

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022	
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD		STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712		
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E 000	Initial Comments An unannounced Recertification survey was conducted 01/03/22 through 01/07/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# B98411.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 01/03/22 through 01/7/22. A total of 27 allegations were investigated and 3 were substantiated. Event ID# B98411.	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		2/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2022

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 582 Continued From page 1 F 582

covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to provide a CMS-10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 3 of 3 residents reviewed for beneficiary protection notification review (Residents #7, #53 and #109).

CORRECTIVE ACTION:

The Case Mix Director completed an audit on 2/2/22 on completion of CMS-1055 SNF ABN and notification of resident and/or responsible party prior to discharge from Medicare Part A skilled services within the last 30 days.

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F 582	<p>Continued From page 2</p> <p>Findings included:</p> <p>1. Resident #7 was admitted to the facility on 06/08/21.</p> <p>A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #7's Responsible Party (RP) on 07/22/21 which indicated Medicare Part A coverage for skilled services would end on 07/26/21. Resident #7 remained in the facility.</p> <p>A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #7 or her RP.</p> <p>An interview was conducted with the Minimum Data Set Registered Nurse (MDS RN) on 01/06/22 at 3:15 PM. The MDS RN explained she issued the NOMNC prior to Medicare Part A services ending but was not aware a SNF ABN was also required. The MDS RN confirmed Resident #7 nor her RP was issued a SNF ABN.</p> <p>An interview was completed with the Administrator on 01/06/22 at 4:41 PM. The Administrator explained the MDS RN was not aware to issue a SNF ABN in conjunction with the NOMNC and stated it was an honest mistake. The Administrator added education would be provided to the MDS RN to ensure residents and/or their RP were issued the required notices when Medicare Part A skilled services were ending.</p> <p>2. Resident #53 was admitted to the facility on 07/29/20.</p>	F 582	<p>AFFECTED RESIDENTS:</p> <p>All residents have the opportunity to be affected by this deficient practice.</p> <p>SYSTEMIC CHANGES:</p> <p>Administrator conducted on in-service on 1/31/202 to Case Mix Director, Director of Health Service and Financial Counselor on facility policy on completion CMS-1055 SNF ABN and notification of resident and/or responsible party prior to discharge from Medicare Part A skilled services.</p> <p>MONITORING:</p> <p>The Case Mix Director will audit completion of CMS-1 055 SNF ABN and notification of resident and/or responsible party prior to discharge from Medicare A skilled services weekly times four (4) weeks. Ongoing audits will be determined based on results of prior audits. Audit tools will be reviewed monthly times three (3) months by Administrator and/or designee and during the monthly Quality Assurance and Performance Improvement Committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. Corrective Action will be completed by 2/2/2022.</p>	

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F 582	<p>Continued From page 3</p> <p>A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #53's Responsible Party (RP) on 02/22/21 at 2:12 PM which indicated Medicare Part A coverage for skilled services would end on 02/24/21. Resident #53 remained in the facility.</p> <p>A review of the medical record revealed a second CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #53's RP on 03/09/21 which indicated Medicare Part A coverage for skilled services would end on 03/11/21. Resident #53 remained in the facility.</p> <p>A review of the medical record revealed CMS-10055 SNF ABNs were not provided to Resident #53 or his RP.</p> <p>An interview was conducted with the Minimum Data Set Registered Nurse (MDS RN) on 01/06/22 at 3:15 PM. The MDS RN explained she issued the NOMNC prior to Medicare Part A services ending but was not aware a SNF ABN was also required. The MDS RN confirmed Resident #53 nor his RP was issued a SNF ABN.</p> <p>An interview was completed with the Administrator on 01/06/22 at 4:41 PM. The Administrator explained the MDS RN was not aware to issue a SNF ABN in conjunction with the NOMNC and stated it was an honest mistake. The Administrator added education would be provided to the MDS RN to ensure residents and/or their RP were issued the required notices when Medicare Part A skilled services were ending.</p> <p>3. Resident #109 was admitted to the facility on</p>	F 582		

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F 582	Continued From page 4 07/11/21. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed with Resident #109's Responsible Party (RP) on 07/16/21 which indicated Medicare Part A coverage for skilled services would end on 07/19/21. Resident #109 discharged to the community on 07/20/21. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #109 or her RP. An interview was conducted with the Minimum Data Set Registered Nurse (MDS RN) on 01/06/22 at 3:15 PM. The MDS RN explained she issued the NOMNC prior to Medicare Part A services ending but was not aware a SNF ABN was also required. The MDS RN confirmed Resident #109 nor her RP was issued a SNF ABN. An interview was completed with the Administrator on 01/06/22 at 4:41 PM. The Administrator explained the MDS RN was not aware to issue a SNF ABN in conjunction with the NOMNC and stated it was an honest mistake. The Administrator added education would be provided to the MDS RN to ensure residents and/or their RP were issued the required notices when Medicare Part A skilled services were ending.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		2/2/22

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F 583	<p>Continued From page 5</p> <p>confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health information for 1 of 1 sampled resident (Resident #11) by leaving confidential medical information unattended in an area visible and accessible to the public in West Wing nurse station.</p>	F 583	<p>AFFECTED RESIDENTS: The facility failed to ensure that Resident #11 confidential medical information was protected and was not accessible to the public. The Director of Health Services conducted an in-service with Nurse #6 on</p>

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F 583	<p>Continued From page 6</p> <p>The findings included:</p> <p>Resident #11 admitted to the facility on 03/26/19.</p> <p>A continuous observation was made on 01/05/22 from 3:34 PM through 3:41 PM of an unattended computer in West Wing nurse station. Nurse #6 left the computer with the physician order for Resident #11 visible on the computer screen when she was away with no other staffs in the nurse station. The surveyor could see the physician order of Resident #11 from the perimeter of the nurse station without any problems. The unattended computer was accessible by anyone who was not authorized to view this confidential information in the nurse station.</p> <p>During an interview with Nurse #6 on 01/05/22 at 3:36 PM, she explained while she was reviewing the physician order for Resident #11, the Assistant Director of Nursing (ADON) wanted to see her in the ADON's office. She was distracted and had forgotten to turn on the privacy protection screen before leaving the nurse station. She stated it was an oversight and acknowledged that it was inappropriate to leave the computer unattended. She indicated that she had received the Health Insurance Portability and Accountability Act (HIPAA) training during orientation and yearly from the facility.</p> <p>In an interview conducted on 01/05/22 at 4:38 PM, the Director of Nursing (DON) expected the nurse to turn on the privacy protection screen before leaving the computer unattended to protect Resident's confidential personal and medical information. It was her expectation for all</p>	F 583	<p>1/5/2022 on resident rights to secure and confidential private health information.</p> <p>POTENTIALLY AFFECTED RESIDENTS: All resident's confidential medical information has the potential to be affected by the deficient practice. No adverse effect noted.</p> <p>SYSTEMS CHANGE: All Staff were in-serviced by Director of Health Services and Assistant Director of Health Services on 1/27/22 and completed on 1/31/22 regarding resident's right to personal privacy/confidentiality of records to assist in ensuring that the deficient practice will not recur. The above education will be included in subsequent new-hire orientations. All other staff who have not received education and/or otherwise out will be educated before working their next assigned shift by the Director of Health Services and/or designee.</p> <p>MONITORING: To ensure that solutions are sustained the Director of Health Services (DHS) and/or designee will monitor to ensure privacy protection screen is turned on before leaving the computer unattended two (2) times a week times four (4) weeks then one (1) time a week times four (4) weeks to ensure that confidentiality of resident's medical records are secured and protected starting on 2/1/2022. Results of monitoring will be summarized and presented to the facility Quality</p>

