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	345313	A. BUILDING _____ B. WING _____	C 01/24/2025

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NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/21/25 through 1/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# DFR911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/21/25 through 1/24/25. Event ID# DFR911. The following intakes were investigated: NC00224778 and NC00221034. 12 of the 12 complaint allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		2/18/25

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

Electronically Signed | 02/14/2025

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Responsible Party (RP) interview, the facility failed to hold a care plan meeting and invite the resident and the RP to participate in the care planning process for 1 of 3 residents reviewed for care planning (Resident #76). The findings included: Resident #76 was admitted to the facility on 7/30/24. Review of the Care Plan General Note dated 8/22/24 by the Social Worker revealed Resident #76 had a care plan meeting held with the Responsible Party (RP) via telephone. Review of Resident #76's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #76 or the RP was invited to participate in a care plan meeting after the 8/22/24 meeting.	F 553	On 1/23/2025, a care plan meeting was held with Resident #76 and the Interdisciplinary Care Team (IDT). The resident□s representative #1 was physically present and the resident□s representative #2 attended via telephone conference. On 2/10/25, the Minimum Data Set Coordinator (MDS) initiated an audit of all residents most recent care plan meeting. This audit is to ensure that a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided a written invitation to the care plan meeting with documentation in the electronic record. The Social Worker will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting when indicated and providing a written invitation to the resident and/or resident representative per facility guidelines with	

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F 553	Continued From page 2 Review of the Minimum Data Set (MDS) quarterly assessment dated 11/01/24 revealed Resident #76 had moderate cognitive impairment. A telephone interview was conducted with Resident #76's RP on 1/21/25 at 3:02 pm who revealed he had not been invited to participate in a care plan meeting or notified that a meeting was held for Resident #76. An interview was conducted on 1/23/25 at 2:04 pm with the Social Worker who reported the MDS Nurse provided her with a list of the residents that were due for a care plan meeting, and she was responsible for scheduling and inviting the resident and RP to the meetings. The Social Worker stated Resident #76 was not listed on the care plan meeting list provided by the MDS Nurse for November 2024, so Resident #76's care plan meeting was not scheduled. During an interview on 1/23/25 at 3:06 pm the MDS Nurse reported she provided the Social Worker with a list of residents that required a care plan meeting every month along with a date range that the meetings should be scheduled. The MDS nurse confirmed Resident #76 was on the list provided to the Social Worker for November 2024 to have a care plan meeting scheduled. The MDS Nurse stated the Social Worker was responsible for the coordination of the care plan meeting. A follow-up interview was conducted with the Social Worker on 1/24/25 at 8:02 am who revealed she reviewed the November 2024 list provided by the MDS Nurse and she did see that Resident #76 was listed and should have been scheduled for a care plan meeting. The Social	F 553	documentation in the electronic record. The audit will be completed by 2/18/2025. On 2/10/2025, the Nursing Home Administrator educated the Social Services Director and the MDS Nurse regarding Resident Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) timely scheduling of care plan meetings following admission, with changes in plan of care and/or quarterly and (3) providing the resident and/or resident representative a written invitation to care plan meeting with documentation in the electronic record. All newly hired Social Services Director or MDS nurses will be educated during orientation by the Administrator regarding Resident Care Plan Process. The MDS nurse will audit 5 residents on the Resident Assessment Instrument (RAI) Schedule weekly x 4 weeks then monthly x 1 month to ensure a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided with a written invitation to the care plan meeting with documentation in the electronic record. The Administrator will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting per facility guidelines, providing a written invitation to the resident and/or resident representative with documentation in the electronic record and/or re-education of staff. The Administrator will review the care plan audit weekly x 4 weeks then monthly x 1 month to ensure all concerns	

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F 553	Continued From page 3 Worker stated she just missed Resident #76's name on the list and no care plan meeting was held. An interview was held on 1/24/25 at 5:39 pm with the Administrator who revealed the Social Worker was responsible for scheduling Resident #76's care plan meeting.	F 553	are addressed. The Administrator will forward the results of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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	F 657		2/18/25

