STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MONROE	204 OLD HIGHWAY 74 EAST MONROE, NC 28112

(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 and complaint investigation survey was conducted from 3/31/2025 to 4/3/2025. Additional information was obtained on 4/10/2025. Therefore, the exit date was changed to 4/10/2025. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID # 5H6G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/31/2025 to 4/3/2025. Additional information was obtained on 4/10/2025. Therefore, the exit date was changed to 4/10/2025. Event ID #5H6G11. The following intakes were investigated NC00226764 and NC00228537. 2 of 2 complaint allegations did not result in deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		4/25/25

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

Electronically Signed | 04/22/2025

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F 623	Continued From page 1	F 623		

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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F 623	Continued From page 2	F 623		

completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 3 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to notify residents and their family members in writing of a transfer to the hospital for 3 of 4 residents reviewed for hospitalization (Resident #1, Resident #24, and Resident #33). The findings included: a. Resident #1 was admitted to the facility 1/10/20. A nursing note dated 4/3/24 documented Resident #1 was sent to the hospital for a change in condition. Hospital discharge orders dated 4/7/25 revealed Resident #1 was discharged from the hospital after treatment for acute parotitis (infection of the parotid [salivary] gland). A nursing note dated 4/7/25 documented Resident #1 was readmitted to the facility. Review of the medical record for Resident #1 revealed no evidence a written notice of transfer was issued to the resident or the resident representative. Resident #1 was interviewed on 3/31/25 at 10:04 AM and he reported he was admitted to the hospital in April of 2024 for an infected salivary gland, and he did not recall receiving a letter of transfer from the facility. Resident #1 reported he was his own representative.	F 623	#1. Facility failed to provide notice of transfer/discharge in writing to resident #1, #24, and #33 upon transfer to hospital. All residents still reside in the facility. #2. On 4/22/25 the facility Social Worker completed an audit of resident hospital transfers from 4/1/25 to present for evidence of timely written notice to Resident/Representative of notification of transfer/discharge to hospital. Any missing notifications were immediately mailed to resident/representative. #3 On 04/01/25, the Administrator provided education to the Social Worker and Director of Nursing (DON) on the requirements of the facility to notify the resident and the resident's representative(s) prior to any facility-initiated transfer or discharge and the reasons for the move in writing and in a language and manner they understand (form NC Medicaid-9050). The facility must send a copy of the notice to the local Ombudsman representative. The Social Worker will be responsible for providing written notices prior to transfer/discharge or as soon as practical and will maintain a Transfer/Discharge Notice Log with date and method written notices are provided. Newly hired Social Workers will receive education upon hire. #4 The Administrator or DON will	

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F 623	Continued From page 4 b. Resident #24 was admitted to the facility 3/1/23. A nursing note dated 1/21/25 documented a change in condition and Resident #24 was sent to the hospital for evaluation and treatment. Hospital discharge orders dated 1/29/25 revealed Resident #24 was admitted to the hospital for treatment of acute respiratory failure. A nursing note dated 1/29/25 documented Resident #24 was readmitted to the facility. Review of the medical record for Resident #24 revealed no evidence a written notice of transfer was issued to the resident or the resident representative. Resident #24 was interviewed on 3/31/25 at 10:19 AM and she reported she was her own representative. Resident #24 reported she was admitted to the hospital in January 2025 for respiratory failure and she did not receive a letter of transfer from the facility. c. Resident #33 was admitted to the facility 2/7/20. A nursing note dated 1/29/25 documented Resident #33 had a fall and the Nurse Practitioner was notified. The note documented Resident #33 had pain in his left hip and elbow and an x-ray was ordered. Hospital discharge orders dated 2/3/25 documented Resident #33 was in the hospital for repair of a left hip fracture.	F 623	complete quality assurance monitoring of facility-initiated transfers and discharges for accurate, timely notifications. Monitoring will be completed weekly for four weeks, then monthly for three months. The Administrator will report findings of the monitoring to the Quality Assurance Performance Improvement (QAPI) Committee during monthly QAPI meeting for three months and will make changes to the plan as necessary to maintain compliance.	