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F 583	Continued From page 7 the staff to follow the HIPAA guidelines when working in the facility. During an interview with the Administrator on 01/05/22 at 4:45 PM, she stated all the staff had received training on HIPAA and added nursing staff had to secure the computer before leaving it unattended. It was her expectation for the staff to follow the HIPAA guidelines all the times.	F 583	Assurance Performance Improvement Committee meeting by the Director of Health Services and/or designee and will be reviewed for two (2) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. The Director of Health Services and Administrator are responsible for implementing and maintaining the acceptable plan of correction. Corrective action will be completed by 2/2/2022.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		2/2/22

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F 622 Continued From page 8

F 622

under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

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F 622	<p>Continued From page 9</p> <p>needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and Responsible Party (RP), Family Member, and staff interviews, the facility failed to allow a resident to remain in the facility and provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 2 residents reviewed for transfer and discharge (Resident #108).</p> <p>The findings included:</p> <p>Resident #108 was admitted to the facility on 07/19/21 with multiple diagnoses that included</p>	F 622	<p>AFFECTED RESIDENT/CORRECTIVE ACTION:</p> <p>The affected resident no longer resides in the facility.</p> <p>The Administrator and Director of Health Services called Resident #108's spouse on 1/28/22 to discuss readmission to the facility and the call was not answered. A follow up call was made on 1/31/22 by Administrator and Financial Counselor, bed offer was made for Resident #108 to</p>	

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F 622	<p>Continued From page 10</p> <p>Parkinson's disease and dementia with behavioral disturbance.</p> <p>A discharge care plan initiated on 07/20/21 revealed Resident #108's discharge planning would begin upon admission. An identified approach included long-term care/skilled nursing facility versus assisted living facility and involve the resident, representative and interdisciplinary team in the discharge planning process.</p> <p>A staff progress note dated 09/10/21 completed by the Social Worker (SW) noted in part, a meeting was held with Resident #108 to discuss the events of last night. Resident #108 was observed in a female resident's room, touching her thigh area. When questioned, Resident #108 stated he did not remember doing that. Resident #108 stated he was a "people person and tended to be "touchy feely." Resident #108 was made aware that he is making other female residents feel nervous and uncomfortable. Resident #108 stated he meant no harm and was reminded that the perception of these female residents may differ. Resident #108 agreed that he would remain in the halls or public areas, not go into other resident's rooms, and would keep his hands to himself. SW spoke with Resident #108's RP. Staff continuing to monitor Resident #108's whereabouts.</p> <p>A behavioral care plan initiated on 09/10/21 revealed Resident #108 displayed inappropriate touching, especially toward females. The approaches identified were for staff to encourage him to participate in activities to keep him busy and redirect him when he attempted to touch others.</p>	F 622	<p>be readmitted back to the facility, and resident's spouse declined the bed offer.</p> <p>POTENTIALLY AFFECTED RESIDENTS:</p> <p>To ensure other residents were not affected by this deficient practice, the Social Worker and Case Mix Director conducted 100% audit on 1/31/2022 of all residents that were discharged in the last 30 days to ensure they meet criteria for appropriate transfer/discharge per facility policy and procedures. No other issues were found.</p> <p>On 1/31/2022, the Area Vice President educated the Administrator on Transfer and Discharge Requirements and F622 requirements.</p> <p>The Administrator On 1/31/2022 educated the Director of Social Services, Director of Health Services, Financial Counselor and Case mix Director on Transfer and Discharge Requirements and F622 requirements</p> <p>All new staff that are hired in these roles will be trained upon hire.</p> <p>Social Services Director and/or Case Mix Coordinator will audit all discharges beginning the week of 1/31/2022 of all discharges to ensure they meet all requirements for transfer and discharge weekly times four (4) weeks, biweekly times one (1) month then once monthly times two (2) months.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
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F 622	<p>Continued From page 11</p> <p>The quarterly Minimum Data Set (MDS) dated 10/23/21 assessed Resident #108 with severe cognitive impairment and displaying no behaviors during the MDS assessment period. The MDS noted Resident #108's RP did not wish to talk to anyone about the possibility of Resident #108 leaving the facility and returning to the community to live and receive services.</p> <p>A staff progress note dated 10/25/21 completed by the SW noted in part, Resident #108 was observed by staff in a female resident's room, lying in bed with the female resident, and he was immediately removed from the room. Resident #108's RP was notified of the incident on 10/25/21, as well as previous instances of him going into female residents' rooms, and came into facility to speak with the Administrator and SW. The Administrator and SW explained to the RP that Resident #108 was not compliant with staying out of female resident's room and his behavior had now escalated to this morning's incident. The RP was informed that Resident #108 would not be able to remain at facility due to the potential threat to others. The RP has chosen to take Resident #108 home.</p> <p>A physician's progress note dated 10/25/21 revealed Resident #108 was evaluated due to agitated behavior and worsening Parkinson's disease and read in part, "Resident #108 was admitted to the facility for rehabilitation services after hospitalization for multiple falls, weakness and need for increased assistance with care. While at the facility, Resident #108's medication was increased due to anxiety and visual hallucinations associated with Parkinson's disease. His hallucinations overall have improved; however, his mental status continues</p>	F 622	<p>Results of audits will be forwarded to the Quality Assurance and Performance Improvement Committee for review times three (3) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p> <p>The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective Action will be completed by 2/2/2022.</p>	

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F 622	Continued From page 12 to decline. He has wandered into other resident rooms with witnessed behavior of inappropriate touching of other female residents, a meeting was held with his RP and he will be discharged from the facility. Medications for a 30-day supply along with home health services will be sent with the patient." There was no notation describing the specific needs that could not be managed or met at the facility and the facility efforts to meet those needs. The discharge MDS dated 10/25/21 for Resident #108 was coded as "return not anticipated." During a telephone interview on 01/04/22 at 10:35 AM, Resident #108's Family Member recalled when Resident #108's RP told him about the incident that occurred on 10/25/21, the RP stated she was informed by facility staff that Resident #108 could not remain in the facility and she had to take him home that same day. During a telephone interview on 01/05/22 at 9:55 AM, Resident #108's RP confirmed she was notified of the incident involving Resident #108 and another resident on 10/25/21 and came to the facility. The RP stated once at the facility, she spoke with the Administrator and SW and during the conversation, was informed Resident #108 had to be out of the facility within 24 hours. The RP added this came as a shock to her because she had planned for Resident #108 to remain at the facility for long-term care. The RP did not recall anyone offering to assist with finding alternate placement for Resident #108. The RP added during the conversation, she was made to believe there were no other options and she felt she had no choice but to take him home on 10/25/21. The RP reported Resident #108 was	F 622		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 622 Continued From page 13 F 622

recently placed in another skilled nursing facility approximately one hour from her home and she was no longer able to visit with him daily.

A telephone attempt on 01/06/22 at 9:35 AM to speak with the facility's former physician who evaluated Resident #108 on 10/25/21 was unsuccessful.

