STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	11/27/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

(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 on 11/24/24 through 11/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # B6IC11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted on 11/24/24 through 11/27/24. Event ID# B6IC11	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medication for 2 of 20 residents (Resident #2 and Resident #17)whose MDS was reviewed. Findings included: 1. Resident #2 was admitted to the facility on 2/12/24. A review of Resident #2's Medication Administration Record (MAR) for October 2024 revealed documentation aspirin (an antiplatelet medication) 81 milligrams (mg) was administered to Resident #2 on 10/31/24 at 8:00 AM. A review of Resident #2's November 2024 MAR revealed documentation aspirin (an antiplatelet medication) 81 milligrams (mg) was administered to Resident #2 on 11/1/24 through 11/6/24 at 8:00	F 641	F 641 Accuracy of Assessments On 11/26/2024, the MDS nurse updated The Minimum Data Set (MDS) assessments for residents # 2 and 11/27/2024 for resident # 17 to reflect accurate coding for medications, including anticoagulants and diuretics. On 12/06/2024, the Administrator, Director of nursing (DON), and/or MDS nurse initiated a 100% audit of the last completed MDS assessment for each resident to ensure the MDS assessment reflected accurate coding for medications-anticoagulants and diuretics. This audit was completed on 12/06/2024. Any identified areas of concern were modified by the MDS nurse as indicated by the RAI Manual. On 12/06/2024, the Administrator	12/20/24

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

Electronically Signed | 12/16/2024

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F 641	Continued From page 1 AM. A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 11/6/24 revealed she was not coded for use of antiplatelet medication during the 7 day look back period of the assessment. On 11/26/24 at 8:36 AM an interview with an interview with the MDS Nurse indicated she coded the medication section on Resident #2's quarterly MDS assessment dated 11/6/24. She stated the look back period of the assessment would be from 10/31/24 through 11/6/24. She reported the medication section of this assessment was coded inaccurately. She went on to say there was documentation on Resident #2's MAR's for October 2024 and November 2024 that aspirin was administered to Resident #2 during the look back period of the assessment and the assessment should reflect this. The MDS Nurse stated she might have been interrupted while coding Resident #2's assessment resulting in this mistake. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. On 11/27/24 at 8:52 AM an interview with the Administrator indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. 2. Resident #17 was admitted to the facility on 5/17/2019. A review of Resident #17's quarterly Minimum	F 641	re-educated the MDS nurses on MDS Accuracy to include the following: MDS assessments must contain accurate information of resident assessment including medications such as Diuretics and anticoagulants. On 12/06/2024, the Administrator re-educated the Director of Nursing and MDS nurses on Assessment/Accuracy/ Coordination/Certified which included: 1. The MDS must be accurately coded based on guidelines listed in the Resident Assessment Instrument (RAI) manual. 2. Medications must be coded accurately per the medication's therapeutic category and/or pharmacological classification and number of days actually received during the 7 day look back period. 3. For example, Lasix a medication that contains furosemide, a diuretic medication should be coded as a diuretic for the number of days actually received during the 7 day look back period. 4. Another example, Aspirin must be coded as an anticoagulant regardless of the intended use. This re-education was completed 12/06/2024. All future MDS coordinators will receive this education during their orientation process. Beginning 12/16/, the Administrator, Director of Nursing, and/or registered nurse (RN) supervisor will utilize a MDS Accuracy audit tool to monitor the accuracy of future completed MDS assessments for coding of medication classification. The MDS Accuracy Audit tool will be completed for 10 MDS assessments weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 3	

