STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

(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 survey was conducted 6/23/24 through 6/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# YGOH11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 6/23/24 through 6/26/24. Event ID# YGOH11.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		7/12/24

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

Electronically Signed | 07/11/2024

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F 636	Continued From page 1 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete an annual comprehensive assessment within the required time frame (Resident #29) for 1 of 15 sampled residents.	F 636	1.Address how the corrective action will be accomplished by the deficient practice. 1a. Resident #29 will have a Minimum Data Set Annual Assessment scheduled for July 3, 2024, completed and submitted	

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F 636	Continued From page 2 The findings included: Resident #29 was admitted to the facility on 4/27/23. A review of Resident #29's Minimum Data Set (MDS) assessments revealed an admission MDS completed on 5/4/24, and Quarterly MDS assessments completed on 8/4/23, 11/4/23, 2/4/24 and 5/6/24. The annual assessment was not completed. On 6/25/24 at 11:10 AM, an interview occurred with the MDS Nurse #1. She reviewed the MDS assessments that had been completed for Resident #29 and stated that the quarterly MDS assessment that was completed on 5/6/24 should have been an annual assessment. She further explained the facility had recently transitioned to a new Electronic Medical Record (EMR) system in April 2024 and felt it was an oversight due to the transition that another quarterly assessment was completed instead of an annual assessment. The Administrator was interviewed on 6/25/24 at 1;30 PM and stated that she would expect the annual MDS assessment to be completed in the required time frame for Resident #29.	F 636	July 9, 2024 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On July, 10, 2024, The Regional Clinical Reimbursement Specialist for Saber Healthcare completed a 100% Audit of all residents currently in the facility per the annual assessment schedule. No discrepancies were identified. 3. Address how measures will be put into place for system changes made to ensure that the deficient practice will not recur. 3a.Minimum Data Set Nurse #1 is no longer employed by the facility. 3b. On July 9, 2024, Regional Clinical Reimbursement Specialist provided education to Minimum Data Set Nurse #2 and the Director of Nursing on the scheduling of assessments. 4. Indicate how the facility plans to monitor its performance that solutions are sustained. 4a. The Licensed Nursing Home Administrator or the designee will randomly audit the Minimum data Set Accuracy on a scheduling audit tool weekly x 12 weeks then monthly x 3 months. Results of the audit will be brought to the Quality Assurance Performance Improvement meeting for review monthly for 6 months. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		7/12/24

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F 641	Continued From page 3 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of trach care (Resident #17), prognosis (Resident #47), discharge (Resident #63), and medication (Resident #41 and #55). This was for 5 of 17 residents reviewed for MDS accuracy. The findings included: 1. Resident #17 was admitted to the facility on 01/25/19 with diagnoses that included a tracheostomy. The quarterly MDS assessment dated 06/01/24 indicated Resident #17 ' s cognition was intact. The special treatments, procedures, and programs section for tracheostomy care while a resident was not coded. Review of Resident #17 ' s active orders revealed an order that read in part to change inner cannula of trach daily for infection control, the medication administration record (MAR) was signed daily as being completed. Another order read to change trach ties weekly on Tuesdays for infection control, the MAR was signed every Tuesday as being completed. An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #17 had a tracheostomy and that she did not code the special treatments, procedures,	F 641	1. Address how the corrective action will be accomplished by the deficient practice. 1a. Resident #17, #47, #63, #4 and #55. All _were corrected by June 27, 2024. 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On July 10,2024, The Regional Clinical Reimbursement Specialist for Saber Healthcare completed a 100% audit of all residents in the facility in the last 3 months. All discrepancies were immediately corrected. 3. Address how measures will be put into place for system changes to ensure that the deficient practice will not occur. 3a. Minimum Data Set nurse #1 is no longer employed by the facility. 3b. The Regional Clinical Reimbursement Specialist educated Minimum Data Set nurse #2 and the Director of Nursing on July 9, 2024, regarding accuracy of assessments. 4. Indicate how the facility plans to monitor its performance that solutions will be sustained. The Licensed Nursing Home Administrator or the designee randomly audit the Minimum Data Set Accuracy of Assessments audit tool weekly x 12 weeks then monthly x 12 weeks, then monthly x 3 months. The results of the audit will be brought to the Quality	