During an interview on 01/06/22 at 4:41 PM, the Administrator explained on 10/25/21 she and the SW spoke with Resident #108's RP at the facility to discuss the incident involving him and another resident. The Administrator stated prior to the incident on 10/25/21, there were complaints from other female residents that Resident #108 was too friendly, such as sitting too close and talking too much, but nothing about him touching them inappropriately, just that they didn't like it when he got into their personal space. The Administrator recalled Resident #108's RP stated Resident #108 told her he did not do what was accused and the RP felt he wouldn't lie to her. The Administrator explained to the RP they had to protect the safety of other residents and could not have Resident #108 displaying that type of behavior. She added they discussed with the RP finding alternate placement at other skilled nursing facilities or assisted living facilities; however, Resident #108's RP wanted to visit facilities before referrals were made. The Administrator stated she explained to the RP that until alternate placement could be found for Resident #108, he would remain under one-to-one staff supervision. On 10/25/21 mid-morning, the Administrator stated she was informed by the SW that Resident #108's RP had returned to the facility with luggage to take Resident #108 home. The Administrator recalled

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 622 Continued From page 14 F 622

when she spoke with Resident #108's RP again, the RP stated she did not want Resident #108 going to another facility and wanted to take him home. The Administrator stated they then discussed the home health services Resident #108 would need, all services were arranged, remaining medications were given to the RP, prescriptions were called in to the preferred pharmacy, and he was discharged home with the RP on 10/25/21. The Administrator stated that although they discussed sending referrals for placement to other facilities, neither she nor the SW told Resident #108's RP she had 24 hours to remove him from the facility and was not sure how the RP misconstrued the conversation thinking she had no choice but to take Resident #108 home.

During a joint interview on 01/07/22 at 1:34 PM, the SW and Administrator confirmed they both met with Resident #108's RP on 10/25/21 to discuss his behaviors. Both the SW and Administrator confirmed they did not mention an official discharge or imply to the RP Resident #108 had to be removed from the facility within 24 hours. Both the SW and Administrator stated the RP's recollection of their discussion was not how it was presented and explained during the conversation, they only mentioned the possibility of finding alternate placement in the event Resident #108's behaviors did not improve and at the time, there were no plans for his discharge. The Administrator confirmed there was no written physician statement in Resident #108's's medical record summarizing the specific needs that could not be met, facility efforts to meet those needs or the specific services another facility could provide that would meet his needs.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 15	F 623		
F 623	Notice Requirements Before Transfer/Discharge	F 623		2/2/22
SS=D	CFR(s): 483.15(c)(3)-(6)(8)			
	<p>§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is</p>			

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F 623	<p>Continued From page 16</p> <p>required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. 	F 623		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	<p>Continued From page 17</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party (RP) and staff, the facility failed to provide a resident's RP written notification explaining the reason why the resident was being discharged 30 days before discharge that included a statement of the resident's appeal rights for 1 of 2 residents reviewed for transfer and discharge (Resident #108). The findings included: Resident #108 was admitted to the facility on 07/19/21. A staff progress note dated 10/25/21 completed by the SW noted in part, Resident #108 was observed by staff in a female resident's room, lying in bed with the female resident, and he was immediately removed from the room. Resident</p>	F 623	<p>AFFECTED RESIDENT/CORRECTIVE ACTION:</p> <p>The affected resident no longer resides in the facility. The Administrator and Director of Health Services called Resident #108's spouse on 1/28/22 to discuss readmission to the facility and the call was not answered. A follow up call was made on 1/31/22 by Administrator and Financial Counselor, bed offer was made for Resident #108 to be readmitted back to the facility, and resident's spouse declined the bed offer.</p> <p>POTENTIALLY AFFECTED RESIDENTS:</p> <p>All discharged residents have the potential to be affected.</p>	

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F 623	<p>Continued From page 18</p> <p>#108's RP was notified of the incident on 10/25/21, as well as previous instances of him going into female residents' rooms, and came into facility to speak with the Administrator and SW. The Administrator and SW explained to the RP that Resident #108 was not compliant with staying out of female resident's room and his behavior had now escalated to this morning's incident. The RP was informed that Resident #108 would not be able to remain at facility due to the potential threat to others. The RP has chosen to take Resident #108 home.</p> <p>During a telephone interview on 01/05/22 at 9:55 AM, Resident #108's RP confirmed she spoke with the Administrator and SW on 10/25/21 to discuss Resident #108's behaviors. During the same conversation, the RP stated she was informed Resident #108 had to be out of the facility within 24 hours. The RP added this came as a shock to her because she had planned for Resident #108 to remain at the facility for long-term care. The RP did not recall anyone offering to assist with finding alternate placement for Resident #108. The RP added during the conversation, she was made to believe there were no other options and she felt she had no choice but to take him home on 10/25/21. The RP reported Resident #108 was recently placed in another skilled nursing facility approximately one hour from her home and she was no longer able to visit with him daily.</p> <p>During a joint interview on 01/07/22 at 1:34 PM, the SW and Administrator confirmed they both met with Resident #108's RP on 10/25/21 to discuss his behaviors. Both the SW and Administrator confirmed they did not mention an official discharge or imply to the RP Resident</p>	F 623	<p>SYSTEMIC CHANGES: Administrator and Social Worker reviewed each resident record to address discharge planning and have imminent discharge plans. This was completed on 2/1/2022.</p> <p>Administrator received in-service by Area Vice President on 1/31/2022 on facility-initiated discharges per regulations, including notification to Ombudsman and resident representative.</p> <p>The Administrator conducted on in-service 1/31/2022 to Social Services Director, Case Mix Coordinator, Director of Health Services and Financial Counselor on facility-initiated discharges per regulations, including notification to Ombudsman and resident representative.</p> <p>Administrator and/or designee will audit each facility-initiated discharge to ensure written notification explaining the reason why the resident is being discharged and the resident's appeal rights for transfer and discharge has been provided to resident and/or resident representative timely per regulation weekly time four (4) weeks then monthly times three (3).</p> <p>Results of audits will be forwarded to the Quality Assurance and Performance Improvement Committee for review times three (3) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued</p>	