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F 657	Continued From page 4 assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to revise the care plan in the area of indwelling urinary catheter (Resident #36) and use of side rails (Resident #67) for 2 of 3 residents reviewed for care plan revision. The findings included: 1. Resident #36 was admitted to the facility on 6/07/22. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/13/24 revealed Resident #36 has severe cognitive impairment and was always incontinent of bladder. Review of Resident #36's care plan last reviewed 11/26/24 revealed no care plan for use of an indwelling urinary catheter. Resident #36 had a physician order dated 1/11/25 to place an indwelling urinary catheter until further notice for decreased urine output. The nursing progress note dated 1/11/25 at 2:35 pm by the Nurse Supervisor revealed Resident #36 had an indwelling urinary catheter placed and the resident tolerated the procedure. An observation was conducted on 1/21/25 at 10:37 am of Resident #36 who was observed to have an indwelling urinary catheter in place. A telephone interview was conducted on 1/24/25 at 11:16 am with the Nurse Supervisor who	F 657	On 1/23/2025, Resident #36□s care plan was updated by the Minimum Data Set (MDS) Coordinator to reflect an indwelling foley catheter. On 1/23/2025, Resident #67□s care plan was updated by the MDS Coordinator to reflect siderail usage for bed mobility. On 02/11/2025, the Director of Nursing (DON) initiated an audit of all residents with indwelling catheters or residents utilizing side rails for bed mobility. This audit is to ensure the care planned accurately reflects the use of indwelling catheters and side rails. The DON will address all concerns identified during the audit to include updating the care plan when indicated and education of staff. The audit will be completed by 2/18/2025. On 02/11/2025, the Staff Development Coordinator initiated an in-service with all nurses regarding Care Plan Revisions with emphasis on the responsibility of the nurse for updating care plans timely when there are changes in any aspect of care to include but not limited to use of side rails, indwelling catheters, ADL needs, new diagnoses, medications, treatments, wounds, infections, safety interventions to prevent accidents, adaptive equipment, and diet. The in-service will be completed by 2/18/2025. After 2/18/2025, any nurse who has not worked or received the in-service will complete it upon to the next scheduled work shift. All newly hired nurses will be in-serviced during orientation by the Staff Development	

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F 657	Continued From page 5 revealed she obtained a physician order to place Resident #36's indwelling urinary catheter but she did not start a care plan because she believed the Resource Nurse would make sure a care plan was put in place. An interview was conducted on 1/24/25 at 1:49 pm with the Resource Nurse who revealed Resident #36 should have had a care plan started and the care guide should have been updated for the use of an indwelling urinary catheter when it was placed. She stated that either the Nurse Supervisor or the MDS Nurse should have revised Resident #36's care plan to reflect the use of the indwelling urinary catheter. The Resource Nurse stated resident orders would have been reviewed during the next clinical meeting and if no care plan was noted the MDS Nurse would start the care plan based on the orders. The Resource Nurse stated she was not responsible to ensure Resident #36 had a care plan in place for the indwelling urinary catheter. During an interview on 1/24/27 at 2:47 pm with the MDS Nurse she revealed the nurse that obtained the order and placed the indwelling catheter should have revised Resident #36's care plan. The MDS Nurse stated she would assist nursing with care plans when asked but she did not recall discussing Resident #36's new indwelling urinary catheter during the clinical meetings. An interview was conducted with the Director of Nursing (DON) on 1/24/25 at 3:08 pm who revealed the Nurse Supervisor who placed Resident #36's indwelling urinary catheter was responsible for revising the care plan. The DON stated all new resident orders were reviewed in	F 657	Coordinator. The Director of Nursing or designee will audit all new orders for indwelling catheters or residents with newly added use of side rails for bed mobility weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure the care planned accurately reflects the use of indwelling catheters and side rails. The Director of Nursing will address all concerns identified during the audit to include updating the care plan when indicated and re-training of staff. The DON will present the Care Plan Audit Tools to the facility□s Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 657	Continued From page 6	F 657		

the clinical meetings. She stated she recalled seeing the new order and discussing in the clinical meeting and she thought the MDS Nurse revised the care plan but must have been sidetracked.

An interview was conducted with the Administrator on 1/24/25 at 5:41 pm. The Administrator stated that the missing care plan should have been identified during the clinical meeting.

