care needs. F761 - Based on observation and staff interviews the facility failed to keep medications locked while unattended for 1 of 1 treatment carts observed and failed to refrigerate insulin for 1 of 3 medication carts observed (Treatment Cart #1, Medication Cart #1). During the recertification and complaint investigation survey of 6/10/21 the facility was cited for failing to discard expired medications, failing to monitor the temperature of a medication storage refrigerator containing medications, and failing to lock an unattended medication storage cart.	F 867	Detailed plans of correction, along with monitoring tools have been developed and executed to address all survey findings including the repeat deficiencies cited (dignity, the right to forms of communication in private, care plan timing and revision, storage of drugs and biologicals, and sanitary food service). The facility administrator/DON will meet with the facility administrative team to give updates regarding thee submitted plan of correction on December 19, 2022. All areas of deficient practice have been added to the facilities QAPI plan and will be reviewed in the QAPI meeting scheduled for December 27, 2022, at 2:00 pm. Facility administrative staff will be in-serviced by Chief Clinical Officer or designee on December 27, 2022. This in-service will cover implementation, monitoring and revisions of action plans and processes to achieve and sustain compliance. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The facility Administrator will assure that audit schedules are followed, and findings are presented to the QAPI team monthly and as needed. Areas of concern will immediately be addressed by the Administrator and QAPI team including staff re-training and plan	

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F 867	Continued From page 60 F812 - Based on observations and staff interviews the facility failed to have a barrier between a nurse aide's (Nurse Aide #1) bare hands and ready to eat food for 1 of 4 dining observations. This practice had the potential to affect food served to a resident. During the recertification and complaint investigation survey of 11/22/19 the facility was cited for failing to date milk shakes after removal from the freezer in order to track the shelf life; failing to use an ice scoop in a manner to prevent contamination; and failing to keep dirty and clean dishes separate in the kitchen. During an interview on 11/18/22 at 4:19 PM the Administration stated her first day at work with this facility was on 11/7/22 and she had not had sufficient time to fully familiarize herself with this facility and was unsure why these repeated deficiencies were ongoing at this time.	F 867	revisions. Carrolton Facility Management Corporate staff members will oversee facility QAPI meetings and survey corrective action monthly until consistent substantial compliance has been achieved. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 30, 2022.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/30/22

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F 880	Continued From page 61 §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 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	F 880		

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F 880	Continued From page 62 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician interviews, the facility failed to follow infection control practices when 4 of 4 staff members (Medication Aide #2, Medication Aide #4, Treatment Nurse, and Housekeeper #2) failed to perform hand hygiene between tasks and don a gown when entering a resident's room (Resident #79) who was on contact precautions. Findings included: Review of the facility's "Hand Hygiene" policy dated 10-1-22 revealed in part; perform hand hygiene prior to donning gloves and immediately after removing gloves. 1. An observation of Medication pass occurred on 11-16-22 at 8:10am with Medication Aide #2. The Medication Aide was observed to don a pair of gloves, pick up the resident's medication from the medication cart, walk into the resident's room, place the medication on the resident's table touching the top of the table, providing the resident with his medication in pill form with a glass of water touching the rim of the cup after the resident had drank the water, then provided	F 880	CARROLTON OF WILLIAMSTON Directed Plan of Correction Including Root Cause Analysis Date of Compliance: December 30, 2022 DIRECTED PLAN OF CORRECTION Background Carrolton is a 150-bed licensed skilled nursing facility in Williamston, North Carolina, with an average daily census of 89 for the past year. The facility provides skilled nursing and rehabilitative services to short-term, long-term, and residents seeking respite. The facility also received citations related to infection control in November 2022 on our annual survey. These citations included failure to perform proper hand hygiene and failure to don a gown when entering a resident's room on contact isolation. The facility has participated in and successfully completed two QIO Quality Improvement Initiatives related to	

