STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 12/04/2023

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

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted on 12/04/23. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# S1YR11.	E 000		
F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted on 12/04/23. Event ID #S1YR11. The following intakes were investigated NC002209785 and NC00210039. 2 of 2 allegations did not result in deficiency.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide complete incontinent care and maintain personal hygiene for 1 of 4 dependent residents (Resident #2) reviewed for activities of daily living (ADL). The findings included: Resident #2 was admitted to the facility on 8/9/23 with diagnoses of debility, heart failure, diabetes mellitus, non-Alzheimer's dementia, chronic lung disease, and respiratory failure with hypoxia. The quarterly Minimum Data Set (MDS)	F 677	1) Resident #2 was provided incontinent ADL care on 12/4/2023 by NA #1 and medication aide #2. NA #1was re-educated on the facility policy on incontinent care. The education was provided by the Director of Nursing (DON) and/or Administrator and completed on 12/22/2023 2) All resident have the potential to be affected, therefore skill observations and re-education was provided for 100% of current certified nursing assistants on incontinent care. Skills observations and education was provided by the DON and	12/28/23

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

Electronically Signed | 12/28/2023

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F 677	Continued From page 1 assessment dated 11/9/2023 revealed that Resident #2's cogniton was moderately impaired.and was dependent for transfers, bathing, and moderate assistance with personal hygiene and bed mobility. Resident was coded as always incontinent of bowel and bladder. The MDS was coded as no behavior noted during assessment period. The care plan stated the resident requires substantial/max assistance for toileting hygiene, personal hygiene, bed mobility, turning, and repositioning in bed. An observation on 12/4/23 at 9:40 AM revealed Resident #2 had bowel movement on the front side of her gown, abdomen, both legs, peri area, and on the bedding underneath her. Nurse Aide (NA) #1 was observed using the corners of a large bath towel to clean Resident #2. NA#1 started incontinence care with one towel and one brief. There was liquid bowel movement noted on the resident's peri area, buttocks, top of legs, abdomen, and bottom bed sheet. NA #1 started to get the towel wet in the sink; no soap or peri-care cleaning products were noted. NA #1 started the incontinence care, cleaning the perineal and abdominal areas. One towel was used, there was no basin at the bedside, and there was no cleaner for incontinent care with the resident. NA #1 rolled Resident #2 to the right side and noted the bowel movement on the bottom sheet removing the sheet completely, leaving Resident #2 on the mattress with nothing between the skin and mattress top. At this point, NA #1 left the room, and returned to the bedside with a clean towel and bottom sheet. NA #1 wet the towel in the sink and no soap or perineal cleaner was applied. NA #1 started to clean the	F 677	completed on 12/11-12/28/2023 3) Beginning on 12/11/2023, all Certified Nursing Aides, to include agency staff will be in-serviced by the Administrator and/or Director of Nursing (DON) on the policy and procedure for incontinence care. To include effective incontinent care, ensuring that all supplies are gathered before starting task, not to lay resident against bare mattress, maintain privacy during care, and ensure resident is cleaned thoroughly before applying new brief or linen. All newly hired employees will receive education in new hire orientation. No employee will be allowed to work without education after 12/28/2023. This education will be monitored by the DON and Administrator to ensure completed prior to working. 4) Effective 12/29/2023, The Director of Nursing/ Designee will monitor ADL to ensure that incontinent care is performed per facility policy by monitoring 5 residents per day 5 times per week x 4 weeks then 5 residents per day 3 times per week for 8 weeks. The Administrator will review the results of the weekly audit to ensure that incontinence care was provided timely and effectively. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued	

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F 677	Continued From page 2 buttocks, back, and top of the legs on the left side. The resident was then turned onto the left side, and no bottom sheet was applied. Then NA #1 started to clean the right side of the buttocks, back, and top of the area and then had Resident #2 turn back onto her back. NA #1 then rolled the resident side to side again and placed bed pads and depends under the resident. When NA #1 was pulling the brief up between Resident #2's legs, the surveyor noted that bowel movement was still noted on the abdomen and perineal area. NA #1 finished incontinence care, covered the resident with a sheet, and stated, "I will bring you back a gown." On 12/04/23 at 10:25 AM, an interview was conducted with NA #1. During the interview NA #1 was asked what should be at bedside for incontinent care and stated, "something to clean resident with and a new depends". NA #1 was asked if he noticed Resident #2 still had bowel movement on her after he had provided incontinence care. NA #1 stated "No". The surveyor reported there still bowel movement visible on Resident #2's abdomen and perineal area. NA #1 stated, "well I did not see it". The surveyor informed Medication Aide #2 on 12/4/23 at 11:00 AM that stool was still present after incontinence care was provided to Resident #2 and she stated, "I will go deal with it now." She was observed going to the linen cart, taking off two wash clothes and a towel, and headed into the room. The Medication Aide was observed leaving Resident #2's room 11:20 AM with dirty linens in a trash bag. On 12/04/23 at 1:45 PM, an interview was conducted with the Director of Nursing (DON).	F 677	auditing is necessary to maintain compliance 5) Compliance date 12/28/2023	

