PRINTED: 11/08/2022 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			SURVEY PLETED
		245242	B. WING			1	С
		345313	D. WING			09/	/29/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
NORTHAN	MPTON NURSING AND R	REHABILITATION CENTER		HWY 305 NORTH			
				JACKSON, NC 27845			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B TO THE APPROPRIA		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	complaint investigation through 9/30/22. The compliance with the r	requirement CFR483.73, eness. Event ID # PRBM11.	F	000			
	A recertification and	complaint survey was /22 through 9/30/22. Event was investigated:					
F 758 SS=D	S483.45(e) Psychotron S483.45(c)(3) A psychotron S483.45(e)(1) Resident Psychotronic Grugs and Living S483.45(e)(1) Resident Psychotron S483.45(e)(1) Resident Psychotronic Grugs and Living S483.45(e)(1) Resident Psychotron S483.45(e)(1) Resident Psychotronic Grugs and Living S483.45(e)(1) Resident Psychotron S483.45(e)(1) Resident Psychotron Psychotron S483.45(e)(1) Resident Psychotron Psychotro	opic Drugs. hotropic drug is any drug that s associated with mental vior. These drugs include, drugs in the following	F	758			10/31/22
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE			(X6) DATE

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.

Electronically Signed

10/21/2022

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345313	B. WING		C 09/29/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE HWY 305 NORTH JACKSON, NC 27845	09/29/2022	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 758	drugs receive gradua behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs properties that medication diagnosed specific contrained in the clinical record; §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the appropriate for the Properties for the duration of the duration of the properties for the Pr	nts who use psychotropic I dose reductions, and ns, unless clinically effort to discontinue these onts do not receive ursuant to a PRN order in is necessary to treat a indition that is documented and orders for psychotropic drugs. Except as provided in intending physician or er believes that it is RN order to be extended or she should document their int's medical record and for the PRN order. Indeed to the provided in the pro	F 75		tion	
	Physician interview, a interview, the facility orders for PRN (as not medications were times 5 Residents (Resident unnecessary medications included The findings included	and Pharmacy Consultant failed to ensure Physician's eeded) psychotropic e limited in duration for 1 of t #16) reviewed for ions.		Center acknowledges receipt of the Statement of Deficiencies and propos this Plan of Correction to the extent the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of resider The Plan of Correction is submitted awritten allegation of compliance. Northampton Nursing and Rehabilitati	es at nts. s a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
		245242	B WING				С
		345313	B. WING _			09/	29/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
NORTHAN	IPTON NURSING AND	REHABILITATION CENTER			WY 305 NORTH		
				J	ACKSON, NC 27845		
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F 758	Continued From pag	ge 2	F	758			
	6/8/22 with diagnose	es that included Parkinson's			Center response to this Statement of		
	disease and Lewy B				Deficiencies does not denote agreeme	nt	
	•	•			with the Statement of Deficiencies nor		
	The admission Minir	mum Data Set (MDS)			does it constitute an admission that an	y	
		3/15/22 revealed the Resident			deficiency is accurate. Further,		
		nitively impaired. He was not			Northampton Nursing and Rehabilitation		
		y behaviors during the			Center reserves the right to refute any	of	
	assessment period.				the deficiencies on this Statement of		
	A mlam last				Deficiencies through Informal Dispute		
	-	t revised on 8/29/22 for use of ation use. Interventions			Resolution, formal appeal procedure and/or any other administrative or lega	J	
		medications as ordered by			proceeding.	.1	
		nonitor and notify Physician of			procedurig.		
		ted to the medication.			F758 Free from Unnecessary Psychotropic Meds/PRN Use		
	A Physician order da	ated 6/8/22 indicated			1 Sydnotropio Midde/1 111 dec		
		grams (mg) 1 tab by mouth			On 9-29-22, the Director of Nursing		
		eded (PRN) for anxiety was			clarified the stop date for the PRN		
	ordered without a st				antianxiety medication order for reside	nt	
					#16. The order was updated in the		
		ated 8/27/22 indicated Haldol			electronic record.		
