| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

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| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

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| E 000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 7/25/21 through 7/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GYZO11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 7/25/21 through 7/28/21. Event ID #GYZO11.<br>1of the 4 complaint allegations was substantiated resulting in a deficiency.<br>1 of 1 FRI was substantiated but did not result in a deficiency.<br><br>The Statement of Deficiencies was amended on 8/16/21 at tags F550, F686, F689, and F947. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 9/30/21 |

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

Electronically Signed | 08/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and resident and staff interview, the facility failed to protect the dignity of a resident by displaying a sign regarding resident care in an area that was visible to visitors for 1 of 1 residents reviewed for dignity (Resident #24).<br><br>The findings included:<br><br>Resident #24 was admitted to the facility on 3/9/2011. Her diagnoses included moderate protein-calorie malnutrition, and history of stage two pressure injury to buttocks and coccyx area.<br><br>Resident #24's most recent quarterly Minimum | F 550 | F550, level E- Resident Rights/Exercise of Rights<br><br>1. The room of resident #24 was immediately checked by the administrator, Social Worker and Director of Nursing (DON) for signage following the survey team□s exit from the building on 7/28/21. The charge nurse who posted the sign had already removed it.<br>2. A room to room audit was performed by the DON for the entire skilled area on August 16-18, 2021 to check for any inappropriate/unapproved signage. None | |

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| F 550 | Continued From page 2<br>Data Set (MDS) date 6/11/2021 indicated the resident was severely cognitively impaired and had no behaviors during the assessment period. The resident required extensive assistance with bed mobility, activities of daily living, toileting, and personal hygiene.<br><br>On 7/26/2021 at 11:00 AM a sign was observed hanging on wall of Resident #24's room. The sign was visible from the threshold of the resident's room and instructed caregivers not to put sport bras on resident, they were too small.<br><br>At 11:07 AM on 7/26/2021 and interview was conducted with Resident #24. She stated she was receiving visitors and would be embarrassed if visitors saw the sign regarding her bras. Resident #24 did not know who hung the sign in her room or how long the sign had been hanging.<br><br>On 7/27/2021 at 11:42 AM an interview was conducted with Nurse #1, she stated she made the sign and hung the sign in resident's room. She stated she thought the resident knew what the sign said. Nurse #1 stated she did not recall if she asked the resident's permission to hang the sign, it had been hanging in Resident #24's room for a long time.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/28/2021 at 3:00pm and she stated she expected the staff to maintain the resident's dignity when hanging signs regarding resident care. | F 550 | was observed.<br>3. Staff education will be provided for all healthcare team members by the DON or designee to include the following: review resident rights, including the use of signage in a resident□s room or other publically visible areas, the resident or their Power of Attorney must agree to any signage posted in the resident□s room, additionally, a charge nurse or member of the clinical team will be the person to ask permission for any recommended signage intended to improve communication among staff before a sign will be post. Corrective action complete by September 30th, 2021.<br>4. An environmental room-to-room audit to search for unapproved signage will be conducted by the DON or designee monthly for the next three months (September-November 2021) and then quarterly monitoring by the DON or designee will begin in January 2022 for six months. Findings of the audits will be reported in QA by the DON or designee. | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans | F 658 | | 9/30/21 |

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| F 658 | Continued From page 3<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to follow doctor's order (Resident #15) and failed to document injection sites (Resident #25) for 2 of 5 sampled residents reviewed for unnecessary medications.<br><br>Findings included:<br><br>1. Resident #15 was admitted to the facility on 11/19/19 with multiple diagnoses including hypertension. The quarterly Minimum Data Set (MDS) assessment dated 5/14/21 indicated that Resident #15 had memory and decision-making problems.<br><br>Resident #15 had a doctor's order dated 11/19/19 for Metoprolol (used to treat hypertension) extended release (ER) 50 milligrams (mgs) 1 tablet by mouth every morning- check blood pressure (BP) before administration and to hold if systolic BP (SBP) is less than 100, notify MD if SBP is greater than 150.<br><br>The May 2021, June 2021, and July 2021 Medication Administration Records (MARs) were reviewed. The MARs revealed that some days, Resident #15's SBPs were greater than 150 and there was no indication that the doctor was notified. Resident #15's SBPs were greater than 150 on the following dates:<br>5/9/21 - BP 165/92 6/2/21 - BP 160/70<br>6/28/21 - BP 160/93 7/16/21 - BP 163/53<br>5/11/21 - BP 178/97 6/3/21 - BP 181/84 | F 658 | F658, level D 483.21-Services Provided Meet Professional Standards<br><br>Blood Pressure Meds:<br><br>1. The orders for residents #15 and #25 were audited for accuracy and clarity by the Clinical Manager and Director of Nursing (DON) on 7/29/21.<br>2. All residents on blood pressure medications were audited and reviewed by the Clinical Manager and DON on 7/29/21 for correct parameters to ensure clarity of orders. No further corrections were warranted from audit findings. DON also requested a report from our pharmacist with MediPack on 8/9/21 for the residents on the medicine in question.<br>3. A weekly audit will be done by the DON or designee for 4 weeks to ensure full follow thru of orders as stated.<br>4. Then, audits of BP medication and insulin orders will continue monthly for one quarter (October-December 2021).<br>5. Results of audits will be presented by the DON or designee and analyzed at Quality Assurance (QA) meetings for one quarter (October-December 2021).<br>6. Licensed nurses will be in-serviced by the DON or designee on doctor□s orders involving parameters and the importance of follow up and notification as per each specific order. Any communication with | |

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|---|---|---|---|---|
| F 658 | Continued From page 4 | F 658 | | |