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F 641	Continued From page 2 Data Set (MDS) assessment dated 11/8/24 revealed she was not coded for use of diuretic medication during the 7 day look back period of the assessment. A review of Resident #17's November 2024 revealed documentation furosemide (a diuretic medication) 80 milligrams (mg) was administered to Resident #2 on 11/2/24 through 11/8/24 at 9:00 AM. On 11/26/24 at 8:36 AM an interview with an interview with the MDS Nurse indicated she coded the medication section on Resident #17's quarterly MDS assessment dated 11/8/24. She stated the look back period of the assessment would be from 11/2/24 through 11/8/24. She reported the medication section of this assessment was coded inaccurately. She went on to say there was documentation on Resident #17's MAR's for November 2024 that furosemide was administered to Resident #2 during the look back period of the assessment and the assessment should reflect this. The MDS Nurse stated she had not seen this and had made a mistake. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving. On 11/27/24 at 8:52 AM an interview with the Administrator indicated resident's MDS assessments should be an accurate reflection of the medication they were receiving.	F 641	months. All identified areas of concern will be addressed immediately by the Administrator, Director of Nursing and/or Assisted Director of Nursing, for modification or significant correction of the MDS assessment by the MDS nurse to accurately reflect the resident's current condition. The administrator will monitor for proper completion and follow up of the MDS Accuracy Audit tool by signing the audit tool. The Director of Nursing and/or Assistant Director of Nursing will present all findings at the monthly Quality Assurance Quality Improvement committee meeting x 3 months for review and recommendations for any modification of monitoring process.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		12/20/24

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F 657	Continued From page 3 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, and family interviews, the facility failed to invite residents to care plan meetings (Resident #40, Resident #16, and Resident #79) for 3 of 3 residents reviewed for care planning. Findings included: 1. Resident #40 was admitted to the facility on	F 657	Care Plan Timing and Revision F657 On 12/16/2024 a care plan meeting was offered to residents # 40, # 16, # 79	

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F 657	Continued From page 4 7/12/21 with diagnosis that include stroke, anemia and hypertension. The quarterly Minimum Data Set (MDS) dated 8/27/24 revealed Resident #40 was cognitively intact. The care plan for Resident #40 was initiated on 8/10/21 and last revised on 9/12/24. An interview with Resident #40 on 11/25/24 at 10:00 a.m. revealed he had not been invited to care planning meetings. Record review revealed no previous care plan meetings scheduled prior to 11/26/24. An interview with the Social Worker on 11/26/24 at 10:12 a.m. revealed Resident #40 had a care plan meeting scheduled for that day. The Social Worker could not locate any previous care plan meetings in her record review. The Social Worker did state her expectation would be that care planning meetings were held quarterly. 2. Resident #16 was admitted to the facility on 10/13/23 with diagnosis that included hypertension, and Alzheimer's disease. The care plan for Resident #16 was initiated on 10/16/23 and revised on 10/11/24. The quarterly MDS dated 10/25/24 revealed Resident #16 was cognitively intact. Record review revealed there was a care plan meeting held in March 2024 and on 9/24/24. No other care planning meetings were noted in the record.	F 657	and/or resident's responsible party. A meeting was scheduled to be held on 12/31/2024 for resident # 40. A meeting was scheduled to be held on 12/31/2024 for resident # 16. A meeting was scheduled to be held on 12/24/2024 for resident # 79. A 100% audit of current residents was conducted to ensure a care plan meeting was held quarterly. Residents found to be deficient and/or resident's responsible parties were invited to attend a care plan by the Social Worker, Minimum Data Set (MDS) Coordinator, and/or MDS nurse by 12/20/2024. All care plan meetings will be scheduled within 90 days and will continue to be scheduled quarterly and/or with a significant change in status with the resident and/or resident responsible party being invited. On 12/06/2024 the Social Worker, MDS Coordinator and MDS nurses were in-serviced related to the requirements of having care plan meetings by the Administrator. The Administrator and/or Director of Nursing will audit the care plan meeting calendar weekly x 12 weeks using the care plan audit tool to ensure all residents due for a care plan have care plans	

