STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/18/24 through 11/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 16AF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/24 through 11/21/24. Event ID# 16AF11 The following intakes ware investigated: NC00215306, NC00213532, NC00213327, NC00221569. 2 of the 7 complaint allegations resulted in a deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 2 of 2 residents (Resident # 348 & Resident #147) reviewed for misappropriation of residents' property. Findings included:	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 12/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

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F 602	Continued From page 1	F 602		

The facility has a policy against abuse, neglect, exploitation and misappropriation with a revised date of 3/3/2017. The policy states that any suspected incident of abuse, neglect, exploitation, or misappropriation of resident property is to be reported immediately to a supervisor or a member of administration. The facility will subsequently report any and all suspected incidences of abuse, neglect, exploitation, and/or misappropriation of resident property to the required State and Federal agencies. Any staff member who witnesses abuse, neglect, exploitation, or misappropriation should immediately intervene to protest the resident involved. The witnessing staff member should then report the abuse to their immediate supervisor and/or administrative personnel. All staff members reporting abuse will be protected from reprisal. Any staff member suspected of abuse, neglect, exploitation, or misappropriation will be suspended without pay pending the outcome of the investigation and reported to the proper agencies. The facility will also comply with any instructions or requests that are given or made by any agencies while investigating a situation of abuse, neglect, exploitation, or misappropriation.

1. Resident #348 was admitted to the facility on 9/04/23.

The significant change Minimum Data Set dated 1/19/24 revealed Resident #348 had severe cognitive impairment. He was coded for a scheduled pain medication regimen, answered yes to the presence of occasional pain, and rated his pain intensity as a 5 on a 0-10 pain scale. He was coded as taking opioid medication.

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

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SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 2	F 602		

The Physician's order dated 1/23/24 revealed Resident #348 had an order for Hydromorphone (pain medication) 2 milligram (mg) ½ tablet by mouth every 8 hours for pain.

Review of the Medication Administration Record (MAR) for February 2024 revealed Resident #348 received Hydromorphone three times per day scheduled for 6:00 AM, 2:00 PM, and 10:00 PM. It was signed as administered as scheduled except for being held on 2/06/24 at 10:00 PM for the resident's condition.

The controlled substance count sheet for Resident #348's Hydromorphone was requested from the Director of Nursing during interview on 11/20/24 at 8:22 AM. She stated it was probably in a box somewhere in storage. As of the survey exit, the controlled substance count sheet was not provided.

The initial allegation report completed by the Administrator dated 2/09/24 revealed the facility became aware of the misappropriation of Resident #348's property on 2/09/24 at 7:20 AM. There were 4 Hydromorphone pills unaccounted for and two nurses (Nurse #6 & Nurse #7) were suspended pending the outcome of the investigation.

The 5-day investigation report completed by the Administrator dated 2/14/24 revealed the allegation of misappropriation of resident's property was substantiated as the pills were unaccounted for. Nurse #7 discovered some pills were missing and notified the Director of Nursing (DON). It was discovered that a narcotic medication card containing Resident #348's Hydromorphone tablets were missing from the

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 3	F 602		

medication cart. The narcotic count sheet was still in the narcotic count book and showed that the missing card should have had 4 tablets. Review of the facility security camera revealed that Nurse #6 and Medication Aide (MA) #1 had completed the narcotic change of shift count on 2/08/24 at 10:46PM. At 11:03 PM Nurse #6 was observed on the security camera to access the narcotic drawer and take out a narcotic medication card. She removed a pill from the package and placed the medication card on top of the medication cart. She crushed the pill and walked into Resident #348's room. At 1:51 AM on 2/09/24, Nurse #6 was observed to pick up the narcotic medication card and walk into the nurses' station. On exiting the nurses' station at 1:52 AM she had the top portion of the medication card in her hand. She was observed to walk down the hall and throw the top portion of the medication card into the trash can at the end of the hall at 1:53 AM. The trash cans and dumpster were searched but the missing medication card or pills were not located. Nurse #6 and #7 completed urine drug screens which were negative on 2/13/24. Nurse #6 was terminated on 2/14/24. Law enforcement was notified on 2/09/24 at 2:45 PM.