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F 677	Continued From page 3 The DON stated staff should assess the care that needed to be provided first and obtain all needed materials to complete the task. She stated when providing incontinence care, the NA should bring in a basin, washcloth, towel, bedding, soap, and gowns if needed to prevent the staff from having to leave the room during care. The DON stated that expectations are that staff should check that all areas are clean, and no bowel movement remained before they place a brief or clean linens on the resident. On 12/04/23 at 3:10 PM, an interview was conducted with the Administrator and she stated that all staff were expected to understand the process of the procedure that they were completing. She also stated that her expectation was that stool was not expected to still be present when a clean depends is placed on the resident.	F 677		
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 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.	F 867		12/28/23

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F 867	Continued From page 4 §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 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	F 867		

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F 867	Continued From page 5	F 867		

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.

§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.

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F 867	Continued From page 6 §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, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following surveys 02/11/21, 07/09/21, 09/08/21 and 06/16/22. The area activities of daily living (ADL) care for dependent residents was originally cited during a recertification and complaint survey dated 07/09/21, recited during the onsite revisit and complaint survey dated 09/08/21, recited on the focused infection control and complaint investigation survey dated 06/16/22 and subsequently recited during the onsite revisit and complaint survey dated 12/04/23. The area of infection control and prevention was originally cited during an onsite focused infection control and complaint survey dated 02/11/21, recited during the recertification survey completed on 07/09/21, recited during the onsite revisit and complaint survey dated 09/08/21 and also recited on the focused infection control and complaint	F 867	1. Resident #2 was provided incontinent ADL care on 12/4/23 by NA #1 and medication aide #2. As of 12/19/2023 facility Quality Assurance Performance Improvement (QAPI) process has been corrected to effectively correct and monitor deficient areas. The Regional Director of Operations re-educated the Adminsitrator on the facility QAPI process to ensure QAPI proccess is followed per policy. All repeat citations were reviewed by the Administrator and Regional Director of Operations to ensure monitoring is in place and compliance is in place for infection control process and ADL care according to policy as of 12/28/2023. 2. All prior identified deficient citations have the potential to be affected by this deficient practice therefore, the Administrator has reviewed annual and	

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F 867	Continued From page 7 investigation survey dated 06/16/22. Infection control and prevention was subsequently recited during the onsite revisit and complaint survey dated 12/04/23. The continued failure of the facility during five federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: The tag is cross referenced to: F677- Based on observations, record reviews, and resident and staff interviews, the facility failed to provide complete incontinent care and maintain personal hygiene for 1 of 4 dependent residents (Resident #2) reviewed for activities of daily living (ADL). During the complaint survey dated 6/16/22, the facility failed to provide incontinent care for 1 of 1 dependent resident reviewed for activities of daily living. During the complaint survey and onsite revisit dated 9/08/21, the facility failed to provide showers or bed baths for 1 of 3 dependent residents reviewed for assistance with activities of daily living (ADL). During the recertification and complaint survey dated 7/09/21, the facility failed to provide showers as scheduled to 7 of 14 residents reviewed for assistance with activities of daily living. F880- Based on observation, and staff interview, the facility failed to implement their infection control policy when Nurse Aide (NA) #1 did not	F 867	complaint surveys for the prior 3 years to review all areas of repeat deficient practice as of 12/27/2023 to identify patterns and root causes of repeat deficiences. This information will be used to identify any areas where the QAPI process can be improved. 3. As of 12/19/2023 Regional Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and process of removing monitoring of areas. Regional Director of Operations will review QAPI minutes monthly to ensure improvement and monitoring of areas of deficient practice. The administrator will review Plan of Correction during weekly AdHoc QAPI meeting to ensure no future repeats of prior tags. 4. The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan. 5. Compliance Date: 12/28/2023	

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F 867	Continued From page 8	F 867		

change gloves while providing incontinence care for 1 of 1 resident (Resident #2) reviewed for infection control.

During the complaint survey dated 06/16/22, the facility failed to ensure 3 of 4 nursing staff, Nurse Aide (NA) and the Assistant Director of Nursing (ADON), performed hand hygiene after removing gloves during a dressing change and Activities of Daily Living (ADL) care for 1 resident.

During the complaint survey and onsite revisit survey dated 9/08/21, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 1 staff member (Nurse #1) failed to wear eye protection prior to entering the room of 1 of 3 residents on enhanced droplet isolation. This failure occurred during a COVID-19 global pandemic.

During the recertification and complaint survey dated 07/09/21, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 2 staff members failed to wear an N95 mask, eye protection, gown and gloves prior to entering the room of 1 of 1 resident on enhanced droplet isolation.

