STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING ______ B. WING ______	C 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	**2502 S NC 119 MEBANE, NC 27302**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/07/24 through 10/10/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # GV0C11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/07/24 through 10/10/24. Event ID# GV0C11. The following intakes were investigated NC00212007, NC00209873, NC00213423, NC00211568, NC00214154, NC00222375, NC00215191, and NC00211293. 4 of the 18 complaint allegations resulted in deficiency. Due to a computer system update the 2567 was not posted until 10/25/24.	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	F 550		11/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/04/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 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 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat a resident with dignity and respect when a nurse aide was witnessed yelling at a resident during an interaction in the resident's room for 1 of 4 residents reviewed for dignity (Resident #75). A reasonable person expects to be treated with respect and dignity by their caregivers in their home environment. Findings included:	F 550	F550 Resident Rights This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted	

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F 550 Continued From page 2

Resident #75 was admitted on 10/6/23.

Review of Resident 75's quarterly Minimum Data Set 3/26/24 revealed Resident #75 was cognitively intact.

Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident # 75 was involved in an altercation with Nurse Aide #1 on 3/27/24 in which Therapy Assistant #1 heard Nurse Aide #1 shouting at Resident #75 but unable to determine the exact words spoken at that time.

Review of the facility provided schedules revealed Nurse #1 was assigned as the hall nurse the day of the incident and Nurse Aide #2 was assigned to Resident #75 on the day of the incident. Nurse Aide #2 was assigned to Resident #75's hall but on another assignment.

An interview with Resident #75 was completed on 10/8/24 at 9:23 AM. Resident #75 had no recollection of the event and stated she felt safe at the facility. Resident #75 did not report any issues or concerns at that time

An interview with Nurse Aide #1 was conducted on 10/9/24 at 12:21 PM revealed she worked on first shift on 3/27/24 but was not assigned to Resident #75. She further revealed that she recalled during first shift on 3/27/24 that she heard Resident #75 hollering, so she went in to see why Resident #75 was hollering and if she needed anything. Resident #75 voiced that she just wanted someone to sit with her and she tried to explain that she had other residents that needed care, but she would come back, and

F 550

solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.

The staff member found to have mistreated the resident was terminated at the time of the initial investigation into the incident.

All residents in the facility were identified as having the potential to be affected by the deficient practice.

Beginning November of 2024, the facility will require all employed caregivers to complete a training course on burn-out upon hire and annually to recognize the signs of burn-out and learn strategies to help prevent burn-out among healthcare workers. The “Preventing Burnout” course will be added by the HR Manager to the list of mandatory caregiver courses on the e-learning/staff training platform, “Relias”. Relias is the platform used by the facility to provide staff with required and relevant training and instruction. This coursework will supplement the existing mandatory staff training on resident's rights, abuse and neglect.

Audits will be conducted monthly x 6 months. Audits will include a review of the newly added burn-out course completion for all newly hired staff members for each month. Audits to be completed by administrator/designee. Results to be

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F 550	Continued From page 3 Resident #75 continued to holler out. An interview with Therapy Assistant #1 on 10/9/24 at 12:25 PM revealed she was working on the first shift on 3/27/24 with another resident across the hall from Resident #75's room when she overheard Nurse Aide #1 yelling at Resident #75. She further revealed that she was not able to determine the words that were spoken by Nurse Aide #1 but felt that the level of Nurse Aide #1's voice was not respectful. An attempt was made to reach Nurse # 1 by telephone however the facility was not able to provide a working telephone number. An interview with the Unit Manager #1 on 10/10/24 at 9:14am revealed she worked the day of the incident and Resident #75 reported to her around shift change that Nurse Aide #1 told Resident #75 to "shut up." She further revealed that when she interviewed Therapy Assistant #1, she was informed that Nurse Aide #1 was yelling at Resident #75 who was working in a room across the hall. An interview with Nurse Aide #2 on 10/10/24 at 9:48 AM revealed she did recall this incident. An interview with the Administrator on 10/10/24 at 11:40 AM revealed that the investigation revealed Nurse Aide #1 spoke to Resident #75 in a tone that was not acceptable or respectful and therefore Nurse Aide #1 was terminated. He further revealed that all residents should be treated with dignity and respect.	F 550	reported to monthly QAPI committee meeting until a pattern of compliance is established. Compliance Date: 11/7/2024	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		11/7/24

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F 695	Continued From page 4 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to apply signage indicating the use of oxygen outside residents' rooms with supplemental oxygen for 1 of 2 residents reviewed for respiratory care (Resident # 79). The findings included: Resident # 79 was admitted on 6/25/24 with diagnoses of acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. A physician's order for Resident # 69 dated 9/20/24 read oxygen at 3 liters per minute via nasal canula continuously. Review of the admission Minimum Data Set (MDS) dated 10/1/24 indicated Resident # 79 was cognitively intact and coded for the use of oxygen. During an observation on 10/7/24 at 2:38 PM of Resident #79's room, there was no signage for oxygen use found anywhere near Resident # 79's room entrance. Resident #79 was observed	F 695	F695 This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. An oxygen in use sign was placed on the door frame of resident #79 on 10/10/24. All residents in the facility have the potential to be affected by the deficient practice. Since residents are free to move about the facility while using oxygen, oxygen in use signage will be added to all resident accessible areas in the facility: resident	