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F 623	Continued From page 5 A nursing note dated 2/4/25 documented Resident #33 was readmitted to the facility after repair of a fractured left hip. Resident #33 was unable to be interviewed due to cognition. The Resident Representative was not available for interview. Review of the medical record for Resident #33 revealed no evidence a written notice of transfer was issued to the resident or the resident representative. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/1/25 at 1:51 PM. The ADON explained that nursing did not send a written notice of transfer to the resident or the representative. The Business Office Manager was interviewed on 4/1/25 at 2:07 PM and she reported she did not send a written notice of transfer after hospitalization. The Social Worker was interviewed on 4/1/25 at 2:18 PM and he reported he did not send a letter of transfer to the resident and the representative after hospitalization. The Administrator was interviewed on 4/3/25 at 1:54 PM and she reported she was under the impression that the written notices of transfer were being completed at the same time as the hospital transfers were completed and she was not aware of residents and their representatives were not receiving written notices of transfer after hospitalization.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		4/25/25

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F 625	Continued From page 6 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to provide written bed hold notices for 2 of 4 residents reviewed for hospitalization (Resident #1 and Resident #24). The findings included:	F 625	#1. Facility failed to provide written bed hold policy to residents #1 and #24 up transfer to hospital. #2. A review was completed on 4/11/25 by the Administrator for any residents in the hospital to ensure they had been notified	

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F 625	Continued From page 7 1. a. Resident #1 was admitted to the facility 1/10/20. A nursing note dated 4/3/24 documented Resident #1 was sent to the hospital for a change in condition. Review of the medical record for Resident #1 revealed no written bed hold notice had been provided. A nursing note dated 4/7/25 documented Resident #1 was readmitted to the facility. Resident #1 was interviewed on 3/31/25 at 10:04 AM and he reported he was admitted to the hospital in April of 2024 for an infected salivary gland, and he did not recall receiving a bed hold notice when he went to the hospital. Resident #1 reported he was his own representative. b. Resident #24 was admitted to the facility 3/1/23. A nursing note dated 1/21/25 documented a change in condition and Resident #24 was sent to the hospital for evaluation and treatment. Review of the medical record for Resident #24 revealed no evidence a written bed hold notice had been provided. A nursing note dated 1/29/25 documented Resident #24 was readmitted to the facility. Resident #24 was interviewed on 3/31/25 at 10:19 AM and she reported she was her own representative.	F 625	of bed-hold policy. All had been notified verbally by Business Office Manager and the facility sent written notice via direct mail on 4/14/25. #3. On 4/22/25 education on bed-hold policy was provided by regional Clinical Nurse Consultant to Business Office Manager, Social Worker, Administrator, and DON regarding written bed-hold notification to be sent and documented in medical record during a resident transfer out of the facility. Education was provided by Nursing Home Administrator to Clinical Management regarding transferred residents charts to be reviewed in Clinical Morning Meeting to ensure proper written notification is provided and documented as required. Education will be completed by 4/18/25. On 4/22/25 Director of Nursing or designee began education to licensed nurses and unit managers on the bed-hold policy. Newly hired Licensed Nurses, Admissions Director, Social Worker, Administrator, and Business Office Manager will be educated during Department Orientation by the Staff Development Coordinator/Designee. #4. The Administrator will conduct an audit of facility transfers weekly for four weeks, then monthly for three months. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance Committee by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the	

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F 625	Continued From page 8 Resident #24 reported she was admitted to the hospital in January 2025 for respiratory failure and she did not receive a bed hold notice. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/1/25 at 1:51 PM. The ADON explained that nursing did not send a bed hold notice when a resident was sent to the hospital and the Business Office was responsible for the bed hold notice. The Business Office Manager was interviewed on 4/1/25 at 2:07 PM and she reported she called the resident or the resident representative when a resident was hospitalized and explained the bed hold, but she did not provide a written copy of the bed hold notice. The Business Office Manager reported the residents only received a written copy of the bed hold notice if they wanted to sign and hold their bed during hospitalization. The Business Office Manager reported no residents had wanted to sign the bed hold notice since she started at the facility a year ago. The Administrator was interviewed on 4/3/25 at 1:54 PM and she reported she was under the impression that the bed hold notices were being completed at the same time as the hospital transfers were completed and she was not aware of residents and their representatives were not receiving the written bed hold policy when hospitalized.	F 625	interventions to determine if continued auditing is necessary to maintain compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/25/25

