STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 The survey team entered the facility on 08/05/24 to conduct a recertification and complaint survey and was unable to return to the facility on 08/07/24 due to adverse weather of hurricane and unsafe travel conditions. The survey team returned to the facility on 08/12/24 and completed the survey on 08/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # QEA411.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 08/05/24 to conduct a recertification and complaint survey and was unable to return to the facility on 08/07/24 due to adverse weather of hurricane and unsafe travel conditions. The survey team returned to the facility on 08/12/24 and completed the survey on 08/12/24. Event ID #QEA411. The following intake was investigated NC00215130. 1 of the 1 complaint allegation did not result in deficiency.	F 000		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff.	F 851		9/5/24

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

Electronically Signed | 09/06/2024

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F 851	Continued From page 1	F 851		

Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing

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F 851	Continued From page 2 information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to electronically submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid Services (CMS) as required for quarter three of fiscal year (FY) 2023 (April 1- June 30, 2023). This failure occurred for 1 of 4 quarters reviewed. The findings included: A review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database revealed the facility failed to submit the required PBJ Staffing Data for quarter three of FY 2023. According to CASPER the data was not submitted. On 8/12/24 at 11:03 AM an interview with the Administrator indicated she was responsible for submitting PBJ data to CMS and was aware the PBJ staffing submission was late for quarter three FY 2023. The Administrator further revealed the data was submitted one day late due to staff changes.	F 851	Corrective action to be accomplished for the deficient practice: The facility has a process in place to compile data from the payroll Paychex system and upload these file to the Simple PBJ system for review and submission. The facility has completed a process with no failure to submit previously. The new staff hired to complete the submission for 8/14/2023 had marked the deadline to submit this quarter on 8/15/2023. The data was compiled and attempt for submission was requested through the SimplePBJ system and logged as Failed to Send on 8/15/23 at 3:48:19 PM. Upon efforts to determine why the file would not send, the employee discovered the deadline was the previous day and there was no mechanism to submit the quarter. The Facility has designated staff and data collection tools/systems in place to submit the quarterly reports as required. Address how the facility will identify other issues with the potential to be affected by the same deficient practice: The facility has designated staff in place to complete the data collection, review and submission of the Payroll Based	

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F 851	Continued From page 3	F 851	Journal (PBJ) files to CMS quarterly as required. Files are compiled from the Paychex Payroll system and other contract invoicing records and entered/verified through the SimplePBJ software program. CMS Submission reports are provided to administration for the PBJ Final File Validation Report prior to the quarterly deadline. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Measures were put in place on 8/15/23, when the error with timing of the completed files was discovered to ensure timely filing. Designated staff and schedules for submission were put in place. Files used for reporting are provided to the designated staff during the quarter and final data is provided at the end of the quarter to complete the required file for submission. Since this time, the quarterly reports have been completed and submitted timely Indicate how the facility will monitor our performance to make sure that solutions are sustained: Since the failure to submit on 8/15/2023, measures were immediately put in place for timely completion. The quarterly reports have been completed and submitted timely as evidenced by the CMS validation reports on 11/13/2023, 2/14/2024, 5/15/2024 and 8/13/2024. This demonstrates compliance for the last 12 months.	

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F 851	Continued From page 4	F 851	Performance will be monitored by the administrator and reported quarterly in November, February, May and August to the Nursing Home QAPI committee as well as the Housewide QAPI committee. This reporting will continue quarterly to make sure the solution is maintained.	
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, 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	F 880		9/5/24

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F 880	Continued From page 5 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. §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 staff interviews, the facility failed to have a documented water	F 880	Corrective action to be accomplished for the residents found to be affected by the	

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F 880	Continued From page 6 management program for Legionella. Failure to have a water management program had the potential to affect 34 of 34 residents in the facility. The findings included: Review of the facility's Emergency Preparedness Plan last reviewed by the facility on 2/17/2024 and Infection Control policies revealed no evidence of a water management program for Legionella. Interview with the Infection Preventionist (IP) on 8/12/24 at 1:13 PM revealed the IP was unsure about any written water management program for Legionella. Interview with the Administrator on 8/12/24 at 1:24 PM revealed it was the IP that oversaw water management. Further interview revealed the Maintenance Director did not have any knowledge in water management. She further revealed there was not a specific Legionella water management program to follow. The Administrator indicated it should have been her overseeing the IP and water management programs. The Administrator explained there should have been a written Legionella water management program to follow.	F 880	deficient practice: The facility Water Management Plan has been in place with effective date of 8/13/2018 with the last annual review of 7/30/2022 as a maintenance policy. The stated purpose for the plan is to address primary waterborne infections which would be synonymous with Legionellosis. The Safety Committee met on 7/19/2018 to review the ASHRAE 188: legionellosis: Risk Management for Building Water Systems- June 26, 2015, CDC: Water Management toolkit, CDC: June 5, 2017 Construction. These tools were utilized by the committee to develop and implement the Water Management Plan. As part of the water management plan, testing for Legionella was conducted per the policy for nursing home respiratory illness as part of the root cause analysis on 4/11/2022 and was negative. No further testing has been determined necessary or advisable by the Infection Preventionist since this time. The Infection Preventionist completes an annual risk assessment summary and detailed Infection Prevention and Control Risk Assessment which had been completed on 7-10-2024. The facility also completes an annual hazard and vulnerability assessment which includes Legionella Risk. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility Water Management Plan has	

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F 880	Continued From page 7	F 880	been in place with effective date of 8/13/2018 with the last annual review of 7/30/2022 as a maintenance policy. The stated purpose for the plan is to address primary waterborne infections which would be synonymous with Legionellosis. The Safety Committee met on 7/19/2018 to review the ASHRAE 188: legionellosis: Risk Management for Building Water Systems- June 26, 2015, CDC: Water Management toolkit, CDC: June 5, 2017 Construction. These tools were utilized by the committee to develop and implement the Water Management Plan. As part of the water management plan, testing for Legionella was conducted per the policy for nursing home respiratory illness as part of the root cause analysis on 4/11/2022 and was negative. No further testing has been determined necessary or advisable by the Infection Preventionist since this time. The Infection Preventionist completes an annual risk assessment summary and detailed Infection Prevention and Control Risk Assessment which had been completed on 7/10/2024. The facility also completes an annual hazard and vulnerability assessment which includes Legionella Risk. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The facility Water Management Plan was	

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F 880	Continued From page 8	F 880	reviewed with updated standards/references and revised on 8/29/24. The policy will be reviewed and updated annually. Staff education to review roles for housekeeping, dietary and maintenance regarding operational management of risks was conducted. Effectiveness of the Water Management Plan has been added to the Utility Management section of the Physical Environment Management Systems Annual Evaluation. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance of compliance with our Water Management Plan will be monitored monthly for 1 year and recorded on the Maintenance Scorecard and reported quarterly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue quarterly for 1 year to make sure the solution is maintained.	