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	345293	A. BUILDING _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND PINES HEALTHCARE AND REHABILITATION CENTE	HIGHWAY 177 S BOX 1489 HAMLET, NC 28345

(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
F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 11/16/21 to 11/18/21. Event ID NBCW11. 1 of the 4 allegations was substantiated resulting in a deficiency.	F 000		
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 - §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 record review and staff interviews the facility failed to supervise residents on the Alzheimer's Unit that resulted in an altercation between 2 of 4 residents reviewed for behaviors (Resident #1 and Resident #7. The findings included: Resident #1 was admitted to the facility on 3/2/18 and had a diagnosis of Alzheimer's Disease with behaviors and anxiety. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 7/29/21 noted the resident had severe cognitive impairment, had no behaviors during the lookback period, and required extensive assistance with most activities of daily living. The resident was not steady during transitions but was able to stabilize without staff	F 689	Richmond Pines Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Corrections submitted as a written allegation of compliance. Pine Ridge Nursing and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Richmond Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	1/3/22

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

Electronically Signed | 12/03/2021

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F 689	Continued From page 1 assistance and had no impairment in range of motion of the upper or lower extremities. The MDS noted the resident received antipsychotic and antianxiety medications for 7 days during the lookback period. The care plan for Resident #1, updated 8/16/21 revealed the resident had a problematic manner in which the resident acted characterized by verbal and physical aggression and agitation, combativeness related to cognitive impairment - threatens/curses staff members and scratched another resident, curses and name calling with other residents. The interventions included the following: Allow the resident to pace where she can be observed. Be cognizant of not invading the resident's personal space, monitor and document behaviors, remove the resident from public area when behavior is disruptive/unacceptable. Provide diversional activity. Resident #7 was admitted to the facility on 10/30/20 and had a diagnosis of Alzheimer's Disease. The Annual Minimum Data Set dated 10/13/21 noted the resident had severe cognitive impairment and had no behaviors during the lookback period. The MDS noted the resident required extensive assistance with bed mobility and transfers and limited assistance with walking in room or in the corridor. The MDS noted the resident required extensive assistance with dressing, toileting and personal hygiene and total assistance with bathing. The MDS noted the resident was not steady and only able to stabilize with staff assistance during transitions. The MDS revealed the resident had no impairment in range	F 689	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F689 Free of Accident Hazards/Supervision/Devices On 8/15/21 following Resident #1 and Resident #7 altercation. Resident #1 and Resident #7 were separated by facility staff and safety was maintained for Resident #1 and Resident #7. Resident #1 was assessed by hall nurse for injury and pain No injury noted and no voiced or signs of pain noted. Resident #1 continues to reside in the facility. On 8/17/21, Resident #1 was assessed by the facility Medical Doctor (MD) who noted no injury. On 8/19/21 Resident #1 was seen by Life Source (facility Psychiatric Services) for behavior modification. on 9/6/21 Resident #1 was moved off the SPARK/Alzheimer's Unit due to improvement in cognitive status no longer requiring a secured unit. Resident #7 continues to reside in the facility and remains in the secured SPARK/Alzheimer's Unit. Resident #7 was assessed by hall nurse for injury and pain on 8/15/21 following Resident #1 and Resident #7 altercation. No injury noted and no voiced or signs of pain noted. Resident #7 was assessed by the facility Medical Doctor (MD) on 8/17/21, who noted no injury. Resident #7 was seen by Life Source (facility Psychiatric Services) on 8/19/21 for behavior modification. Resident #1 and Resident #7 continue to be observed for behaviors; appropriate interventions/staff redirection are put in	

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F 689	Continued From page 2	F 689		

of motion of the upper or lower extremities.

During the investigation, Resident #7 was observed to walk around on the unit and in the day room independently. On 11/18/21 at 8:47 AM an interview was conducted with MDS Nurse #1 who stated that during October 2021 when the Annual MDS Assessment was done, something was going on with the resident and she required more assistance with ambulation but was now back to her prior level of function. The MDS Nurse further stated the resident's functional abilities vary throughout the day and sometimes would need more assistance with ambulation in the morning and by the evening she might be ambulating without assistance.