		6 hours PRN for hallucinations			On 10 20 22 the Director of Nursing		
	was ordered without	ı а эюр чак е .			On 10-20-22, the Director of Nursing initiated an audit of all PRN psychotrogen	nic	
	A telephone intervie	w was completed on 9/29/22			medications to ensure PRN psychotro		
		Pharmacy Consultant. She			medications for all residents to include		
	-	hotropic medications required			resident # 16 were limited to a duration		
		o date. The Pharmacy			14 days unless the attending physiciar	ı or	
		d to state the Physician then			prescribing practitioner documented th		
	reevaluated the Res	sident for continued use of the			rational for the extended time period in	the	
		umented the rationale for			medical record and indicated the spec	fic	
	extending the medic	cation.			duration. The DON or designee will		
					address all concerns identified during		
		nducted on 9/29/22 at 3:25			audit to include clarifying order with the)	
		of Nursing (DON). She			physician and updating the electronic	vudit	
		ware all PRN psychotropic d an initial 14 day stop date,			record for appropriate stop date. The a will be completed by 10-31-22	luull	
		nen reevaluated the resident			wiii be completed by 10-31-22		
		edication regimen for			On 10-20-22, the DON initiated an		
	1	J	1		, -		1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345313	B. WING_			l	C 09/29/2022		
NAME OF PE	ROVIDER OR SUPPLIER	040010	1	STE	REET ADDRESS, CITY, STATE, ZIP CODE	09/	29/2022		
TO THE OT THE	TO VIDER OR GOT I EIER				/Y 305 NORTH				
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER			CKSON, NC 27845				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page 3 continued use.		F 7	758	in-service will all nurses and providers				
	An interview was compm with the Administrexpectation all PRN phave a stop date included the Atelephone interview at 8:20 am with the PPRN psychotropic mental days. The Physicial the resident and extending frame he felt applied indicated he did not refuse the resident and stoppindicated he did no	was completed on 9/30/22 hysician. He revealed all edications were ordered for an stated he then revaluated nded the medication for a propriate. The Physician ecall being notified Resident I not include stop date and ethe Resident during his			regarding PRN Psychoactive Medication Monitoring with emphasis on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for extended time period in the medical record and indicates the specific duration-service will be completed by 10-31-2 After 10-31-22, any nurse or provider whas not received the in-service will be in-serviced prior to next scheduled wor shift. All newly hired nurses and/or providers will be in-serviced during orientation regarding PRN Psychoactive Medication Monitoring. 10% audit of all residents to include resident # 16 physician orders for PRN psychotropic medications will be review by the DON and/or Administrative nurse weekly x 4 weeks then monthly x 1 moutilizing the Psychoactive Medication A Tool. This audit is to ensure that the duration of the psychotropic medication limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extend time period in the medical records. The DON or designee will obtain a clarificat order from the physician and retrain the nurse for any identified areas of concerduring the audit. The Administrator will review the Psychoactive Medication Audit review the Psychoactive Medica	e on the on. 22. who k e e wed es onth udit			
					Tool weekly x 4 weeks then monthly x month to ensure all concerns were addressed.	1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345313	B. WING			1	C 29/2022
NAME OF PI	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	29/2022
NORTHAN	IPTON NURSING AND R	EHABILITATION CENTER			WY 305 NORTH ACKSON, NC 27845		
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F 758 F 814 SS=F	Dispose Garbage and CFR(s): 483.60(i)(4)			814	The Administrator will present the finding of the Psychoactive Medication Audit To the Executive Quality Assurance (Quality Assurance) (Quality As	ool A)	10/31/22