2. Resident #67 was admitted to the facility on 11/15/24.

Review of the physical device use evaluation dated 11/15/24 revealed Resident #67 was assessed for the use of 1/4 assist side rails for mobility. The side rails were noted as used daily for enhanced independence.

The Minimum Data Set (MDS) admission assessment dated 11/21/24 revealed Resident #67 had moderate cognitive impairment and required assistance by staff for turning, repositioning, and transfers.

Review of Resident #67's care plan last reviewed 11/27/24 revealed no care plan was in place for use of side rails for mobility.

An observation and interview were conducted with Resident #67 on 1/21/25 at 10:49 am who revealed he had the side rails on his bed since he was admitted to the facility, and he stated he just received a new bed the other day that did not have side rails and he had the nurse put the side rails on the new bed.

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F 657	Continued From page 7 An interview was conducted with the Resource Nurse on 1/24/25 at 1:54 pm who revealed a care plan was required for a resident that used side rails for mobility. She stated Resident #67 would have been reviewed in the clinical meeting upon admission and the MDS Nurse would have put in a care plan. The Resource Nurse stated she was not responsible for the care plan, and she was unable to state why a care plan was not in place for Resident #67's side rails. An interview was conducted on 1/24/25 at 2:49 pm with the MDS Nurse who reported the nursing staff were responsible to revise Resident #67's care plan for side rails when they were placed on his bed. She stated she would assist with care plans when asked but she would not know about Resident #67's use of side rails if she was not told by nursing. During an interview on 1/24/25 at 3:14 pm the Director of Nursing (DON) stated Resident #67's use of side rails for mobility should have been added to his care plan. She stated Resident #67 had side rails since admission. The DON stated a care plan should have been in place for Resident #67's use of side rails, but she stated it must have been missed during the clinical meeting. An interview was conducted with the Administrator on 1/24/25 at 5:41 pm. The Administrator stated that the missing care plan should have been identified during the clinical meeting.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		2/18/25

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F 690	Continued From page 8 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to obtain physician orders for the management of an indwelling	F 690	On 2/05/2025, the Resource Nurse clarified with the physician parameters for changing indwelling catheter and the	

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F 690	Continued From page 9 urinary catheter for 1 of 3 residents reviewed for urinary catheter (Resident #36). The findings included: Resident #36 was admitted to the facility on 6/7/22 with diagnoses which included stroke. The Minimum Data Set (MDS) quarterly assessment dated 11/13/24 revealed Resident #36 had severe cognitive impairment and was coded as always incontinent of bladder. Resident #36 had a physician order dated 1/11/25 to place an indwelling urinary catheter until further notice for decreased output. Review of Resident #36's electronic medical record revealed no physician orders regarding what size of catheter, how many cubic centimeters (cc) of fluid to anchor the catheter, the time frame to change the indwelling urinary catheter, and time frame to change the indwelling catheter bag. The nursing progress note dated 1/11/25 at 2:35 pm by the Nurse Supervisor revealed Resident #36 had an 18 french (size of the catheter) 5 cubic centimeters (amount of fluid placed in the bulb to anchor the catheter) indwelling urinary catheter placed and tolerated the procedure well. A physician order dated 1/12/25 to monitor and record indwelling urinary catheter output every shift. An observation was conducted on 1/21/25 at 10:37 am revealed Resident #36 had an indwelling urinary catheter in place.	F 690	order for the indwelling catheter was updated to include size of catheter for resident #36. On 2/11/2025 the Director of Nursing initiated an audit of residents with indwelling catheters. This audit is to ensure that the order for indwelling catheter identifies reason for use, size of catheter and parameters for changing catheter. The Director of Nursing will address all concerns identified during the audit to include clarifying order with the physician, updating electronic record when indicated and education of staff. The audit was completed on 2/12/2025. On 2/6/25, the staff facilitator initiated an in-service with all nurses regarding Indwelling Catheters with emphasis on ensuring the order identifies reason for use, size of catheter and parameters for changing catheter. The in-service will be completed by 2/18/2025. After 2/18/2025 compliance date, any nurse who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses will be educated during orientation by the staff facilitator. The Unit Managers and Treatment Nurses will audit all newly written orders for indwelling catheters weekly x 4 weeks the monthly x 1 month utilizing the Indwelling Catheter Audit Tool. This audit is to ensure that the order for indwelling catheter identifies reason for use, size of catheter and parameters for changing catheter. The Director of Nursing will address all concerns identified during the audit to include clarifying order with the	