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F 641	Continued From page 4 and programs section. She stated it was an oversight that she did not code tracheostomy care on his MDS assessment. An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded. 2. Resident #47 was admitted to the facility on 08/05/24 with diagnoses that included Dementia Disorder. Record review revealed Resident #47 started receiving Hospice services on 08/17/22. Review of Resident #47 ' s orders revealed an order that read in part that resident was admitted to Hospice Services for significant decline in overall health and a decline in status was expected related to terminal illness. Resident #47's active care plan, last revised on 02/28/24, included a focus area that read Resident #47 was on Hospice services for significant decline in overall health. Has expected to decline in status related to terminal illness. The interventions included for staff to contact hospice for changes in resident condition and to keep resident comfortable. The quarterly MDS assessment dated 05/22/24 indicated Resident #47 ' s cognition was severely impaired. The health conditions section for Resident #47 under prognosis was coded as not having a condition or chronic disease that may result in a life expectancy of less than 6 months although she was coded as receiving Hospice services while being a resident.	F 641	Assurance Performance Improvement meeting for monthly review x 6 months. If any discrepancies are noted, further action will be implemented by the Licencsed Nursing Home Administrator.	

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F 641	Continued From page 5	F 641		

An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #47's Health Conditions section for terminal prognosis was coded as "No". She stated she was aware Resident #47 was being followed by Hospice and it was an oversight that she miscoded this question. She verified the resident was covered by Hospice and had a life expectancy of 6 months or less.

An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded.

3. Resident #63 was admitted to the facility on 03/19/24 with diagnoses that included type 2 diabetes mellitus and closed fracture with routine healing.

The discharge MDS assessment dated 04/15/24, identification information section under discharge status indicated Resident #63 was discharged to a short-term general hospital.

Review of a Nursing Progress Note dated 04/15/24 revealed that Resident #63 was discharged home with son.

Review of Discharge Summary, dated 04/15/24, revealed Resident #63 was discharged home with family.

An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #63's Identification Information section under discharge status was coded as being discharged to a short-term general hospital. She

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F 641	Continued From page 6	F 641		

stated she was aware Resident #63 was discharged home and it was an oversight that she miscoded this question.

An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded.

4. Resident #41 was admitted to the facility on 04/10/24 with diagnoses that included essential (primary) hypertension and primary pulmonary hypertension.

Review of Resident #41 ' s active orders revealed an order for furosemide (used to treat high blood pressure (hypertension), heart failure and a buildup of fluid in the body) 40 milligram (mg) tablet once a day, 1 tablet, with a start date of 04/10/24.

The admission MDS assessment dated 04/16/24 indicated Resident # 41 was not coded for diuretics.

An Interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #2. She verified she did not code that Resident #41 received diuretics during the look back period of his admission assessment. She stated she overlooked Resident #41's diuretic medication order when she was completing his assessment. It was an oversight that she did not code the diuretic on his MDS assessment.

An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded and that care plans should be patient

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F 641	Continued From page 7	F 641		

centered.
5. Resident #55 was admitted to the facility on 9/26/23 with diagnoses that included anxiety disorder and dementia with mood disorder.

a. A review of Resident #55's physician orders included orders dated 3/26/24 for Trazodone (an antidepressant medication) 50 milligrams one tablet by mouth once a day and Duloxetine (an antidepressant medication) 30 milligrams three capsules by mouth one a day.

A review of the May 2024 Medication Administration Record (MAR) showed that Resident #55 received the antidepressant medications during the 7-day look back period for the 5/9/24 MDS assessment (5/3/24 through 5/9/24).