	by: Based on observation facility failed to maintand dumpster free of debrobserved. The findings included During an observation the dietary manager (on 9/27/22 at 10:12 A square feet of debrish of dumpster #1 and dincluded: Styrofoam of plastic cups, straws, in cookie wrapper, a paparans, etc. The DM states occupy this area stated the dumpster as	is not met as evidenced in and staff interviews, the ain the area surrounding the is for 2 of 2 dumpsters in of the dumpster area with DM) and dietary consultant M, approximately 400 was behind and to the right tumpster #2. Debris items containers, plastic lids, napkins, rubber gloves, a per straw box, aluminum ated a lot of racoons and in The dietary consultant area should be a lot cleaner the dumpsters were shared			F814 Dispose Garbage and Refuse Properly On 9-29-22, the Dietary Consultant cleaned up trash and debris to include Styrofoam containers, plastic lids, plastic ups, straws, napkins, rubber gloves, a cookie wrapper, a paper straw box, and aluminum cans around dumpster #1 ard dumpster #2. On 10-20-22, the Maintenance Director initiated an audit of surrounding exterior areas to include dumpsters #1 and #2 ensure areas were free of trash and debris. The Administrator addressed all concerns identified during the audit. The audit will be completed by 10-31-22.	a d nd r or to I	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP		
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		345313	B. WING _			09/	29/2022	
NAME OF PR	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE			
				HW	/Y 305 NORTH			
NORTHAN	IPTON NURSING AND R	REHABILITATION CENTER		JA	CKSON, NC 27845			
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IAG			IAG		DEFICIENCY)			
F 814	Continued From page	2.5	F8	.11				
1 014	Continued From page	- 5	ГО	14				
					an in-service with all Department Head			
		dumpster area conducted			Maintenance staff, Housekeeping staff			
		ultant on 9/29/22 at 8:25 AM			Dietary staff and the Maintenance staff			
		er area to be in the same			regarding Trash/Dumpsters with			
		y consultant indicated that			emphasis on the responsibility of each			
		rtment heads about the			department to ensure dumpster areas	are		
	excess debris yestero	day afternoon, and they			kept clean from trash and debris.			
		s in the area. He stated he ld be picked up by now, but			In-service will be completed by 10-31-2	2.		
	it looked the same.				The Maintenance Director and/or			
					Housekeeping Director will complete			
	During a follow-up int	erview with the dietary			exterior environmental rounds weekly	•		
	_	2 at 11:34 AM, he stated he			weeks then monthly x 1 month utilizing			
		rea around the dumpsters			Environmental Rounds Audit Tool. This			
		not sure who would be the			audit is to ensure all exterior areas are			
		ge the area in the future.			free of trash and debris. The Maintenar	nce		
	point person to mana	ge the area in the luture.			Director and/or Housekeeping Director			
	The Administrator wa	s interviewed on 9/29/22 at			address all concerns identified during t			
					•	ie		
		ed that her expectation was			audit to include cleaning areas of			
		area clean, and it was the			identified concern and re-education of			
	housekeeping and die	•			staff. The Administrator will review the			
		up after themselves. The			Environmental Rounds Audit Tool week	ily		
		she planned to assign an			x 4 weeks then monthly x 1 month to			
		ember to oversee the			ensure all concerns were addressed.			
	cleanliness of the dur	mpster area going forward.						
					The Administrator will present the finding	ngs		
					of the Environmental Rounds Audit Too	l to		
					the Executive Quality Assurance (QA)			
					committee monthly for 2 months. The			
					Executive QA Committee will meet			
					monthly for 2 months and review the			
					Environmental Rounds Audit Tool to			
					determine trends and/or issues that ma	ıy		
					need further interventions put into place	-		
					and to determine the need for further			
					frequency of monitoring.			