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F 689	Continued From page 9 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to perform quarterly safe smoking assessments and secure smoking materials, specifically a vaping pen (an electronic nicotine delivery system/electronic smoking device), for 1 of 4 residents (Resident #20) reviewed for safe smoking. Findings included: A review of the facility's smoking policy titled Smoking Permitted with a revision date of 10/20/22 stated in part: Residents, visitors, and staff may smoke in designated areas only. Smoking will be strictly prohibited in all non-smoking areas. All areas indoors including but not limited to . . . resident rooms, common living and dining areas. Residents who desire to smoke may not keep smoking related materials (i.e. cigarettes, electronic smoking devices [e-cigarettes], refill cartridges/fluid) . . . on their person when not smoking or in their room. Residents who are determined by the interdisciplinary team as safe for independent smoking will request smoking materials when desiring to smoke and will return them upon completion of the smoking session. Evaluations will be reviewed by the interdisciplinary team at least quarterly and as the resident's functional, behavioral, or cognitive	F 689	#1. Facility failed to perform quarterly smoking assessment and secure smoking materials properly for resident #20. On 3/31/25 safe smoking assessments were completed on all residents that smoke or vape in the facility by the nurse manager. Care plans were updated as needed to reflect smoking status. On 4/1/25 the Director of Nursing (DON), Social Worker (SW), and Administrator met with resident and removed all smoking/vaping materials from her person and room. DON, SW, and Administrator re-educated resident #20 on the smoking policy. A new safe smoking assessment was completed on 4/2/25 and resident #20□s care plan was updated to reflect that resident now requires supervision during smoking. #2. On 4/2/25 all residents that smoke had a new safe smoking assessment completed by facility nurse managers. No other changes were made to any resident current smoking status. All residents who smoke received re-education on the facility smoking policy and rules by the facility Activity Director. #3. Beginning 4/22/25 the DON began education to all staff on the facility resident smoking policy and to notify Administrator, DON, or Supervisor if any	

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F 689	Continued From page 10 status change; impacting their ability to smoke safely. Residents who are determined by the interdisciplinary team as needing supervision will be within the eyesight of staff, family, or designated volunteer during the time that the resident is smoking. Resident #20 was admitted to the facility on 10/21/21 with diagnoses of type 2 diabetes, cerebral infarction (stroke) without residual deficits, and nicotine dependence. A review of Resident #20's care plan revised on 8/24/22 indicated the resident smoked and vaped. The care plan further indicated the resident was assessed to be a safe smoker. A review of the safe smoking screening assessment dated 2/7/24 revealed staff had educated Resident #20 on the smoking policy related to smoking times as well as the storage of smoking materials, and the resident acknowledged understanding. Resident #20 was assessed as a safe smoker and could smoke independently. The most recent quarterly Minimum Data Set (MDS) assessment dated 3/7/25 indicated Resident #20 was cognitively intact without behavioral concerns. On 4/1/25 a continuous observation was made from 1:15 PM to 1:35 PM. At 1:15 PM Resident #20 was observed sitting in a wheelchair in the doorway of her room. Her right hand covered the lower part of her face, and a large white cloud of smoke was observed to exit her cupped hand. Resident #20 was immediately interviewed, and she stated she did smoke, but lately she had	F 689	resident is observed to be non-compliant with facility smoking policy, including keeping smoking materials in a restricted location or area. All licensed nursing staff will be educated on completing safe smoking assessments upon admission, readmission, quarterly and with any significant change. All staff not educated, including agency staff, on 4/22/25 will be educated prior to next shift. All newly hired staff will be educated in orientation. All newly admitted residents who smoke will continue to be educated on facility smoking policy and securement of smoking/vaping materials. #4. On 4/22/25 and Ad-Hoc Quality Assurance Performance Improvement (QAPI) was held with the Interdisciplinary Team (IDT) to review the deficiency and plan of correction. Beginning 4/28/25 the DON or designee will conduct audits of current residents and newly admitted residents that smoke to ensure timely safe smoking assessments are completed. Administrator or designee will complete random audits of smoking area during smoking times to ensure that residents adhere to safe smoking practices including securement of smoking materials. Audits will occur three times a week for six weeks, then weekly for six weeks. These audits will be reviewed by the Administrator and DON at the monthly QAPI meeting for three months for further recommendations to maintain compliance as necessary.	