6/30/21 - BP 160/70 7/17/21 - BP 199/90
5/14/21 - BP 166/95 6/4/21 - BP 174/86
7/1/21 - BP 169/81 7/18/21 - BP 165/91
5/17/21 - BP 162/91 6/5/21 - BP 153/94
7/3/21 - BP 159/65 7/20/21 - BP 164/91
5/20/21 - BP 164/90 6/7/21 - BP 160/70
7/4/21 - BP 163/94 7/22/21 -BP 169/79
5/24/21 - BP 198/92 6/ 15/21 -BP 185/88
7/7/21 - BP 166/78 7/26/21 - BP 168/92
5/25/21 - BP 165/71 6/16/21 - BP 155/75
7/8/21 - BP 165/73 7/27/21 - BP 184/91
5/26/21 - BP 160/72 6/17/21 - BP 160/70
7/10/21 - BP 170/78
5/28/21 - BP 188/85 6/20/21 - BP 156/92
7/11/21 - BP 155/76
5/31/21 - BP 160/80 6/23/21 - BP 152/70
7/13/21 - BP 159/63

Nurse #1 was interviewed on 7/27/21 at 1:40 PM. She verified that she was assigned to Resident #15 on 7/3/21, 7/4/21, 7/17/21, 7/18/21, 7/26/21 & 7/27/21. When asked if she was aware of the doctor's order to notify the doctor if the SBP was greater than 150, she responded that the doctor was aware that Resident #15's BP was always high. Nurse #1 commented that if the doctor was notified it should have been documented in the computer under interdisciplinary (ID) notes. Nurse #1 reviewed the ID notes and was unable to find documentation that the doctor was notified on the days the SBP was greater than 150.

Charge Nurse Manager #2 was interviewed on 7/28/21 at 2:10 PM. She verified that she was assigned to Resident #15. When asked if she was aware that Resident #15 had an order to notify the doctor if the SBP was greater than 150, she responded that Resident #15's BP was always high, and the doctor was aware. She

the physician must be documented in MatrixCare. A short checklist will be provided along with the in-service for the nurses to utilize. A laminated reminder card with the checklist will also be kept on the med carts for this particular situation. Education will also be provided to the nurses on timely clarification of orders, as necessary. Corrective action complete by September 30th, 2021.

Insulin

1. The only resident (#25) on insulin was reviewed by the DON to ensure injection site was identified.
2. Weekly audit will be conducted for 4 weeks to ensure consistency and accuracy for insulin injection sites, with nurse note in the Medication Administration Record indicating correct location of injection given.
3. Then, audits will be done monthly for one quarter (October-December 2021).
4. Results of audits will be presented by the DON or designee and reviewed and analyzed at QA meetings for one quarter.
5. Team members will be educated by DON or designee on proper documentation practices involving insulin injection site documentation. Corrective action will be complete by September 30th, 2021.

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|---|---|---|---|---|
| F 658 | Continued From page 5 | F 658 | | |

added that if the doctor was notified, it should have been documented under the ID notes section. She reviewed the ID notes and was unable to find documentation that the doctor was notified on the days the SBP was greater than 150.

The Director of Nursing (DON) was interviewed on 7/28/21 at 2:50 PM. The DON stated that she expected the nurses to follow doctor's orders. When a resident has a doctor's order to notify the doctor when the SBP was greater than 150, she expected the BP to be checked prior to the administration of the medication and to document the BP on the MARs. She also expected the nurses to document under ID notes when the doctor was notified.

2. Resident #25 was admitted to the facility on 6/8/21 with multiple diagnoses including diabetes mellitus. The admission Minimum Data Set (MDS) assessment dated 6/14/21 indicated that Resident #25's cognition was intact.

Resident #25 had doctor's orders dated 3/3/21 for Novolog (used to treat diabetes mellitus) 100 units per milliliter (ml) sliding scale subcutaneous (SQ) 3 times a day (6 AM, 11:30 AM and 4:30 PM). The sliding scale was for Blood sugar (BS) 150-199 - give 2 units; 200-249 - give 4 units; 250-299 - give 6 units, 300-349 - give 8 units, 350-399 - give 10 units and to call the doctor if more than 400 and for Toujeo (used to treat diabetes mellitus) 300 units per ml - give 16 units SQ twice a day (8 AM & 8 PM).

Resident #25's Medication Administration

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| F 658 | Continued From page 6<br>Records (MARs) for May 2021, June 2021 and July 2021 were reviewed. The Novolog sliding scale and the Toujeo were administered as ordered but there were no injection sites recorded.<br><br>Nurse #1 (assigned to Resident #184) was interviewed on 7/27/21 at 2:20 PM. She reviewed the MARs and verified that there were no injection sites recorded when the Novolog and Toujeo were administered. She stated that she would fix the MARs to ensure that the injection sites were recorded and to ensure the nurses were rotating the injection sites.<br><br>Charge Nurse Manager #2 was interviewed on 7/28/21 at 11:15 AM. She was assigned to Resident #25. When she reviewed the MARs, she stated that she didn't realize that the injection sites were not recorded on the MARs. She commented that it was important to document the injection sites to ensure the nurses were rotating the sites.<br><br>The Director of Nursing (DON) was interviewed on 7/28/21 at 2:50 PM. The DON stated that as nurses, we were trained to document the site when we were administering a medication via injection. She indicated that she expected the nurses to document the injection site to ensure the sites were rotated. | F 658 | | |
| F 686 SS=E | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that- | F 686 | | 9/30/21 |