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F 690	Continued From page 10 A telephone interview was conducted on 1/24/25 at 11:16 am with the Nurse Supervisor who revealed she obtained a physician order for the indwelling urinary catheter for Resident #36, and she entered the order she received. She stated she did not enter any other orders for the management of Resident #36's indwelling urinary catheter, because she believed the Resource Nurse would enter any other orders that were needed. An interview on 1/24/25 at 1:49 pm with the Resource Nurse revealed when a resident had an indwelling urinary catheter physician orders were required for the catheter to be in place, the size of the catheter, how often to change the indwelling catheter and the catheter bag, and monitoring urine output. The Resource Nurse stated the Nurse Supervisor was responsible for entering all standing orders that were associated with the indwelling urinary catheter management. An interview was conducted with the Director of Nursing (DON) on 1/24/25 at 3:08 pm who revealed the nurse who obtained the physician order and placed the indwelling urinary catheter for Resident #36 was responsible for implementing all the standing orders that were required for the catheter. The DON stated Resident #36 should have had orders for the size of the catheter, changing the catheter, and how often to change the catheter bag. The DON stated she was not aware Resident #36 was missing physician orders for the management of the catheter, but she must have missed it when the orders were reviewed. The Administrator was interviewed on 1/24/25 at 5:42 pm who revealed the nurse who obtained	F 690	physician, updating the electronic record when indicated and re-training of staff. The Director of Nursing will review the audit tools weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator or The Director of Nursing (DON) The DON will present the Indwelling Catheter Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 690	Continued From page 11 the order was responsible for entering associated orders for Resident #36's indwelling urinary catheter.	F 690		
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 date opened leftover food items in 2 kitchen refrigerators (the walk-in refrigerator and the free-standing refrigerator), failed to remove an expired food item stored for use from the dry goods storage room, and failed to remove a plastic measuring cup from the sugar storage bin located near the tray line. The plastic measuring cup was resting in the sugar which has the potential for cross-contamination. These practices had the potential to affect food served	F 812	On 1/21/2025, the Dietary Manager removed and discarded the open plastic bag of shredded lettuce without a date from the walk-in refrigerator, the open box of grated parmesan cheese without a date from the free standing refrigerator and a box of hard taco shells with an expiration date of 10/5/24 from the dry goods storage room. On 1/21/2025, the sugar scoop was removed from the container of sugar,	2/18/25

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F 812	Continued From page 12 to residents. The findings included: During the initial observation of the kitchen on 1/21/25 at 9:36 am with the Dietary Manager the following was observed: a. The walk-in refrigerator, located near the dry goods storage room, was observed to have the following: 1 open plastic bag of shredded lettuce without a date. b. The free-standing refrigerator, located near the tray line, was observed to have an open, large box of grated parmesan cheese without a date. c. The dry goods storage room, located in the kitchen near the walk-in refrigerator, was observed to have one box of hard taco shells with an expiration date of 10/05/24. d. A plastic measuring cup was observed inside the large sugar storage bin resting in the sugar. The Dietary Manager confirmed all findings and removed identified items from the refrigerators, dry goods storage room, and the sugar storage bin. During an interview on 1/23/25 at 1:53 pm with the Dietary Manager she revealed all items placed in the refrigerator were to be dated when opened. The Dietary Manager stated the measuring cup was to be washed after being used and was not to be left inside the bin. She stated she must have missed the hard taco shells when she checked the dry goods storage room for expired items. The Dietary Manager stated	F 812	cleaned, and stored appropriately per facility protocol. On 1/21/2025, the Dietary Manager immediately educated all dietary staff currently working regarding (1) storage of scoops with emphasis on not placing scoops in containers and (2) rotating stock to ensure items are used prior to expiration dates and (3) process for checking/removing items when outdated and proper labeling of leftover, opened food. On 1/22/2024, an audit of the walk-in refrigerators, free standing refrigerators and dry storage areas was completed by the Dietary Manager under the oversight of the Dietary Consultant to ensure all food items were labeled with an open or use by date and that no items were expired. There were no additional concerns identified during the audit. On 1/22/2024, the Dietary Manager under the supervision of the Dietary Consultant completed an audit of all scoops to ensure scoops were stored appropriately and not left inside containers. There were no additional concerns identified during the audit. On 1/21/2025 an in-service was initiated by the Dietary Consultant with all dietary staff regarding (1) Label/Dating and Expired Foods with emphasis on removing and discarding items per facility protocol when out of date/expired and (2) Storage of Scoops with emphasis on not storing scoops inside containers. The in-services will be completed by 2/18/2025. After 2/18/2025, any dietary staff who have not worked or received the	