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F 689	Continued From page 11	F 689		

enjoyed vaping more. She stated she was an unsupervised smoker and had a locker in the courtyard where she stored her smoking supplies. Resident #20 stated she kept a key to her locker, could retrieve her smoking supplies, and smoke or vape in the courtyard during the scheduled smoking times. Upon further questioning she did confirm that she had a vaping pen on her person and presented a blue vape pen in her left hand. She stated she knew she should not smoke or vape in her room and was supposed to put her supplies away after smoking. Resident #20 indicated the facility was unaware she had a vape pen in her possession in her room. There was no oxygen in use in the resident's room, or in the vicinity of the resident while she had been observed to be vaping. While waiting for Nurse #2, the nurse assigned to Resident #20 who was completing care with another resident, the surveyor remained on the hall to continually observe Resident #20. Resident #20 was not observed to vape during the time of the observation. The continuous observation concluded at 1:35 PM when Nurse #2 was made aware Resident #20 had a vaping pen in her possession.

During an interview conducted with Nurse #2 on 4/1/25 at 1:35 PM he stated 4/1/25 was his first day working for the facility. He further stated he had not observed Resident #20 smoking or vaping in the facility during his time at the facility. Nurse #2 was then observed to go to Resident #20's room.

The Unit Manager was interviewed on 4/1/25 at 1:50 PM and stated residents were not allowed to smoke or vape inside the facility. The Unit Manager indicated all residents who chose to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING _____ B. WING _____	C 04/10/2025

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F 689	Continued From page 12	F 689		

smoke were educated face to face regarding the facility's smoking policy upon entry into the facility. She further stated if the facility discovered someone had smoking materials, including vaping materials, in their room then they would be removed from the resident, and she would report the incident to her supervisor. The Unit Manager was made aware by Nurse #2 that Resident #20 had been observed vaping in the facility at 1:15 PM. The Unit Manager responded she had never observed Resident #20 smoking or vaping in the facility. The Unit Manager further stated she would notify the Administrator the resident was vaping.

On 4/1/25 at 2:48 PM an interview was conducted with the Administrator who stated she had never observed Resident #20 smoking or vaping in the facility. During the interview, the Administrator called the former Director of Nursing (DON) to give details concerning the latest educational session held with the residents who smoked. The former DON stated she had educated all the residents who smoked in the facility regarding the facility's smoking policy before leaving in March 2025 and had the residents sign a copy of the smoking agreement that acknowledged they agreed not to smoke or vape in their room. According to the Administrator, the facility had identified some residents who smoked were missing quarterly safe smoking assessments in the electronic charting system, including Resident #20. The root cause identified was all the resident assessment schedules, including the smoking assessments, had been cleared during the company changeover in December 2024. Per the Administrator, safe smoking assessments were completed on all residents who smoked or vaped by the facility unit manager on 3/31/25 and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 13	F 689		

assessments would be completed on admission, readmission, quarterly, and with changes in condition.

A review of Resident #20's electronic medical record revealed she had signed a copy of the smoking policy agreement. However, the document was undated.