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F 880	Continued From page 63 the resident his inhaler medication touching the mouth piece of the inhaler after the resident used the inhaler and then without changing gloves or performing hand hygiene, the Medication Aide provided the resident his eye drops touching the residents eye lids. Medication Aide #2 was interviewed on 11-16-22 at 8:15am. The Medication Aide stated she had received education on passing medication by the Pharmacist and was not aware she should have performed hand hygiene and changed her gloves prior to providing the resident his eye drops. The Director of Nursing (DON) was interviewed on 11-16-22 at 9:13am. The DON stated the proper procedure would have been for Medication Aide #2 to remove her gloves, perform hand hygiene and don another pair of gloves prior to providing the resident with his eye drops. 2. An observation of medication pass occurred on 11-16-22 at 8:20am with Medication Aide #4. The Medication Aide was observed preparing a resident's medication that included pills and creams. The Medication Aide was observed to don a pair of gloves without performing hand hygiene then walked into the resident's room and provided the resident with his pills and cream. The Medication Aide was observed washing his hands prior to leaving the resident room. During an interview with Medication Aide #4 on 11-16-22 at 8:39am, the Medication Aide stated he was aware he should perform hand hygiene prior to donning his gloves but stated he was nervous and forgot. He also discussed receiving education from the Pharmacist on passing medication which included hand hygiene.	F 880	Infection Control related to Covid-19 outbreaks (2021 and again in 2022). Methodology The root cause analysis was completed using a multi-faceted approach. Survey History-Facility infection control surveys from 2020 to current were reviewed and analyzed for trends/patterns to include causes of infection control deficiency and assigned scope/severity. Facility Practice □ Foundational systems for support of sustained compliance were evaluated. These reviews consisted of an analysis of the facility's structure and processes related to: Interview with staff cited in the 2567 Review of the use of PPE in the facility Review of handwashing Review of the use of PPE to include Gown Use Assessment of system monitoring for infection control practices Sufficient Hand Hygiene supplies Personal Protective Equipment inventory and availability Observation of donning and doffing PPE Review environmental cleaning and disinfection observation Review areas identified for Contact Isolation, including signage and PPE carts Quality Assurance / Performance Improvement plans and implementation as it	

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F 880	Continued From page 64 The Director of Nursing (DON) was interviewed on 11-16-22 at 9:13am. The DON stated Medication Aide #4 had received education on proper hand hygiene which included performing hand hygiene prior to donning gloves. She stated she would have expected the Medication Aide to perform hand hygiene between tasks and donning gloves. The facility Pharmacist was interviewed on 11-16-22 at 1:15pm. The Pharmacist stated she observed one medication pass a month and provided a yearly in-service on general medication administration. She clarified that she does not speak of hand hygiene specifically unless she was discussing a medication that required immediate hand hygiene. 3. An observation of wound care occurred on 11-15-22 at 3:37pm with the Treatment Nurse. The Treatment Nurse was observed to don a pair of gloves, clean the resident's wound, remove her gloves and without performing hand hygiene donned another pair of gloves to place a clean dressing on the resident's wound. The Treatment Nurse was observed to wash her hands prior to leaving the resident's room. During an interview with the Treatment Nurse on 11-15-22 at 3:44pm, the Treatment Nurse stated she was aware she should have performed hand hygiene prior to donning another pair of gloves but stated she did not have any hand sanitizer and she did not want to turn her back on the resident leaving her wound exposed to go wash her hands. She said if she would have had an assistant, she would have washed her hands prior to donning a new pair of gloves.	F 880	relates to hand hygiene and proper use of PPE. Analysis Facility Leadership / Corporate Support Corporate Structure / Oversight Carrolton Facility Management initiated a comprehensive Infection Control Plan initiated in October 2020. The administrative team received extensive training, as guidance was developed to coincide with CDC, CMS, and state requirements. The Carrolton Facility Management Director of Infection Control/Facility Nurse Consultant does routine visits at a minimum monthly and clinical services. Staff Competency In-service Education / Orientation Orientation is completed upon hire, and in-services are reviewed with staff annually and as needed. Corporate updates guidance as CDC, CMS, and State office information is received regarding Infection Control Procedures. Observations Observations noted during the review by the surveyor noted: An alleged failure of staff to correctly complete hand hygiene during wound care on November 15, 2022, at 3:37 pm and a medication pass on November 16, 2022, at 8:20 am. An alleged failure to don a gown when entering a room of a resident on contact isolation on November 16, 2022 Root Cause Analysis Review	