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F 623	Continued From page 19 #108 had to be removed from the facility within 24 hours. Both the SW and Administrator stated the RP's recollection of their discussion was not how it was presented and explained during the conversation, they only mentioned the possibility of finding alternate placement in the event Resident #108's behaviors did not improve and at the time, there were no plans for his immediate discharge. The Administrator confirmed there was no written documentation provided to Resident #108's RP explaining the reason he was discharged since it was the RP's choice to take him home.	F 623	compliance. The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective Action will be completed by 2/2/2022.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Physician Assistant (PA) and the Medical Director (MD), the facility failed to discontinue a probiotic as ordered resulting in 23 additional administrations of the supplement for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #14). The findings included: Resident #14 was admitted to the facility on 05/09/21 with diagnoses included urinary tract infection (UTI). The quarterly Minimum Data Set (MDS)	F 658	AFFECTED RESIDENTS: The deficient practice affected Resident #14. Medication was discontinued on 9/23/2022. No adverse effect noted as a result of this deficient practice. POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by this deficient practice. The Assistant Director of Health Services (ADHS) and designee reviewed all pharmacy recommendations for the last 3 reviews to ensure all recommendations have been accepted by the providers and implemented. This was completed on	2/2/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 658	<p>Continued From page 20</p> <p>assessment dated 11/01/21 coded Resident #14 with severe impairment in cognition.</p> <p>A physician's order dated 01/25/21 indicated Resident #14 was ordered to receive 1 capsule of probiotic 1.5 milligram (mg) by mouth once a day.</p> <p>Review of Consultant Pharmacist's recommendation dated 08/16/21 revealed the Consultant Pharmacist had recommended to discontinue the probiotic as Resident #14 was no longer on antibiotic therapy. The Physician Assistant (PA) agreed and had signed and dated the recommendation on 08/31/21.</p> <p>Review of the Medication Administration Records (MARs) revealed Resident #14 had received 1 capsule of probiotic 1.5 mg once daily from 09/01/21 through 09/23/21. Further review of the MARs indicated Resident #14 was not receiving any antibiotic throughout September 2021.</p> <p>During an interview conducted on 01/06/22 at 2:43 PM, Nurse #7 confirmed Resident #14 had received 23 capsules of probiotic in September 2021.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) on 01/06/22 at 3:12 PM. She stated every month after the Consultant Pharmacist had reviewed all the medication regimens for the residents, the Consultant Pharmacist would forward all the recommendations to her. Then, she would sort all the recommendations and forward it to the 3 physicians working under the Medical Director (MD) to address the recommendations. Resident #14's Consultant Pharmacist's recommendation were handled by the PA who was also responsible</p>	F 658	<p>2/1/2022.</p> <p>SYSTEM CHANGE: To ensure continued compliance, the Director of Health Services and Assistant Director of Health Service conducted an in-service training to providers and all nursing staff regarding pharmacy recommendations and implementation of the pharmacy recommendations in a timely manner on 1/27/22 and completed on 2/2/2022.</p> <p>MONITORING: The Director of Health Services and/or designee will audit the pharmacy recommendations for the next three (3) reviews to ensure all recommendations have been accepted and implemented in a timely manner. If there are findings, the Director of Health Services and/or designee will immediately correct the issue. The audit will continue until 100% compliance is obtained and maintained. Results of monitoring will be summarized and presented to the facility Quality Assurance Performance Improvement Committee meeting by the Director of Health Services and/or designee and will be reviewed for two (2) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance. The Director of Health Services and Administrator are responsible for implementing and maintaining the acceptable plan of correction.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2022
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F 658	<p>Continued From page 21</p> <p>to implement all the accepted recommendations in the computer system. The PA failed to discontinue the probiotic order and did not notify her to discontinue it for him. When the PA returned the recommendations to her on 09/23/21, she noticed that the probiotic order was still active, and she discontinued the order immediately.</p> <p>During an interview conducted on 01/06/22 at 3:25 PM, the Director of Nursing (DON) stated it was her expectation for all the Consultant Pharmacist's recommendations accepted by the physician to be in place in a timely manner.</p> <p>During a phone interview conducted on 01/06/22 at 5:15 PM, the MD stated it was very unlikely that 23 additional doses of probiotic would cause any physical harm to Resident #14. It was his expectation for all the Consultant Pharmacist's recommendations approved by the physician to be implemented in a timely manner.</p> <p>An interview was conducted with the Administrator on 01/06/22 at 5:34 PM. She stated it was her expectation for all the Consultant Pharmacist's recommendations agreed by the physician to be executed in a timely manner.</p> <p>During a phone interview conducted on 01/07/22 at 12:07 PM, the PA recalled after he had reviewed the Consultant Pharmacist's recommendation and decided to discontinue the probiotic, he had forgotten to discontinue the order in the computer system.</p>	F 658	<p>Corrective action will be completed by 2/2/2022.</p>	
F 810	<p>Assistive Devices - Eating Equipment/Utensils SS=E CFR(s): 483.60(g)</p>	F 810		2/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2022
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F 810	<p>Continued From page 22</p> <p>§483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide adaptive equipment for meals for 4 of 5 residents reviewed for adaptive equipment (Resident #9, Resident #14, Resident #30, and Resident #39).</p> <p>Findings included:</p> <p>1. Resident #9 was admitted to the facility 03/27/20 with diagnoses including non-Alzheimer's dementia and cerebrovascular accident (abbreviated as CVA and meaning a stroke).</p> <p>A regular mechanical soft diet with built-up utensils (utensils with large handles that decrease the amount of hand strength needed to grip silverware), a divided plate (a plate with partitions that help push food onto the utensil), and a cup with a lid and a straw was ordered 04/17/21.</p> <p>A quarterly Minimum Data Set (MDS) dated 12/16/21 revealed Resident #9 was severely cognitively impaired, required supervision assistance with eating, and received a mechanically altered diet.</p> <p>The nutrition care plan last revised 01/06/22 revealed Resident #9 had difficulty feeding herself and required a cup with a lid and a straw, built-up utensils, and a divided plate to support</p>	F 810	<p>AFFECTED RESIDENTS: The deficient practice affected Resident #9, Resident #14, Resident #50, and Resident #39. The Director of Health Services and Rehab. Manager reviewed Occupational Therapy recommendations on 1/25/22 and completed on 1/28/22 for all affected residents to ensure assistive devices <input type="checkbox"/> eating equipment and/or utensils are still appropriate. Resident #9 and Resident #30 adaptive equipment were discontinued on 1/28//2022 per Occupational Therapy recommendation.</p> <p>POTENTIALLY AFFECTED RESIDENTS: A review of dietary tray cards and Occupational Therapy recommendations was completed on 2/1/22 by the Director of Health Services and Dietary Manager to ensure residents have assistive devices <input type="checkbox"/> eating equipment/utensils as recommended.</p> <p>SYSTEMS CHANGE: The Director of Health Services conducted an in-service on 1/27/22 and was completed on 2/2/22 to nursing and dietary staff of ensuring assistive devices <input type="checkbox"/> eating equipment/utensils is on resident's tray per Occupational Therapy recommendations and tray card.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
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OMB NO. 0938-0391