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| F 686 | Continued From page 7<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, staff interviews and wound care provider interview, the facility failed to complete and document wound care as ordered (Residents #6, #7 and #24), failed to ensure a pressure relieving device was in place (Resident #7) and also failed to accurately transcribe physician orders for pressure ulcer care (Resident #7). This was for 3 of 4 residents reviewed for pressure ulcers.<br><br>The findings included:<br><br>1) Resident #24 was admitted to the facility on 3/9/2011. Her diagnoses included multiple sclerosis, moderate protein-calorie malnutrition, and history of stage two pressure injury to buttocks and coccyx area.<br><br>Resident #24's most recent quarterly Minimum Data Set (MDS) date 6/11/2021 indicated the resident was severely cognitively impaired and had no behaviors during the assessment period. The resident required extensive assistance with bed mobility, activities of daily living, toileting, and personal hygiene. The resident was coded as high risk for pressure ulcers with one stage two pressure injury present at the time of the | F 686 | F686, level E 483.25-Treatment/Services to Prevent/Heal Pressure Ulcer<br><br>1. Resident #7 who was using an ordered pressure relieving device was assessed by therapy/Occupational Therapy (OT) for appropriateness of current devices and possible recommendations. The assessment was completed for the hand roll and correctly ordered on 7/25/21 and the foot elevator was assessed on 8/25/21 by OT. It was discovered that the pressure relieving cushion was easily removable by the resident, therefore having no effectiveness. The left foot float was not effective due to resident movement, so device was discontinued from use.<br>2. The transcription error for treatment of Resident #7 was corrected on 7/29/21 to communicate order prescribed by the Wound Care Provider. Due to the agency nurse admitting to not completing the treatments for #6 and #24 as ordered by the physician, the agency was told that that nurse was not to return to work any | |

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| F 686 | Continued From page 8<br>assessment.<br><br>The resident's most recent comprehensive care plan dated 4/7/2021 had a focus for skin rashes and skin breakdown related to decreased bed mobility and incontinence.<br><br>Resident #24's active physician's orders for July 2021 revealed an order for calmoseptine application to buttocks and coccyx area twice daily and as needed for skin protection.<br><br>Resident #24's July 2021 Treatment Administration Record (TAR) indicated the calmoseptine treatment was not initialed as completed on the morning of 7/23/2021or the morning of 7/24/2021.<br><br>Progress notes for July 2021 did not reveal the resident had a history of refusing care.<br><br>On 7/28/2021 at 11:00am a phone interview was conducted with Nurse #3. She stated she worked the 6:00am to 6:00pm shifts on 7/23/2021 and 7/24/2021. She further stated she was an agency nurse and was not aware if the facility had a treatment nurse but she recalled she was told to complete the wound care treatments if she had time. Nurse #3 could not recall the name of the individual who gave her those instructions. Nurse #3 stated she did not complete the wound treatments on Resident #24 on 7/23/2021 or 7/24/2021 due to time constraints.<br><br>An interview was conducted with the Director of Nursing (DON) on 7/28/2021at 3:00pm and she stated she expected wound care to be provided as ordered by the physician. | F 686 | available shifts.<br>3. Audits of all other residents with wound care treatments or preventatives in place were audited on 8/4/21 by the Clinical Manager and Director of Nursing (DON) for need of corrective action with none found.<br>4. Audits for execution of treatment orders will be routinely conducted; weekly x 4 weeks, then twice monthly for the next quarter (October- December 2021).<br>5. Results of audits will be reviewed and analyzed at QA meetings for one quarter (October-December 2021).<br>6. Charge Nurses will be educated by DON or designee regarding the importance of following and completing treatments as ordered. Corrective action complete by September 30th, 2021.<br>7. Monitoring of MD/Rehab orders for current and future pressure relieving devices as well as wound care treatment orders, in general, will be completed by wound care Physician Assistant or his designee for accuracy and clarity. This information will be reviewed with the attending wound nurse, Clinical Manager or designee. This will occur monthly beginning January 2022 for three months. | |

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|---|---|---|---|---|
| F 686 | Continued From page 9 | F 686 | | |

2. Resident #6 was admitted to the facility on 1/20/2021. Her diagnoses included autism with severe intellectual disabilities.

The resident's most recent quarterly Minimum Data Set (MDS) dated 7/14/2021 indicated the resident had severe cognitive impairment, she was not coded as having any moods or refusing care during the assessment period.

Resident #6's most recent comprehensive care plan dated 4/14/2021 had a focus for pressure injury related to intellectual disability and limited mobility.

The resident's active physician orders for July 2021 revealed an order to clean the left lateral malleolus and the left medial malleolus with normal saline, apply silver alginate, and cover with a foam dressing every other day.

Resident #6's July 2021 Treatment Administration Record (TAR) indicated treatment to the left lateral and medial malleolus was not initialed as completed on 7/24/2021.

Progress notes for July 2021 did not reveal the resident had a history of refusing care.

On 7/28/2021 at 11:00am a phone interview was conducted with Nurse #3. She stated she worked the 6:00am to 6:00pm shifts on 7/24/2021. She further stated she was an agency nurse and was not aware if the facility had a treatment nurse but she recalled she was told to complete the wound care treatments if she had time. Nurse #3 could not recall the name of the individual who gave her those instructions. Nurse #3 stated she did not complete the wound treatments on Resident #6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

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| F 686 | Continued From page 10 | F 686 | | |

on 7/24/2021 due to time constraints.

An interview was conducted with the Director of Nursing (DON) on 7/28/2021at 3:00pm and she stated she expected wound care to be provided as ordered by the physician.

3a) Resident #7 was originally admitted to the facility on 1/18/19. Resident #7's list of diagnoses included a stage 4 pressure ulcer, dementia, and moderate protein calorie malnutrition.

The annual Minimum Data Set (MDS) assessment dated 7/14/21 indicated Resident #7 had severe cognitive impairment and displayed no behaviors or refusal of care during the 7 day look back period. She required total assistance from staff for all Activities of Daily Living (ADL's). Resident #7 had limited range of motion to all 4 extremities and was coded with two stage 4 pressure ulcers.

Resident #7's active care plan, last reviewed 7/20/21, included a problem area for stage 4 pressure injuries to the left outer foot and left heel. The interventions included to change dressings per physician orders.

A review of the wound care physician's report dated 7/20/21 revealed the pressure area to the left heel measured 1.9 centimeters (cm) in length, 1.3 cm in width and 0.3 cm in depth and indicated the wound had scabbed over. The pressure area to the left outer foot measured 6.2 cm in length, 5.8 cm in width and 0.4 cm in depth and indicated the area had moderate drainage with a mild odor.