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F 880	Continued From page 65 A telephone interview occurred with the facility's Physician on 11-17-22 at 3:35pm. The Physician stated he would have expected staff to perform hand hygiene between residents, between activities and prior to donning gloves. The Director of Nursing (DON) was interviewed on 11-17-22 at 3:46pm. The DON stated she would have wanted to see the Treatment Nurse perform hand hygiene between steps in the wound care process to include performing hand hygiene after cleaning the wound and applying a clean dressing. The Administrator was interviewed on 11-18-22 2:21pm. The Administrator stated the facility had provided education on hand hygiene and did not know why staff were not performing hand hygiene. She said she expected staff to follow the hand hygiene policy. 4. A physician's order for Resident #79 dated 11/16/22 indicated contact precautions (everyone entering the room is to wear a gown and gloves) related to shingles (a reactivation of the chicken pox virus in the body causing a painful rash). On 11/16/22 at 2:45 PM an continuous observation revealed Resident #79 was asleep on his bed in his room on the memory care unit. A contact precautions sign was clearly posted on his room door. The sign specified all persons entering the room must perform hand hygiene before entering and before leaving the room, wear gloves when entering the room and when touching his intact skin, surfaces, or articles in close proximity and wear a gown when entering the room and whenever anticipating that clothing would touch items or potentially contaminated	F 880	The root cause analysis was completed on December 12, 2022, utilizing tools recommended by CMS. Group participants included: " Carrolton Facility Management Corporate Staff (Chief Operation Officer, Chief Clinical Officer, Vice President of Building and Properties, and the Corporate Director of Infection Control/Facility Nurse Consultant) " Facility Leaders (Administrator, Director of Nursing, and the ADON/Infection Preventionist) " Health Care Services Leadership (NC Director of Operations for Healthcare Services Group and the facility Director of Housekeeping) Causative Factors Identified: " The Treatment Nurse failed to have a second person assist with the resident's treatment and failed to have hand sanitizer in her pocket. The bed was lifted for treatment, and turning to wash her hands would have caused a safety issue for the resident. " Lack of knowledge related to policy, nervousness, and anxiety contributed hand hygiene errors with medication pass for Med Aide #4 " The small stop sign on the signage did not catch the attention of Housekeeper #2, who entered the contact isolation room without a gown. " The placement of PPE in the Alzheimer's unit contributed to housekeeper #2 missing the contact isolation. She stated she usually looks for the PPE	

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F 880	Continued From page 66 environmental surfaces. Housekeeper #2 was observed to enter Resident #79's room after performing hand hygiene and putting on gloves. She was not observed to wear a gown. Housekeeper #2 cleaned Resident #79's bedside table and other room surfaces, mopped his floor, and emptied his trash can. She exited his room, disposed of his trash bag, removed her gloves, and performed hand hygiene. She then put on a new pair of gloves and entered another resident's room. On 11/16/22 at 3:04 PM an interview with Housekeeper #2 indicated she saw the contact precautions sign posted on his door. She stated she normally would follow the instructions on contact precautions signs. She went on to say when she needed to wear a gown to enter a resident's room the gowns would be located at the entrance to the room. She further indicated because there were no gowns at the entrance to Resident #79's room she did not think she needed to wear one. On 11/18/22 at 8:07AM an interview with the Housekeeping Supervisor indicated Housekeeper #2 received education on following instructions specified on contact precautions signs which included wearing a gown when entering the room. She stated Resident #79 resided on the memory care unit. She went on to say because of the special needs of these residents, personal protection equipment (PPE) including gowns were kept in the nursing office on this unit rather than at the entrance to the room. The Housekeeping Supervisor stated Housekeeper #2 should have asked the nurse or another staff member when she didn't see the gowns at Resident #79's room entrance if she didn't know	F 880	cart outside of the door. The cart was in the office on the unit due to concerns for the demented residents' safety. Plan: " The group determined the facility's need to increase staff education and monitoring for correct hand hygiene and PPE use. Competency will be validated with a return demonstration for nursing and housekeeping staff. " Signage will also be revised to include a more vibrant color or a larger stop sign. " All staff will receive re-education on contact isolation. Causal Factors Paths Through Root Cause Map QAPI Program implementation QAPI meetings IDT daily meetings Investigation and validation On-going monitoring/auditing Staff competency Staff knowledge of QAPI Medical Director Involvement Leadership /Corporate Support Corporate oversight and support Staff Competency Response to survey findings Monitoring, validation, and accountability with nursing staff and housekeeping performance Staff competency with infection control following CDC, CMS, and State guidance. Communication Leadership	

