STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 01/07/2022

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PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 1/4/22 through 1/7/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RPOF11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and compliant investigation survey was conducted on 1/4/22 through 1/7/22. Event ID # RPOF11 5 of the 5 complaint allegation's were not substantiated.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		2/11/22

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

Electronically Signed | 02/02/2022

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review, the facility failed to repair toilet in resident room and clean resident room for 1 of 14 rooms(Room 240). The findings included: Review of the individual housekeeping checklist for housekeeper #1 and housekeeper #2 documented the required cleaning task for resident rooms dated 1/4/22, room 240 had toilet issues, maintenance was called for clean up at 11:30 AM, the Mop section of the form coded as M2 mop floor was done for room 231. There was nothing documented for room in 240. An observation was conducted on 01/05/22 10:19 AM, the floors in resident room sticky/dirty, old cups food on floor and toilet broken. There was	F 584	Person Memorial Hospital acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Person Memorial Hospital's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Person Memorial Hospital reserves the right to submit documentation to refute any of the stated	

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F 584	Continued From page 2 water on the floor and stain tile around the base of toilet. Observation on 1/5/22 at 5:15 PM, both residents in room eating dinner and the condition of the floor remained unchanged. The same towel behind resident bed, cups that were on the floor. The bathroom floor was very sticky with dried urine like stains under toilet, floor craves had not been cleaned in sometime. Observation on 1/06/22 08:29 AM, with Maintenance Director the toilet for room 240 revealed the toilet was flushing properly. The Maintenance Director stated it was discovered that paper towels and wipes were clogging the toilet and needed to be snaked out several times. Both residents in room stated the toilet was now working properly. The Maintenance Director stated he did periodic room rounds for basic repairs and expected residents or staff to let him know when things were not working in resident room. He stated he became aware of the toilet situation on 1/4/22 and began working on the situation. The floor in resident room was still dirty, sticky with old food from previous night remained on the floor. old towel behind the bed, there was spilled fluids under beds, old paper, and cups. Observation on 1/6/22 at 9:45 AM, the Housekeeper #1 and the Administrator confirmed the condition of the floor in the resident ' s room with the dried foods/liquids on the floor, old towels under resident bed and toilet leaking again on the floor. An interview with the Administrator 1/6/22 at 9:45 AM, who stated the expectation was for the housekeeping supervisor to make sure all	F 584	deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings. Maintenance Director repaired room 240 bathroom toilet and Environmental Service Director cleaned room 240 and bathroom. Maintenance Director completed an audit of all resident room toilets to ensure working properly and no leaks. Environmental Services Director completed an audit of all resident rooms to ensure items on employee's checklist were followed and rooms were cleaned. Maintenance Department was in-serviced to ensure all resident toilets are functioning properly and no leaks are present. Environmental Service Department was in-serviced ensuring staff are completing cleaning checklist and cleaning every resident room and bathroom. Maintenance Director and/or designee will audit 25% of resident bathroom toilets to ensure working properly and no leaks are present weekly for four weeks. Environmental Director and/or designee will audit 25% of resident rooms and bathrooms to ensure cleaning checklist is followed, room, and bathroom are cleaned weekly for four weeks. The Administrator will report the results of	

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F 584	Continued From page 3 resident rooms were cleaned and check behind the staff to ensure housekeeping keep rooms cleaned. Maintenance was responsible for making sure all resident toilets, call lights etc. were working properly. An interview was conducted on 1/6/22 at 9:45 AM, the Housekeeper #1 (HK) stated in the presence of the administrator that she had gone in the room and swept and mopped the room and cleaned the bathroom on 1/5/22. During the observation it was confirmed the sticky floors, towel behind the bed, dried food and liquids remain on the floor. Both residents confirmed no-one had been in the room for several days. An interview was conducted on 1/6/22 at 10:00 AM, HK #1 stated she had not cleaned the resident room on 1/4/22 or 1/5/22. She stated she was not assigned to the room. An observation on 1/6/22 at 10:18 AM, the Environmental Service Director observed the condition of the resident floors and bathroom and confirmed the room needed to be deep cleaned. An interview was conducted on 1/6/22 at 10:18 AM, the Environmental Service Director (EVSD)stated the staff had a check list which should be followed daily. The checklist included high low dusting, sweeping, and mopping. Before the end of the shift a (evening)PM freshen up cleaning would be done. EVSD stated she was responsible for ensuring that her staff were following the cleaning checklist in accordance too the rooms that were assigned. The EVSD confirmed that HK#1 was assigned to the room and reported the floors had been mopped in the bathroom. EVSD stated she was unable to check	F 584	the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for one month and as needed thereafter. Administrator will be responsible for implementation of this plan of correction	