The July 2021 physician orders read once daily,

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|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 686 | Continued From page 11 | F 686 | | |

cleanse open areas to left outer foot with normal saline, pat dry with gauze and then apply Chlorhexidine gluconate solution (an antiseptic skin cleanser) on gauze then on open areas, cover with dry gauze, wrap with Kerlix and secure with tape.

The July 2021 Treatment Administration Record (TAR) indicated wound care to Resident #7's left outer foot was not initialed as completed on 7/23/21 and 7/24/21.

The nursing progress notes from 1/1/21 to 7/27/21 were reviewed and indicated Resident #7 had no episodes of refusal of wound care.

An interview occurred with the Wound Care Provider on 7/27/21 at 1:00 PM, who stated he was unaware the wound care to Resident #7's left outer foot, had not been completed as ordered on 7/23/21 and 7/24/21.

On 7/28/21 at 11:00 AM, a phone interview was completed with Nurse #3. She was scheduled for the 6:00 AM to 6:00 PM shift on 7/23/21 and 7/24/21. The July 2021 TAR was reviewed, and she stated she was an agency nurse and thought there was a treatment nurse at the facility. She then stated she was told to complete wound care if she had time but was unable to state who told her this. Nurse #3 further stated she could not recall completing the wound care for Resident #7 on the dates reviewed with her.

An interview was conducted with the Director of Nursing on 7/28/21 at 3:00 PM and stated she expected wound care to be followed as ordered for residents by all licensed nursing staff.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 686 | Continued From page 12 | F 686 | | |

3b) Resident #7 was originally admitted to the facility on 1/18/19. Resident #7's list of diagnoses included a stage 4 pressure ulcer, dementia, and moderate protein calorie malnutrition.

A physician order written 4/24/20 directed staff to use a foot elevator to Resident #7's left ankle at all times to prevent the foot from touching the bed.

The annual Minimum Data Set (MDS) assessment dated 7/14/21 indicated Resident #7 had severe cognitive impairment and displayed no behaviors or refusal of care during the 7 day look back period. She required total assistance from staff for all Activities of Daily Living (ADL's). Resident #7 had limited range of motion to all 4 extremities and was coded with two stage 4 pressure ulcers.

Resident #7's active care plan, last reviewed 7/20/21, included the following problem areas:
- Stage 4 pressure injuries to left outer foot and left heel. The interventions included to change dressings per physician orders.
- Risk for pressure ulcer related to immobility, malnutrition, episodes of incontinence and need for total assistance with self-care. The interventions included a foot elevator while in bed per physician order.

A review of the wound care physician's report dated 7/20/21 revealed the pressure areas to the left heel and left outer foot were in-house acquired and had no signs of acute decline. Preventive measures in place included to float the heel.

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|---|---|---|---|---|
| F 686 | Continued From page 13 | F 686 | | |

Observations of Resident #7 revealed her lying in bed on 7/25/21 at 2:49 PM, 7/26/21 at 11:00 AM, and 7/27/21 at 12:48 PM. There was no foot elevator in place to protect the left foot from touching the bed. On 7/27/21 at 11:01 AM, the left heel float was observed around Resident #7's left thigh and the left foot was observed touching the bed.

An interview occurred with Nurse #1 on 7/27/21 at 9:10 AM, who confirmed Resident #7 was to wear a left heel float at all times and staff were to ensure it was in the correct position when personal care was rendered throughout the day. She was unable to state why the left heel float had not been in place or in correct placement.

An interview occurred with the Wound Care Provider on 7/27/21 at 1:00 PM. He stated the left heel elevator had been beneficial to the slow healing of Resident #7's pressure areas to her left foot.
On 7/28/21 at 1:25 PM, an interview was conducted with Nurse Aide #5 (NA), who was familiar with the resident and had been assigned to Resident #7 on 7/26/21, 7/27/21 and 7/28/21. She acknowledged Resident #7 had a left foot elevator that was to be worn at all times and she made sure it was in the correct location when personal care was provided. NA #5 further stated she was unable to explain why the left foot elevator had not been present or in the correct location for the above dates.

An interview was held with the Director of Nursing (DON) on 7/28/21 at 3:00 PM. The DON revealed she expected physician orders to be followed and Resident #7's left foot elevator to be

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 686 | Continued From page 14 | F 686 | | |

in place.

3c) Resident #7 was originally admitted to the facility on 1/18/19. Resident #7's list of diagnoses included a stage 4 pressure ulcer, dementia, and moderate protein calorie malnutrition.

The annual Minimum Data Set (MDS) assessment dated 7/14/21 indicated Resident #7 had severe cognitive impairment. She required total assistance from staff for all Activities of Daily Living (ADL's). Resident #7 had limited range of motion to all 4 extremities and was coded with two stage 4 pressure ulcers.

Resident #7's active care plan, last reviewed 7/20/21, included a problem area for stage 4 pressure injuries to the left outer foot and left heel. The interventions included to change dressings per physician orders.

A review of the wound care physician's report dated 7/20/21 revealed the primary dressing to the pressure area on the left heel was a foam dressing and the primary dressing to the pressure area on the left outer foot was Polymem AG (a foam dressing that aides in reducing drainage and provides antimicrobial protection). The note section stated to continue current dressings to both wounds but recommended cleansing the left outer foot wounds with Chlorhexidine Gluconate 4% solution (an antiseptic skin cleanser) at each dressing change.

A review of the physician orders revealed the following orders:
- An order dated 5/19/21 to cleanse the areas of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PENICK VILLAGE | 401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 |

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|---|---|---|---|---|
| F 686 | Continued From page 15 | F 686 | | |

the left outer foot with wound cleanser, pat dry with gauze. Apply Polymem AG to the wound beds, cover with gauze and a thicker dressing, then wrap with gauze and secure with tape. Change every other day and as needed. This order was discontinued on 7/22/21.
- An order dated 7/8/21 to cleanse the left heel with normal saline and pat dry. Apply a foam dressing and change every other day and as needed. This order was discontinued on 7/22/21.
- An order dated 7/20/21 to cleanse the open areas to left outer foot with normal saline, pat dry with gauze and then apply Chlorhexidine gluconate solution on gauze and apply to open areas, cover with dry gauze, wrap with gauze and secure with tape every day.