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F 880	Continued From page 67 where they were kept. On 11/18/22 at 10:04 AM an interview with the Infection Preventionist Nurse (IP) indicated Resident #79 resided on the memory care unit. She stated due to the special needs of the residents on this unit, PPE including gowns was kept in the nursing office on this unit rather than at the entrance to the room. She went on to say Housekeeper #2 should have worn a gown as instructed on the contact precautions sign before entering Resident #79's room to clean. She further indicated if there were no gowns located at the room entrance and Housekeeper #2 did not know where they were kept, she should have asked another staff member. On 11/18/22 at 3:18 PM an interview with the Director of Nursing (DON) indicated PPE including gowns were kept in the nursing office on the memory care unit rather than at the room entrances. She stated Housekeeper #2 should have followed the instructions on the contact precautions sign posted on Resident #79's room door and worn a gown when she entered his room to prevent the spread of infection. She went on to say if Housekeeper #2 did not know where PPE was kept on this unit, she should have asked someone.	F 880	Corporate Support Facility Meetings Family and Resident updates on initiatives Plan of Correction: 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing re-educated the Treatment Nurse on November 15, 2022, regarding the importance of hand hygiene. Medication Aide #2 and Medication Aide #4 were re-educated by the DON regarding the importance of hand hygiene on November 16, 2022, by the DON. All Housekeeping staff were in-serviced on infection control procedures, including isolation precautions and appropriate PPE use, November 16, 2022 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Survey reminders were given by the DON on December 6, 2022, to include sanitizing hands and appropriate use PPE.	

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F 880	Continued From page 68	F 880	In accordance with the Directed Plan of Correction (DPOC), a facility management meeting was held in the facility on December 12, 2022, to complete the root cause analysis (RCA) and discuss the corrective action needed. Meeting participants included the Administrator, Director of Nursing, Corporate Infection Preventionist, Chief Operating Officer, Chief Clinical Officer, VP of Building and Properties, Facility Nurse Consultant, and the NC Director of Operations for Healthcare Services Group (HSG) -Housekeeping corporate employee. In-services were completed by the Corporate Director of Infection Control and the Director of Nursing on December 15, 2022, for all facility staff, including (NAs, LPNs, RNs) and housekeeping staff. The in-service included the following topics: " Hand Hygiene, " Transmission Based Precautions, " Standard Precaution " Use of Personal Protective Equipment including, donning, and doffing PPE " Review of UNC SPICE infection control signage including Transmission Based Precautions " Including the following facility policies: Carrolton Policy # IC 4.1 Transmission-Based (Isolation) Precautions Carrolton Policy # IC 4.2 Personal Protective Equipment	

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F 880	Continued From page 69	F 880	Carrolton Policy # IC 4.0 Standard Precautions In-services were completed by the Pharmacy Nurse Consultant December 19, 2022, for all facility staff, including (NAs, LPNs, RNs). In addition, housekeeping staff were re-assigned all in-services related to isolation precautions and cleaning in the course in the HSG catalog to be completed by December 15, 2022. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Infection Preventionist/Director of Nursing (DON), or designee, will observe facility staff (including nursing and housekeeping staff) on hand hygiene and the selection and use of PPE and donning/doffing PPE. " At least five (5) staff members per week will be observed over the next three (3) months to ensure staff are properly preforming hand hygiene. " At least (5) staff members per week will be observed over the next (3) months to ensure the appropriate use selection and use of PPE including donning and doffing PPE. Routine monitoring of proper hand hygiene, the selection and use of PPE including donning/doffing PPE has been added to the facility QAPI plan. Validation checklists will be reviewed by	

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F 880	Continued From page 70	F 880	the Corporate Infection Control Director. Observation reports and competencies will be reviewed by the Carrolton Facility Management (CFM) Compliance Team monthly until such time consistent and substantial compliance has been achieved as determined by CFM. Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 30, 2022. DPOC with RCA, Education Attestation, Education Proof, Skills Validation Tools uploaded	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 883		12/19/22

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F 883	Continued From page 71	F 883		