A telephone interview on 11/21/24 at 10:50 AM with MA #1 revealed she and Nurse #6 completed the narcotic medication count at the change of shift on 2/08/24, and it was correct when she turned the narcotic keys over to Nurse #6.

A telephone interview on 11/19/24 at 7:14 PM with Nurse #6 revealed she denied taking any narcotic medication. She stated the medication count was correct when she and Nurse #7 verified the count at shift change. She stated she had no idea what

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SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 4	F 602		

happened to the missing narcotics.

Attempts to interview Nurse #7 by phone were unsuccessful.

An interview on 11/20/24 at 8:22 AM with the Director of Nursing (DON) revealed she believed Nurse #6 had either taken the missing pills or thrown them away. The narcotic count sheet showed the missing medication card should have had 4 tablets. She stated she had completed an audit of all narcotic medications in the facility and found no other discrepancies. She stated that based on her observations from the security camera, Nurses #6 and #7 had not counted the narcotic medication cards correctly and miscounted the number of narcotic cards that were in the drawer and the card was not in the drawer at the change of shift. She stated Nurse #7 completed a pain assessment as scheduled on 2/09/24 at 7:00 AM on Resident #348 which was negative. She stated that Resident #348 did not miss any scheduled pain medication.

An additional interview on 11/21/24 at 8:24 AM with the DON revealed they completed a corrective action plan for Resident #348's missing narcotic medication. She stated she completed a weekly audit of all narcotic medications in the facility for 6 months and staff in services for misappropriation were conducted on 2/12/24.

An interview on 11/21/24 at 9:00 AM with the Administrator revealed she had no idea what happened to the missing narcotic medication but expected the staff to properly count and safeguard the residents' property. She stated the corrective action plan included staff education on misappropriation on how to properly count

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 5	F 602		

narcotic medications during shift change and weekly narcotic medication audits for 6 months and these items were completed.
2. Resident #147 was admitted to the facility on 7/15/23.

There was a physician's order dated 12/21/23 stating that Resident #147 could receive 1 tablet of Oxycodone (controlled narcotic pain medication) 5 milligrams (mg) every 4 hours as needed for pain.

An Initial Allegation Report completed by the Administrator on 03/29/24 revealed the facility became aware of a possible narcotic diversion on 3/29/24 at 9:00 pm involving Resident #147. The report stated that Nurse #2 called the Director of Nursing (DON) and informed her that she believed there was a possible narcotic diversion involving Nurse #1. Nurse #2 believed that Nurse #1 signed her name on a narcotic count sheet and that Nurse #1 signed off narcotics with a future date. On 3/30/24 at 7:35PM the local police department was notified, and a telephone message was left for the Department of Social Services. Nurse #1 was terminated from her position on 3/30/24 and the allegation was substantiated.

The quarterly Minimum Data Set (MDS) dated 7/6/24 revealed that Resident #147 was cognitively intact. He had a diagnosis of diabetic foot ulcer and currently prescribed an opioid.

On 11/19/24 at 3:30 PM a telephone call was made to Nurse #1 and was unsuccessful in reaching her.

On 11/19/24 at 5:30 PM a telephone interview

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

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SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 6	F 602		