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F 657	Continued From page 5 An interview with Resident #16 on 11/24/24 at 12:30 p.m. revealed he had not been invited to care planning meetings. An interview with the Resident Representative for Resident #16 on 11/26/24 at 4:30 p.m. revealed a care planning meeting on the 3/26/24 and sometime in the 4th quarter of 2024, she attended this meeting via telephone. She also stated there were no other care plan meetings and Resident #16 was never invited to participate. An interview with the Social Worker on 11/26/24 at 10:12a.m. revealed Resident #16 had one care plan meeting on 9/24/24 with only the MDS nurse and Social Worker in attendance. Resident #16 also had a care plan meeting on 10/29/24 with the only attendee being the MDS nurse. The Social Worker stated her expectation would be that care planning meetings were held quarterly. 3. Resident #79 was admitted to the facility on 4/25/24 with diagnosis that included stroke, diabetes, and hypertension. The quarterly MDS dated 9/17/24 revealed Resident #79 was cognitively intact. The care plan for Resident #79 was initiated on 5/15/24 and revised on 11/10/24. Review of Resident #79's medical record revealed no indication that he or his representative had been invited to a care plan meeting. An interview with Resident #79 on 11/24/24 at 10:48 a.m. revealed he did not recall being	F 657	completed as required with resident and/or responsible party involvement. The results of the Care Plan Audit Tool will be compiled by the Administrator and/or Director of Nursing and presented to the Quality Improvement Committee monthly x 3months. Identification of trends will determine the need for further action and/or a change in the frequency of required monitoring.	

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F 657	Continued From page 6 invited to a care planning meeting. An interview with the Social Worker on 11/26/24 at 10:12a.m. revealed Resident #79 had a care plan meeting on 9/24/24 with the Social Worker and MDS nurse only in attendance. Upon record review there were not any previous care plan meetings. There was no documentation that the resident or his representative had been invited to care planning meetings. The Social Worker stated her expectation would be that care planning meetings were held quarterly. An Interview with the Administrator on 11/26/24 at 11:26 a.m. revealed her expectation was for care plan meetings to be held upon admission, quarterly or if a family had concerns. She would also expect the unit manager, MDS nurse, dietary representative, activities representative, Social Worker, resident and resident responsible party to be in attendance.	F 657		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to maintain a medication administration error rate of less than 5% when a nurse failed to prime an insulin pen and failed to administer Tylenol as ordered by the physician. This resulted in an error rate of 8% for 2 of 25 opportunities observed during medication	F 759	Medication Plan of Correction Resident # 95 was assessed by Assigned Nurse on 11/26/2024. NP notified on	12/20/24

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F 759	Continued From page 7 pass. (Resident #95) Findings included: a. Review of the manufacturer's recommendations for the Humalog insulin pen used by the facility dated 7/21/23 revealed the insulin pen was to be primed before each injection. (Priming an insulin pen means to remove the air from the needle and cartridge and ensures the pen is working correctly). To prime the insulin pen, the user was to turn the dose knob to select 2 units, hold the pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, and push the dose knob in until it stopped and read 0 on the dose window. The user should see the insulin at the tip of the needle. If insulin was not observed at the tip of the needle the steps were to be repeated no more than 4 times. If there was still no insulin observed at the top of the needle, the needle would need to be replaced. Resident #95 was admitted to the facility on 11/20/24. Her active diagnoses included diabetes mellitus. Review of Resident #95's orders revealed on 11/20/24 she was ordered Humalog KwikPen subcutaneous solution pen-injector 100 unit/milliliter (mL) inject subcutaneously as per sliding scale: if blood sugar is 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units >500= 14 units and call the physician. During observation on 11/26/24 at 8:26 AM Nurse #1 was observed providing Resident #95 her medications. The nurse checked Resident #95's	F 759	11/26/2024 by Director of Nursing. Medication error report completed by the Director of Nursing on. The nurse was reeducated by the Director of Nursing on 11/26/2024 related to the 5 rights of medication administration to ensure the correct medication is being given as ordered by the physician. The Director of Nursing also reeducated nurse on how to prime an insulin pen on 11/26/2024. + On 11/27/2024 the Director of Nursing initiated a Medication pass audit for current nurses to ensure the correct medications are being given when ordered by the Director of Nursing, Assisted Director of Nursing, and/or Unit Managers. NP and/or MD will be notified of any negative findings by the Director of Nursing to be completed by 12/20/2024. On 11/26/2024 an in-service was initiated by the Director of Nursing for all LPN's, RN's, and Medication Aides related to the 5 rights of medication administration to ensure the correct medication is being given as ordered. The licensed nurses were also in-service on how to prime an insulin pen by the Director of Nursing on 11/26/2024. All licensed nurses going through orientation will have a medication pass completed and this in servicing completed prior to going to the floor by the Director of Nursing/ designee.	