F 880	Infection Prevention 8	R Control	F 8				10/31/22	
			F 8	100			10/31/22	
SS=D	CFR(s): 483.80(a)(1)	(∠ <u>/</u> (ᠲ/(ᠲ/(۱)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	345313	B. WING		C 09/29/2022		
OVIDER OR SUPPLIER PTON NURSING AND I	REHABILITATION CENTER		HWY 305 NORTH	00/20/2022		
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\$483.80 Infection Co. The facility must esta infection prevention a designed to provide comfortable environr development and tra diseases and infection sorogram. The facility must esta and control program a minimum, the follor s483.80(a)(1) A syst reporting, investigatin and communicable of staff, volunteers, visi providing services un arrangement based of conducted according accepted national sta s483.80(a)(2) Written conducted according accepted national sta s483.80(a)(2) Written conducted for the propertion of surve consible communica infections before the consistency of the propertion of the propertion of the conducted according accepted national sta s483.80(a)(b) system of surve consistency of surve consistency of the propertion of the communication	ablish and maintain an and control program a safe, sanitary and ment and to help prevent the insmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: em for preventing, identifying, ing, and controlling infections is eases for all residents, tors, and other individuals inder a contractual upon the facility assessment to §483.70(e) and following andards; In standards, policies, and rogram, which must include, it illiance designed to identify ble diseases or your can spread to other (f); Impossible incidents of se or infections should be insmission-based precautions	F 880				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pages S483.80 Infection Confection prevention and the designed to provide a comfortable environment of the facility must estand control program. The facility must estand control program a minimum, the following services under the facility must estand control program are minimum, the following services under the facility must estand communicable destaff, volunteers, visitoroviding services under the facility must estand communicable destaff, volunteers, visitoroviding services under the facility of the facility of the procedures for the proposed for the pr	ASAB3.80(a) (1) A system for preventing, investigating, and control program (IPCP) that must include, at a minimum, the following elements: S483.80(a)(1) A system for preventing, infections and communicable diseases for all residents, 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, policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(2) Written standards policies, and procedures for the program, which must include, out are not limited to: (§483.80(a)(b) Program program, which must include, out are not limited to: (§483.80(a)(b) Program program, which must include, out are not limited to: (§483.80(a)(b) Program program, which must include, out are not limited to: (§483.80(a)(c) Program program, which must include, out are not limited to: (§483.80(a)(c) Program progr	A BUILDING 345313 B. WING DIDENTIFICATION NUMBER: A BUILDING 345313 B. WING DIDENTIFICATION NUMBER: A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING B. WING DIDENTIFICATION CENTER PTON NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 S483.80 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. S483.80(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: S483.80(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; S483.80(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 poersons in the facility; ii) When and to whom possible incidents of communicable disease or infections should be reported; iii) Standard and transmission-based precautions on be followed to prevent spread of infections; iii) When and how isolation should be used for a	A BUILDING 345313 STREET ADDRESS, CITY, STATE, ZIP CODE HWY 305 NORTH JACKSON, N. 27845 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING MYORMATION) Continued From page 6 \$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 rogram. 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, eporting, 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 proposedures for the program, which must include, but are not limited to: 1) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other propose in the facility: 1) When and to whom possible incidents of communicable diseases or infections should be eported; 1) When and to whom possible incidents of communicable disease or infections should be eported; 1) When and to whom possible incidents of communicable diseases or infections should be eported; 1) When and to whom possible incidents of communicable diseases or infections should be eported; 1) When and to whom possible incidents of communicable diseases or infections should be eported; 1) When and to whom possible ordinations and the facility: 1) When and to whom possible communicable diseases or infections should be eported; 2) When and how isolation should be used for a		

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOE DEFICIENCY)	BE COMPLETION
F 880	(A) The type and dur depending upon the involved, and (B) A requirement that least restrictive possic circumstances. (v) The circumstance must prohibit employ disease or infected s contact with resident contact will transmit to (vi) The hand hygiene by staff involved in disease of infected secontact will transmit to (vi) The hand hygiene by staff involved in disease of infection active actions take \$483.80(a)(4) A system identified under the factorrective actions take \$483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual result that the facility will condustry in the facility will condustry in the facility personal protective estaff (Nursing Assistation) gown before isolation precautions. The findings included Review of the Infection.	ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct sor their food, if direct the disease; and a procedures to be followed rect resident contact. The for recording incidents acility's IPCP and the ten by the facility. The store, process, and so to prevent the spread of the ir program, as necessary. The is not met as evidenced on, record review and staff failed to implement its quipment policy when 1 of 1 and #1) failed to remove an exiting a resident's room on the stage of the stage o	F 88	F880 Infection Control On 9-29-22, the Staff Development Coordinator (SDC) verbally educated nurse aide #1 regarding donning/doffii personal protective equipment (PPE) emphasis on removing PPE prior to exiting resident room and removal/changing N95 mask between isolation rooms.	with