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F 810	<p>Continued From page 23</p> <p>self-feeding with meals.</p> <p>An observation of Resident #9's tray card on 01/03/22 at 12:26 PM revealed she was to receive a cup with a lid and a straw. An observation of Resident #9's meal tray revealed there was no cup with a lid and a straw.</p> <p>An interview with Nurse Aide (NA)#7 on 01/03/22 at 12:41 PM revealed she did not check the tray card for Resident #9 when she set up the meal tray and did not notice Resident #9 did not receive a cup with a lid and a straw.</p> <p>An interview with the Dietary Manager on 01/03/22 at 1:02 PM revealed a dietary aide checked the meal trays for accuracy, including the presence of adaptive equipment, before the trays left the kitchen and she did not know why Resident #9 did not receive a cup with a lid and a straw on her meal tray.</p> <p>A joint interview with Dietary Aide #1 and the Dietary Manager on 01/03/22 at 1:08 PM revealed Dietary Aide #1 was responsible for ensuring accuracy of meal trays before they left the kitchen for the lunch meal on 01/03/22. The Dietary Manager and Dietary Aide #1 stated Resident #9 not receiving a cup with a lid and straw on her meal tray was an oversight.</p> <p>An observation of Resident #9's meal tray on 01/05/22 at 12:45 PM revealed her food was served on a regular plate instead of a divided plate.</p> <p>A follow-up interview with the Dietary Manager on 01/05/22 at 12:53 PM revealed approximately 2 weeks ago the Occupational Therapist saw a</p>	F 810	<p>In-service education also included staff serving the tray will make sure all adaptive equipment is present on the tray and if it was not present on the tray, staff will obtain adaptive equipment from the kitchen or the Rehab. Dept.</p> <p>The Registered Dietitian have modified the tray ticket feature so that the adaptive equipment is in larger font and is underlined on 1/27/2022.</p> <p>The Dietary Manager will print the adaptive equipment report from Meal Tracker weekly and will be posted in the kitchen for staff to review and as a reference if needed.</p> <p>The Dietary Manager and/or designee will compare dietary tray cards and meal trays on tray line to ensure adaptive equipment is on resident tray as recommended by Occupational Therapist.</p> <p>Nursing and Dietary Staff who have not received education will be educated before working their next assigned shift by the Director of Health Services and/or designee.</p> <p>MONITORING: The Director of Health Services (DHS) and/or designee will complete quality monitoring on 5 residents with assistive devices <input type="checkbox"/> eating equipment/utensils two (2) times weekly to include breakfast, lunch or dinner meals and weekends for twelve (12) weeks then monthly times three (3) months to validate resident</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 810	<p>Continued From page 24</p> <p>number of residents and recommended their food be served on divided plates. She stated since that time there had not been enough divided plates to serve every resident's food on a divided plate that had an order for a divided plate.</p> <p>The Dietary Manager provided an invoice on 01/05/22 at 12:53 PM for 15 divided plates that were ordered on 12/31/21.</p> <p>An interview with the Occupational Therapist (OT) on 01/06/22 at 9:08 AM revealed the recommendation for Resident #9 to receive a cup with a lid and a straw was to decrease the chances of her spilling her beverages. She stated the divided plate helped Resident #9 scoop her food onto her utensils and allowed more independence with feeding herself. The OT stated if adaptive equipment was not available she would like to be notified so she could suggest an alternative.</p> <p>An interview with the Director of Nursing (DON) on 01/07/22 at 12:07 PM revealed she expected nursing staff to check the tray card to make sure all adaptive equipment was in place when setting up the meal tray and if it was not to notify the nurse, herself, or the kitchen to obtain the correct equipment.</p> <p>An interview with the Administrator on 01/07/22 at 12:36 PM revealed she expected staff in the kitchen to ensure trays left the kitchen with the correct adaptive equipment in place. She also stated she expected the staff serving the tray to make sure all adaptive equipment was present on the tray and if it was not to go to the kitchen or the Rehab Department to get the correct equipment.</p> <p>2. Resident #14 was admitted to the facility</p>	F 810	<p>provided assistive devices/equipment as recommended. Opportunities will be corrected by the Director of Health Services and/or designee as identified during these quality monitoring.</p> <p>The Director of Health Services and/or designee will monitor adaptive equipment report from Meal Tracker is posted in the kitchen weekly for four (4) weeks then monthly times three (3) months.</p> <p>The Director of Health Services and/or designee will report on the results of the quality monitoring during the monthly Quality Assurance and Performance Improvement Committee meeting times three (3) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p> <p>The Director of Health Services and Administrator are responsible for implementing and maintaining the acceptable plan of correction.</p> <p>Corrective Action will be completed by 2/2/2022.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 810	<p>Continued From page 25</p> <p>05/09/11 with diagnoses including Alzheimer's disease and non-Alzheimer's dementia.</p> <p>Review of Resident #14's medical record revealed an order for a divided plate dated 05/21/19.</p> <p>Review of the quarterly MDS dated 11/01/21 revealed Resident #14 was severely cognitively impaired, required supervision assistance with eating, and received a mechanically altered therapeutic diet.</p> <p>The nutrition care plan last revised 12/22/21 revealed Resident #14 experienced weight loss related to dementia and should be encouraged with oral intake of food and fluids.</p> <p>An observation of Resident #14's tray card on 01/03/22 at 12:32 PM revealed Resident #14 was to receive her food in a divided plate. An observation of Resident #14's meal tray at the same date and time revealed her food was served on a regular plate instead of a divided plate.</p> <p>An interview with NA #7 on 01/03/22 at 12:41 PM revealed she did not check the tray card when she set up Resident #14's meal tray and did not notice Resident #14 did not receive her food on a divided plate.</p> <p>An interview with the Dietary Manager on 01/03/22 at 1:02 PM revealed a dietary aide checked the meal trays for accuracy, including the presence of adaptive equipment, before the trays left the kitchen and Resident #14 did not receive her food on a divided plate because the kitchen ran out of divided plates. She stated trays were delivered to the Memory Service Unit</p>	F 810		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 810	<p>Continued From page 26</p> <p>(MSU) first and most of those residents received their food on a divided plate so sometimes the kitchen ran out of divided plates.</p> <p>An interview with the Occupational Therapist (OT) on 01/06/22 at 9:12 AM revealed Resident #14 needed a divided plate to help her scoop her food onto her utensils to allow more independence with feeding herself. The OT stated if adaptive equipment was not available she would like to be notified so she could suggest an alternative.</p> <p>An interview with the Director of Nursing (DON) on 01/07/22 at 12:07 PM revealed she expected nursing staff to check the tray card to make sure all adaptive equipment was in place when setting up the meal tray and if it was not to notify the nurse, herself, or the kitchen to obtain the correct equipment.</p> <p>An interview with the Administrator on 01/07/22 at 12:36 PM revealed she expected staff in the kitchen to ensure trays left the kitchen with the correct adaptive equipment in place. She also stated she expected the staff serving the tray to make sure all adaptive equipment was present on the tray and if it was not to go to the kitchen or the Rehab Department to get the correct equipment.</p> <p>3. Resident #30 was admitted to the facility 09/09/20 with diagnoses including CVA and paraplegia (paralysis of one side of the body).</p> <p>Review of the quarterly MDS dated 11/19/21 revealed Resident #30 was cognitively intact and required supervision assistance with eating.</p> <p>The nutrition care plan last revised 11/30/21 revealed Resident #30 was at nutrition risk</p>	F 810		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