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal

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F 883	Continued From page 72 immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a pneumococcal vaccine (a vaccine which can prevent a type of bacterial lung infection) in accordance with the signed informed consent. This was for 1 of 5 residents (Resident #80) reviewed for immunizations. Findings included: A review of the Advisory Committee on Immunization Practice (ACIP) recommendations titled "Use of 15-Valent Pneumococcal Conjugate Vaccine (PCV) and 20-Valent PCV Among U.S. Adults: Updated Recommendations of the Advisory Committee on Immunization Practices" dated 1/28/2022 revealed in part, "Recommendations for use of 15-valent PCV in series with 23-valent pneumococcal polysaccharide vaccine (PPSV) or 20-valent PCV in PCV-naïve adults aged greater than or equal to19 years; Adults aged greater than or equal to 65 years who have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of PPSV23". A review of the facility policy titled "Pneumococcal Vaccine" last revised on 9/14/22 revealed in part, "Each resident will be assessed for pneumococcal immunization upon admission. Each resident will be offered a pneumococcal	F 883	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #80 was given the Pneumococcal Vaccine on December 6, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. The Infection Preventionist/Director of Nursing (DON), or designee, performed a 100% audit on current resident immunization records completed on December 15,2022, to ensure all immunization consents had appropriate follow up and requested immunizations have been given. Vaccines were ordered will be given for all identified residents requesting a vaccination. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Admission Coordinator and Infection Preventionist were in-serviced on	

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F 883	Continued From page 73	F 883		

vaccine unless it is medically contraindicated or the resident has already been immunized. A pneumococcal vaccine is recommended for all adults 65 years and older."
Resident #80 was admitted to the facility on 2/10/22 with a diagnosis of dementia.

A review of her quarterly Minimum Data Set (MDS) assessment dated 8/16/22 revealed she was 69 years old. She was severely cognitively impaired. She had not received the pneumococcal vaccine.

A review of a facility corporate Pneumococcal Vaccine Consent form for Resident #80 dated 2/10/22 signed by Resident #80's Representative (RP) revealed Resident #80 had no medical contraindications to receiving the vaccine. It further indicated the RP read the 2021-2022 Pneumococcal Vaccine Information Statement, understood the risks and benefits of the vaccine, and provided consent for Resident #80 to receive this.

A review of Resident #80's medical record revealed a physician's order dated 2/10/22 may give pneumococcal vaccine according to acceptable standards of clinical practice or unless medically contraindicated (consent at admission) entered by Nurse #1. Further review did not reveal any documentation evidence of administration of the vaccine or a refusal.

Attempts at telephone interview with Resident #80's RP were unsuccessful.

On 11/18/22 at 12:18 PM an interview with the Corporate Infection Preventionist (IP) revealed the facility process was to determine a resident's

December 15, 2022, on Influenza, Pneumococcal and COVID-19 immunizations including the verification process at time of resident admission.
The following Carrolton policies were also reviewed:
" Carrolton Policy # IC 5.0 Influenza Vaccination
" Carrolton Policy # IC 5.2 Pneumococcal Vaccine (Series)
" Carrolton Policy # IC 16.8 COVID-19 Vaccination

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
100% new admissions to the facility will be audited for weekly for 6 weeks, by the Director of Nursing or designee to assure that consents were obtained and vaccinations were given for all requested Influenza, Pneumococcal and COVID-19 immunizations.
The Carrollton Facility Management Director of Infection Control will review the weekly audits for 6 weeks.

The DON/Infection Preventionist will present the findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months.

Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee.

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F 883	Continued From page 74 pneumococcal vaccination status on their admission to the facility. She stated if a resident had no history of receiving a pneumococcal vaccine one would be offered. She went on to say Resident #80 had an informed consent for the pneumococcal vaccine dated 2/10/22 and the vaccine should have been administered by now and it's administration documented. The Corporate IP further indicated if Resident #80 had refused administration of the vaccine the refusal should be documented in her medical record. She further indicated it would be the admitting nurse's responsibility to verify the history of pneumococcal vaccine on admission and to get a physician's order to administer the vaccine if one was indicated. On 11/18/22 at 12:34 PM in an interview Nurse #1 stated she was the admitting nurse for Resident #80. She further indicated she did enter the facility standing order for the pneumococcal vaccine for Resident #80 on 2/10/22. She went on to say she was not aware this meant she was supposed to make sure Resident #80 received the vaccine. On 11/18/22 at 3:18 PM an interview with the Director of Nursing indicated someone should have followed up to make sure Resident #80 received her pneumococcal vaccine. She went on to say the facility was currently working on a process to ensure everyone knew who was responsible for doing what with regards to vaccines.	F 883	Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: December 19, 2022.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control	F 925		12/16/22