On 4/3/25 at 10:14 AM an interview was conducted with the current Director of Nursing who stated the vaping pen had been removed from Resident #20 once it was discovered on 4/1/25. She further stated that she, the Social Worker, and the Administrator met with and re-educated Resident #20 about the smoking policy that day. The DON stated the resident had been changed to a supervised smoker after reassessment.

A review of the care plan revealed it was revised on 4/2/25 and indicated Resident #20 had been updated as a supervised smoker.

A follow-up phone interview with the Administrator occurred on 4/10/25 at 11:43 AM. She stated she had been notified Resident #20 had been seen vaping in her room on 4/1/25 shortly after it occurred. After being notified, she, the Social Worker, and the DON went to the resident's room to speak with her. She stated Resident #20 had denied having vaping materials to Nurse #2 and the Unit Manager who questioned her immediately after the surveyor had reported to Nurse #2 Resident #20 had vaping materials. She further stated the Unit Manager took over monitoring of Resident #20 to ensure the resident was not using any vaping materials until the administrative team arrived. Nurse #2 continued

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F 689	Continued From page 14 with his assignment for his shift. She reported the resident had not produced any vaping materials to Nurse #2 or the Unit Manager. The Administrator stated the resident initially denied having vaping materials, but she eventually admitted she had a vaping pen. According to the Administrator, the team searched the room for any other smoking or vaping materials and the DON took the vaping pen as well as the key to the smoking locker from Resident #20 at that time. The vaping pen was placed in the resident's locker in the smoking area, and the key was locked in the medication cart where the supervised smoking locker keys were kept. The Administrator indicated she informed Resident #20 due to being changed to a supervised smoker she would have to request smoking and vaping materials from the nurse on duty during smoking times. The Administrator indicated either she, the nurse on duty, or a department head provided supervision during supervised smoking times.	F 689		
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:	F 880		4/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 15 §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 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.	F 880		

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F 880	Continued From page 16 §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 observations, record review, and Physician Assistant and staff interviews, the facility failed to follow their hand hygiene and enhanced barrier protection portion of the infection control policy when 2 of 3 staff (Physician Assistant and Nurse #1) did not don personal protective equipment and perform hand hygiene before donning clean gloves during wound care. This deficient practice occurred for 2 of 3 staff members reviewed for infection control practices. The findings included: A review of the facility's Infection Prevention and Control Policy revised 6/1/23 revealed in part: Hand hygiene should be completed after contact with non-intact resident's skin, wound dressings, or contaminated items. A review of the facility's Enhanced Barrier Precautions policy dated 3/28/24 revealed in part: Enhanced Barrier Precautions (EBP) refer to the infection control intervention aimed at reducing transmission of MDRO's (Multidrug-Resistant	F 880	#1 The facility failed to follow hand hygiene and enhanced barrier precaution (EBP) measures per the infection control policy when a Physician Assistant (PA) and Nurse #1 did not don personal protective equipment (PPE) and perform hand hygiene before donning clean gloves during wound care. On 4/2/2025, re-education was provided to the PA and Nurse #1 by the Director of Nursing (DON) on the EBP and handwashing policies to include the following: proper donning of PPE upon entering the room of a resident on EBP as well as proper hand hygiene techniques including handwashing and donning and doffing gloves during wound care. #2 All residents in the facility who require EBP or wound care have the potential to be affected. On 4/22/25 an audit was completed by the DON for all residents that require EBP to ensure appropriate signage and PPE was in place and visible to staff.	