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F 810	<p>Continued From page 27</p> <p>related to facility admission and was to have Speech Therapy evaluation and treatment as ordered.</p> <p>Review of the medical record revealed an order for red foam handles for utensils on 03/22/21.</p> <p>An observation of the tray card for Resident #30 revealed he was to receive red foam handles for his utensils. An observation of Resident #30's meal tray at the same date and time revealed no red foam handles were on his tray.</p> <p>An interview with the Dietary Manager on 01/03/22 at 1:02 PM revealed red foam handles were kept in resident rooms.</p> <p>The Dietary Manager looked in Resident #30's room on 01/03/22 at 1:04 PM and was unable to locate red foam handles in his room.</p> <p>An interview with NA #6 on 01/03/22 at 1:05 PM revealed she did not look at the tray card when she delivered Resident #30's meal tray and did not notice he did not have red foam handles on his utensils.</p> <p>An interview with the Occupational Therapist (OT) on 01/06/22 at 9:12 AM revealed Resident #30 usually kept his red foam handles for utensils in his room. She stated the red foam handles aided Resident #30 with gripping objects, including his utensils. The OT stated she had plenty of red foam available in the therapy department and no one had notified her there were no red foam handles in Resident #30's room.</p> <p>An interview with the Director of Nursing (DON) on 01/07/22 at 12:07 PM revealed she expected</p>	F 810		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 810	<p>Continued From page 28</p> <p>nursing staff to check the tray card to make sure all adaptive equipment was in place when setting up the meal tray and if it was not to notify the nurse, herself, or the kitchen to obtain the correct equipment.</p> <p>An interview with the Administrator on 01/07/22 at 12:36 PM revealed she expected staff in the kitchen to ensure trays left the kitchen with the correct adaptive equipment in place. She also stated she expected the staff serving the tray to make sure all adaptive equipment was present on the tray and if it was not to go to the kitchen or the Rehab Department to get the correct equipment.</p> <p>4. Resident #39 was admitted to the facility on 8/9/17 and current diagnoses included Alzheimer's Disease, dementia, and dysphagia (difficulty with swallowing).</p> <p>Review of the annual Minimum Data Set (MDS) dated 12/7/21 assessed Resident #39's cognition as being severely impaired with limited assistance needed for eating and no identified swallowing disorders.</p> <p>Resident #39's care plan last revised on 12/21/21 identified a problem with nutrition and potential for altered nutritional status related to the diagnosis of dysphagia with a mechanically altered and therapeutic diet in place and included interventions to observe for signs and symptoms of aspiration and notify the Medical Doctor as needed and serve the diet as ordered.</p> <p>During the dining observation made on 1/3/22 at 12:24 PM Resident #39 was feeding himself using a regular spoon and drinking juice from a regular plastic cup without difficulty.</p>	F 810		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 810 Continued From page 29

F 810

Review of the physician orders on 1/3/22 at 4:43PM revealed adaptive equipment included a maroon spoon (spoon with narrow, shallow bowls) and nosey cup (adaptive cup with a U-shaped cut out on one side).

A second dining observation made on 1/5/22 at 12:31 PM revealed Resident #39 was served a maroon spoon but no nosey cup. Resident #39 was able to feed himself using the maroon spoon and drink from the regular plastic cup without difficulty.

An interview was conducted with Nurse #3 on 1/5/22 at 12:37 PM. Nurse #3 revealed when a food tray was delivered missing adaptive equipment he would go to kitchen and ask if available if really needed and stated Resident #39 wasn't cognitively capable of using the nosey cup and tried to drink from the back of the cup. Nurse #3 revealed Resident #39 could drink from a regular plastic cup and didn't think it was necessary to go the kitchen and inquire about the nosey cup.

An interview was conducted on 1/6/22 at 9:07 AM with the Occupational Therapist (OT). The OT revealed Resident #39 attempts to use the nosey cup the wrong way and could be discontinued but the maroon spoon was in place to slow down eating. The OT stated Resident #39 was known to shovel food at a fast pace placing him at risk for aspiration and should always have the maroon spoon when eating.

An interview was conducted with Director of Nursing on 1/7/22 at 12:07 PM. The DON revealed when staff serve resident meals, they

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 810	Continued From page 30 should check the tray cards to make sure there were no problems and if they discover problems should ask the kitchen to try to resolve.	F 810			
F 812	Food Procurement,Store/Prepare/Serve-Sanitary SS=E CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard potentially hazardous food with signs of spoilage and discard expired food items available for resident use in 1 of 1 walk-in coolers, label and date food in 1 of 2 nourishment room freezers (in the nourishment room for 400, 500, 600 halls), remove expired food from 1 of 1 dry storage areas, and remove expired food from 1 of 2 storage bins. Findings included:	F 812		2/2/22	
			CORRECTIVE ACTION: Items from cold storage and dry storage were removed from coolers and dry storage room and were not used in production. Unlabeled frozen meals and food items from nourishment room freezer were removed and discarded. POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by this deficient practice. No		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2022
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD		STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712		
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F 812	Continued From page 31 1. An initial observation of the walk-in cooler on 01/03/22 at 10:14 AM revealed a tray of white grapes with signs of spoilage, a bag of parsley with signs of spoilage, a pack of salami with an expiration date of 01/01/22, and 2 bags of collard greens with a use-by date of 12/11/21. 2. An observation of the dry storage room on 01/03/22 at 10:35 AM revealed 5 packs of hamburger buns with a use by date of 12/31/21. 3. An observation of a flour bin that was approximately ¼ full revealed an expiration date of 12/24/21. 4. An observation of the nourishment room freezer for 400, 500, and 600 halls revealed 2 unlabeled frozen meals, an unlabeled frozen taco, and an unlabeled frozen sandwich. An interview with the Dietary Manager on 01/06/22 at 2:51 PM revealed all food should be used by or discarded by the expiration date. She stated she checked the cooler and dry storage for expired food weekly and she had not had time to check the cooler and dry storage the morning of 01/03/22. The Dietary Manager stated the nourishment room freezers were checked daily for unlabeled food and unlabeled food was removed but staff continued to place unlabeled items in the freezer. An interview with the Administrator on 01/07/22 at 12:36 PM revealed she expected all food to be labeled and used or discarded by the expiration date.	F 812	adverse effect was noted as a result of this deficient practice. SYSTEMS CHANGE: The Director of Health Services conducted an in-service on 1/27/2022 on dating, labeling, and discarding expired food items to all dietary staff. The in-service also included nursing staff on dating and labeling of food items placed in nourishment rooms refrigerator and/or freezer. Nursing and Dietary Staff who have not received education will be educated before working their next assigned shift by the Director of Health Services and/or designee. Updated signs were posted in each nourishment room on 1/28/22 as follows: Resident food and beverages must be labeled with their name and dated, frozen food will be discarded after 14 days, refrigerated food will be discarded after 48 hours and food/beverage without a name and date will be discarded. MONITORING: All items upon delivery will have a received date, open date and used by date. The Dietary Manager will do audits two (2) times weekly times eight (8) weeks, weekly times two (2) months then monthly times two (2) months to ensure all policies for labeling and discarding expired food items are being followed. The Dietary Manager and/or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2022
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F 812	Continued From page 32	F 812	<p>complete quality monitoring of nourishment room refrigerators/freezer two(2) times weekly times eight (8) weeks then weekly times four (4) weeks to ensure all policies for labeling of food items and discarding unlabeled food items are being followed. Opportunities will be corrected by the Dietary Manager and/or designee as identified during these quality monitoring.</p> <p>The Dietary Manager and/or designee will report on the results of the quality monitoring during the monthly Quality Assurance and Performance Improvement Committee meeting times three (3) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p> <p>The Administrator and Dietary Manager are responsible for implementing and maintaining the acceptable plan of correction.</p> <p>Corrective Action will be completed by 2/2/2022.</p>	
F 880	<p>Infection Prevention & Control SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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</p>	F 880		2/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022
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NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712
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F 880 Continued From page 33 F 880

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 least restrictive possible for the resident under the circumstances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022
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NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712
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F 880 Continued From page 34 F 880

(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, record review, and interviews with staff and the Infection Preventionist the facility failed to implement infection prevention for hand hygiene by not sanitizing hands and/or removing gloves when providing incontinence care to residents for 4 of 5 facility staff (Nurse #1, NA #1, NA#2, and NA #3) observed for infection control.

The findings included:

A review of the facility's policy and procedure titled, "Infection Prevention - Hand Hygiene revised on 3/8/19 stated indications requiring hand washing with soap and water or the use of an alcohol-based antiseptic hand rub included before and after contact with the resident, after

CORRECTIVE ACTION:

Identify the root cause resulting in the facilities failure: A thorough analysis of contributing factors which lead to identifying the root cause regarding the failure to implement infection prevention for hand hygiene by not sanitizing hands and/or removing gloves when providing incontinence care for Resident #33, Resident #39, and Resident #5 was conducted.