was completed with Nurse #2. She stated that she worked the evening shift from 6:30 pm till 6:30 am and knew Resident #147 very well. Nurse #2 stated that when assigned to Resident #147 he had never asked for more than 1 of his (as needed) PRN narcotic pain pills (oxycodone) during her 12 hour shift. Nurse #2 stated that Resident #147 was alert and oriented times 4. Nurse #2 stated on 3/28/24 she started her shift at 6:30 PM. She remembers giving Resident #147 a oxycodone medication at 2:00 AM on 3/29/24 and remembers signing the narcotic record sheet. Nurse #2 remembered that after giving out the 2:00 AM oxycodone pill there was at least 4 pills left maybe more she could not remember for sure. Nurse #2 did not give out any more oxycodone during her shift and left around 6:30 AM on 3/29/24. Nurse #2 came back on shift around 6:30 PM on 3/29/24 and was given report from Nurse #1 who was leaving her shift. During report Nurse #1 told Nurse #2 that if Resident #147 needed any oxycodone that Nurse #2 would need to get more of the medication from the automated medication dispersing unit. Nurse #2 was surprised to hear this since when she left 12 hours ago there were at least 4 oxycodone pills left. Nurse #2 went to find the narcotic record sheet and noticed that Nurse #2's signature was on the sheet showing she (Nurse #2) gave Resident #147 a oxycodone at 6:00 AM on 3/29/24. Nurse #2 knew that she did not give out this pill and that it appeared that Nurse #1 had forged her signature. Nurse #2 called the Director of Nursing (DON) about this. Then Nurse #2 looked at the sheet more closely and noticed that Nurse #1 had signed out oxycodone for a date of 3/30/24. Nurse #2 called the DON again and informed her that pills had been signed out for a future date.

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 7	F 602		

On 11/20/24 at 9:30 AM an interview was conducted with the DON. She stated that she got a call from Nurse #2 around 7:30 PM on 3/29/24 regarding the narcotic sheet for Resident #147. The DON stated that Nurse #2 explained to her that she gave Resident #147 a oxycodone at 2:00 AM but the sheet was showing that she signed out a pill for him at 6:00 AM on 3/29/24 and Nurse #2 let the DON know she did not administer the pill. The DON started reviewing the medication administrative record from home. The DON stated she could not remember if it was her or Nurse #2 that noticed that oxycodone pills were signed out for 3/30/24 and it was the evening of 3/29/24. On 3/30/24 Nurse #1 came to the facility to start her 6:30 AM shift and the DON and the Assistant Director of Nursing (ADON) questioned Nurse #1 about the narcotic sheet and Nurse #1 admitted to taking 4 oxycodone pills from Resident #147. The DON stated that Nurse #1 was terminated on the spot and Nurse #1 told them that she would be giving up her license voluntarily. The DON had already informed the Administrator by this time. The local police department was called as well. The DON stated medication costs for Resident #147 were being paid by the facility, so it was no cost to him.

On 11/20/24 at 2:35 PM an interview was conducted with the ADON. The ADON stated she got a call from the DON the evening of 3/29/24 about a possible drug diversion and asked her to meet her at the facility. She came to the facility the morning of 3/30/24 and met Nurse #1 along with the DON. They went into an office and spoke to Nurse #1 regarding Resident #147's narcotic sheet. Nurse #1 admitted to taking 4 oxycodone pills from Resident #147. The ADON

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 8	F 602		

stated that when she was first notified of this incident she and the DON called the local police and the police came to the facility to start their investigation. The ADON and DON also called the Administrator, Medical Director and the Resident #147's family.

On 11/21/24 at 10:35 AM an interview was conducted with the Administrator. She stated that she received a call from the DON regarding a possible drug diversion involving Nurse #1 and Resident #147. The Administrator met with the Nurse #1 on 3/30/24 and she was terminated. The Administrator stated she and the DON started a plan of correction involving monitoring the narcotic drug sheets, in service on signing the sheets and reviewing the cards to make sure they are correct. The Administrator stated they have not had any other drug diversion since March 2024.

The facility provided the following Corrective Action Plan with a correction date of 3/31/24.

Corrective action for resident(s) affected by the alleged deficient practice.

- Employee was immediately terminated after her own admission to protect residents. The facility reported the nurse to the Local Police Department, Adult Protective Services, NC Healthcare Personal registry, and NC Board of Nursing. Completed on 3/30/24.
- The DON will complete a misappropriation in-service with nurses including agency staff and medication aides about Diversion of Narcotics, the severity of diverting medications, and the ramifications of taking part in diverting narcotics. Completed on 3/30/24

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 9	F 602		

- Resident's medication administration records (MARs) were audited on the nurse's assignment on March 29, 2024, to identify if the nurse may have diverted any other narcotics from any other residents. There was no evidence that any other medication had been diverted from any other residents.

Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

- They had previously educated the employee on the facility misappropriation policy upon hire in November 2023, and during the quarterly abuse in-service on February 21, 2024. The nurse would have received extensive training to obtain her license in not diverting medications.
- The facility followed pre-employment procedures, which include background check, references checked, orientation, and all other in-services.
- The facility immediately reported the incident, investigated, and took action.

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

- The DON or designee will audit the narcotic sign out books for suspicious entries every week for 3 months, every two weeks for 1 month, and then monthly thereafter for six months, unless deficient practice is found, and the time will be extended until total compliance is achieved.
- This audit will be documented and turned into the Administrator to be reviewed with the IDT in the monthly QAPI meeting to assure complete compliance.

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 10	F 602		

- Nurses and medication aides were in-serviced prior to the start of their next shift.

Date of Compliance : 3/31/24

On 11/21/24, the facility's corrective action plan effective 3/31/24 was validated by the following: On 3/29/24 the DON started in-service training for all nurse and medication aides. The in-service was to ensure nurse/medication aides visualized both the medication card and the narcotic count sheets together at the medication cart. The nurse coming on and the nurse signing off would be doing the narcotic medication count together at the cart seeing both the medication card and the narcotic sheet. If the nurse/medication aide notice anything suspicious with the count, the number of medications given or missing medication they were to call the DON immediately. They were also in-serviced on the fact that drug diversion was a criminal offense and will result in termination and could result in license suspension, criminal charges and or jail time. There was an in-service attendance sign in sheet dated 3/30/24 that had 32 signatures and 4 attendees that were in-serviced by telephone. Interviews were conducted with licensed nurses, and they were able to verbalize going over the narcotic sheet and count book when ending or beginning a shift. They were able to verbalize if they see something wrong they would call the DON immediately and report what they saw. Starting on week 3/30/24 the DON started doing a narcotic sheet audit every week for each hall. This audit started on 3/30/24 and shows audit being done weekly for all halls in the facility. It was confirmed through the Board of Nursing that Nurse #1's license had been suspended on 4/22/24 for a minimum of 12 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 602	Continued From page 11 The completion date of 3/31/24 was validated.	F 602		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II was completed for 1 of 2 residents (Resident #74) reviewed for PASRR. The findings included: Resident #74 was admitted to the facility on 9/28/23. A review of Resident #74's medical record	F 644	1. The facility Social Service Director updated and submitted for a Level 2 Pre-admission Screening and Resident Review on 11/21/24. 2. The facility Administrator in-serviced the Medical Records, Minimum Data Set and Social Services on the requirements of submitting a review for a Level 2 Pre-admission Screening and Resident Review. The Social Services reviewed all residents□ diagnoses on 11/21/24 to	12/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HIGHWAY SYLVA, NC 28779

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F 644	Continued From page 12 indicated post-traumatic stress disorder (PTSD) was added to his diagnoses list effective 4/22/24. Resident #74's medical record indicated he currently had a PASRR Level I. An interview with the Social Services Director (SSD) on 11/20/24 at 1:29 PM revealed she was responsible for PASRR, and she confirmed that Resident #74 currently had a PASRR Level I. The SSD stated she did not know about Resident #74's PTSD diagnosis and if she had, she would have applied for a PASRR Level II. The SSD further stated that she wasn't sure when Resident #74 was diagnosed with PTSD, but the nurses would need to notify her if the residents had a new mental health diagnosis. An interview with the Minimum Data Set (MDS) Coordinator on 11/20/24 at 1:36 PM revealed she added PTSD to Resident #74's diagnoses list on 4/22/24 based on a note from the psychiatric provider for the same date. The MDS Coordinator stated that Resident #74 was diagnosed with PTSD on 4/22/24. She stated that she didn't have anything to do with PASRR and this was handled by the SSD. The MDS Coordinator further stated that the SSD worked closely with the psychiatric provider, and they should be giving her information about any new mental health diagnoses. During a follow-up interview with the SSD on 11/20/24 at 2:03 PM, the SSD stated that the previous psychiatric provider worked closely with her. She stated that they have had a new psychiatric provider before April 2024, and he did not always notify her of any new mental health diagnosis. She added that she would not apply for a PASRR Level II for Resident #74 because	F 644	assure that anyone with a new psychiatric diagnosis was submitted for review of Level 2 Pre-admission Screening and Resident Review. 3. A systemic change was implemented to assist in the tracking of diagnosis changes to ensure a review is submitted. " Psychotherapist and psychiatric provider will provide a list of residents/patients they see on the day of visit. " Medical Records will review the residents/patients seen by the psych providers and add new psychiatric diagnoses to electronic records. Medical records will then notify Social Services of new diagnosis added. " Social Services will review new diagnosis and submit for a Level 2 when appropriate. 4. The Administrator will ensure the audit is completed by Social Services. The interdisciplinary Team (IDT) will review each resident/patient that had a new psychiatric diagnosis that was added each week in the daily clinical meeting for six weeks and monthly for four months. This audit will be documented and turned into the Administrator to be reviewed with the interdisciplinary Team in the monthly Quality Assurance and Performance Improvement meeting to assure complete compliance. 5. Date of compliance: 12/4/24	

