STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKESBORO HEALTH AND REHABILITATION	**204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659**

(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 and complaint investigation was conducted on 09/08/24 through 09/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D1V11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 09/08/24 through 09/11/24. The following intakes were investigated: NC00219315 and NC00215921. Two (2) of the 2 complaint allegations did not result in deficiency. Event ID #1D1V11.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		9/12/24

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

Electronically Signed | 10/03/2024

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F 582	Continued From page 1 services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) by omitting the estimated out of pocket cost for care for 4 of 4 residents reviewed for beneficiary notices (Residents #4, #151, #45, #11).	F 582	Facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) by omitting the estimated out of pocket cost for care for 4 of 4 residents (#4, #151, #45, #11). Facility will Inform each resident of services available in the facility and the charges for those services	

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F 582	Continued From page 2 The findings included: a. Resident #4 was admitted to the facility on 8/10/2023. The medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was relayed by phone on 8/21/24 to Resident #4's representative. The notice indicated that Medicare coverage for skilled services was to end on 8/23/24. Resident #4 remained in the facility when Medicare coverage ended. Review of Resident #4's record indicated the SNF ABN dated 8/21/2024 had no estimated cost for care documented on the form. b. Resident #151 was admitted to the facility on 7/8/2024. The medical record revealed a CMS-10123 NOMNC was relayed to Resident #151's representative on 8/16/24. The notice indicated that Medicare coverage for skilled services was to end on what 8/20/2024. Resident #151 remained in the facility when Medicare coverage ended. Review of Resident #151's record indicated the SNF ABN dated 8/16/2024 had no estimated cost for care documented on the form. c. Resident # 45 was admitted to the facility on 1/05/2024. Medicare part A services began on 1/5/2024. The medical record revealed a CMS-10123 NOMNC was signed by Resident #45 on 4/16/2024. The notice indicated that Medicare	F 582	not covered under Medicare/Medicaid or by the facility's per diem rate. On 9/10/24 an ad hoc QAPI was held to discuss the deficient practice and implement a plan of correction with auditing tools. On 9/11/24 the Business Office Manager/designee informed each resident/Responsible Party (RP) of services available in the facility and the charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate. The Administrator educated the Business Office Manager and Business Office Assistant on 9/10/2024 informing each resident/RP of services available in the facility and the charges for those services not covered under Medicare/Medicaid or by the facility's per diem rate. Education will be added to the new hire orientation for Business Office staff, and they will not be allowed to work until education has been completed. The Administrator/BOM/designee will ensure the estimated dollar amount is listed on form SNFABN. A 100% audit of new notices signed will be completed 5x per week for 4 weeks, then 3x per week for 4 weeks, then weekly for 4 weeks to ensure new practice is followed. The date of compliance is 9/12/2024.	

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F 582	Continued From page 3	F 582		

coverage for skilled services was to end on 4/18/2024. Resident #45 remained in the facility when Medicare coverage ended.

Review of Resident #45's record indicated the SNF ABN dated 4/16/2024 had no estimated cost for care documented on the form.

d. Resident # 11 was admitted to the facility on 3/27/2024. Medicare part A services began on 3/27/2024.

The medical record revealed a CMS-10123 NOMNC was signed by Resident #11 on 6/18/2024. The notice indicated that Medicare coverage for skilled services was to end on what 6/20/2024. Resident #11 remained in the facility when Medicare coverage ended.

Review of Resident #11's record indicated the SNF ABN dated 6/18/2024 had no estimated cost for care documented on the form.

During an interview on 9/10/2024 at 9:31 am with Business Office Employee #1, she said she presented SNF ABN to the resident, or resident representative after she was notified in the weekly meeting on Thursdays where the Medicare A cases were reviewed and talked to the resident or representative about the rates but had not written the rate on the SNF ABN form. Review of the SNF ABN form with Business Office Employee #1 revealed "private pay" was written in the block for estimated cost. Business Office Employee #1 verified 4 of 4 forms reviewed did not have the estimated cost provided on the SNF ABN form. She stated she had never been told it had to be a specific amount.