The care Plan for Resident #7 updated on 10/27/21 noted a problematic manner in which the resident acts characterized by verbal/physical aggression or agitation and combativeness related to dementia and cognitive decline. The resident swings at staff and other residents and spits on staff and other residents. The interventions included the following: Allow the resident to pace where she can be observed. Approach the resident slowly and from the front. Be cognizant of not invading the resident's personal space. Document summary of each episode. Note cause and successful interventions. If aggressive, try and remove from recreational program and provide individualized program. Medications as prescribed. Remove resident from public area when behavior is disruptive/unacceptable. Talk with resident in a low pitch calm voice to decrease/eliminate undesired behavior and provide diversional activity.

place as indicated. Resident #1 and Resident #7 continue to be assessed by MD and Life Source for acute/ chronic visits and behavior modification.
On 8/15/21 Resident #1 nor Resident #7 was identified requiring 1:1 supervision during the time in question. No resident was exhibiting aggressive behaviors toward other residents that required staff to consider constant supervision to prevent meeting all residents' needs. SPARK/Alzheimer's Unit census: average daily census 13. Staffing – 2 Nursing Assistant (NA) , 1 nurse (may be off the hall if needed to assist on another hall), Patient Per Day (PPD) for SPARK Unit = 5.3

All residents have the potential to be affected.

On 8/15/21, safety was maintained with all residents in the SPARK/Alzheimer's Unit and remaining facility. No injury occurred requiring medical intervention.
On 12/3/21 the facility administrator completed an audit of resident-to-resident altercations for past 6 months noting there were no resident-to-resident altercations for the past 6 months requiring 1:1 supervision. This audit also revealed there were no noted resident to resident altercations requiring medical interventions greater than minor first aid.
On 12/3/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, Staff Development Coordinator, and Minimal Data Set nurse completed an audit to identify all residents

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F 689	Continued From page 3 A progress note dated 8/15/21 noted the nursing assistants (NAs) reported they observed a resident engaging in a physical conflict involving both residents hitting and kicking one another. There were verbal insults from the residents calling one another names. The residents were separated by staff and observed for injuries. The Director of Nursing was notified as well as the Nurse Practitioner and the Resident Representatives. There were no injuries to either resident. On 11/17/21 at 4:24 PM an interview was conducted with Nursing Assistant (NA) #3 who was working on the Alzheimer's unit when the incident occurred. The NA stated she and another NA were working on the unit and the nurse was at the other end of the 400 Hall passing medications. The NA further stated 2 residents needed to go to the bathroom at the same time and each of the NAs took a resident to the bathroom. The NA stated they heard a commotion and went to the TV room and Resident #1 was leaning over Resident #7 who was on the floor. The NA stated they separated the residents immediately, got the nurse and the incident was reported to the Director of Nursing. The NA stated that Resident #1 did not like Resident #7. On 11/18/21 at 12:45 PM an interview was conducted with NA #4 who was working on the Alzheimer's Unit on the day shift. The NA stated they currently had 7 residents on the unit and they have one Nurse and 2 NAs on the day and evening shifts. The NA further stated if the residents have behaviors, they distant the residents and engage them in games, coloring books and other activities. Stated if a resident	F 689	with behaviors. On 12/3/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, Staff Development Coordinator, and Minimal Data Set nurse obtained orders from facility medical providers for appropriate diagnosis of behaviors. On 12/3/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, Staff Development Coordinator, Social Worker, and Minimal Data Set nurse completed an audit to ensure all residents with documented behaviors are being seen by Licensed Provider. On 12/3/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, Staff Development Coordinator, Social Worker, and Minimal Data Set nurse completed an audit to ensure all residents with documented behaviors are care planned with appropriate personalized interventions to maintain resident safety. On 12/2/21 the Staff Development Coordinator began education to all staff on identifying patterns of/or behaviors that my result in a resident-to-resident altercation. This education included providing the importance of providing supervision on the SPARK/Alzheimer's Unit to ensure resident safety. This education will be completed by 12/8/21. Any staff member that has not received this education by 12/8/21 will be mailed this education. This education will be added to the facility new hire orientation packet.	