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	345400	A. BUILDING _____ B. WING _____	C 11/21/2024

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F 644	Continued From page 13 PTSD was not included in the list of approved diagnoses for designation as serious mental illness or serious and persistent mental illness. During the interview, the SSD shared a list entitled, "Pre-Admission Screening and Resident Review for Adult Care Homes." The SSD stated that she was told during a seminar about MDS and PASRR that this list also applied to nursing home residents. An interview with the Administrator on 11/20/24 at 2:03 PM revealed they would not necessarily apply for a PASRR Level II for a new diagnosis of PTSD, and it would depend on the circumstances when Resident #74 was diagnosed with PTSD. The Administrator stated that she agreed that PTSD was not included in the list of mental health diagnoses that the SSD used.	F 644		
F 880 SS=F	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		12/6/24

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F 880	Continued From page 14	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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 15 §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 record review, and Physician and staff interviews, the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 89 of 89 residents in the facility. Findings included: The "Surveillance Plan for Infections) policy (Revised May 2022) read in part: "The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions." -"The Purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections." -"The Criteria for such infections are based on the current standard CDC definitions of infections." -"Infections that will be included in routine	F 880	1. Infection Preventionist audited all residents for infections and/or symptoms on 12/5/24. It was found that all infections were recorded in Electronic Health Record (EHR) correctly. The Director of Nursing (DON) held a training session on 12/5/24 with the Infection Preventionist to ensure that the facility policy and procedures for: • Auditing all residents for infections and/or symptoms • Tracking signs and symptoms, locations, labs, and x-rays • Entering confirmed infections into the electronic health record • Using the infection surveillance tools for respiratory and urinary tract infections • Reporting requirements to the local health department. The facility also registered the IP with the Spice Mentoring Program for additional training, the mentorship begins in January. 2. Infection Preventionist audited all residents for infections and/or symptoms on 12/5/24. It was found that all infections	

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F 880	Continued From page 16 surveillance include those with: evidence of transmissibility in a health care environment; available processes and procedures that prevent of reduce the spread of infection; clinically significant morbidity or mortality associated with infection (e.g., pneumonia, urinary tract infections, C. difficile); and pathogens associated with serious outbreaks. (e.g., invasive streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza.)" -"The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data. " -"For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: infection site (be as specific as possible, e.g., cutaneous infections should be listed as "pressure ulcer, left foot," pneumonia as "right upper lobe," etc.); pathogens; pertinent remarks (additional relevant information, i.e., temperatures, other symptoms of specific infection, white blood cell count, etc.);Treatment measures and precautions." The infection surveillance monthly report for October 2024 was reviewed. The section of the line listing surveillance report labeled symptoms was blank for all the listed infections. There were no diagnostic or laboratory results for any of the listed infections. An interview was conducted with the Infection Preventionist (IP) on 11/20/24 at 10:13 AM. The IP explained she had started the IP role in February 2024 and had attended the North Carolina State Program for Infection Control and Epidemiology (NCSPICE) in April 2024. The IP	F 880	were recorded in Electronic Health Record (EHR) correctly. The Director of Nursing (DON) held a training session on 12/5/24 with the Infection Preventionist to ensure that the facility policy and procedures for: • Auditing all residents for infections and/or symptoms • Tracking signs and symptoms, locations, labs, and x-rays • Entering confirmed infections into the electronic health record • Using the infection surveillance tools for respiratory and urinary tract infections • Reporting requirements to the local health department. The facility also registered the IP with the Spice Mentoring Program for additional training, the mentorship begins in January. 3. There were no systemic changes as the facility has policies in place regarding monitoring and tracking infections. Inform Jackson County Health Department of any reportable infections. 4. The IP will turn in a weekly report to the DON of any new infections, IVs, and catheters. The Director of Nursing or designee will review the weekly report in the IDT daily clinical meeting for 8 weeks, monthly for 4 months, unless deficient practice is found, and the time will be extended until total compliance is achieved. The weekly report will then be turned into the Administrator to be	