A review of the quarterly Minimum Data Set (MDS) assessment dated 5/9/24 did not have antidepressant medications coded.

b. A review of Resident #55's physician orders included an order dated 5/1/24 for Macrobid (an antibiotic) 100 milligrams 1 capsule by mouth twice a day with a stop date of 5/8/24.

A review of the May 2024 MAR showed that Resident #55 received the antibiotic medication during the 7-day look back period for the 5/9/24 MDS assessment (5/3/24 through 5/8/24).

A review of the quarterly MDS assessment dated 5/9/24 did not have antibiotic medications coded.

On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurse #1 and #2, who reviewed the MDS assessment dated 5/9/24 as well as

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F 641	Continued From page 8 Resident #55's medical record. MDS Nurse #1 stated she failed to include the antidepressant and antibiotic medications on the assessment and felt it was an oversight. Both MDS Nurse #1 and #2 stated the MARs should be reviewed carefully to code the medication section of the MDS assessment accurately. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated she would expect the MDS assessments to be accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		7/12/24

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F 656	Continued From page 9 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for the presence of a nephrostomy tube (a tube that let's urine drain from the kidney through an opening in the skin on the back-Resident #2), and a skin condition (Resident #34). This was for 2 of 15 resident care plans reviewed. The findings included: 1) Resident #2 was originally admitted to the facility on 10/30/20. She was hospitalized from 2/19/24 to 2/29/24 and found to have a complex urinary tract infection due to a kidney stone. At that time a left sided nephrostomy tube was placed.	F 656	1 Address how the corrective action will be accomplished by the deficient practice. 1a. Resident #2 and #34 had a care plan correction on June 25, 2024. 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On July 7, 2024, the Director of Nursing and the Unit Manager conducted a 100% audit of all residents currently in the facility in the area of the care plans to assure they are comprehensive. Any discrepancies were corrected. 3. Address how measures will be put into place for system changes to ensure the deficient practice will not recur. 3a. Minimum Data Set Nurse #1 is no	

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F 656	Continued From page 10 A quarterly Minimum Data Set (MDS) assessment dated 5/28/24 indicated Resident #2 had severe cognitive impairment. She was coded with an indwelling catheter. Review of the active care plan, last revised 6/14/24, did not include the presence of a nephrostomy tube. On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurses #1 and #2 who reviewed Resident #2's active care plan. They confirmed a care plan was not developed for the presence of a nephrostomy tube but should have been and stated it was an oversight. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated it was her expectation for the care plan to be person centered and should have included the presence of the nephrostomy tube for Resident #2. 2) Resident #34 was admitted to the facility on 5/26/23. A physician progress note dated 4/25/24 indicated Resident #34 was seen for skin lesions to the scalp and left ear and had a history of skin cancers to his head in the past. A referral was made to dermatology. A review of Resident #34's medical record revealed he was seen by the dermatologist and had a procedure completed to remove skin cancer lesions to his scalp and left ear on 5/21/24. The annual Minimum Data Set (MDS)	F 656	longer employed. 3b. On July 9, 2024, The Regional Clinical Reimbursement Specialist with Saber Healthcare re-educated the Minimum Data Set Nurse #2 and Director of Nursing on care planning completion. 4. Indicate how the facility plans to monitor its performance that solutions are sustained. The Licensed Nursing Home Administrator or the designee will randomly audit the Resident Care Plan for person centered care plan audit tool weekly x 12 weeks then monthly x 3 months. Results of the audit will be brought to the Quality Assurance Performance Improvement meeting for monthly review x 6 months. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	