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F 582	Continued From page 4 During an interview on 9/10/2024 at 9:40 am with the Administrator she said a weekly meeting was held on Thursdays and all Medicare part A cases were reviewed. She said the business office gave SNF ABN notifications to residents or resident representatives. Resident #4, Resident #151, Resident #45, and Resident #11's SNF ABN form was verified with the Administrator that private pay was written in the block for estimated cost on the SNF ABN form. The Administrator stated she did not know and had not been told previously that a specific amount needed to be placed in the estimated cost section of the SNF ABN form.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		9/25/24

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F 583	Continued From page 5 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record by leaving a medication cart laptop unattended with resident information exposed in an area accessible and visible to the public on 1 of 6 medication carts (Medication cart #3). The findings included: During an observation of 200 hall on 09/09/24 at 4:04 PM, medication cart #3 was observed unattended. The laptop screen was open and displayed resident names, medications, and diagnoses. Staff were observed in the area and the treatment nurse passed by while the residents' information was visible on the open laptop screen at 4:06 PM. On 09/09/24 at 4:07 PM, a resident passed by the open laptop screen on the medication cart #3 while residents' information remained visible. Medication Aide (MA) #2 was observed returning to the 200 hall with medication cart #2 at 4:10 PM.	F 583	On 9/9/24 at 4:00 PM, medication cart #3 was observed unattended and laptop screen was open and displayed resident names, medications, and diagnoses. On 9/9/24 the Assistant Director of Nursing (ADON) re-educated Medication Aide #1(CNA) on facility policy related to resident privacy and HIPPA. On 9/9/24 a 100% Audit was completed by the ADON, on all computers to ensure privacy was being protected and any resources needed to ensure privacy were in place. On 9/9/24 the Director of Nursing (DON) and/or designee completed 100% re-education of staff to ensure staff log off computers and double check computer screens display no patient information before walking away. On 9/25/24 the Facility Information Technology department replaced laptop closures to allow for full closure of laptop	

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F 583	Continued From page 6 An interview with MA #2 was completed on 09/09/24 at 4:10 PM. She stated she was assigned to two medication carts (cart #2 and cart #3). She verbalized that she usually clicked the walkaway tab when she left the medication cart unattended, so resident information was not visible. MA #2 indicated she thought she had hit the button to minimize the screen before she left the hall. An interview with the Assistant Director of Nursing was completed on 09/09/24 at 4:21 PM. She stated staff clicked the walkaway button on the computer screen of the laptop when they left the medication cart unattended. An interview with the Director of Nursing (DON) was completed on 09/09/24 at 4:38 PM. She explained to protect the health privacy of residents, the laptops on medication carts were minimized if staff were not in attendance of the medication carts. The DON verbalized MA #2 should have made sure the laptop screen was locked, and no personal health information was visible prior to leaving the medication cart unattended.	F 583	when attached to medication cart. The DON/Unit Managers/designee will audit staff randomly for adherence to HIPPA and privacy protocol 5x per week for 4 weeks, then 3x per week for 4 weeks, then weekly for 4 weeks to ensure procedures remain in place. The findings of these audits will be reviewed in the facility Quality Assurance Performance Improvement Committee meeting for need of further audits or education. The date of compliance is 9/25/2024	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		9/12/24

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residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,

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receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 585	Continued From page 9 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to ensure a prompt resolution to a grievance and failed to provide a written summary about a grievance for 1 of 1 resident reviewed for grievances (Resident #43). The findings included: Facility Grievance/Complaint filing policy stated resident or any family member of the resident could file a grievance/ complaint orally or in writing. Upon reciept of a grievance /complaint the Grievance Officer would review and investigate the allegations and submit a written report of such findings to the Administrator within 5 working days of having received the grievance/ complaint. The Grievance officer, Administrator and Staff would take immediate action to prevent further potential violations of resident rights while the alleged violation was being investigated. The Administrator would review the findings with the Grievance Officer to determine what corrective actions, if any, needed to be taken. The Resident or person filing the grievance/compliant on behalf of the resident would be informed (verbally and in writing) of the findings of the investigation and the actions that would be taken to correct any, identified problems. Resident #43 was admitted to the facility on 12/14/2021. The quarterly Minimum Data Set (MDS) dated	F 585	On 9/8/24 at 12:37 PM, resident #43 stated she was missing some personal items and filed a grievance July 2024, which was not yet resolved. Facility policy indicated grievances to be resolved within 5 days. The resident agreed to allow facility staff to resolve grievance with replacement of comparable item and grievance was resolved on 9/10/2024. An ad-hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 9/8/24 to discuss root cause and identify plan of corrective action. On 9/10/24, a 100% audit of all grievances was completed by the Social Worker and Administrator to ensure no other grievances were unresolved. No new residents were identified. On 9/8/24 Regional operations manager educated Administrator and Social Worker regarding resolving grievances per facility policy. Residents will be offered resolution of grievances within 5 days per facility policy. The Social Worker and/or designee will	