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F 759	Continued From page 8 blood sugar which was 343. The nurse was then observed to return to her cart, take the insulin pen, place the needle on the Humalog insulin pen, and turn the dial to 6 units. Nurse #1 did not prime the insulin pen needle prior to setting the dose. She then entered the resident's room, held the pen against Resident #95's abdomen, and pressed the dose knob in. During an interview on 11/26/24 at 9:47 AM Nurse #1 stated it was her understanding that priming the insulin pen was to set the number of units to be injected prior to giving the injection. During an interview on 11/26/24 at 10:54 AM the Director of Nursing stated she expected her staff to follow the manufacturer's instructions for insulin pens during medication administration. b. Resident #95 was admitted to the facility on 11/20/24. Her active diagnoses included other idiopathic peripheral autonomic neuropathy. Review of Resident #95's orders revealed on 11/20/24 she was ordered Acetaminophen oral tablet 500 mg (milligrams) give 1 tablet by mouth every 6 hours as needed for pain. During observation on 11/26/24 at 8:26 AM Nurse #1 was observed providing Resident #95 her medications. Resident #95 stated to Nurse #1 that she had pain in her shoulder and leg and rated it as a 6 on a scale of 1 to 10. She requested the nurse give her two tablets of Acetaminophen. The nurse was then observed to return to her cart, dispense two 500mg tablets of Acetaminophen into a medication cup. She then entered the resident's room and administered the two tablets of Acetaminophen to Resident #95.	F 759	Medication Pass Audits will be conducted utilizing the Medication Pass Audit tool to ensure residents medications are given as ordered / insulin pens are primed correctly by the Director of Nursing, Assisted Director of Nursing, and/or Unit Managers. The audit will be completed 3x/week x 4 weeks, weekly x 4 weeks, then monthly x 3 months using the Medication Pass Audit Tool. The Administrator will review the audit tool weekly x 8 weeks, then monthly times 3 months. The Administrator and/or the Director of Nursing will present findings from the Medication Pass Audit Tool at the monthly Quality Assurance Quality Improvement committee meetings for three months for further recommendations.	

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F 759	Continued From page 9 During an interview on 11/26/24 at 9:47 AM Nurse #1 stated because Resident #95 told her she gets two tablets of Tylenol, she gave two tablets which were 1000 mg in total. During an interview on 11/26/24 at 10:54 AM the Director of Nursing stated staff were to follow physician orders and the nurse should not have given 2 tablets only because the resident said she took 2 tablets. She further stated the nurse could have clarified with the physician since the resident was contradicting the order for Tylenol 500 mg take 1 tablet as needed every 6 hours.	F 759		
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:	F 812		12/20/24