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F 584	Continued From page 4 behind the floor staff assignment on 1/5/22. Review of the daily huddle book for staff in-service dated 11/30/21 revealed a maintenance reporting process in-service documented staff must promptly report/place work order into maintenance of any issues with equipment or needed repairs to maintenance to ensure all repairs are done and resolved. A follow-up interview was conducted on 1/6/22 at 10: 20 AM, the Maintenance Director stated he rechecked the toilet and did not know where the leak was coming from the toilet, and he suspected the gentlemen in the room may have urinated on the floor. He further stated he did not see or feel any cracks in the bowl or back of the toilet during his inspection. Observation of the floor revealed the floor was warping around the base of the toilet and the tiles were heavily stained and buckling at the edges. Maintenance Director also entered resident room and bathroom and confirmed the floors were dirty and extremely sticky.	F 584		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		2/11/22

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F 761	Continued From page 5 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to lock an unattended medication administration cart for 2 of 3 carts reviewed for medication storage (Rehabilitation Hall cart and Long Hall cart) and failed to lock the controlled substances storage drawer on 1 of 3 carts (Rehabilitation Hall cart). The findings included: 1. a. On 1/4/22, during the continuous observation on Rehabilitation Hall at 6:15-6:35 PM, the medication administration cart, located next to room #261, was unlocked, unattended, with push button in the sticking out position. The Nurse #2, assigned for the medication administration cart, was not observed on the Rehabilitation Hall. On 1/6/22 at 12:30 PM, during the phone interview, Nurse #2 indicated that on 1/4/22, she left the medication administration cart to reposition the resident in room #272. Nurse#2	F 761	On 1/7/2022 the Director of Nursing got with the assigned nurses to lock the two carts and the controlled substance storage drawer. The Director of Nursing completed an audit on 1/7/2022 to ensure all unattended nurse carts were locked and all controlled substance storage drawers were locked. All nurses were in-serviced on 1/7/2022 to ensure all unattended nurse carts should be locked to include locking the controlled substance storage drawer. Director of Nursing and/or designee will audit nurse carts to ensure locked while unattended and to ensure controlled substance storage drawers are locked weekly for four weeks. The Director of Nursing will report the results of the audits to the Quality	

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F 761	Continued From page 6 stated she should have not walked away from the cart without pushing the lock button in the lock position. b. On 1/6/22, during the continuous observation on Rehabilitation Hall at 2:12 PM- 2:28 PM, the medication administration cart between room #261 and nurses ' station, was unlocked, unattended with push button in the sticking out position. The Nurse #3, assigned for the medication administration cart, was not observed on the Rehabilitation Hall. On 1/6/22 at 2:45 PM, during an interview, Nurse #3 indicated that she left the medication administration cart to assist the residents in room #262 and #269. Nurse#3 stated she should have not walked away from the cart without pushing the lock button in the lock position. On 1/7/22 at 4:50 PM, during an interview, the Director of Nursing (DON) indicated that the nurses were responsible for keeping the medication cart locked at any time, when they were not at the cart. c. On 01/06/22, during a continuous observation on Long Hall at 08:13 AM - 08:15 AM, the medication administration cart was unlocked and unattended with the push button in the sticking out position. The cart was located next to room #251 and facing into the hall. Nurse #7, assigned to the medication administration cart, was not observed in the Long Hall. d. On 01/06/22 at 08:28 AM, Nurse #7 left the medication administration cart on Long Hall unlocked and unattended with the push button in the sticking out position. Nurse #7 went to the medication storage room located on	F 761	Assurance and Performance Improvement Committee for further review and recommendations monthly for one month and as needed thereafter. Administrator will be responsible for implementation of this plan of correction	

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F 761	Continued From page 7	F 761		

Rehabilitation Hall and to a resident room. Nurse #7 returned to the unlocked medication cart at 08:34 AM.

e. On 01/06/22, during a continuous observation on Long Hall at 12:31 PM - 01:41 PM, the medication administration cart, located next to room #259, was unlocked and unattended, with the push button in the sticking out position. Nurse #7 returned to the medication administration cart at 01:41 PM.