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F 689	Continued From page 4 goes to the bathroom the staff go with the resident to keep a close eye on them and one of the NAs stays on the floor to keep an eye on the residents. The Nurse assigned to the Alzheimer's Unit at the time of the altercation no longer worked at the facility and could not be reached for an interview. The incident report for the altercation that occurred on 8/15/21 between Resident #1 and Resident #7 was reviewed with the Director of Nursing and the Administrator. The DON was unable to provide any interventions put in place as a result of the incident. Review of the Investigation Report of the incident with Resident #1 and Resident #7 on 8/15/21, completed on 8/23/21 and filed with the State Health Personnel Investigations noted the Corrective Actions as follows: "Facility will continue to monitor our dementia residents for non-acceptable behaviors and separate as required and needed." On 11/18/21 at 1:18 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated the staff should have called for another NA to stay with the residents in the TV room or could have called the DON and not leave the residents unsupervised. The DON stated they could have called the Nurse working on the floor. The DON stated Resident #1 was high functioning and was ultimately moved off the Alzheimer's Unit to the regular floor and the resident was doing much better there.	F 689	Beginning December 6, 2021, monitoring of resident behaviors that may cause resident to resident altercation will be completed daily (Monday through Friday) during Cardinal Intradisciplinary Team (IDT) to review any new behaviors or any residents requiring additional/updated interventions to prevent accidents from resident behaviors on the SPARK/Alzheimer's Unit. The review/report will be documented daily Monday through Friday during the Cardinal IDT meeting minutes by the facility administrator or DON for 3 months. Beginning December 2021, the facility administrator and/or the DON will review all accident/incidents to ensure facility staff adequately supervised residents to prevent resident-to-resident altercations and maintain resident safety in the monthly facility Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849		1/3/22

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F 849	Continued From page 5	F 849		

§483.70(o) Hospice services.
§483.70(o)(1) A long-term care (LTC) facility may do either of the following:
(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure

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F 849	Continued From page 6	F 849		

that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and

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F 849	Continued From page 7	F 849		

delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related

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F 849	Continued From page 8	F 849		

conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.

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F 849	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review, staff and Hospice staff interviews the facility failed to notify Hospice of a change in condition for 1 of 1 resident reviewed for Hospice (Resident #4). The findings included: Resident #4 was admitted to the facility on 7/12/21 and had a diagnosis of chronic obstructive pulmonary disease (COPD), acute necrotizing pancreatitis, protein-calorie malnutrition, ascites (fluid in the abdomen) and abnormal weight loss. The Admission Minimum Data Set (MDS) Assessment dated 7/18/21 noted the resident had moderate cognitive impairment. Review of the record revealed Resident #4 was admitted to Hospice services on 7/28/21. There were no progress notes that the resident had any vomiting until 8/1/21. A progress note dated 8/1/21 at 2:27 PM noted that Nurse #1 that was assigned to the resident on 8/1/21 received a call from a family member that the resident had called them and was vomiting dark, thin liquid. It was noted the nurse would go and check on the resident. A progress note dated 8/1/21 at 2:38 PM by Nurse #1 revealed upon entering the room of Resident #4 the resident had a dark, watery substance running from the mouth and the nurse was unable to obtain a blood pressure. The note revealed Hospice had been called. An interview was conducted with Nursing	F 849	F849 Hospice Services Resident #4 no longer resides at the facility. All residents have the potential to be affected. On 12/3/21 a facility audit was completed to identify all residents under a contracted Hospice service. On 12/3/21 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and Staff Development Coordinator (SDC) reviewed each identified Hospice resident with the assigned Hospice agency via phone to ensure the assigned Hospice agency was aware of current resident condition. The assigned nurse completing this update documented this review in the resident chart. On 12/2/21 SDC completed education to nursing staff and department heads on notification to resident assigned Hospice agency of any resident change in condition timely. This education included nurse/department head documentation of notification and documentation of what change in condition prompted notification. In addition, this education included notifying the DON and facility administrator of any Hospice resident change in condition so that the DON/administrator may review the chart for accuracy of notification and documentation. This education will be completed 12/8/21. Any nursing staff or department head will not be able to work until this education has been completed.	