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F 695	Continued From page 5 wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 79's room. During an observation on 10/10/24 at 8:37 AM there was no signage for oxygen use found anywhere near the entrance of Resident # 79's room. Resident #79 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 79's room. During an interview with Nurse #2 on 10/10/24 at 08:40 AM she stated that Resident #79 received oxygen continuously and nursing staff made sure oxygen was applied to Resident #79 and he was monitored. Nurse #2 further revealed that she did not know for sure why Resident #79 was missing the signage, but it should have been posted outside his door. An interview occurred on 10/10/24 at 08:44 with the Director of Nursing (DON). She stated it was the nursing staff's responsibility to put up the oxygen in use sign on the resident's door and if the signage is missing the nurse should have it replaced. An interview on 10/10/24 at 1:37 PM occurred with the Administrator. The Administrator indicated that Resident #79 should have had signage posted outside the room to indicate the use of oxygen.	F 695	rooms, dining rooms, activity rooms, chapel, barber shop, patios, hallways, foyers, therapy gym etc. In addition, signage will be posted at each entrance into the facility, notifying all who enter that oxygen is in use throughout the facility. Administrator/designee to audit all areas of facility to ensure oxygen in use signage is present throughout facility and at each facility entrance. Audits to be completed monthly for 6 months beginning in November. This monitoring will be reported to the regularly held QAPI committee meetings. The QAPI committee members will determine the cadence of any additional monitoring once a pattern of compliance has been established. Compliance Date: 11/7/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		11/7/24

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F 812	Continued From page 6 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 store food in the walk-in freezer not open to air and without freezer burn. The facility failed to discard foods past their use-by date, failed to label and date food placed in the nourishment refrigerator in 1 of 2 nourishment refrigerator/freezers reviewed for food storage (E/F hallway). The facility also failed to hold cold foods in a safe temperature range during tray line observation. These practices had the potential to affect food being served to the residents. Findings included: An observation of the walk-in freezer on 10/7/24 from at 9:30 AM to 9:45 AM revealed the following were located on shelves below the compressor:	F 812	F812 Dietary This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. No residents were identified as being	

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F 812 Continued From page 7

1 a. An opened brown cardboard box labeled "Chicken -10 lbs." that had ice on top of the box. Inside the box was an opened plastic bag containing 7 pieces of breaded chicken tenders with ice on them. There was no label or date on the bag.

1b. An opened brown cardboard labeled "Chicken -10 lbs." that had ice on it. Inside the box was an opened plastic bag containing 5 pieces of chicken patties with no label or date on the bag.

1c. An opened white cardboard that had ice on it. Inside the box was an opened plastic bag with no label or date containing 24 Manicotti (type of pasta) with freezer burn.

1d. An opened brown cardboard labeled "beef steak fritters - 71 pieces" that had ice on top of the box. Inside the box was an opened plastic bag containing approximately 50 portions of meat with ice on plastic bag. The plastic bag was not labeled or dated.

1e. An opened brown box with 2 unopened bags labeled "Italian Sauage - 2 lbs." that had ice on the box. The sausages inside the bags had freezer burn with ice crystals on them.

1f. An opened white cardboard box labeled "Breaded Cod -10 lbs." that had ice on the box. Inside the box was an opened plastic bag containing 9 pieces of breaded fish that had freezer burn. There was on label or date on the plastic bag.

During an interview on 10/7/24 at 9:45 AM the Dietary Manager indicated the freezer's compressor was having some issues and was

F 812 (Plan of Correction)

affected by the deficient practice. All food items have been properly labeled or removed from the facility. All food items past use by date have been discarded from the facility. All foods observed to have freezer burn have been discarded. All food being stored below the compressor in freezer has been removed from that area of the freezer. The food was brought to acceptable temperatures below 40 degrees Fahrenheit prior to being served to residents.

All residents in the facility were identified as having the potential to be affected by the deficient practice.

A) Labeling/food storage: All dietary staff members will be educated on or before 11/7/2024 about the proper labeling/dating and discarding/storage of food items, to include identification of freezer burned items, proper disposal and proper sealing and labeling of opened goods stored in the freezer. The area underneath the compressor will no longer be available for food storage to avoid ice buildup and freezer burn on food. Any dietary staff members not educated by this date will be suspended until education is completed.
B) Food temperatures: The process for maintaining cold food items at their appropriate temperature has been changed to include the following steps. “Upon pulling prepared cold foods from the refrigerator, they will be immediately placed in the ice bin to maintain temperatures below 41 degrees Fahrenheit”. All dietary staff members will

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F 812

Continued From page 8

repaired recently by maintenance. He stated when the freezer defrosted, it over cooled causing ice on the food placed on the shelves under the compressor and causing food to have freezer burn. He stated the food placed in the freezer should be properly closed and labeled. The Dietary Manager stated that all dietary staff were responsible to check the walk-in freezer temperature and ensure food packages were properly closed, labeled after use and ensure food had no freezer burn.