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F 656	Continued From page 11 assessment dated 5/21/24 indicated Resident #34 was cognitively intact and was coded for open lesions other than ulcers, rashes or cuts. A review of the May 2024 physician orders included an order dated 5/24/24 to cleanse the scalp and left ear gently with soap and water twice a day and apply a thin layer of Vaseline. Review of the active care plan, last revised 5/31/24, did not include the skin condition to Resident #34's scalp and left ear. On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurse #1 and #2 who reviewed Resident #34's active care plan and MDS assessment dated 5/21/24. They confirmed a care plan was not developed for the skin condition to Resident #34's scalp and left ear but should have been and stated it was an oversight. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated it was her expectation for the care plan to be person centered and should have included the skin condition to Resident #34's scalp and left ear.	F 656		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to	F 693		7/12/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 12 eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to change a gastrostomy tube dressing site that was ordered to be completed daily for 1 of 2 residents reviewed for gastrostomy tubes (Resident #31). The findings included: Resident #31 was admitted to the facility 1/9/2024 with diagnoses including stroke and gastrostomy tube for feeding. Resident #31's medical record was reviewed, and a physician order dated 4/25/2024 ordered for daily gastrostomy site dressing to be completed by cleaning the site and applying clean gauze. The quarterly Minimum Data Set (MDS) assessment dated 5/14/2024 assessed Resident #31 was severely cognitively impaired, and he received tube feeding nutrition daily. The treatment record for Resident #31 indicated the gastrostomy tube dressing change had been changed on 6/22/2024 and 6/23/2024.	F 693	1. Address how the corrective action will be accomplished by the deficient practice. 1a. On June 24, 2024 the nurse for resident #31 povided a clean and dry gastrostomy tube dressing dated 6/24/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. The Unit Manager and the Director of Nursing conducted a 100% audit of all residents treatments for completion, including dating of the dressing. No deficiencies identified. 3. Address how measures will be put into place for system changes to ensure that the deficient practice will not recur. 3a. The weekend nurse #1 received re-education from the Director of Nursing on the Skin and Wound Management Policy on July 1, 2024. 3b. 100% of the nursing staff we re-educated by the Director of Nursing and the Assistant Director of Nursing on	

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	345392	A. BUILDING _____ B. WING _____	06/26/2024

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F 693	Continued From page 13 Resident #31 was observed on Monday 6/24/2024 at 2:05 PM. A gastrostomy tube with a dressing was noted and the dressing was dated Friday 6/21/2024. The gastrostomy dressing appeared to be wet with a clear, light yellow, odorless drainage. Nurse #1 was interviewed at the time of the observation, and she reported the gastrostomy dressing was ordered to be changed daily and she was going to change the dressing in a few minutes. The Director of Nursing (DON) was interviewed on 6/24/2024 at 2:17 PM. The DON explained that the weekend supervisor was responsible for completing all treatments in the facility during the weekend. The DON reported the dressing should have been changed by the weekend supervisor. MDS Nurse #1 was interviewed on 6/25/2024 at 9:03 AM. MDS Nurse #1 reported she was responsible for the treatments and wound care on the weekend as the weekend supervisor. MDS Nurse #1 ran a report of the treatments that were due for Resident #31 and the gastrostomy dressing change was not on the report. MDS Nurse #1 explained that she was not aware the gastrostomy dressing needed to be changed and she would have changed the dressing if it was on her report. The Administrator was interviewed on 6/25/2024 at 1:23 PM and she reported the gastrostomy dressing change was not entered into the electronic medical record as a treatment and the dressing change was not completed by the weekend supervisor. The Administrator reported she expected gastrostomy dressing changes to be added to the treatment plan so dressing	F 693	the Skin Wound Management Policy June 27, 2024. 3c. 100% of the nursing staff received competency re-training by the Director of Nursing and the Assistant Director of Nursing, completed by July 3, 2024. 4. Indicate how the facility plans to monitor its performance that solutions are sustained. 4a. The Director of Nursing or the designee will conduct a random audit for dressing cleanliness and date. The audit will be conducted weekly x 12 weeks and monthly x 3 months. The results of the audit will be brought to the Quality Assurance Performance Improvement meeting for monthly review x 6 months. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	