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F 880	Continued From page 17 discussed how she tracked the facility infections. The IP explained she used the electronic computer systems infection control program to track infections. She stated when a resident was started on an antibiotic or a medication for treating an infection the electronic computer systems infection control program added the resident as an infection case. The IP said she did not track infections that were not treated with an antibiotic or anti-infective medication because they were not triggered as a new case in electronic computer systems infection program. She explained a new infection case was triggered in the electronic computer systems infection program when an order was entered for an antibiotic or other anti-infective medication. The IP said infections that were not treated with a medication were not triggered by the electronic computer systems infection program and were not included in the surveillance report. The IP explained she did not have a way she tracked those type of infections. The IP said viral infections, gastrointestinal illnesses such as norovirus, or respiratory illnesses that did not require an antibiotic/ medication for treatment were not tracked. The IP said if an influenza case was not treated with an antiviral medication, it would not be tracked. The IP opened the electronic computer systems infection program and after reviewing the program, she thought she could generate and add a new case manually for an infection that was not treated with an antibiotic/ medication. The IP said, "I may start doing that, it would give me a way to track those type infections". The IP agreed those type of infections should be tracked to identify infection trends or outbreaks. The IP said there had not been any outbreaks of GI illness, influenza, or respiratory illnesses that she was aware of. During the	F 880	reviewed in the monthly Quality Assurance meeting to ensure complete compliance. The DON is responsible for ensuring all reports are received weekly and infections are tracked appropriately in the electronic health record. 5. E. Date of compliance: 12/6/24	

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F 880	Continued From page 18	F 880		

interview the IP was unfamiliar with standardized infection definitions and was unable to say what standardized definitions the facility's infection program used. The IP explained if a provider ordered an antibiotic for an infection, she included it as a health care associated infection (HAI) if the antibiotic had not been present on admission. The IP said there was not an infection definition criterion she used to review infections that determined if the infection met the criteria to be counted as a HAI. The IP explained she did not collect data related to infection symptoms to include in the infection surveillance report. The IP said infection symptoms were documented by the provider when they saw the resident and were documented by the floor nurses. The IP said she did review diagnostic and laboratory results but did not include the data on the infection surveillance tracking report.

An interview was conducted with the Director of Nursing (DON) on 11/20/24 at 2:15 PM. The DON said the IP should track all infections not just infections that were treated with antibiotics. The DON said all infections needed to be tracked to monitor for trends or a potential outbreak. The DON said she was familiar standardized definition of infections and that the facility used the McGreer Criteria for urinary tract infections. The DON explained she knew there were standardized definitions for other types of infections, but the facility currently did not use them. She said the facility went by what the provider said and the diagnosis the provider gave. The DON stated infection symptoms, diagnostics, and laboratory data results should be included in the surveillance report. The DON had not been aware the IP was only tracking infections that were treated with an antibiotic/medication.

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F 880	Continued From page 19 An interview was conducted with the Administrator on 11/21/24 at 10:15 AM. The Administrator said the IP should track all infections not just infections that required a medication for treatment. The Administrator agreed all infections should be tracked to monitor for trends or an outbreak. The Administrator said it was important to monitor so interventions could be put into place if trends or an outbreak occurred.	F 880		