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F 585	Continued From page 10 05/21/24 revealed Resident #43 was cognitively intact. Record Review revealed on 07/03/2024 Resident #43 had filed a grievance with the facility Social Worker for missing 4 to 5 embroidered sheets: blue, pink yellow and peach color, 3 gowns, tote bag, and a Yeti cup. On 07/03/2024 the Social Worker documented on the grievance form under investigation/finding that the resident's room was searched, and the items were not found. The Investigation resolution on the grievance form dated 07-03-2024, had documentation by the Social Worker that she left a message for the resident's family member inquiring about when the items were delivered to the resident and inquired about the cost and quantity of the lost items. The Social Worker further documented the facility would not resolve the grievance until these items were found. An interview with Resident # 43 on 09/08/24 at 12:37PM revealed the resident had filed a grievance back in July 2024 about some personal items missing from her room. She stated she was missing embroidered sheets and gowns. She stated the facility staff had not found her items. She went on to state she had informed the staff, and the facility Social Worker. She added the housekeeping and laundry staff looked for these items and had not found them. She stated she was aggravated and gave up. She stated she was verbally informed that her missing items were not found but the facility would continue to look for it. The Guest/ Family member follow up	F 585	audit grievance log randomly for timely resolution of grievances 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then 1 day per week for 4 weeks to ensure grievances are resolved according to policy. All findings will be brought to the Quality Assurance Performance Improvement Committee by the Administrator for review and need for further auditing or education. The date of compliance is 9/12/2024.	

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documentation dated 09/09/2024 on the grievance form revealed, the Social Worker documented that she left a message with the resident's family member and then spoke to the resident's family member and explained to her that the grievance was not yet resolved because they were hoping the lost items would reappear. The facility settled the grievance with Resident #43 on 09/09/2024. The facility agreed to replace the resident's lost items on 09/09/2024

A follow up interview with Resident #43 on 09/10/2024 at 9:00AM revealed the facility had agreed to settle Resident # 43's grievance on 09/09/2024 evening. Resident stated the Social Worker had verbally informed her that the facility would be settling her grievance by purchasing new bed sheets and gowns for her and would embroider Resident # 43's name on it.

In an interview conducted with the Social Worker who was also the Grievance Officer on 09/09/24 at 3:37PM she stated the facility's handbook documented the facility was not responsible for lost items. She stated the facility's policy for grievance resolution was to resolve within 5 days. She stated during their last care plan meeting dated 07/28/2024 Resident #43's family member who had attended the care plan meeting via telephone along with the Resident# 43 informed the care team that several embroidered sheets along with Resident #43's gowns were missing. She stated she informed the family member a grievance was already filed by Resident # 43; she stated the facility had already looked for the missing items and did not find them. She stated she informed the family member they would keep looking for the missing items.

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F 585	Continued From page 12	F 585		

Interview with the Director of Nursing (DON) on 09/09/24 at 4:02PM indicated a grievance could be filed by anyone with the facility social worker. The grievance was then forwarded to the respective department to be processed even if it was on a weekend, as some grievance need immediate attention and cannot wait till Monday. She stated the grievance resolution time varied; it depended on the item. She stated they searched the whole facility and sometimes it took them about a month to resolve a grievance. She stated they had tried to resolve grievance faster for the short-term residents. For the long-term residents, it may take about a month to month and a half to resolve the grievance. She further stated if the lost items were not found the facility reimbursed the resident the value of the item. She stated she became aware of the grievance dated 07/03/2024 on 08/05/2024 when Resident #43's family member informed her. She stated none of the staff had seen these items mentioned in the grievance. She stated she had directed staff to look for the lost bedsheets one more time on 09/09/2024; if not found instructed staff to buy Resident # 43 new bedsheets and get them embroidered.