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F 849	Continued From page 10 Assistant #1 on 11/16/21 at 2:55 PM. The NA stated she was assigned to the resident on the day shift on 8/1/21 and he had vomited greenish-yellow emesis and she told Nurse #1. The NA further stated she went in later to give the resident a bath and noted he had vomited some dark material and had dark emesis from his mouth and nose, and he was not responding so she called the nurse. An interview was conducted with Nursing Assistant (NA) #2 on 11/17/21 at 11:41 AM. The NA stated she saw the resident at breakfast, and he had spit up a little dark material, like he had coughed it up and she told Nurse #1 and the Nurse told her this was normal for him. On 11/17/21 at 3:20 PM an interview was conducted with Nurse #1. The Nurse stated Resident #4 had been vomiting up thin black liquid for several days but was not coffee grounds like would be seen with gastrointestinal bleeding. The Nurse further stated she told the NA this was normal for the resident because someone had told her that the vomiting of dark, thin liquid was normal for the resident. The Nurse stated she could not remember who told her this. The Nurse stated she could not remember if she called Hospice or not. On 11/16/21 at 8:00 PM an interview was conducted with the Hospice Nurse that was taking call on 8/1/21. The Hospice Nurse stated he received a call from the facility on 8/1/21 that the resident was vomiting, and he told the staff he was on his way but before he could get to the facility, they called him back and told him the resident had expired.	F 849	This education will be added to the facility new hire orientation packet. On 12/5/21 the DON, ADON, Unit Manager (UM), and/or the administrator began reporting daily, Monday through Friday, in the Cardinal Intradisciplinary Team (IDT) meeting on any change in condition with any Hospice resident for any additional needs/concerns by the Cardinal IDT. The review/report will be documented daily Monday through Friday during the Cardinal IDT meeting minutes by the facility administrator or DON for 3 months. Beginning December 2021, the facility administrator and/or the DON will review the Hospice resident change in condition notification and documentation in the monthly facility Quality Assurance Performance Improvement (QAPI) Committee meetings monthly for three months to identify trends and/or need for additional monitoring to maintain regulatory compliance.	

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F 849	Continued From page 11 On 11/17/21 at 3:34 PM an interview was conducted with the facility Physician who stated the resident could have been vomiting bile, blood or something he ate. The Physician further stated since the resident was a Hospice patient, he would expect the staff to notify Hospice. On 11/17/21 at 3:37 PM an interview was conducted with the Nursing Director of the Hospice service that admitted Resident #4. The Nursing Director stated she had reviewed the calls and the only call they received from the facility regarding Resident #4 was on 8/1/21. The Nursing Director stated she would expect the facility staff to notify Hospice when the resident started vomiting dark liquid. The Nursing Director further stated the Hospice nurse would have gone to the facility and assessed the resident and made sure the resident was on the correct medications. The Nursing Director stated the resident was on palliative care and the nurse would not have initiated aggressive treatment.	F 849		
F 880 SS=F	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		1/3/22

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F 880	Continued From page 12 §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; §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 13 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, the Center for Disease Control (CDC) guidelines for the use of Personal Protective Equipment (PPE), CDC COVID-19 Data Tracker for Richmond County Transmission Rate, and staff interviews, the facility failed to wear eye protection when caring for residents for 4 of 4 halls (100, 200, 300 and 400 Halls). The findings included: Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated September 10, 2021 read as follows:" Implement Universal Use of Personal Protective Equipment for Healthcare Personnel: If SARS-CoV-2 infection is not suspected in a patient presenting for care, healthcare personnel working in facilities located in counties with substantial or high transmission should also use PPE as described below. The third bullet read: Eye protection (goggles or face shield) that covers the front and sides of the face should be worn during all patient care encounters."	F 880	F880 Infection Prevention & Control On 11/16/21 observations noted facility staff failed to wear eye protection while caring for residents. No residents were affected (increase/prolonged signs/symptoms of infection) by this deficient practice. The facility administrator, Director of Nursing (DON), Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP) were unaware of 9/10/21 Center for Disease Control (CDC) updated infections prevention guidance: Healthcare Personnel (HCP) must wear goggles or face shields when in areas of substantial to high transmission areas. Root Cause Analysis: facility staff were not wearing goggles or face shields during resident encounter. The facility staff were unaware of CDC updated guidance on 9/10/21 of Long-Term Care Facilities located in substantial to high transmission counties should wear goggles or face shields during resident encounters. Rationale: The facility administrator,	