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F 925	Continued From page 75 program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain an effective pest control program for 1 of 4 halls reviewed for pests (Martin Hall). The findings included: Pest control summary of services from the pest control service were reviewed for the following dates of 1/24/22, 2/24/22, 3/18/22, 4/19/22, 5/19/22, 6/27/22. 7/25/22, 8/22/22, 9/29/22, 11/1/22. There were no recommendations on the materials summaries. Observation of the Martin unit on 11/15/22 at 12:52 PM flies were visible in Room #2. Resident #27 was observed to fan by his head to remove the fly. Observation of the Martin unit on 11/15/22 at 1:38 PM flies were visible in Room #1. Resident #44 was observed to swat a fly with a fly swatter he had in his hand. An interview was conducted with Resident #44 on 11/17/22 at 2:12 PM. Resident #44 was cognitively intact. Resident #44 stated that he always kept a fly swatter in his room. He stated that flies were an issue, and something needed to be done about them. An observation was conducted of the Martin unit on 11/17/22 at 12:43 PM. Resident #21 was observed sitting up in bed with his eyes closed. His uncovered tray was sitting on the bedside	F 925	1. Immediate action(s) taken for the resident(s) found to have been affected include: Immediately upon learning about the fly situation, the Administrator and Director of Nursing were called to join the Maintenance Director on the Martin Hall to assess the situation. The housekeeping director was notified and called to the hall. The VP of Property Management and the VP of Housekeeping for HSG, joined the senior team members. Resident #21 requested a fly swatter and the Maintenance Director offered to purchase one for him. All rooms on the Martin Hall including #21, #27, and #44 were assessed to determine the root cause of the excess of flies. A neighboring room, with an alert and oriented resident, (Resident #2 who maintains a fly swatter in his room) was found to have an assortment of food items in unsealed containers. Resident # 2's room was deep cleaned, the floors were mopped, all areas were sanitized, and the windows were cracked open. A sealed container will be provided for the resident #2, whose perishable food (fruit) was deemed to be the source of the problem. The resident roster does not have an entry for Resident #44. 2. Identification of other residents having the potential to be affected was	

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F 925	Continued From page 76 table and Resident #21 was observed with a fly sitting on his forehead and another fly sitting on his head. There were multiple flies in resident's room. An interview was conducted with Resident #21 on 11/17/22 at 12:58 PM. Resident #21 had moderate cognitive impairment. He stated that the flies were so aggravating, and something needed to be done about them. Resident #21 stated that he wished he had a fly swatter to kill the flies. An interview was conducted with Nursing Assistant (NA) #1 on 11/17/22 at 1:10 PM. NA #1 stated that the staff would normally get a fly swatter from maintenance when there were flies on the unit. The NA stated that she had verbally mentioned the issue to the Maintenance Director. The NA stated that there had been issues with flies in the facility at times. An interview was conducted with the Maintenance Director on 11/17/22 at 2:48 PM. The Maintenance Director stated that pest control service visited the facility once a month to spray for bugs. He stated the treatment did not target flies. The Maintenance Director stated that the facility did have a fly fan outside the entrance door to the facility but there were no other measures in place to control flies. He stated that the staff could ask for a fly swatter to kill the flies but the resident's did not have their own. The Maintenance Director further stated that any time there was a concern about pests the pest control service was immediately called to have them treat the facility as soon as possible. He stated that he had seen a few flies at times and staff had requested fly swatters to kill the flies.	F 925	accomplished by: Walk throughs were completed throughout the entire facility by the VP of Property Management and the VP of EVS. No other flies were identified. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Dodson Pest Control, our pest control contractor, was called and recommended ultraviolet fly traps. The light is on order and will be placed strategically on the hall. Housekeeping will make daily rounds on all halls, including the rooms of residents #21, #27, and #44, interviewing 5 residents, to inquire about flies or other pests. Housekeeping will assess the room of the resident (resident #2) with the stored food, as frequently as the patient will allow. Immediate action will be taken to correct problems identified. Nursing and dietary staff will encourage the resident to place his snacks in the sealed container. Manager on duty tool sheet will be updated to include questions about flies / pests. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Results of resident interviews will be submitted to the QAPI committee for analysis and trending until the problem is	

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F 925	Continued From page 77 An interview was conducted with the Administrator on 11/17/22 at 3:20 PM. The Administrator stated that the pest control service was conducted monthly and as needed. She stated that she had not been made aware of any issues with flies in the facility.	F 925	deemed corrected. Corrective action completion date: 12/16/22.	