In a follow up interview with the Social Worker on 09/10/2024 at 9:11AM, the Social Worker stated she knew it had been over 2 months since Resident #43 had filed her grievance and said it was a long time to settle a grievance, but she was hoping these items would show up. She stated it was not unusual for facility to take this long to settle grievance regarding lost clothing items because many times they were found a few weeks later. She stated she informed Resident #43 on 07/03/2024 that they were going to look for these items. The Social Worker stated that

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F 585	Continued From page 13	F 585		

she had informed the laundry and housekeeping staff, but they were unable to find these items. She stated she kept inquiring with the resident if her items had showed up each time, she was in the resident's room but had not documented the follow ups or able to recall when the encounters with Resident#43 occurred. The Social worker did not provide a summary of investigation provided to Resident #43. The Social Worker stated they had not seen Resident #43's belongings. She stated that she had tried to contact Resident # 43's family member to determine the value of the items missing and left her a message to return her call. She stated the family member had not returned her call. Social worker did not clarify when or how attempts were made by her to contact Resident # 43's family member. She stated she decided to settle the grievance on 09-09-2024 because "it was sitting on my desk and I wanted it off my desk." She stated she then contacted the family member the on 09/09/2024 and the family member said to settle the matter. The Social Worker stated they would replace the bed sheets and get them embroidered and replace all the other lost/ stolen items.

On 09/09/24 at 4:18PM the Administrator was interviewed about the facility's grievance policy. She stated anyone could file a grievance which was then forwarded to the facility social worker. She stated typically they resolved the grievance within 5 days. She stated that she believed the facility handbook stated grievances were to be resolved within 5 days. She stated they very rarely had problems with missing items. When they did have a grievance, the facility would replace or reimburse the resident immediately. She stated she would contact the resident's family to determine the monetary value of the lost

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F 585	Continued From page 14 item and would settle the grievance. She further added sometimes the family members took time to provide the information. She stated to her knowledge Resident # 43's family member was contacted immediately by the facility social worker to determine the value of the lost items, but the family member did not follow up with the facility promptly therefore was unable to resolve this grievance sooner. The Administrator did not provide any verification of a written summary to provide to Resident #43.	F 585		
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 expired food and food items with signs of spoilage stored for use in 1 of	F 812	All items found during initial walk through were corrected immediately. The containers of soy sauce, salsa, egg salad,	9/12/24

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F 812	Continued From page 15 1 walk-in cooler. The facility also failed to label and date food items in 1 of 1 walk in cooler and in 1 of 2 nourishment room freezers (Hall 100). Additionally, the facility failed to store a dry ingredient scoop in a manner to prevent cross-contamination of food. These practices had the potential to affect food served to residents. The findings included: a. An initial tour of the kitchen was made on 09/08/24 at 11:13 AM. The following food items were observed in the walk-in-cooler: soy sauce 3.79 Liters (L) opened: 8/21with no use by or best before date salsa 8 pounds (lbs.) opened: 8/23 with no use by or best before date egg salad with the manufacturer use by date 8/13/24 ricotta cheese 3 lbs. unopened - Use by date: 8/26/24 1 piece of egg on top of a cracked eggshell that was stuck on the egg carton noted to have fuzzy, black specks of dirt formed surrounding the cracked eggshell A follow up observation of the walk-in cooler on 09/10/24 at 11:07AM revealed the cracked eggshell with fuzzy, black specks was still present. During an interview on 09/10/24 at 2:34 PM, the Certified Dietary Manager (CDM) verbalized that for labeling and dating, they go by the manufacturer's expiration date or the day it came in from the supplier. He also mentioned that he completed daily rounds within the kitchen and the	F 812	and ricotta cheese were removed from walk-in-cooler immediately and discarded. The cracked egg was removed and discarded. Flour scoop was placed back in the approved holder in the lid of flour bin. Unlabeled food items were removed immediately from 100 Hall nourishment room freezer and discarded. A 100% audit of all food storage was completed on 9/10/2024 by Dietary Manager to verify all food was stored, dated, and labeled correctly. Any concerns found at time of audit were resolved immediately. An ad hoc QAPI meeting was held on 9/9/24 to discuss deficient practice, determine the root cause analysis and create a plan of correction. To prevent this from recurring, education was provided on 9/9/2024 to the Dietary Manager by the Administrator related to the expectation that items be stored, labeled with all required information, and discarded immediately upon expiration or use by date. The Dietary Manager provided education to all dietary staff on the above education. No dietary staff will be allowed to work until education is provided. Education will be added to the new hire orientation and new dietary employees will not be allowed to work until education has been completed.	