The internal investigation included:
"Interview with the CNAs and Nurse identified in the 2567.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/07/2022
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F 880	<p>Continued From page 35</p> <p>contact with body fluids or excretions, and when hands move from a contaminated body site to a clean body site during resident care.</p> <p>1. A continuous observation of Nurse #1 assisting Resident #33 with dressing, transfers, and incontinence care was made on 1/3/22 from 2:49 PM to 3:00 PM. Without performing hand hygiene Nurse #1 donned gloves then removed a pair of wet pants from Resident #33 and begun to wipe the resident's perineal and buttocks area with disposable wipes to assist with an episode of urinary incontinence. When completed with peri-care and while wearing the same gloves Nurse #1 removed Resident #33's wet shirt and place a clean shirt then physically assisted the resident by the arm to sit in a wheelchair Nuse #1 had pulled close while wearing the same gloves then dressed the resident in a pair of clean pants. While wearing the same gloves Nurse #1 wiped both of Resident #33's hands using disposable wipes. When Nurse #1 completed resident care, she removed her gloves and used an alcohol-based hand rub before exiting the room.</p> <p>During an interview on 1/3/22 at 3:29 PM when asked about hand hygiene Nurse #1 revealed she wore the same gloves to assist Resident #33 with urinary incontinence care, dressing, transfer, and personal hygiene. Nurse #1 revealed she knew incontinence care was a dirty process and when completed gloves should be removed and hand hygiene done. Nurse #1 stated she should've removed her gloves and washed her hands before putting gloves on and after urinary incontinence care before she continued to assist Resident #33.</p> <p>An interview was conducted with the Infection</p>	F 880	<p>"The completion of the 5 WHYS WORKSHEET in collaboration with the QAPI Committee. The analysis concluded the root cause is nursing staffing is challenged including the Clinical Competency Coordinator (CCC) who is responsible for the implementation and maintenance of re-education and competency regarding Infection Control /Infection Prevention including hand hygiene.</p> <p>The corrective action: The CNAs and Nurse were reeducated on 1/28/2022 by the Director of Health Services on the facility's policy on Infection Prevention-hand hygiene practices.</p> <p>POTENTIALLY AFFECTED RESIDENTS: All residents have the potential to be affected by this deficient practice.</p> <p>SYSTEMIC CHANGES: Solutions and systemic changes that need to be taken to address the root cause:</p> <p>1. On 1/27/22, the Director of Health Service started re-education to the current facility staff on facility's policy on Infection Prevention -Hand Hygiene. The in-service also includes CMS Recommendation LIVE HANDWAHING PRESENTATION via YouTube video. The Director of Health Services will continue the education which will be completed by 2/2/2022.</p> <p>A module on Relias, the facility's online continuing education platform, has been</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 36</p> <p>Preventionist (IP) on 1/5/22 at 10:19 AM. The IP revealed she had performed a hand hygiene audit back in November and observed concerns related to staff performing hand hygiene during resident care. The IP revealed she provided staff with education related to preventives of urinary tract infections including hand hygiene.</p> <p>During an interview on 1/7/22 at 12:07 PM the DON expected after incontinence care nursing staff should remove soiled gloves and perform hand hygiene. The DON also expected gloves be removed and hand hygiene performed before other items were touched.</p> <p>2. A continuous observation of incontinence care provided by NA #1 and NA #2 was made on 1/5/22 from 5:54 AM to 6:07 AM. NA #2 was observed to don gloves without performing hand hygiene. NA #1 and NA #2 assisted Resident #39 on his side and was held in position by NA #1 while NA #2 begun to provide incontinence care and wipe the resident's buttocks area to remove a small amount of stool. NA #1 squeezed a tube of protective cream into NA #2's hand who then applied the cream to the buttocks area. While wearing the same gloves NA #2 placed a clean brief and helped NA #1 reposition the resident then pulled up with the bed linens. While wearing the same gloves NA #2 touched the closet door handle to open and close the door. When completed with incontinence care NA #1 and NA #2 removed their gloves and used an alcohol-based hand rub before exiting the room.</p> <p>An interview was conducted on 1/5/22 at 6:15 AM with NA #1 and NA #2. NA #1 and NA #2 were asked about the facility's infection control policy</p>	F 880	<p>assigned to current facility staff on Basics of Hand Hygiene with completion date of 2/2/22. This education will be a part of new hire orientation.</p> <p>All other staff who have not received education and/or otherwise out will be educated before working their next assigned shift by the Director of Health Services and/or designee.</p> <p>2. The Nursing Home Administrator and Director of Health Services hired a nurse for the Clinical Competency Coordinator position and will assume her new role effective 2/1/2022. The Clinical Competency Coordinator (CCC) will be responsible for the implementation and maintenance of re-education and competency regarding Infection Control Prevention including Basic Hand Hygiene.</p> <p>3. The Director of Health Services and/or designee will observe three (3) employees per audit daily times five (5) days, weekly times four (4) weeks, bi-weekly times four (4) weeks and then monthly times two (2) months to ensure all policies on Infection Prevention □ Hand Hygiene are being followed. The audit will include all shifts and weekend shifts. Opportunities will be corrected by the Director of Health Services and/or designee as identified during these quality monitoring.</p> <p>MONITORING of approaches to ensure infection control policy are followed going forward:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD		STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712	
(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)
F 880	<p>Continued From page 37</p> <p>and training for hand hygiene. NA #1 revealed incontinence care was dirty process and both NA #1 and NA #2 stated gloves should be removed, and hand hygiene done before the resident or items in the room were touched.</p> <p>An interview was conducted with the Infection Preventionist (IP) on 1/5/22 at 10:19 AM. The IP revealed she had performed a hand hygiene audit back in November and observed concerns related to staff performing hand hygiene during resident care. The IP revealed she provided staff with education related to preventives of urinary tract infections including hand hygiene.</p> <p>During an interview on 1/7/22 at 12:07 PM the DON expected after incontinence care nursing staff should remove soiled gloves and perform hand hygiene. The DON also expected gloves be removed and hand hygiene performed before other items were touched.</p> <p>3. A continuous observation of incontinence care provided by NA #1 and NA #2 was made on 1/5/22 from 6:07 AM to 6:15 AM. Both NA #1 and NA #2 used an alcohol-based hand rub prior to donning gloves. NA #1 assisted Resident #5 on her side while NA #2 wiped the resident's buttocks area from front to back. When finished NA #2 repositioned the resident on her back while NA #1 wiped the resident's front perineal area from front to back. After NA #1 and NA #2 assisted Resident #5 with urinary incontinence care and while wearing the same gloves both placed pillows under and between the resident's legs then pulled the bed linens over the resident. While wearing the same gloves NA #2 pushed buttons on the bed remote located on foot board</p>	F 880	<p>The Nursing Home Administrator and/or designee will review the results of the quality monitoring observation audits weekly times three (3) weeks, bi-weekly times two (2) and then monthly times two (2) to ensure infection prevention control/infection prevention practices are followed and implemented per facility policy.</p> <p>Findings will be reported monthly to the Quality Assurance and Performance Improvement Committee meeting for review times three (3) months. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p> <p>Root Cause Analysis (RCA):</p> <p>Problem Statement: Infection Control <input type="checkbox"/> Proper Hand Hygiene when providing incontinence care.</p> <p>Define the Problem: 4 out of 5 facility staff failed to implement infection prevention for hand hygiene by not sanitizing hands and/or removing glove when providing incontinence care to residents.</p> <p>Why is it happening? (Identify each as a concern, influence, or control.)</p> <p>Interviews of 3 of the 4 staff demonstrated they had been trained on Infection Prevention - Hand Hygiene including</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022
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NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712
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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
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F 880 Continued From page 38

to adjust the height. NA #1 and NA #2 remove their gloves and use an alcohol-based hand rub before exiting the room.