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F 880	Continued From page 17 Organism) through the targeted use of gown and gloves during high contact resident care activities. High-contact resident care activities requiring EBP: Wound care (any skin opening requiring a dressing). On 4/2/25 at 1:53 PM, an observation was made of the Physician Assistant (PA) and Nurse #1 as they provided wound care to Resident #5 who was on enhanced barrier precautions. Nurse #1 stood at the wound care cart in the hallway and gathered supplies to perform wound care. She used hand sanitizer then donned 4 gloves on each hand. Without donning one of the gowns in the EBP supply caddy on the resident's door, Nurse #1 and the PA entered the resident's room. The PA washed his hands and donned gloves at the sink at the resident's bedside. Nurse #1 laid the barrier with the wound care supplies on the resident's bed then she removed the elastic bandage from the resident's left leg. With the same pair of gloves, Nurse #1 removed the elastic bandage from the resident's right leg. Once the elastic bandage was removed, Nurse #1 then removed the white dressing from the resident's right foot then she removed the bandage from the left foot. Nurse #1 then doffed the top glove on both hands and threw them in the trash. She did not perform hand hygiene. With the second layer of gloves Nurse #1 washed the resident's left foot wound with normal saline and then she washed the right foot wound with normal saline without changing gloves or performing hand hygiene in between. The PA assessed each wound then instructed Nurse #1 to complete the dressing change. Nurse #1 then doffed the second layer of gloves and did not perform hand hygiene. She applied the bordered gauze dressing to the resident's right foot wound,	F 880	#3 On 4/22/25, the DON and designee began education with all nurses and certified nursing assistants (CNA□s), including agency staff on the EBP and handwashing policies to include proper donning of PPE upon entering the room of a resident on EBP as well as proper hand hygiene techniques including handwashing and donning and doffing gloves during wound care. All staff not educated on 4/22/25 will be educated prior to their next shift. All newly hired nurses and CNA□s, including agency staff will be educated by the DON or designee during orientation. #4 On 4/22/25 an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held with the interdisciplinary team to review the deficiency and plan of correction. Beginning 4/28/2025, the DON or designee will conduct random observations of staff to ensure appropriate handwashing and PPE measures are being followed. Observations will occur 3 times a week for 6 weeks, then weekly for 6 weeks. These audits will be reported by the Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as necessary to maintain compliance.	

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F 880	Continued From page 18	F 880		

then without changing gloves, she applied the bordered gauze dressing to the left foot wound. Nurse #1 then doffed her gloves and did not perform hand hygiene. She used the last layer of gloves to wrap the resident's right leg with an elastic bandage, then without changing gloves or performing hand hygiene, she wrapped the resident's left leg in an elastic bandage. Nurse #1 then doffed her gloves and washed her hands. She donned another pair of gloves and removed the trash from the resident's room.

On 4/2/25 at 2:23 PM the Physician Assistant was interviewed, and he stated he did not don a gown and gloves before entering the resident's room because he did not think Resident #5 was still placed on enhanced barrier precautions because her foot wounds were not infected.

Nurse #1 was interviewed on 4/2/25 at 2:40 PM and stated she was an agency nurse and had only worked at the facility one other day during the week of the survey. She stated she knew she was supposed to wear a gown and gloves while providing wound care to Resident #5. She stated she thought it was the facility's policy that she could wear multiple layers of gloves to perform resident care, but she realized she made a mistake and had used the same pair of gloves when she cleaned then dressed Resident #5's wounds on both feet.

An interview was conducted with the Unit Manager on 4/2/25 at 2:46 PM, and she stated Nurse #1 did not follow the infection control policy for enhanced barrier precautions or hand hygiene. She indicated Nurse #1 should have donned a gown and gloves before entering Resident #5's room to perform wound care. The

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F 880	Continued From page 19	F 880		

Unit Manager further stated it had never been the policy of the facility to don multiple layers of gloves during wound care, and Nurse #1 should have changed gloves and performed hand hygiene between each step.

The Administrator was interviewed on 4/2/25 at 2:50 PM and stated Nurse #1 was an agency nurse. She stated her preference was for the facility's staff to perform wound care due to the agency staff not being familiar with the residents. She stated she had a dedicated wound care nurse, but she was off that week.

On 4/3/25 the Director of Nursing was interviewed. She stated Nurse #1 and the Physician Assistant should have followed the facility's EBP policy since the signage and caddy were both posted on Resident #5's door. She stated hand hygiene should have been completed with each glove change, and donning 4 pairs of gloves prior to performing wound care was not a safe infection control practice.

A review of Nurse #1's education records revealed she had completed the facility's course on infection control and handwashing on 3/31/25.