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F 693	Continued From page 14 changes were not missed.	F 693		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. 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 discard opened food items ready for use within 7 days of opening in 1 of 1 walk-in refrigerators and in 1 of 2 reach-in refrigerators. The facility also failed to label, and date opened food items in 1 of 1 walk-in refrigerators and in 1 of 2 reach-in refrigerators. This practice had the potential to affect food served to residents. The findings included: Observations during the initial tour of the main kitchen with Dietary Cook/Aide #1 on 06/23/24 at	F 812	1. Address how the corrective action will be accomplished by the deficient practice. 1a. On June 23, 2024, the Dietary Manager discarded all food items from the walk in and the reach in refrigerator out of date range/not labeled properly. 2. Address how the facility will identify other residents having the potential to be affected the same deficient practice. 2a. As of June 24, 2024, the Dietary Manager has completed inventory of the kitchen, items that must be labeled and no items are out of date.	7/12/24

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F 812	Continued From page 15 10:55 AM, revealed the following: a. In the walk-in refrigerator the following items were observed. -32 oz pack (3/4 full) sliced Virginia baked ham-no open date. -21 hot dogs in a zip lock bag with an opening date of 06/11/24. -Twelve 8 ounce (oz) bowls with a yellow pudding like substance in them that were not dated and were not covered. - Forty-eight 8 oz bowls with a yellow pudding like substance in them were not dated. b. In the reach-in refrigerator #1 the following items were observed. -2 pounds of sliced turkey with no open date. -1/4 of quart sized zip lock bag with sliced onions with an opening date of 06/11/24. -1/4 of a gallon size zip-lock bag with sliced cheese with no open date. -3-pound container of Pimento cheese spread with an opening date of 03/19/24. On 06/23/24 at 10:55 AM an interview was conducted with Dietary Cook/Aide #1. She stated the Dietary Manager (DM) checks the coolers and freezers for undated foods and expired food, use by dates. She also stated she was unaware how many days items could be stored in the coolers before discarding them. She verified staff were to	F 812	3. Address how measure will be put into place for system changes to ensure that the deficient practice will not recur. 3a. On July 1, 2024, The Licensed Nursing Home Administrator reeducated the Dietary Manager on the storage and labeling of food. 3b. On July 1, 2024, the Dietary Manager educated 100% of the dietary staff on the Storage of Refrigerated Foods policy. 4. Indicate how the facility plans to Monitor its performance that solutions will be sustained. The Licensed Nursing Home Administrator or the designee will conduct a random weekly audit with the Dietary Manger for proper storage and labeling. The audit will be conducted weekly x 12 weeks and monthly x 3 months. The results of the audit will be brought to the Quality Assurance Performance Improvement meeting for monthly review x 6 months. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	

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F 812	Continued From page 16 label and date items after opening or preparing. Dietary Cook/Aide #1 discarded the above items at the end of the initial tour. On 06/23/24 at 10:59M an interview was conducted with Dietary Cook #2, and Dietary Aide #1. They both stated they were unaware how many days items could be stored in the coolers before discarding them. They verified staff were to label and date items after opening or preparing. On 06/23/24 at 12:10 PM an interview was conducted with the Dietary Manager (DM). She verified all items that were not dated or had not been removed within 7 days had been discarded. She stated she forgot to date the sliced lunch meat in the coolers and did not remove the dated food items that were unused after 7 days. A follow-up interview was conducted on 06/24/24 at 10:56 AM with the Dietary Manager (DM). She stated she was the only one responsible for monitoring the freezer and coolers for food dates and labels. She also stated she tries to check the opened items and discard dates daily or at least every other day. She indicated she had been having staffing issues lately and she had been covering shifts. She also indicated she had forgotten to check the coolers and freezers. She then stated, "I dropped the ball on it, I just have to make it right now". She then stated that the kitchen cooks and aides are to put the food in an airtight container/baggy and write their initials and open date on the containers. She then stated she needed to reeducate staff.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/12/24