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F 812	Continued From page 10 Based on observations and staff interviews the facility failed to label and date leftover food items stored in the walk-in refrigerator for one of one walk in refrigerators observed for food storage. This practice had the potential to affect food served to residents. Findings included: On 11/24/24 at 10:38 AM an observation of the walk in refrigerator with the Assistant Dietary Manager revealed a 4 quart clear plastic container with a green lid which contained approximately 2 quarts of whole corn in liquid with no label to identify the contents or the date it was placed in the refrigerator, a 4 quart clear plastic container with a green lid which contained approximately 4 quarts of cooked rice, a 4 quart clear plastic container with a green lid which contained approximately 2 quarts of red colored liquid, a 4 quart clear plastic container with a green lid which contained approximately 1/2 quart of a mayonnaise based salad, approximately ½ of a small cooked ham wrapped in plastic wrap, a large silver container covered in plastic wrap containing whitish liquid, a bowl of fruit cocktail, and a plastic storage container of sliced peaches in liquid. None of the stored food items were labeled to identify them or the date the items were placed in the refrigerator. During an interview on 11/24/24 at 10:45 AM with the Assistant Dietary Manager she stated the red liquid was marinera sauce, the whitish liquid was biscuit gravy and the mayonnaise based salad was tuna salad. She went on to say she did not see any labels or dates on the leftover food items stored in the walk in refrigerator. She stated she had to come to work in the kitchen unexpectedly	F 812	F 812 Food Procurement, Store/Prepare/Serve/Sanitary On 11/24/2024, the Dietary manager disposed of food/containers that were not properly labeled and/or dated. On 11/24/2024 the Dietary Manager completed a 100% audit of all resident foods to ensure all food and containers that hold food were properly labeled and dated in the dietary department. Any negative findings were immediately corrected. On 12/13/2024, the Dietary Manager in-serviced 100% of Dietary Staff on Sanitary Conditions. The in-service included A. Foods must be stored, prepared, distributed and served under sanitary conditions B. Expired food must be discarded immediately to include Items that are not properly labeled or dated. Any containers found not properly labeled with date and/or identification must be discarded. On 12/16/2024, the Administrator initiated an audit tool titled Dietary Sanitation Audit Tool to monitor food/containers being properly labeled and/or dated five times weekly for four weeks, weekly for four weeks, then monthly times three months. Any negative findings will be corrected immediately. The Dietary Manager and/or Dietary Assistant will present findings from the Audit Tools at the monthly QI committee meetings for six months for further recommendations.	

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	345317	A. BUILDING _____ B. WING _____	11/27/2024

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F 812	Continued From page 11	F 812		

that morning when the scheduled cook had not shown up and she had not had a chance to check the walk in refrigerator yet. The Assistant Dietary Manager stated it was the cooks' responsibility to ensure all leftover food items that were placed in the walk-in refrigerator were labeled and dated with the date they were placed in the refrigerator. She went on to say the corn, rice and peaches were from yesterday, but she was not sure how long the other items had been stored.

On 11/26/24 at 10:24 AM a telephone interview with Cook #1 indicated she had been the cook on 11/23/24 from 5:30 AM until 1:00 PM. She stated it was the cook's responsibility to ensure all leftover food items placed into the walk-in refrigerator were labeled and dated with the date they were placed into the refrigerator. She reported all the unlabeled food items were from her shift on 11/23/24 and she had left them for the afternoon Cook #2 who told her he would label and date them.

On 11/25/24 at 3:41 PM a telephone interview with Cook #2 indicated he was the cook on 11/23/24 from 1:00 PM until 7:30 PM. He stated as a cook it was his responsibility to check the walk-in refrigerators at the start of his shift to ensure all leftover food items were labeled and dated when they were placed in the refrigerator. He reported on 11/23/24 he had not done this. He went on to say he had immediately started cooking when he arrived for his shift on 11/23/24, and after he finished cooking, he cleaned up. Cook #2 stated he did not recall having any conversation with Cook #1 regarding leftover food. He went on to say he had last worked on 11/21/24, and did not recall seeing any leftover food in the walk-in refrigerator that day.

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F 812	Continued From page 12 On 11/26/24 at 1:25 PM an interview with the Dietary Manager indicated all leftover food should be labeled and dated when placed in the walk in refrigerator for storage. She went on to say it was the cook's responsibility to ensure this was done, and to discard any leftover storage food that was unlabeled and undated. On 11/27/24 at 8:54 AM an interview with the Administrator indicated there should not be any leftover unlabeled and undated food stored in the walk-in refrigerator.	F 812		
F 880 SS=D	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 §483.71 and following accepted national standards;	F 880		12/20/24