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	345313	B. WING		0.0	C b/ 29/2022
NAME OF PROVIDER OR SUPPLIER	1.00.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	08	112912022
			HWY 305 NORTH		
NORTHAMPTON NURSING AND I	REHABILITATION CENTER		JACKSON, NC 27845		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
precautions. The pol should be removed a appropriate contained. An observation was 9/29/22 at 8:30 AM. that read to use eye gloves to protect res. An observation was Assistant (NA) #1 on room door had cautic resident was on isolated were required to use gloves when entering exited a resident's reprecautions without a gloves. NA #1 walke placed a tray on the the same resident's and gloves. An interview was con 9/29/22 at 8:48 AM. not aware that she con hallway. NA #1 state educated on donning protective equipment read the sign. An interview was con Nursing (DON) on 9/ stated that NA #1 she gown and gloves in the same resident of the sign.	is to be worn when residents on isolation icy further stated that PPE and discarded in an reprior to exiting room. conducted of the 100 Hall on The room door had a sign wear, mask, gown, and idents on room restrictions. conducted of Nursing 19/29/22 at 8:35 AM. The on signage that indicated the ation precautions and staff eyewear, mask, gown, and gresidents' room. NA #1 from that was on isolation removing her gown and dover to the meal cart and cart. NA #1 then returned to room and removed her gown and the stated with NA #1 on NA #1 stated that she was ould not wear her gown in the	F8	On 10-20-22, the DON/Infection Preventionist initiated an audit or currently working on use of PPE audit was to ensure staff don/do appropriately when entering/exit quarantine rooms. The Director will address all concerns identifies the audit. The audit will be comp 10-20-22. On 10-20-22 the DON/Infection Preventionist initiated an in-serventurn demonstration with all nur nursing assistants, therapy staff, staff, housekeeping staff, Accou Receivable, Administrator, Accou Payable, medical records, recep screener, social worker and main staff regarding PPE Use. Empha appropriate donning/doffing PPE include but not limited to gowns/ and use of PPE when enter resignorms and/or quarantine rooms CDC guidelines. In-service will be completed by 10-31-22. After 10 any staff who has not received the in-service will be in-serviced upon scheduled work shift. All newly he will be in-serviced with return demonstration during orientation regarding facility PPE Use. On 10-20-22, the DON/Infection Preventionist initiated an in-servinurses, nursing assistants, there dietary staff, housekeeping staff. Accounts Receivable, Administration Accounts Receivable, Administration Receivable, Receivable, Administration Receivable,	f all staff . This . This ff PPE ing of Nursing ed during eleted by vice with ses, , dietary nts unts tionist, ntenance asis is on E to gloves dent based on e 0-31-22 ne on next nired staff ice with all apy staff, , ator, rds,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		LETED
		345313	B. WING _			1	C 29/2022
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		HWY	ET ADDRESS, CITY, STATE, ZIP CODE 305 NORTH KSON, NC 27845	1 03/	<i>E3/E</i> 422
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From pag	e 9	F	Description of the second of t	naintenance staff regarding Principle covid 19 Guidelines with emphasis on ource control measures. In-service will e completed by 10-31-22. After 0-31-22 any staff who has not receive the in-service will be in-serviced upon a cheduled work shift. All newly hired simil be in-serviced with return emonstration during orientation egarding Principle Covid 19 Guideline the Minimum Data Set (MDS) Nurse and/or nurse supervisor will complete that observations to include staff on all hifts weekly x 4 weeks then monthly x that is to ensure staff donned/doffed in propriately when entering/exiting esident room when isolation precaution are required. The MDS nurse and/or the include estraining of staff. The Director of Nurse supervisor will address all concentrations of staff. The Director of Nurse DON) will review the PPE Audit Tool weekly x 4 weeks then monthly x 1 more ensure all areas of concerns were addressed. The Director of Nursing (DON) will resent the findings of the PPE Audit Tool weekly x 4 weeks then monthly x 1 more ensure all areas of concerns were addressed. The Director of Nursing (DON) will resent the findings of the PPE Audit Tool weekly x 4 weeks then monthly x 1 more ensure all areas of concerns were addressed. The Director of Nursing (DON) will resent the findings of the PPE Audit Tool of the Executive Quality Assurance the enough of the PPE Audit Tool to determine trends and/or assues that may need further intervention that into place and to determine the new or further frequency of monitoring.	ed next taff 10 I C 1 PPE ons sing onth	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						С	
		345313	B. WING _	B. WING		09/29/2022	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE HWY 305 NORTH JACKSON, NC 27845			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	