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F 812	Continued From page 16 facility to check on food items and discard when expired. b. During the initial tour of the kitchen made on 09/08/24 at 11:43 AM an observation of the dry ingredient bins revealed, a plastic scoop (inclusive of handle) observed resting in flour bin and not stored in scoop holder. During an interview on 09/10/24 at 2:34 PM, the Certified Dietary Manager (CDM) stated the flour scoop (including the handle) should not have been resting in the flour. The flour scoop should have been stored in the scoop holder of the flour bin. c. During an observation on 09/10/24 at 3:30 PM, two sausage breakfast sandwiches were observed inside the nourishment room freezer on the 100 Hall. These items were outside of their original cardboard packaging. Ice crystals were noticed to form inside the plastic packaging. No name and use by date indicated. There was a handwritten date of 09/08/24 on the clear packaging. During a follow up interview with the CDM on 09/10/24 at 4:04 PM, he explained he put out sandwiches (variety), juices and milk cartons. The CDM explained the two frozen sausage breakfast sandwiches must be from a resident or a resident's family. He verbalized he has educated the nursing staff on all halls to place proper labels and dates on food or beverage items being placed in the nourishment refrigerators. During an interview with the Administrator on 09/11/24 at 11:57 AM, she verbalized that she	F 812	The Dietary Manager will conduct audits on all food storage areas 5 times a week for 4 weeks, and then all food storage areas 3 times a week for 4 weeks, and then all food storage areas 1 time a week for 4 weeks to ensure all food is stored, dated, and labeled correctly. The Administrator will bring audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of compliance: 9/12/2024	

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F 812	Continued From page 17 conducted daily rounds of the facility including the nourishment rooms and refrigerators. She stated that dietary was responsible for throwing food items away that were not properly labelled, dated or expired.	F 812		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.	F 847		10/3/24

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F 847	Continued From page 18 §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident, resident representative, and staff interviews the facility failed to explain the arbitration agreement to a resident, or the resident's representative, prior to having them sign the agreement This occurred for 1 of 3 residents (Resident #296) reviewed for arbitration. The findings included: Review of the facility's "Agreement for Arbitration" which was not dated, revealed by signing the Agreement for Arbitration, the resident and/or resident's representative acknowledged they had read and understood the agreement. Resident # 296 was admitted to the facility on 09/05/2024. Review of Resident # 296's Agreement for	F 847	Resident#296 responsible party was notified, and the signed Arbitration Agreement was removed from file. An ad-hoc Quality Assurance Performance Improvement (QAPI) Committee meeting was held on 9/10/24 to discuss root cause and identify plan of correction. A 100% audit of all signed arbitration agreements was completed on 10/3/2024 by the Admissions Coordinator and resident/responsible party were contacted to ensure understanding of agreement. Any concerns identified were corrected immediately. To prevent this from recurring, education on the importance of the	