In an interview with Nurse #7 on 01/06/22 at 01:41 PM, she stated she was responsible for the medication cart on Long Hall. Nurse #7 indicated she thought she had locked the medication cart before leaving it to assist staff with an emergency. Nurse #7 stated she normally locked the medication administration cart when she left it unattended.

An interview was conducted with the Director of Nursing (DON) on 01/07/22 at 02:03 PM. She stated medication administration carts should be locked when left unattended. If there was a problem locking the medication administration cart, the DON or pharmacy should immediately be notified.

2. On 01/07/22, during an observation of the medication administration cart on Rehabilitation Hall, the DON and Nurse #4 opened the cart for medication storage review. Controlled substance Drawer #1 was unlocked. Nurse #3 was responsible for the Rehabilitation Hall medication cart and Nurse #4 called her to return to the cart. A controlled substance count was immediately completed by Nurse #3 and Nurse #4 and revealed the medication count was correct. The

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F 761	Continued From page 8 DON stated the controlled substance drawer should have been locked. In an interview on 01/07/22 at 03:48 PM, Nurse #3 stated controlled substance Drawer #1 gets stuck and she had to "beat it down to close it." Review of the medication storage policy dated 01/01/13 revealed controlled substances should be kept in a separate compartment within locked medication carts and have a different key or access device. An interview was conducted with Administrator #1 on 01/07/22 at 05:20 PM. He indicated it was the nurses' responsibility to have the medication administration cart locked if the nurse needed to leave the cart. Controlled substances should be double locked.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		2/11/22

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F 812	Continued From page 9 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure the following kitchen equipment was clean: the stove, the oven, 2 compartment hot box and 2 compartment cold box. The facility failed to clean the cooler and discard rotten vegetables, expired juice, and unlabeled produce from 1 cooler. The facility failed to remove dented cans from use. Findings included: 1.During an initial kitchen tour on 1/5/22 at 7:45 AM, the following observations were made: a. The 9-burner stove had a large volume of heavy grease build up on the stove burners, walls, and fronts of the stove. There were large amounts of burnt foods, dried liquid encrusted and splatters throughout the stove area. The stove continued to have encrusted burners with heavy grease build up and food debris. b. 4 ovens had a large volume greasy buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where foods were being cooked. There was a large volume of dried grease buildup was observed on the fronts of the ovens and on the walls. c. The 2-compartment hot box where warm food was stored, had large volumes of dried brown/yellow liquid matter encrusted on edges inside/outside.	F 812	The Food and Nutrition Director cleaned the stove, oven, 2 compartment hot box, 2 compartment cold box, and cooler. Food and Nutrition Director discarded the rotten vegetables, expired juice, unlabeled produce, and dented cans. Food and Nutrition Director completed an audit of cleanliness of the stove, oven, 2 compartment hot box, 2 compartment cold box, and cooler. Food and Nutrition Director completed an audit to ensure rotten vegetables, expired juice, unlabeled produce, and dented cans are not present. Food and Nutrition Department was in-serviced to ensure stove, oven, 2 compartment hot box, 2 compartment cold box, and cooler are cleaned regularly and as needed. Also, Food and Nutrition Department was in-serviced to ensure rotten vegetables, expired juice, unlabeled produce, and dented cans are discarded regularly and as needed. Food and Nutrition Director and/or designee will audit cleaning of stove, oven, 2 compartment hot box, 2 compartment cold box, and cooler weekly for four weeks. Food and Nutrition Director and/or designee will audit rotten vegetables, expired juice, unlabeled produce, and dented cans to ensure items	

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F 812	Continued From page 10 d. The 2-compartment cold box where cold food was stored, had large volumes of dried food and liquid matter encrusted on the edges inside/outside. An interview was conducted on 1/5/22 at 7:55 AM, the Kitchen Supervisor stated he was responsible for ensuring the kitchen staff kept the equipment clean and orderly. He added the kitchen equipment should be cleaned weekly in accordance too the kitchen cleaning checklist. 2. During an observation on 1/5/22 at 7:50 AM, the cooler had dried foods and liquids splattered on the sides of cooler. The following rotten vegetables were mixed in with fresh vegetables: 1 full container of tomatoes, 1 full container of cucumbers, 1 opened bag of spinach not labelled, 1 open bag of basil not labelled. The cooler also contained 2 full gallon containers of orange juice and opened and half full gallon of orange with expiration date 12/18/21 on it. A Follow-up observation was conducted on 1/6/22 at 11:29 AM, revealed the cooler still had the container of rotten tomatoes, cucumbers, opened/unlabeled package of basil. The 2-compartment hot box and cold box and oven had not been cleaned. 3. During an observation on 1/5/22 at 7:55 AM, the dry storage area revealed a rack of dented cans along with regular cans. The following dented cans were found on the rack: 1 can of spaghetti, 5 cans of pears, 3 cans of mandarin oranges and 3 cans of red beans. An interview was conducted on 1/6/22 at 11:40	F 812	are discarded weekly for four weeks. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for one month and as needed thereafter. Administrator will be responsible for implementation of this plan of correction	