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F 880	Continued From page 13 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 14 §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 observations, record review, and staff interviews the facility failed to implement their infection control policy when Nurse Aide (NA) #1 did not perform hand hygiene during meal delivery and set-up after knocking on the room door, handling the bed control, moving the overbed table and handling bed linens for 1 of 2 NAs observed passing meal trays on 1 of 4 halls. This had the potential to result in the cross contamination of microorganisms (germs) between residents. Findings included: A review of the facility's policy titled "Handwashing/Hand Hygiene" dated last revised August 2019 revealed in part the following: "This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol based hand rub containing at least 62 percent alcohol, or alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: I. After contact with objects in the vicinity of the resident." On 11/24/24 from 1:10 PM until 1:14 PM a continuous observation of the lunch meal tray delivery service was conducted in the facility on the 100 Hall. Four hand sanitizing dispensers were observed in place at intervals on the wall on	F 880	F 880 Infection Control On 11/24/2024, CNA # 1was educated on the importance of hand hygiene after contact with each resident to include in between passing trays to residents. On 11/24/2024, the Director of Nursing and/or Unit Managers initiated a handwashing competency check for current staff; including an in service on contact precautions to ensure residents remained free of infectious agents. Any findings were addressed immediately by the Director of Nursing, Assisted Director of Nursing, and/or Unit Managers. On 12/13/2024 the Director of Nursing and/or Unit Managers initiated re-education on infection control and conducted hand washing competencies for all staff. This re-education included the following: 1. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. 2. The facility must establish an infection control program under which it---Decides what procedures, such as isolation, should be applied to an individual resident. 3. “Isolation” refers to the practices employed to reduce the spread of an infectious agent and/or minimize the	

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F 880	Continued From page 15 this hall, including one on the wall outside Resident #245's room. At 1:12 PM Nurse Aide (NA) #1 was observed to sanitize her hands and remove a lunch meal tray from the meal delivery cart, knock on the door to Resident #245's room, enter the room, place the meal tray on Resident #245's overbed table, use Resident #245's bed control to adjust the head of Resident #245's bed, adjust Resident #245's bed linen, and leave Resident #245's room without performing hand hygiene. At 1:14 PM NA #1 was then observed to remove another resident's lunch meal tray from the cart without performing hand hygiene. NA #1 was interrupted before delivering this meal tray. On 11/24/24 at 1:14 PM an interview with NA #1 indicated she should have performed hand hygiene after contact with Resident #245's environment before removing another meal tray from the cart. She stated she had been educated to do this to prevent the spread of germs. She reported there were hand sanitizing dispensers available on the hall. She stated she had just been moving too quickly and had forgotten. On 11/26/24 at 12:12 PM an interview with the facility's Regional Clinical Director indicated she was currently working as the facility's Infection Preventionist. She stated NA #1 should have performed hand hygiene after delivering Resident #245's lunch meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart to prevent the spread of germs. She stated NA #1 had been re-educated on this. On 11/27/24 at 8:46 AM an interview with the Director of Nursing indicated NA #1 should have performed hand hygiene after delivering Resident	F 880	transmission of infection. 4. “Contact precautions” are measures that are “intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident’s environment.” 5. NOTE: It is important that all infection prevention and control practices reflect current Centers for Disease Control (CDC) guidelines. 6. “Contact Precautions” must be followed when indicated and posted on a resident’s door. These precautions include performing hand hygiene in between passing trays to residents. 7. See attached policy. This re-education will be completed by 12/15/2024. All future employees will be educated during their orientation process to include a hand washing competency. On 12/16/2024, the Administrator initiated Infection Control Audit Tool to monitor for proper infection control practices to include following Contact Precautions and washing hands in between meal pass. The Infection Control Audit Tool will be completed 5 x weekly x 4 weeks, twice weekly x 4 weeks, and weekly x 4 weeks. Any negative findings will be addressed immediately with re-training by the Director of Nursing, Unit Manager, and/or Assistant Director of Nursing. The administrator will acknowledge proper completion and follow up of the Infection Control Audit tool by signing of the audit tool. The monthly Quality Assurance	

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F 880	Continued From page 16 #245's meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart. She stated this should have occurred to prevent the spread of germs. On 11/27/24 at 8:54 AM an interview with the Administrator indicated NA #1 should have performed hand hygiene after delivering Resident #245's meal tray and contact with Resident #245's environment prior to removing another lunch meal tray from the cart to prevent the spread of germs.	F 880	Performance Improvement committee will review the results of the Infection Control Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance.	