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F 812	Continued From page 13 she was responsible for ensuring food items were stored properly in the kitchen. An interview was conducted with the Administrator on 1/24/25 at 5:35 pm who revealed the Dietary Manager was responsible for ensuring food items were dated, labeled, and stored properly in the kitchen.	F 812	in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-service during orientation by the Dietary Manager. The Dietary Manager and/or Assistant Dietary Manager will complete kitchen observations of proper labeling/dating open food, expired food product and storage of scoops 2 times a week x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. This audit is to ensure all food items were labeled with an open or use by date, no items were expired and that scoops were stored per facility guidelines. The Dietary Manager and/or Assistant Dietary Manager will address all concerns identified during the audit to include removing and discarding items not dated or out-of-date, proper storage of scoops when indicated and re-training of staff. The Administrator will review the Kitchen Audit Tool twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Dietary Manager will present the findings of the Kitchen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
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	F 847		2/18/25

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F 847	Continued From page 14	F 847		

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.

§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

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F 847	Continued From page 15 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 a review of the facility arbitration agreement and staff interviews, the facility failed to provide an arbitration agreement that explicitly granted the resident or their representative the right to rescind the agreement within 30 days of signing it. The deficient practice was for 3 of 3 residents reviewed for arbitration (Resident #63, Resident #76, and Resident #33). The findings included: A review of the facility's arbitration agreement titled, "Arbitration Agreement," dated 7/15/24 was conducted. The Arbitration Agreement read in part that the agreement may be rescinded by written notice to the facility from the Resident within thirty (30) days of signature. The arbitration agreement did not include the statement that the resident or his or her representative has the right to rescind the agreement within 30 days of signing it. a. Resident #63 was admitted to the facility on 10/29/24. Resident 63's arbitration agreement revealed the resident representative signed the agreement on 10/29/24. b. Resident #76 was admitted to the facility on 7/30/24. Resident #76's arbitration agreement revealed Resident #76 signed the agreement on	F 847	On 2/06/2025, the Admissions Coordinator reviewed the newly updated arbitration agreement to include the verbiage The Resident or the Resident□s representative has the right to rescind the agreement by written notice to the facility within thirty days of signature with resident #63/resident representative. On 2/06/2025, the Admissions Coordinator reviewed the newly updated arbitration agreement to include the verbiage The Resident or the Resident□s representative has the right to rescind the agreement by written notice to the facility within thirty days of signature with resident #76/resident representative. On 2/10/2025, the Admissions Coordinator reviewed the newly updated arbitration agreement to include the verbiage The Resident or the Resident□s representative has the right to rescind the agreement by written notice to the facility within thirty days of signature with resident #33/resident representative. On 1/27/25, the facility arbitration agreement was amended to include the verbiage The Resident or the Residents representative has the right to rescind the agreement by written notice to the facility within thirty days of signature.	