An interview occurred with the Wound Care Provider on 7/27/21 at 1:00 PM. He stated he was unaware Resident #7's wound care to the left heel had been discontinued after his visit on 7/20/21 and explained he intended the Chlorhexidine gluconate solution to be used as a wound cleanser to the left outer foot pressure areas and the dressing of Polymem AG to be continued.

On 7/28/21 at 10:45 AM an interview was completed with the Charge Nurse Manager #1 who stated she normally completed weekly wound rounds with the wound care provider. She reviewed the wound care physician's report dated 7/20/21 and the current physician orders for Resident #7. The Charge Nurse Manager #1 stated the order was transcribed incorrectly on 7/20/21 and the foam dressing to the left heel wound should not have been discontinued. She was able to recall the Wound Care Provider had wanted the dressing orders to stay the same but

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 686 | Continued From page 16<br>wanted the solution to be used as a wound cleanser.<br><br>During an interview with the Director of Nursing on 7/28/21 at 3:00 PM, she stated it was her expectation for the orders to be transcribed correctly for wound care. | F 686 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to determine the root causes of each fall and put effective interventions in place following each fall to prevent repeated falls for 1 of 5 sampled residents reviewed for falls (Resident #30).<br><br>Findings included:<br><br>Resident #30 was admitted to the skilled unit of the facility from the assisted living facility (ALF) on 6/15/21. The admission Minimum Data Set (MDS) assessment dated 6/21/21 indicated that Resident #30 had severe cognitive impairment and she needed supervision with transfers.<br><br>Review of Resident #30's incident tracking records revealed that she had several falls at the | F 689 | F689, level E 483.25- Free of Accident/Hazards/Supervision/Devices<br><br>1. A new fall program organized by the clinical team with the Director of Nursing (DON) and Minimum Data Set Coordinator (MDS) leading the effort, to ensure that a new intervention is documented for each fall and subsequent fall, and was initiated before August 1st.<br>2. Current fall incident policy reviewed and revised on 7/30/21 and Resident #30 care plan was updated to reflect intervention per fall was captured.<br>3. All documented falls will be reviewed by fall team (DON, MDS, Clinical Manager, Administrator, Therapy team member or designees) daily, Monday thru | 9/30/21 |

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|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

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|---|---|---|---|---|
| F 689 | Continued From page 17<br>ALF (5/8/21, 6/10/21 & 6/12/21). Her last fall at the ALF was on 6/12/21, she was sent to the hospital.<br><br>Resident #30's care plan dated 6/20/21 was reviewed. One of the care plan problems was "I am at risk for injury from falls related to weakness, balance issues, need for assistance with mobility and self care and episodes of incontinence." The approaches included "staff will ensure that adaptive devices - walker/cane/wheelchair are within reach and in good repair."<br><br>On 6/30/21, Resident #30 had a fall risk assessment, and she was assessed as high risk for falls.<br><br>Resident #30 had 3 falls since admission to the skilled unit (6/30/21, 7/23/21 and 7/27/21). Review of the incident reports revealed no root cause analysis and no interventions put in place to prevent further falls.<br><br>The incident report dated 6/30/21 at 9:00 AM revealed that Resident #30 was found on the floor in room 133. When assessed, she has bruises to her left forearm, palm ad wrist. X-ray of the left hand and wrist was ordered. The report did not have the root cause of the fall and did not have an intervention to prevent further falls.<br><br>The incident report dated 7/23/21 at 7:40 AM revealed that Resident #30 was found on the floor. When assessed, she was found to have a laceration to her lower back 2 centimeter (cm) x (by) 5 cm. Resident admitted hitting her head on dresser. Neuro check was initiated. The report did not have the root cause of the fall and did not | F 689 | Friday. All incidents that occur over the week-end or on a holiday will be discussed on Monday or the next business day on an ongoing basis.<br>4. Entire incident will be reviewed, discussed and analyzed by the clinical team for root cause and trends. In the event clarification of the incident is needed, the DON or designee will obtain the additional information from the charge nurse who reported the incident in MatrixCare.<br>5. A new intervention is added for each fall occurrence and timely care plan updates are done during the daily meeting based on the reported incidents in MatrixCare during the last 24 -48 hours. This effort will be lead by the DON and MDS Coordinator.<br>6. A new charting option under ID Notes called Fall Intervention was added to existing MatrixCare Electronic Medical Record (EMR) for ease of use and to enhance communication among team members. Each documented incident report will be audited for an accompanying Fall Intervention note in the ID notes section of the EMR weekly for one quarter. Additionally, by reviewing data in the Incident Tracker, the MDS Coordinator will ensure those residents with falls during the last month (August) will have complete interventions for each fall or subsequent fall included in the care plan. The audit for the month of August will be completed by the MDS Nurse by 9/10/21. This practice will be continued for any new falls in the daily clinical meeting indefinitely. | |

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|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