During the complaint survey dated 02/11/21, Based on observations, record reviews, and staff interviews, the facility failed to implement their infection control policies and Centers for Disease Control Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 4 of 4 staff members assigned to the quarantine

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F 867	Continued From page 9 hall failed to change their masks between resident care. An interview with the Director of Nursing (DON) and Administrator on 12/04/23 at 3:30 PM revealed monthly Quality Assurance (QA) meetings were held to review measures put in place and discussed with the Medical Director and other departments for their response and feedback to issues identified. When issues were identified a review and corrective action plan was implemented and if there was no improvement, the QA committee revisited it. The DON and Administrator felt interventions put into place were beginning to aid in preventing repeat deficiencies but need to be revisited by the QA committee to ensure ongoing compliance in all areas.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		12/28/23

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F 880	Continued From page 10	F 880		

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 identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 11 §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, and staff interview, the facility failed to implement their infection control policy when Nurse Aide (NA) #1 did not change gloves while providing incontinence care for 1 of 1 resident (Resident #2) reviewed for infection control. The findings included: The facility policy titled, "Hand Hygiene policy," last revised on 8/2023 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. The policy read," Hand hygiene must be performed after touching body fluids and contaminated items". Expectations were to perform hand hygiene after gloves were removed, and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment, and the environment. On 12/04/23 at 9:53 AM an observation was conducted of Resident #2 receiving incontinence care. Resident #2 who was incontinent of bowel and bladder was observed with visible bowel movement on the front side of her gown, abdomen, both legs, peri area and on the bedding underneath of her. Nurse Aide (NA) #1 was observed using the corners of a large bath	F 880	1) The NA #1 was re-educated by the Nursing Home Administrator and Director of Nursing on 12/22/2023 on the proper procedure for hand hygiene upon changing gloves during incontinent care and upon leaving rooms after care 2) All resident have the potential to be affected, therefore 100% skill observation and education was conducted for licensed staff and certified nursing assistants on handwashing by the DON/ Administrator on 12/20-12/28/2023 3) On 12/20/2023 the Director of Nursing and Administrator initiated education for current nursing assistants and nurses, to include agency on hand hygiene. All staff will be checked off on hand hygiene competency by the Director of Nursing or Administrator. Education will include removing gloves and performing hand hygiene upon leaving the resident□s room, not touching clean items or room items with soiled gloves, and not wiping soiled gloves on towels or washcloths to consider them clean. Education will be completed by 12/28/2023. No employee will be allowed to work without education	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 towel to clean Resident #2. NA #1's gloves were observed to be soiled with liquid stool to the point he was wiping his gloves onto the towel used to clean Resident #2. NA #1 was observed to leave the bedside on three separate occasions and did not remove or change gloves. NA #1 was observed touching the room curtain, door handle and dresser with soiled gloves. NA #1 did not change gloves or wash his hands during the observation of care. On 12/04/23 at 10:25 AM an interview was conducted with NA #1. During the interview NA #1 stated that he should have washed his hands at the beginning of incontinence care and at the end. When asked about the process of going from a dirty activity to a clean activity, he stated "I only need to change my gloves if they are visibly dirty, and my gloves were not". NA #1 stated he wiped his soiled gloves onto the towel to clean off the gloves. The interview revealed NA #1 felt that was efficient for cleaning the gloves and that he did not obtain a new pair. On 12/04/23 at 11:00 AM an interview was conducted with Unit Manager #1. During the interview she was asked about the facility handwashing policy for incontinence care. Unit Manager #1 stated she was unaware of the handwashing policy, therefore could not tell surveyor when a staff member should wash their hands during incontinence care. On 12/04/23 at 1:45 PM an interview was conducted with the Director of Nursing (DON). The DON stated she was the facility Statewide Program for Infection Control and Epidemiology (SPICE) trained nurse and was responsible for the infection control program. The DON stated all	F 880	after 12/28/2023. 4) Beginning 12/29/2023 the Director of Nursing or designee will perform hand hygiene audits during ADL care randomly on 5 residents per day 5 times per week x 4 weeks then 5 residents per day 3 times per week for 8 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI committee by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5) Compliance date 12/28/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING _____ B. WING _____	C 12/04/2023

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F 880	Continued From page 13 staff received training on handwashing and when to change gloves on a computer base training system. The DON stated that during perineal care, staff are told to change gloves between dirty and clean task. She stated staff were expected to always wash hands and change gloves. The interview revealed that staff should assess the care that needed to be provided first and obtain all needed materials to complete the task. She stated when providing incontinence care the NA should bring in a basin, washcloth, towel, bedding, and gowns if needed to prevent the staff from having to leave the room during care. On 12/04/23 at 3:10 PM an interview was conducted with the Administrator. The Administrator stated all staff were expected to understand the process of when to wash their hands. The Administrator stated she had not witnessed any issues with infection control while conducting her daily rounding.	F 880		