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F 847	Continued From page 16 7/30/24. c. Resident #33 was admitted to the facility on 4/23/21. Resident #33's arbitration agreement was signed by the resident representative on 9/18/24. An interview was conducted on 1/24/25 at 8:35 am with the Admission Director who revealed she was responsible for reviewing the arbitration agreement with the Resident or the Representative at the time of admission. The Admission Director stated she was provided with the document by the facility and had no knowledge of what was required to be included. During an interview on 1/24/25 at 5:33 pm with the Administrator she revealed she was new to the facility and was not familiar with the facility's arbitration agreement.	F 847	On 1/27/2025, the Administrator initiated the new Arbitration Agreement amended 1/27/25 to be reviewed with all residents and/or resident representatives. On 2/06/2025, the Admission□s Coordinator began reviewing the updated arbitration agreement with all residents and/or resident representative with emphasis on new verbiage that states The Resident or the Residents representative has the right to rescind the agreement by written notice to the facility within thirty days of signature. The Admission Coordinator will update resident electronic record following review. Any concerns identified during the review will be forward to the administrator for follow up. The review will be completed by 2/18/2025. On 2/13/2025, the Administrator completed an in-service with the Admission Coordinator regarding review and completion of the newly updated arbitration agreement with all new admissions with documentation in the electronic record. The Business Office Manager will monitor all new admissions weekly x 4 weeks then monthly x 1 month to ensure the newly updated arbitration agreement is reviewed with the resident and/or resident representative. The Administrator will address all concerns identified during the audit to include completing review with the resident/resident representative when indicated and re-training of staff. The Administrator will present the audit of arbitration agreements to the Quality Assurance Performance Improvement	

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F 847	Continued From page 17	F 847	(QAPI) Committee monthly x 2 months for review and determine trends and / or issues that may need further interventions put into place.	
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; §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	F 880		2/18/25

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F 880	Continued From page 18 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 observation, record review, and staff interviews, the facility failed to implement its infection prevention and control program when 1 of 1 facility staff (Nurse Aide #1) failed to perform hand hygiene before donning and after removing	F 880	On 1/21/2025, the Director of Nursing immediately in-serviced Nurse Aide #1 regarding changing gloves and sanitizing hands when removing soiled linen from each resident room.	

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F 880	Continued From page 19 gloves for 4 of 4 resident rooms (Room 110, Room 113, Room 114, Room 115). The facility also failed to implement its Personal Protective Equipment (PPE) policy when 2 of 2 staff (Wound Treatment Nurse, Nurse Aide #2) failed to wear isolation gowns while in a resident's room on Enhanced Barrier Precautions (EBP). The findings included: The facility's Infection Prevention and Control Program policy last updated 4/2023 read in part:" The infection Prevent and Control Program of this facility of designated to establish and maintain an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and transmission of disease. The Objective was to ensure proper utilization of standard precautions and or when needed, transmission-based precautions which should be the least restrictive for a resident under the given circumstances. Review of the facility's hand hygiene policy last updated 4/2023 indicated personnel are to wash their hands after each direct or indirect resident contact to include between resident contacts. 1. A continuous observation was conducted on 1/21/25 at 12:02 PM. Nurse Aide (NA) #1 was observed to leave out of room 113 and walk down the hall to the clean linen cart where she retrieved a clothing protector. NA #1 returned to the room and placed a clothing protector on the resident. NA #1 was observed to leave the room without performing hand hygiene. NA #1 entered resident room 114 without performing hand hygiene. NA #1 donned gloves and assisted to slide resident in "A" bed up in the bed. NA #1 removed gloves	F 880	On 1/24/2025, the Director of Nursing immediately in-serviced the treatment nurse and nurse aide #2 on Enhanced Barrier Precautions to include proper utilization of Personal Protective Equipment. On 1/21/2025, the Staff Facilitator initiated an in-service with all staff regarding (1) Handwashing/Glove Use with emphasis on washing hands before donning PPE, after removing gloves, between passing meal trays, after resident contact and when entering/exiting resident room (2) Enhanced Barrier Precautions (EBP) with emphasis on donning appropriate PPE for the type of isolation precautions indicated to include but not limited to gloves, mask or gown and washing hands before entering and when leaving the room. The in-service also included healthcare personnel must wear gowns and gloves for all high-contact resident care activities to include but not limited to wound care. The in-service will be completed by 2/18/2025. After 2/18/2025 any staff who has not completed the in-service will complete it upon next scheduled work shift. All newly hired staff will be in-serviced during orientation regarding Handwashing/Glove Use and Enhanced Barrier Precautions by the Infection Preventionist. The Infection Preventionist and/or Unit Managers will complete 10 staff observations to include Nurse Aide #1, Nurse Aide #2 and Treatment Nurse utilizing the Infection Control Audit Tool weekly x 4 weeks then monthly x 1 months. This audit is to ensure staff	