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F 880	Continued From page 14 The CDC COVID-19 Data Tracker for Richmond County noted the county transmission rate was substantial or high. An initial tour of the facility was conducted on 11/16/21 beginning at 10:30 AM. The tour included all 4 halls in the facility. Staff was observed to go in and out of resident's rooms wearing a face mask, but no staff were wearing eye protection that is (goggles or a face shield). Observations were made on the Alzheimer's Unit where 2 Nursing Assistants were interacting with 5 residents in the day room. The staff were not wearing eye protection. On 11/16/21 at 1:26 PM the Administrator stated in an interview that the COVID transmission rate in Richmond County was high. The Administrator stated the staff in the facility had not been wearing goggles or face shields when in contact with residents during care. The Administrator further stated she was not aware of new CDC guidance that staff working in facilities where the county had a high COVID transmission rate were to wear eye protection during contact with residents. The Administrator stated they had goggles available but was not aware of the new CDC guidance.	F 880	Director of Nursing (DON), Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP) were unaware of 9/10/21 Center for Disease Control (CDC) updated infections prevention guidance: Healthcare Personnel (HCP) should wear goggles or face shields when in areas of substantial to high transmission areas during resident encounters. All residents have the potential to be affected by alleged deficient practice. On 11/16/21 the facility administrator, director of nursing, staff development nurse, and unit managers informally educated staff on required personal protective equipment (PPE), goggles or face shield must be worn for all resident encounters per CDC and Federal & State guidelines when in a substantial to high transmission area. On 11/16/21 the facility administrator posted signage in high traffic employee areas (employee sign in area, nurse stations, employee breakroom, and employee time clock). On 11/16/21 the facility supply clerk placed additional pairs of goggles and face shields throughout the facility for staff easy access. On 11/18/21 the facility department heads observed random staff for 7 days (11/25/21) to ensure staff were properly wearing goggles or face shields during resident encounters. Any staff that were not in compliance with 9/10/21 CDC updated infections prevention guidance: HCP must wear goggles or face shields	

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F 880	Continued From page 15	F 880	when in areas of substantial to high transmission areas during resident encounters were given 1:1 education on properly wearing goggles or face shields during resident encounters. On 12/2/21 the staff development coordinator (SDC) began additional education to include a quiz for return understanding, to all facility staff of the 9/10/21 Center for Disease Control (CDC) updated infections prevention guidance: Healthcare Personnel (HCP) must wear required personal protective equipment (PPE), goggles or face shield must be worn for all resident encounters per CDC and Federal & State guidelines when in a substantial to high transmission area. This education included a quiz on properly wearing goggles or face shields. This education will be completed on 12/8/21. Any staff member that has not completed this education will not be able to work until he/she has completed the education and quiz: of the 9/10/21 Center for Disease Control (CDC) updated infections prevention guidance: Healthcare Personnel (HCP) must wear required personal protective equipment (PPE), goggles or face shield must be worn for all resident encounters per CDC and Federal & State guidelines when in a substantial to high transmission area. This education and quiz on proper use of wearing goggles or face shields for all resident encounters will be added to the facility new hire orientation packet. On 12/9/21, the facility administrator, DON, ADON/ICP, SDC, or unit managers began auditing on required goggles or	

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F 880	Continued From page 16	F 880	face shields being properly worn during resident encounters per CDC and Federal & State guidelines, on 6 random staff members each shift daily x2weeks, then 6 random staff members each shift weekly x3 months. The audit will be documented on F880 Infection Control & Prevention (proper use of goggles or face shields during resident encounters) audit tool. Any staff member noted out of compliance with required PPE (proper use of goggles or face shield during resident encounters) will be given 1:1 education by facility administrator, DON, or staff member's assigned supervisor. Beginning 12/9/21 the Nurse Consultant will facilitate a weekly focus call specific for Richmond Pines with the facility Administrator, DON, ADON/ICP, and SDC unless the Nurse Consultant is present in the facility. The nurse consultant will send a weekly summary of findings for 3 months to the Corporate Clinical Director and Regional Vice President of Operations. Beginning 12/9/21 the nurse consultant will conduct a monthly on-site visit to ensure facility staff continues to follow CDC updated infections prevention guidance and will continue for at least 3 months. Beginning 12/9/21, the DON, ADON/ICP will review results of the audits during the Interdisciplinary Team (IDT) meetings weekly. The results of the audits will also be discussed in the Quality Assurance Performance Improvement (QAPI) Committee meetings monthly beginning December 2021, for 3 months to identify	

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F 880	Continued From page 17	F 880	trends and/or need for additional facility staff education with CDC and Federal & State guidelines/updates, and/or facility protocol. Alleged compliance date 1/3/2022	