2. An observation of the nourishment refrigerator/freezer on the E-F Hallway on 10/7/24 at 9:58 AM revealed a blue green thermal lunch bag with no name or date in the nourishment refrigerator. The freezer contained a 16-ounce (oz) Styrofoam cup with lid. Inside the cup was frozen pink colored liquid. There was no label or date on the Styrofoam cup. There were four (4) Nutritional supplement ice creams with a use by date of 8/31/24.

During an interview on 10/7/24 at 10:00 AM the Dietary Manager stated all food brought in by a resident's family should be labeled and dated by the nursing staff. Employees should not be placing their personal food in the nourishment refrigerator. The Dietary Manager stated he was unsure to whom the insulated lunch bag belonged. to. The Dietary Manager stated all food that had expired should be discarded by the dietary staff when stocking the nourishment refrigerator. The Dietary Manager indicated the Nutritional supplement ice cream were served on the residents' meal tray during meals. The nursing staff may have placed them in the nourishment refrigerator when these were not consumed.

F 812

be educated on the new procedure by 11/7/2024. C) Nourishment room refrigerator/freezer: The process to ensure appropriate labeling, dating and storage of food in nourishment room refrigerator/freezer will now include a daily check to be performed by the unit managers/designee and weekend supervisors/designee. This will be in addition to the daily check performed by the assigned dietary staff members. All dietary staff, unit managers and weekend supervisors will be educated on this process on or before 11/7/2024. Any of these staff members not educated by this date will be suspended until education has been completed.

Audits are to be conducted weekly for 4 weeks, then monthly for 3 months or until a pattern of compliance is achieved. The Infection Preventionist/designee is to audit appropriate food labeling/storage in the walk-in freezer and nourishments room refrigerators/freezers. Infection Preventionist is to audit temperatures of cold food items prior to plating during tray line service. Audit results are to be reported to monthly QAPI committee meeting until a pattern of compliance is established.

Compliance Date: 11/7/2024

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F 812	Continued From page 9 During an interview on 10/7/24 at 10:05 AM Unit Manager #1 stated all resident's food brought in the facility by their family should be labeled by nursing staff prior to be placed in the nourishment refrigerator. The label should have the resident's name and date when the food was placed in the nourishment refrigerator. 3. Tray line observation was made on 10/9/24 from 11:20 AM - 12:00 Noon. The temperatures of foods on the tray line were taken by the Dietary Cook. Coleslaw was the vegetable option on the menu for the lunch meal. The coleslaw was placed in individual cups and was in an insulated cart near the tray line. The temperature of the coleslaw was taken with a calibrated thermometer, and it read 44 degrees Fahrenheit (F). There were 7 individually wrapped plated containing salad with meat for residents who requested alternate option. The temperature of the salad plate with meat was 49 degrees Fahrenheit (F). The Dietary Manager removed the food from the tray line and placed them in the refrigerator until the internal temperature of these foods reached below 40 degrees F. The food was later placed on the tray line over ice and the Dietary Manager rechecked the temperature of the foods to ensure they were below 40 degrees F. During an interview on 10/9/24 at 11:50 AM, the Dietary Manager indicated the coleslaw and salads were prepared prior to lunch and were placed in the refrigerator until tray line started. While setting up for the tray line, the dietary aide had placed the individual cups of coleslaw and salad plates in the insulated cart instead of placing them on ice on the table beside the steam	F 812		

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F 812	Continued From page 10 table. The insulated cart could not maintain the cold temperature, resulting in the temperature of the food going over the recommended level. The Dietary Manager stated the cook was responsible for checking temperature of food before the food was placed on the steam table for tray line and plated. If the cold foods temperature were not the recommended level of 41 degrees or below, then they should be placed back in the refrigerator until the required temperatures were reached. He stated the cold food should be placed in the cold side of the table with ice to maintain their internal temperatures. During an interview on 10/10/24 at 4:02 PM, the Administrator indicated he was unaware that kitchen freezer was having issue with the compressor. The Administrator stated all dietary staff should ensure all opened boxes and bags were properly closed and opened packages were labeled. He further stated that food served to the residents should be maintained at proper temperatures. The Administrator indicated the dietary staff were responsible for nourishment refrigerator/ freezer. The dietary staff should be checking for any expired food items and cleaning the refrigerator/ freezer when stocking it with snacks and food daily. Nursing staff should be labeling and dating food brought in by families, however the dietary staff should be cross checking to ensure the food was dated, labeled and discarded as needed.	F 812		