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F 880	Continued From page 20 and was observed to exit the room and retrieve meal tray for resident in the "B" bed from the meal cart without performing hand hygiene. NA #1 set the meal tray up for the resident and exited the room without performing hand hygiene. NA #1 walked to the meal cart and retrieved the meal tray for resident in room 115. NA #1 placed the meal tray on the bedside table and exited the room. An interview was conducted with NA #1 on 1/21/25 at 12:16 PM. NA #1 stated she was supposed to perform hand hygiene when exiting each resident's room and between residents. NA #1 stated she was trying to get the trays out and didn't realize she had not performed hand hygiene. An interview was conducted with the Director of Nursing on 1/21/25 at 12: 22 PM. The DON stated she expected staff to perform hand hygiene and wear PPE as indicated. An interview was conducted with the Administrator on 1/24/25 at 5:49 PM. The Administrator stated hand hygiene was to be performed as warranted and staff were to perform hand hygiene techniques to prevent the spread of infection. 2. Review of the EBP policy dated 4/1/24 stated EBP used in conjunction with Standard Precautions to reduce the risk of MDRO transmission during high-contact resident care. EBP included the use of gown and gloves. EBP was meant to be in place for the duration of the resident's stay or until resolution of the wound. Resident care activities that are considered high contact include but are not limited to dressing,	F 880	don/doff appropriate PPE for the type of isolation indicated, before donning PPE, after removing gloves, between passing meal trays, after resident contact and when entering/exiting resident room. The Unit Managers will address all areas of concern identified during the audit to include re-education of staff. The DON will review the Infection Control Audit Tool weekly x 4 weeks then monthly x 1 month. The Director of Nursing will present the findings of the Infection Control Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine the need for any trends or further frequency of monitoring.	

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F 880	Continued From page 21	F 880		

bathing/showering, changing linens, wound care.

During an observation of wound care on 1/24/25 at 9:32 AM, the Wound Treatment Nurse and Nurse Aide #2 completed wound care for Resident #17. Resident #17's room door had Enhanced Barrier Precautions signage that instructed staff to utilize Personal Protective Equipment when performing specific care which included wound care. The signage indicated everyone had to clean their hands before entering and after leaving the room. The signage further indicated that all healthcare personnel must wear gowns and gloves for all the following high-contact resident care activities to include wound care. A bin was observed hanging on the back of the door with PPE supplies readily available. The Wound Treatment Nurse and NA #2 were observed to perform hand hygiene and don gloves, no gown was used by either staff member. Resident #17 was positioned on her left side and the old dressing was removed by Wound Treatment Nurse. The Wound Treatment Nurse removed her gloves and hand hygiene was completed with hand sanitizer. Clean gloves were donned by the Wound Treatment Nurse and the wound bed was washed with soap and water. Gloves were removed and hand hygiene was completed using hand sanitizer. Clean gloves were donned, and calcium alginate (used to promote the formation of new granulation tissue) was applied to the wound bed and foam border dressing was applied over the calcium alginate. Resident #17's brief was applied and resident repositioned. Hand hygiene was completed prior to leaving Resident #17's room by the Wound Treatment Nurse and NA #2.

An interview was conducted on 1/24/25 at 9:55

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F 880	Continued From page 22	F 880		

AM with the Wound Treatment Nurse who reported she was nervous during the wound care observation and realized she did not wear the PPE gown when providing wound care. The Wound Treatment Nurse stated she was nervous and just forgot to put the gown on.

An interview was conducted on 1/24/25 at 10:25 AM with NA #2 who reported she was aware she did not wear the gown. NA #2 stated she told the Wound Treatment Nurse after they left the room, they had forgotten to wear their gowns.

During an interview with the Infection Preventionist on 1/24/25 at 10:30 AM, she revealed when a resident is on EBP the staff were required to wear gowns when wound care was performed. The Infection Preventionist stated PPE was available in all residents that were on EBP. The Infection Preventionist reported both the Wound Treatment Nurse and NA#2 had been educated in the past regarding EBP on 12/23/24 -1/6/25.

During an interview with the Director of Nursing on 1/24/25 at 3:24 PM, she stated staff were to wear proper PPE when providing wound care.

During an interview with the Administrator on 1/24/25 at 5:38 PM, she stated the Infection Preventionist was responsible for ensuring all staff were educated.