An interview was conducted on 1/5/22 at 6:15 AM with NA #1 and NA #2. NA #1 and NA #2 were asked about the facility's infection control policy and incontinence care being a dirty process they potentially could come in contact with body fluids. NA #1 stated yes incontinence care was dirty process and both stated gloves should be removed, and hand hygiene done after incontinence care was provided to a resident.

An interview was conducted with the Infection Preventionist (IP) on 1/5/22 at 10:19 AM. The IP revealed she had performed a hand hygiene audit back in November and observed concerns related to staff performing hand hygiene during resident care. The IP revealed she provided staff education related to prevention of urinary tract infections including hand hygiene.

During an interview on 1/7/22 at 12:07 PM the DON expected after incontinence care nursing staff should remove soiled gloves and perform hand hygiene. The DON also expected gloves be removed and hand hygiene performed before other items were touched.

4. A continuous observation of Nurse Aide (NA) #3 providing Resident #22 with incontinence care was made on 01/05/22 from 6:19 AM through 6:26 AM. With her gloved hands NA #3 was observed cleaning stool, removing the soiled brief, and applying the clean brief. NA #3 assisted Nurse #5 pull Resident #22 up in bed, placed a pillow under Resident #22's left side, placed a pillow under Resident #22's head, raised the head of Resident #22's bed, pulled the sheet

F 880

sanitizing hands and/or removing gloves when providing incontinence care to residents but did not apply the core principle as their concentration was to complete the tasks at hand so they can move on quickly to the next resident/rest of the hall who may also need incontinence care.

1 of the 4 staff members stated she was not aware she was supposed to perform hand hygiene after providing incontinence care.

1. Why is that? There is a prolonged timeframe of lack of re-education and competency demonstration of the infection prevention/infection control practices which includes basic hand hygiene.
2. Why is that? There is not a designated staff member to implement and maintain a re-education and competency demonstration on infection control/infection prevention practice.
3. Why is that? The Clinical Competency Coordinator position has been an open position with lack of qualified applicants until recently.
4. Why is that? Staffing is challenged, particularly of nursing management staff i.e. the Clinical Care Coordinator (CCC) who is responsible for the implementation and maintenance of re-education and competency regarding infection control/infection practices per facility policy.
5. Why is that? The CCC position has been filled and will start on

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2022
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NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC 28712
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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
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F 880 Continued From page 39
over Resident #22, and pulled the blanket over Resident #22. NA #3 placed the soiled brief in the trash can, pulled back the privacy curtain, and removed her gloves. NA #3 did not remove her gloves and perform hand hygiene after providing incontinence care and continued to touch other items in Resident #22's room while wearing soiled gloves.

During an interview with NA #3 on 01/05/22 at 6:28 AM she confirmed she wore the same gloves after providing incontinence care that she used to touch other items in Resident #22's room. She stated she did not normally remove her gloves and perform hand hygiene after providing incontinence care because she didn't know she was supposed to.

An interview with the Director of Nursing (DON) on 01/07/22 at 12:07 PM revealed she expected staff to remove soiled gloves and perform hand hygiene after providing incontinence care and before touching other items in the resident's room.

F 880

her new role on 2/1/2022.

Caution: If your last answer is something you cannot control go back up to previous answer.

*Provided as a free template from CMS.gov

The Administrator and Director of Health Services are responsible for implementing and maintaining the acceptable plan of correction.

Corrective Action will be completed by 2/2/2022.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345462	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/7/2022
NAME OF PROVIDER OR SUPPLIER THE OAKS-BREVARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 MORRIS ROAD BREVARD, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 661	<p>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 2 of 2 residents reviewed for a planned discharge to the community (Resident #108 and #107). This practice had the potential to affect other residents who discharged from the facility.</p> <p>Findings included:</p> <p>1. Resident #108 was admitted to the facility on 07/19/21 and discharged to the community on 10/25/21.</p> <p>The quarterly Minimum Data Set (MDS) dated 10/23/21 coded Resident #108 with severe impairment in cognition.</p> <p>Review of Resident #107's Electronic Medical Record (EMR) revealed no discharge summary that included all the components of the recapitulation of stay and a final summary of the resident's status at discharge.</p> <p>During an interview on 01/04/22 at 3:30 PM, the Medical Records (MR) staff member explained a recapitulation of stay should be completed when a resident discharged from the facility. The MR staff member reviewed Resident #108's EMR and confirmed there was no recapitulation of stay completed.</p> <p>During an interview on 01/04/22 at 4:02 PM, the Director of Nursing (DON) revealed she was aware recapitulation of residents' stay were not being completed as required. The DON explained the facility was planning to hire a Nurse Navigator who would be responsible for ensuring recapitulation of stays were done when residents discharged from the facility. The DON confirmed there was no recapitulation of stay completed for Resident #108.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345462	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/7/2022
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F 661	<p>Continued From Page 1</p> <p>During an interview on 01/06/22 at 4:41 PM, the Administrator revealed the Nurse Navigator would be the person responsible for completing recapitulation of stay when a resident discharged from the facility; however, the position has been open since she started her employment in March 2021. The Administrator stated she would have expected for the DON, Assistant Director of Nursing, or nursing staff to complete a recapitulation of stay for discharged residents until the Nurse Navigator position was filled.</p> <p>2. Resident #107 was admitted to the facility on 07/23/21 and discharged to the community on 08/02/21.</p> <p>The discharge Minimum Data Set (MDS) dated 08/02/21 coded Resident #107 with severe impairment in cognition.</p> <p>Review of Resident #107's Electronic Medical Record (EMR) revealed no discharge summary that included all the components of the recapitulation of stay and a final summary of the resident's status at discharge.</p> <p>During an interview on 01/04/22 at 3:30 PM, the Medical Records (MR) staff member explained a recapitulation of stay should be completed when a resident discharged from the facility. The MR staff member reviewed Resident #107's EMR and confirmed there was no recapitulation of stay completed.</p> <p>During an interview on 01/04/22 at 4:02 PM, the Director of Nursing (DON) revealed she was aware recapitulation of residents' stay were not being completed as required. The DON explained the facility was planning to hire a Nurse Navigator who would be responsible for ensuring recapitulation of stays were done when residents discharged from the facility.</p> <p>During an interview on 01/06/22 at 4:41 PM, the Administrator revealed the Nurse Navigator would be the person responsible for completing recapitulation of stay when a resident discharged from the facility; however, the position has been open since she started her employment in March 2021. The Administrator stated she would have expected for the DON, Assistant Director of Nursing, or nursing staff to complete a recapitulation of stay for discharged residents until the Nurse Navigator position was filled.</p>
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