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F 847	Continued From page 19 Arbitration revealed the resident had signed the agreement on 09/05/2024 along with the rest of the admission paperwork. An attempt was made to interview Resident #296 on 09/10/2024 at 10:15 am. The resident was not able to understand or remember having been informed about an arbitration agreement. At the time of the interview, the resident was only oriented to person, and was unable to identify where she was, or the date and time. During the interview, the resident was unable to answer questions beyond her name. During a telephone interview on 09/10/2024 at 10:54 am with Resident # 296's family member, he said he did not think the resident would have been able to understand what the arbitration agreement meant. The family member said the facility should have asked one of her family members about the arbitration agreement because he did not think Resident #296 was able to sign to acknowledge she understood the agreement because she was "too confused." During an interview on 09/10/24 at 01:14 pm with the admission coordinator, she said residents, or their representative were asked to sign the facility's Agreement for Arbitration on admission with their admissions paperwork. She stated she went over everything in the admission packet and the resident, or the resident representative, signed by using the electronic DocuSign. The admission coordinator said the facility had a paper titled "Understanding the Arbitration Agreement," that she would offer to the resident and/or representative. The admission coordinator said she explained everything to the resident/representative before they sign and	F 847	resident/responsible party understanding the Arbitration Agreement was provided on 9/10/2024 to the Admissions Coordinator and Marketing Director by the Administrator. Facility designee will review Arbitration Agreement annually via Resident Council to ensure understanding of agreements and will review as needed with responsible parties via newsletter. The Admission Coordinator or designee will audit random new admission Arbitration Agreements 5 times a week for 4 weeks, 3 times a week for 4 weeks, and then one time weekly for 4 weeks to ensure all Arbitration Agreements are reviewed, signed and understood. The Administrator will bring audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will evaluate the effectiveness of training and observations to determine if continued auditing is necessary to maintain compliance. Date of compliance: 10/3/2024	

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F 847	Continued From page 20 asked if they were willing to participate in the Arbitration process. The Admissions coordinator said if she was talking with a resident and the resident did not understand, or wasn't able to sign, then she would talk to their family/representative about the arbitration agreement. She said if a representative signed the arbitration agreement the representative's name would be on the arbitration agreement. During the interview with the admission coordinator, she verified Resident #296's name was listed as the person who signed the Agreement for Arbitration. The admission coordinator said she had gone over it with Resident #296, and that Resident #296 "seemed fine" during the admission process and was not sure why the resident could not remember. During an interview on 09/10/24 at 01:29 PM the administrator said it was up to the admissions person to make sure the resident/representative understood the agreement. The Administrator explained the resident's name was automatically populated into an electronic form once their admission information was placed into the electronic tablet and the resident did not actually sign a document. She explained the admissions coordinator would review the whole admission packet, which was also an electronic form, to include the Arbitration Agreement with the resident/representative. The Administrator verified Resident #296's name was listed as signing the Agreement for Arbitration but again explained the name was auto populated into the signature line. The Administrator discussed that a resident's representative could sign by overriding the auto populated signature.	F 847		
F 880 SS=D	Infection Prevention & Control	F 880		9/12/24

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F 880	Continued From page 21 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 §483.71 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	F 880		

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F 880	Continued From page 22 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 observation, record review, and staff interviews the facility failed to follow their infection control policy when the Medical Records Assistant delivered a lunch tray to a resident on Enhanced Droplet Precautions without donning a mask, gloves, gown, and/or eye protection for 1 of 1 resident who required Enhanced Droplet Precautions (Resident #19). The findings included	F 880	On 9/8/24 at approximately 1:28 PM, the Medical Records Assistant walked into Resident #19□s room to deliver a lunch tray and failed to don appropriate Personal Protective Equipment (PPE) and follow infection control practice for a COVID positive resident. On 9/8/24 the Assistant Director of Nursing (ADON) counseled and	