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|---|---|---|---|---|
| F 689 | Continued From page 18<br>have an intervention to prevent further falls.<br><br>The incident report dated 7/27/21 revealed that Resident #30 was found on the floor in the bathroom. There were no injuries noted. The report did not have the root cause of the fall and did not have an intervention to prevent further falls.<br><br>Resident #30 was observed on 7/26/21 at 2:45 PM and on 7/27/21 at 8:50 AM. She was in her room sitting in the chair. Her walker was near the bed and was not within reach.<br><br>Charge Nurse Manager #1 was interviewed on 7/28/21 at 2:30 PM. She commented that Resident #30 was admitted from the ALF due to being a high risk for falls. The resident had several falls at the ALF. She reported that incident reports were reviewed daily on the stand-up meeting. The meeting consisted of the department heads. When a resident had a fall, the nurse assigned to the resident would complete an incident report and add interventions to prevent further falls under the comment section of the incident report. She stated that the Director of Nursing (DON) would investigate for the root cause of the fall and add the intervention. She stated that since the previous DON had left in June 2021, nobody was responsible for the investigation and in making sure interventions were put in place to prevent repeated falls.<br><br>The Director of Nursing (DON) was interviewed on 7/28/21 at 2:50 PM. The DON stated that she already had plans in place for fall management. She expected that each fall would have a root cause analysis and interventions in place to prevent further falls. | F 689 | 7. Incidents and falls will continue to be reported at Quality Assurance (QA) by Clinical Manager or designee and discussed at QA meetings each month to include count, severity and interventions initiated and care planned.<br>7. Charge Nurses will be educated by the DON or designee regarding the fall program, updated policy, communication and information sharing among staff.<br>Corrective action complete by September 30th, 2021 | |

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|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced | F 732 | | 9/30/21 |

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|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 732 | Continued From page 20<br>by:<br>Based on record review, observation and staff interview, the facility failed to post nurse staffing information on a daily-basis for 30 of 30 days reviewed.<br><br>Findings included:<br><br>Tour of the facility on 7/25/21 at 2:45 PM and on 7/26/21 at 4:10 PM revealed no posting of the nurse staffing information.<br><br>Nurse #1 was interviewed on 7/26/21 at 4:11 PM. She reported that the previous Director of Nursing (DON) was responsible for completing and posting the nurse staffing information Monday through Friday and the scheduler (Nurse Aide (NA) #1) was responsible for posting it on the weekends. She stated that the staffing information was posted at the nurse's station 1 and when the location was observed, Nurse #1 was unable to locate the nurse staffing information. She further indicated that since the previous DON had left the facility sometime in June 2021, nobody was responsible for completing and posting the staffing information.<br><br>Nurse #2 was interviewed on 7/26/21 at 4:12 PM. She stated that she was assigned on nurse's station 1. She indicated that the nurse staffing information was posted at station 1 by the DON. She reported that the previous DON was responsible for completing and posting the information and when she left, nobody had been posting it. Nurse #2 further stated that today (7/26/21) she was instructed that station 1 nurses were responsible for posting the staffing information every day. | F 732 | F732, level C 483.35- Posted Nurse Staffing Information<br><br>1. It was determined that the daily staffing sheet procedure had been changed by the previous Director of Nursing and Staffing Coordinator unbeknownst to other staff members. When discovered, the previous staffing sheet was edited to reflect staffing changes (new RNs) and saved to Station 1 desktop for continued access. This was completed on 7/27/21.<br>2. Additionally, the administrator produced 20 copies of the staffing sheets and placed on a clipboard kept on Station 1 desk. The last sheet states in red Sharpie to make more copies from the original saved on the desktop at Station 1. This was new practice was initiated on 8/25/21. Administrator reviewed the practice with the charge nurses.<br>3. A new staffing coordinator was hired in August 2021 and trained by the administrator to ensure this report is consistently completed on a daily basis and is collected by the staffing coordinator or designee and kept in chronological order in a binder in the Central Supply Office. This information will be available for public consumption upon request.<br>4. Between previous staffing coordinator and new hire, administrator maintained completed daily staffing sheets in her office until new hire was onboarded.<br>5. The nurse staffing information is posted at Station One and updated each day by a licensed nurse professional. | |

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| F 732 | Continued From page 21<br>NA #1 was interviewed on 7/27/21 at 2:09 PM. NA #1 stated that she used to help the previous DON with the schedule and the posting but when the DON left, she stopped doing it. NA #1 reported that it was around June 18, 2021 when she transitioned from being a scheduler to a NA working on the floor.<br><br>The DON was interviewed on 7/28/21 at 2:50 PM. The DON stated that she started as DON at the facility last week. She indicated that she expected the nurse staffing information posted on a daily -basis. She added that from now on, station 1 nurses were responsible for completing and posting the nurse staffing information every day. | F 732 | 6. The staffing information will be checked daily by the scheduling coordinator and the Director of Nursing (DON) for accuracy and completeness then filed as mentioned in Step 3.<br>7. Administrator will perform weekly audits to ensure no staffing sheets are missing from chronological binder kept in Central Supply Office.<br>8. Administrator will report finding to Quality Assurance meetings for next quarter (October □ December).<br>9. Charge Nurses will be educated by the DON or designee regarding completion of the staffing information each day. Corrective action complete by September 30th, 2021<br>10. Information will be kept and stored for a minimum of eighteen months as per regulations. | |
| F 757 SS=D | Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or | F 757 | | 9/30/21 |

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| F 757 | Continued From page 22<br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to check the resident's blood pressure before administering the Metoprolol (used to treat hypertension) for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #184).<br><br>Findings included:<br><br>Resident #184 was originally admitted on 1/15/21 with multiple diagnoses including hypertension. The quarterly Minimum Data Set (MDS) assessment dated 7/7/21 indicated that Resident #184's cognition was intact.<br><br>Resident #184 had a doctor's order dated 5/28/21 for Metoprolol extended release (ER) 25 milligrams (mgs) 1 tablet by mouth once a day for hypertension, hold if systolic blood pressure (SBP) is below 100, and diastolic blood pressure (DBP) is below 60.<br><br>Review of the May 2021, June 2021, and July 2021 Medication Administration Records (MARs) revealed that Metoprolol was administered daily but there was no documentation of resident's blood pressure.<br><br>Nurse #1 (assigned to Resident #184) was interviewed on 7/27/21 at 2:20 PM. She stated | F 757 | F757, level D 483.45- Drug Regime is Free From Unnecessary Drugs<br><br>1. Resident #184 order for Metoprolol was reviewed by charge nurse and Director of Nursing. Order was clarified and corrected with parameters in the Medication Administration Record (MAR) to reflect the doctor□s intent to have the blood pressure taken to determine whether medication was to be held or administered. With the confirmed parameters, the MD no longer needs to be contacted as the order had been transcribed from the hospital order. This was completed by 7/30/21.<br>2. All other residents on blood pressure medications had their orders reviewed, as well. Each order was checked for parameters and to determine proper entry into the electronic medical record. A space on the record must be utilized to enter in the BP reading. This audit was completed by 7/30/21.<br>3. Weekly audits of BP medication orders will be done by the Director of Nursing (DON) or designee for 4 weeks to ensure full follow thru of orders as stated to be completed August 27, 2021.<br>4. Then, audits will be done monthly for | |