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F 812	Continued From page 11 AM, the Dietary Manager (DM) stated the stock person was responsible for checking all produce once it ' s delivered. The staff should check the produce and discard any spoiled or rotten products. In addition, all items in refrigerator/freezers should be labelled. Any expired products or juices should be discarded. The dented cans should be moved from the primary shelves and later discarded by the end of the week. The DM stated the expectation was for the kitchen staff to follow the kitchen cleaning checklist. The DM stated the 3 supervisors were responsible for ensuring the kitchen team maintained sanitary conditions in the kitchen. The supervisors should be doing shift checks before and after each shift to ensure all tasks were completed. During an interview on 1/6/21 at 11:42 AM, the Kitchen Supervisor stated he was responsible for monitoring and checking behind the kitchen staff to ensure they were completing the checklist and ensuring all sanitation procedures were being followed. The Supervisor stated they had been checking behind the staff weekly to ensure the cleaning was done. During an interview on 1/7/18 at 5:00 PM, the Administrator stated the expectation would be for the kitchen manager to ensure all kitchen cleaning protocols be in place and followed in accordance too kitchen sanitation guidelines.	F 812		
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	F 880		2/8/22

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(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 880	Continued From page 12	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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

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	345004	A. BUILDING _____ B. WING _____	C 01/07/2022

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F 880	Continued From page 13 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff, family interviews, and record review, the facility failed to set up screening stations for signs and symptoms of COVID-19 near each entrance or provide clear instruction how to reach the screening room for 3 facility State Surveyors and 1 Federal Surveyor before entering the facility for 1 of 4 on-site survey days. This failure occurred during a global COVID-19 pandemic. Findings included: Record review revealed the Standard Operation Procedure, updated on 11/4/21, indicated that for indoor visits, all visitors will receive instructions	F 880	Nurse #1 immediately took the four surveyors to the screening room to be screened on 1/4/2022. (Root cause analysis completed by Quality Assurance Committee on 1/31/2022: Facility failed to screen for COVID-19 before entering the unit due to poor communication and education of skilled nursing facility federal guidelines as it relates to COVID-19 screening.) On 1/5/2022 the hospital and extended care unit leadership had amended the COVID-19 screening process to being screened at the front door of the hospital	

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F 880	Continued From page 14 regarding visitation protocols and will be screened for COVID-19 symptoms prior to each visit. On 1/4/22 at 6:10PM, during the observation of the hospital ' s main entrance, the door was automatically opened. There were no staff members present, no screening station/log, or directions for the screening process in the lobby of the main entrance to the hospital. The nursing facility is referred to as the Extended Care Unit, (ECU) and was located on the hospital's second floor. On the way from the main entrance of the hospital to the ECU, there was no posted information about the location of COVID-19 screening for the ECU. At 6:15 PM, four surveyors entered the ECU from the back elevator without COVID-19 screening. The three state surveyors self- screened prior to entering the hospital entrance. All four surveyors walked through the back hallway to the closest nurses ' station and introduced themselves. Record review of the ECU ' s COVID-19 visitor/vendor screening log form revealed the name, temperature, yes/no section for the health-related questions, and signature. On 1/4/22 at 6:15 PM, during the observation on the hallway near the back elevator, there was no COVID-19 screening station noted. There were no residents observed on the hallway near the back elevator. Nurse #1, the charge nurse on duty, escorted the team to the conference room in the Rehabilitation hallway. There were no residents observed on the Rehabilitation hallway when the surveyors entered the conference room. The surveyor team leader asked if the ECU had a COVID-19 screening process for visitors. Nurse #1 found that the survey team did not receive	F 880	Monday to Friday from 7:30am-5:00pm; after 5:00pm and on weekends screening will be at the hospital□s emergency department. Education was provided to all staff, physicians, and vendors by the Director of Nursing on 1/13/2022 ensuring screening at the front door of the hospital Monday to Friday from 7:30am-5:00pm, after 5:00pm and on weekends screening will take place at the hospital□s emergency department. Residents and Families were notified on 1/5/2022 by the Operations Manager via phone and letter of screening at the front door of the hospital Monday to Friday from 7:30am-5:00pm, after 5:00pm and on weekends screening will take place at the hospital□s emergency department. An audit was completed by Administrator on 1/10/2022 to ensure compliance with screening. Administrator and/or designee will conduct weekly audits of the COVID-19 screening process to ensure compliance for four weeks. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for one month and as needed thereafter. Administrator will be responsible for implementation of this plan of correction	