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F 880	Continued From page 23 The facility's COVID-19 Infection Control Practices policy was updated on May 8, 2023. The policy stated that staff should wear an N 95 mask, gown, gloves, and eye protection. The resident was diagnosed with COVID on September 7, 2024. On September 8, 2024, at 1:28pm, an observation was made of the lunch meal trays being delivered to residents. During the observation, the Medical Records Assistant was observed to remove Resident #19's lunch tray from the meal cart and enter the resident's room. The door to Resident #19's room was observed to have an Enhanced Droplet precaution sign that stated staff were to wear gown, an N95 mask, gloves and either face shield or goggles. Resident #19's door also had a metal holder that contained gowns, gloves, and masks. There was a small 3 drawer container next to the room with extra gowns and eye covering. The Medical Records Assistant entered the room with no gown, mask, gloves, or eye covering. The Medical Records Assistant proceeded to stand in front of Resident #19 and assist the resident in setting up her meal tray. The Medical Records Assistant was in the room in front of Resident #19 for approximately 1.5 minutes. When the Medical Records Assistant left Resident #19's room, she performed hand hygiene with hand sanitizer that was available on the wall in the hall. On September 8, 2024, at 1:32 PM, an interview took place with the Medical Records Assistant who confirmed that she had taken a lunch tray to Resident #19 that day. The Medical Records Assistant stated she was unaware of the resident	F 880	re-educated the Medical Records Assistant and all staff regarding PPE and to read the sign posted on the door and follow the procedure for the correct PPE. On 9/8/24 the facility had an ad-hoc Quality Assurance Performance Improvement (QAPI) Committee meeting, which determined the root cause analysis was staff member did not identify the room being entered was a COVID positive room, did not observe Enhanced Barrier Precautions(EBP) sign that was on door. On 9/8/24, a 100% audit of all residents was completed by the Director of Nursing (DON) or designee to ensure that residents requiring isolation or EBP had the correct signs on the door and PPE near the room. No new residents/rooms were identified. On 9/8/24 the ADON and Nurse staff managers completed a 100% re-education to all staff to ensure proper infection control practices related to the donning and doffing of PPE and what PPE is necessary for each level of precaution is followed. They also educated all staff to read the signs on the door to ensure they don the required PPE before entering the room. This education was completed on 9/8/2024 and any staff not educated on this date are not allowed to work until education is completed. On 9/8/24 the Administrator informed the ADON this education needs to be added to the new hire education. No new staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKESBORO HEALTH AND REHABILITATION	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 880	Continued From page 24 being positive for COVID and that the resident was on enhanced droplet precautions. She did acknowledge there was an enhanced droplet precaution sign on the resident's door but stated "I was trying to hurry and did not read what the sign said." The Medical Records Assistant stated she had received infection control training in January of 2024. The Medical Records Assistant also stated that she was aware of the need to wear the required Personal Protective Equipment (PPE) when a resident was placed on enhanced droplet precautions. On September 8, 2024, at 2:00 PM the Infection Prevention (IP) Nurse/Assistant Director of Nursing was interviewed. She stated staff had their annual infection control training in March of 2024. The IP nurse explained that staff would be aware of a resident having COVID by the Enhanced Droplet precaution sign on their door. She further stated that the Medical Records Assistant only came out of her office at mealtimes to help pass trays and probably did not look to see if the resident was on any precautions. She said that the Medical Records Assistant had received infection control training in March of 2024. The IP nurse voiced that the Medical Records Assistant should have looked prior to entering Resident #19's room. On September 8, 2024, at 3:00 PM the Director of Nursing (DON) was interviewed. The DON stated that she was unsure when the last infection control training was held. She explained that when the facility learned of Resident # 19 being positive for COVID on September 7, 2024, an education was sent out to all employees via an electronic messaging system on September 7, 2024. This education message included when	F 880	will be allowed to work until education has been completed. The DON/Unit Managers/designee will audit staff randomly for properly worn PPE 5x per week for 4 weeks, then 3x per week for 4 weeks, then weekly for 4 weeks to ensure infection control practices are followed as staff enter resident rooms. All findings will be brought to the QAPI committee for review and need for further auditing or education. The date of compliance is 9/12/2024.	

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F 880	Continued From page 25	F 880		

and what PPE was involved, and instructions included reading the signage on the resident's door. The DON confirmed the Medical Records Assistant should have received the message on September 7, 2024, but stated that the Medical Records Assistant only came out of her office at mealtime for meal tray passing and did not read the signage on the resident's door.

At 11:34 AM on September 9, 2024, an interview was completed with the Physician. The Physician stated that staff should have worn an N95 mask and all other required PPE due to Resident #19 being on enhanced barrier precautions.

At 2:06 PM on September 8, 2024, the Administrator was interviewed. She stated that annual infection control training was on a computerized training system and was provided as needed when any infection control breaches occurred. The Administrator stated that staff would be made aware if a resident tested positive for COVID by the signage on the resident's door. She further stated that if staff did not understand the signage, then they were required to ask a nurse. She expressed that the Medical Records Assistant just did not read the signage on the door of Resident 19's room but should have.