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| F 757 | Continued From page 23<br>that she didn't remember if Resident #184 had parameters for his Metoprolol. Nurse #1 reviewed the resident's doctor's orders and verified that Metoprolol should be held if the SBP was below 100 and the DBP was below 60. When she reviewed the MARs, she indicated that whoever transcribed the Metoprolol to the MARs did not indicate to check the blood pressure. Nurse #1 indicated that if a medication has a parameter to hold, the blood pressure should have been checked prior to the administration of the medication and the blood pressure should have been documented on the MARs.<br><br>The Director of Nursing (DON) was interviewed on 7/28/21 at 2:50 PM. The DON stated that she expected the nursing staff to follow doctor's orders. If the order has a parameter to hold the blood pressure medication, she expected the nurse to check the blood pressure prior to administering the medication and to document the blood pressure on the MARs. | F 757 | one quarter (October-December 2021).<br>5. Results of audits will be reported by the Director of Nursing or designee and analyzed at Quality Assurance meetings for one quarter (October-December 2021).<br>6. All licensed nurses will be educated by DON or designee on doctor□s orders involving parameters and the importance of follow up and notification as per each specific order. Nurses will also be reeducated on requirement of reconciling all orders put into MAR and TAR. Education will also be provided on timely clarification of orders as necessary. Corrective action complete by September 30th, 2021. | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | | 9/30/21 |

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| F 880 | Continued From page 24<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(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 25<br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to implement the Centers for Medicare and Medicaid Services (CMS) guidelines by not screening vaccinated staff or visitors prior to entering the facility.<br><br>The findings included:<br><br>On 7/28/21 at 2:34 PM the Administrator stated the corporate office made the decision to stop screening vaccinated employees in a memo titled; updated mask guideline: COVID-19, dated 5/19/2021. The memo read, in part: the Governor and federal government had loosened guidelines. These guidelines allowed discretion for organizations to be more specific regarding the use of masks and the screening of employees. Employees who had been fully vaccinated did not need to screen in at the kiosks unless you they were feeling any possible COVID symptoms.<br><br>On Sunday 7/25/2021 at 2:00 PM a survey team with four members entered the facility. Upon entry Nurse #4 instructed surveyors to write their name, department, time of entry, and temperature on a | F 880 | F880, level F 483.80- Infection Prevention & Control<br><br>1. The healthcare building had erroneously stopped screening vaccinated staff members based on an announcement that came from the Human Resources Director and previous, Interim Chief Executive Officer. The announcement was only intended for those working in the Independent Living side of the campus. No future changes to current systems will be instituted unless governmental documentation requires a change (either to further enhance or relax current protocols). The change will then be initiated by the administrator, or designee.<br>2. Upon realizing the error, Healthcare staff were immediately notified through our Jostle Intranet App, by word of mouth and in the next daily Stand-Up meeting. This was completed by 7/30/21. A reminder Jostle post about screening requirements went out again on 9/2/21. | |

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| F 880 | Continued From page 26<br>daily COVID-19 screening log. Surveyors asked Nurse #4 if that was all they needed to do and Nurse #4 stated he was a part time employee with the facility and as far as he knew, that was the screening process. Nurse #4 did not ask any screening questions and did not refer surveyors to any questions prior to allowing entry to the facility.<br><br>On Monday 7/26/2021 this surveyor arrived at the facility at 8:30am. There was no staff at the entry to screen employees and visitors. Surveyor asked Nurse Manager #1 what the screening process was and was told to print name, department, time of entry, and temperature on the log. A hand -held temperature scanner was provided. She did not ask any screening questions and did not refer surveyor to any screening questions.<br><br>On 7/28/2021 at 11:37 AM an interview was conducted with the facility Administrator. When asked what the process was for screening employees and visitors, she stated the employees use the kiosk next to the nurse's station. Some of the vendors such as phlebotomy lab techs also used the kiosk. Visitors were being asked to sign the COVID-19 daily screening log which had the word staff in red letters on the upper right side of the page and consisted of four columns titled name, department, time, and temperature. Above the columns were three screening questions. Those questions were:<br><br>Have you experienced a fever, shortness of breath, cough or other symptoms of COVID-19?<br>Have you or any member of your household been diagnosed with COVID-19?<br>Have you been near anyone with COVID-19 for longer than 15 minutes and without a mask? | F 880 | 3. Our previous screening method was implemented in the following manner: All staff who enter the North Building are screened as they enter the building for each shift using a computerized device (AccuShield) that obtains temperature and asks screening/COVID questions that must be answered. This device can also be programmed to add regular visitors or vendors. If a question is answered with a Yes and/or a temperature is recorded as too high (100.4), the machine tells the person they must leave the building and contact a staff member for next steps.<br>4. Signage is posted outside of entry doors regarding hand hygiene, limiting contact, movement and reporting any COVID symptoms. They are also advised that they must be able to answer No to the COVID screening questions to enter the building.<br>5. The entry door at Station 1 will return to being locked 24/7 to ensure all who enter are screened correctly. A door bell is utilized to alert staff that a visitor or clinician is at the door. Staff have an access card to enter without use of the doorbell. They know to utilize the AccuShield before proceeding to their assigned work area. The door will be locked following a memo being distributed to healthcare families and signage at the entry door. The door will be locked beginning September 8, 2021.<br>6. Visitors or vendors who do not visit regularly, must answer COVID screening questions listed at the top of the sign in sheet that is located next to the AccuShield machine, and record their | |