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F 880	Continued From page 15	F 880		

COVID-19 screening and took the four surveyors through two hallways to the opposite end of the ECU, to the screening room.

On 1/4/22 at 6:20 PM, during the observation in the screening room, located on the hallway near the dining room, the room was set up for COVID-19 screening with electronic temperature terminal and screening logbook. Nurse #1 explained the procedure and helped with screening of the survey team.

On 1/4/22 at 6:55PM, during an interview, Nurse #1 indicated that after 5PM on weekdays and anytime on weekends, all visitors used the Emergency Department ' s entrance, where they received COVID-19 screening, including temperature check and health-related questions. Nurse #1 stated all the visitors should complete COVID-19 screening before entering the ECU.

On 1/5/22 at 7:30AM, during an interview, the Administrator indicated that during business hours,
the front desk employee asked the visitors to take an elevator to the second floor, follow the directions posted to reach the white double door for COVID-19 screening room to enter the ECU. After 5 PM and anytime on weekends, the main hospital entrance was closed, and the visitors used the Emergency Department ' s entrance to get inside. The Administrator could not explain the reason why the main entrance was not closed on 1/4/22 at 6:10PM. He confirmed that the visitors should come to the ECU only after COVID-19 screening.

On 1/5/22 at 12:00PM, during an interview, Nurse #4, who was the infection control nurse, indicated

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F 880	Continued From page 16 that she was responsible for Infection Control and Prevention Program in the ECU. She indicated the room for COVID-19 screening was set up on the hallway near the dining room and included electronic temperature terminal and screening logbook. Nurse #4 confirmed that all the visitors must complete COVID-19 screening prior to entering the ECU. On 1/6/22 at 10:50 AM, during an interview, the Chief Executive Officer (CEO) and Chief Nursing Officer of the hospital, the Administrator, and the Director of Nursing (DON) indicated that the visitors must enter the ECU from one door, which was located on the hallway near the dining room. Behind that door, there was a room set up for the COVID-19 screening, where the visitors had to complete the temperature check, health-related questions and sign the screening log prior to entering the ECU. After 5 PM and anytime on weekends, the main hospital entrance was closed, and the visitors used the Emergency Department ' s entrance to get in. The administrator of the hospital and ECU mentioned that the COVID-19 screening system should not allow the visitors to enter the ECU without COVID-19 screening.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in freezer in good working condition. The kitchen ' s	F 908	Food and Nutrition Director called the service company (Whaley) to service and repair the freezer.	2/11/22

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F 908	Continued From page 17 walk-in freezer had accumulated ice on the freezer floor and door. The findings included: An initial tour observation was conducted on 1/5/22 at 7:45 AM, the walk-in freezer had an ice buildup on the corner left side of the floor and the door also had an ice buildup around and near door frame. Follow-up observation 1/6/22 at 11:29 AM, the walk-in freezer still had the ice buildup on the floor and door of the freezer. During an interview on 1/6/22 at 11: 40 AM, the Dietary Manger (DM) stated she was informed by the kitchen staff upon her arrival between (1/5/22) 7:30 AM/8:00 AM, that the freezer was not working or holding chunks of ice. The DM stated that she reported the problem to the maintenance director and the administrator. The DM indicated she was informed by maintenance director someone would be contacted to repair the freezer; however, she was unaware of when the repair would take place. During an interview on 1/7/22 at 5:00 PM, the Administrator indicated he was unaware of the freezer with the ice buildup in the freezer. The Administrator stated dietary manager should find someone to repair the freezer.	F 908	Food and Nutrition Director and Service Technician completed an audit and repair on the freezer to ensure no leaks nor accumulation of ice. Food and Nutrition staff were in-serviced to ensure no ice accumulation on any part of the freezer. Food and Nutrition Director and/or designee will audit freezer to ensure no ice accumulation weekly for four weeks. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for one month and as needed thereafter. Administrator will be responsible for implementation of this plan of correction	