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F 880	Continued From page 17 §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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 18 (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. §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, observations, and staff interviews, the facility failed to implement the facility's policy for enhanced barrier precautions for 1 of 11 residents reviewed for infection control (Resident #31). The findings included: The facility infection control policy with a revision date of 4/15/2024 read, in part: "Enhanced Barrier Precautions are intended to prevent the	F 880	1. Address how the corrective action will be accomplished by the deficient practice. 1a. On June 24, 2024, Resident #31 had enhanced barrier precautions signage and order initiated. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On June 24, 2024 the Assistant Director of Nursing and the Unit Manager conducted a 100% audit of all residents	

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F 880	Continued From page 19 transmission of multi-drug resistant organisms via contaminated hand and clothing of healthcare workers to high-risk residents." Resident #31 was observed in bed on 6/23/2024 at 10:52 AM. There was no sign on the door indicating EBP were in place and no caddy with Personal Protective Equipment (PPE) outside of his door. Resident #31 was noted to have tube feeding (on hold) and a wound dressing was noted to his left lower leg. Incontinence care for Resident #31 was observed with Nursing Assistant (NA) #1 and NA #2 on 6/24/2024 at 2:03 PM. NA #1 and NA #2 performed hand hygiene and applied gloves but did not don gowns to provide incontinence care to Resident #31. When asked if providing incontinence care for Resident #31 required any additional PPE, NA #1 stated there was not a sign on the door, so there was no need for additional PPE. Nurse #1 was interviewed on 6/24/2024 at 2:05 PM. Nurse #1 explained because Resident #31 had a chronic wound and a gastrostomy tube, he should have EBP in place and the NAs should have worn appropriate PPE to provide care. Nurse #1 explained the signs on the door and the PPE carts outside the door communicated to staff and visitors that EBP were in place for residents. The Infection Control nurse was interviewed on 6/24/2024 at 2:10 PM and she reported that due to Resident #31's wound and gastrostomy tube, the NAs should have applied gowns and gloves to provide incontinence care. The Infection Control nurse explained that when Resident #31 was moved to his current room the sign for EBP was	F 880	that met the criteria for Enhanced Barrier Precautions. All deficient practices were corrected. 2b. On June 24, 2024, the Assistant Director of Nursing and the Unit Manager ensured that all residents with enhanced barrier precautions have proper signage on their door and physicians orders added to their electronic medical record. . 3. Address how measures will be put into place for system changes to ensure that the deficient practice will not recur. 3a. On July 6, 2024, 100% of all employees to include nursing, dietary, therapy, housekeeping, administrative staff received education on enhanced barrier precautions. 4. Indicate how the facility plans to monitor its performance that solutions are sustained. The Director of Nursing or the designee will conduct a random weekly audit of residents meeting the criteria for enhanced barrier precautions. They must have an order and proper signage. The audit will be conducted weekly x 12 weeks and monthly x 3 months. The results of the audit will be brought to the Quality Assurance Performance Improvement meeting for monthly review x 6 months. If any discrepancies are noted further action will be implemented by the Licensed Nursing Home Administrator.	

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F 880	Continued From page 20	F 880		

not moved with him. The Infection Control nurse reported the signs on the door and PPE carts communicated to staff and visitors that EBP were in place.

An interview was conducted with the Director of Nursing (DON) on 6/24/2024 at 2:17 PM. The DON explained any resident with an indwelling device, such as a gastrostomy tube for feeding, and/or a chronic wound should have Enhanced Barrier Precautions implemented to prevent the transmission of pathogens or possible contamination of the indwelling device or wound. The DON reported Resident #31 was moved from a room and the signage for EBP was not moved with him. The DON reported she expected all residents with an indwelling device or chronic wound to have a physician order for EBP, a sign on their door, and a PPE caddy available for staff to use the appropriate PPE. The DON reported EBP were communicated in report to the staff, the signs on the door, and the PPE carts by the resident rooms.

The Administrator was interviewed on 6/25/2024 at 1:23 PM and she reported that staff had received infection control education and should be able to recognize when a resident required EBP.