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| F 880 | Continued From page 27<br><br>There was no area to answer the three questions and no instructions on what to do if the answer to any of the questions was positive.<br><br>There was not a staff member manning the screening station the duration of the survey from 7/25/2021 through 7/28/202.<br><br>On 7/28/21 at 2:34 PM the Administrator stated the infection control nurse was out of the facility for medical reasons and could not be reached. When the Administrator was asked about the Centers for Medicare and Medicaid guidelines regarding screening of visitors and employees, she provided surveyors with QSO-20-39-NH dated September 17, 2020 which stated: screening of all who enter the facility for signs and symptoms of COVID-19 (temperature checks, questions or observations about signs or symptoms) and denial of entry of those with signs or symptoms remained part of the core principles of COVID-19 infection prevention. The Administrator stated they were following the guidance given to them by corporate office on 5/19/2021. | F 880 | temperature. They are advised by a staff member that in order to proceed, they must be able to answer the three COVID screening questions with a NO.<br>7. Family members must make appointments for visits and are screened in person regarding symptoms, contact with others/possible exposure, and are required to wear a mask at all times. Screening questions must be answered accordingly and temperature is taken upon entry into the facility. Masks are worn by all healthcare personnel at all times regardless of vaccination status.<br>8. Healthcare staff will be educated by Director of Nursing or designee regarding visitation precautions, screening and continued vigilance against COVID-19 and the Delta Variant. Current information from APIC (Association for Professionals in Infection Control and Epidemiology) provided re: Myths vs Facts COVID -19: Get the facts straight and vaccinate. A Detailed Plan of Correction (DPoC) for the F-Tag was also imposed and will be completed by September 30th, 2021. Attachments are included in the Plan of correction to demonstrate Root Cause Analysis, training to be utilized ("Keep COVID Out" six minute video will be viewed by Healthcare staff) and visuals of changes that were implemented at three distinct entrance locations of the Healthcare Building.<br>9. Any new COVID-19 or public health updates or guidance will be shared by the Medical Director, Staff Development Nurse or designee as it comes available and also discussed at the monthly Quality | |

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| F 880 | Continued From page 28 | F 880 | Assurance meetings on an on-going basis. The facility also continues to test according to county positivity rate metrics. | |
| F 947 SS=E | Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)<br><br>§483.95(g) Required in-service training for nurse aides.<br>In-service training must-<br><br>§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>§483.95(g)(2) Include dementia management training and resident abuse prevention training.<br><br>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.<br><br>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide dementia management training (Nurse Aides (NAs) #1, #2, #3 & #4) and resident abuse prevention training (NAs # 2 & # 4) for 4 of 5 NAs reviewed.<br><br>Findings included:<br><br>1. NA #1 was hired on 10/9/18. On 7/27/21, NA #1's training records for dementia management | F 947 | F947, level E 483.95- Required In-Service Training for Nurse Aides<br><br>1. The initial group of Elder Assistants (EAs) were informed by Staff Development Nurse (SDC) and/or Administrator that they may have been delinquent on the required annual training. Each of the chosen Elder Assistants completed any required courses on which | 9/30/21 |

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| F 947 | Continued From page 29<br>and resident abuse prevention were requested. The facility provided records that NA#1 had received abuse prevention training on 12/6/20. NA #1 did not have records that she was provided dementia management training prior to 7/27/21.<br><br>2. NA #2 was hired on 8/25/14. On 7/27/21, NA #2's training records for dementia management and resident abuse prevention were requested. The facility did not provide records that NA #2 was provided dementia management and abuse prevention training prior to 7/27/21.<br><br>3. NA #3 was hired on 8/4/05. On 7/27/21, NA #3's training records for dementia management and resident abuse prevention were requested. The facility provided records that NA#3 had received abuse prevention training on 2/8/21. NA #3 did not have records that she was provided dementia management training prior to 7/27/21.<br><br>4. NA #4 was hired on 6/29/17. On 7/27/21, NA #4's training records for dementia management and resident abuse prevention were requested. The facility did not provide records that NA #4 was provided dementia management and abuse prevention training prior to 7/27/21.<br><br>Attempted to interview the Staff Development Coordinator (SDC) but was unsuccessful.<br><br>The Director of Nursing (DON) was interviewed on 7/28/21 at 2:50 PM. The DON stated that the SDC was at the hospital and was not available for interview. She expected NAs to be provided with the required training to include dementia management and abuse prevention training at least yearly. | F 947 | they were delinquent by 7/28/21.<br>2. All healthcare personnel (certified or licensed) will be educated on pertinent topics such as abuse, resident rights and dementia on a routine basis (at least annually).<br>3. EA□s must have no less than 12 hours of education per year. Required educational topics are accomplished in the form of on-line computer training which provides a certificate of completion and/or notice to the program administrators in the form of a completion report. Education is also done in other formats such as in-person small group training, one-on-one training, on the spot education, videos, webinars, quizzes, hand-outs and scenarios.<br>4. The SDC will track team member completion of required items to ensure all required training is kept up to date each year for compliance on a monthly basis. Each staff member will have their own personnel file with course completion tracking completed monthly by SDC. Each personnel file will be audited at the end of each month, at which point the SDC or designee will contact any staff member who is behind in required coursework.<br>5. If found delinquent, the SDC will require that the course(s) be completed within one work week or he or she will be removed from the schedule until completion. This process will be fully implemented by SDC or designee by September 30, 2021.<br>5. SDC audit findings will be reported at the monthly Quality Assurance meetings from October □- December 2021). | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345111 | A. BUILDING _____ B. WING _____ | C 07/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PENICK VILLAGE** | **401 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387** |

| (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 |
|---|---|---|---|---|
| | | | | |