STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREMENT	180 SOUTHWOOD DRIVE CLINTON, NC 28328

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/06/22 through 09/08/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CMH311	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/06/22 through 09/08/22. Event ID# CMH311. The following intakes were investigated: NC00192671, NC00191438, NC00191434 and NC00191326 2 of the 19 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to ensure a resident identified with hearing difficulties was referred for treatment to maintain	F 685	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	9/30/22

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

Electronically Signed | 10/03/2022

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F 685	Continued From page 1 hearing ability for 1 of 1 resident (Resident #266) reviewed for communication. Findings included: Resident #266 was admitted to the facility on 2/24/18. Resident #266's significant change Minimum Data Set (MDS) dated 4/22/22 indicated she was cognitively intact. Resident #266 had minimal difficulty with hearing without a hearing aid. A Care Area Assessment indicated a referral to another discipline was warranted for hearing difficulty. A Care Plan dated 8/25/22 focused on communication problem related to hearing deficit/wax build up/no hearing aids included a goal for Resident #266 to maintain current level of communication through the review period. Interventions included anticipate needs as much as possible, review factors effecting underlying cause of communication deficit. An interview and observation were conducted on 9/7/22 at 8:50 AM of Resident #266 with difficulty hearing the surveyor and frequently requested repeat of words and answered questions inappropriately. Resident #266 admitted to being hard of hearing and would "love" to have hearing aids. She indicated the facility had not discussed hearing aids with her recently, but she had some many years ago. She stated she did not think she could afford new hearing aids. Resident #266 indicated that she did not like the group activities because of her difficulty hearing in crowds. She added that she liked to watch TV and do word searches in her room as well. She reported she	F 685	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F685 A corrective action for the facility failing to ensure a resident identified with hearing difficulties were referred for treatment to maintain hearing ability for 1 of 1 resident reviewed for communication. For resident #266 a consultation order was received from the attending MD on 9/29/2022 to consult with ENT (Ear Nose and Throat)/Audiologist for hearing loss. An appointment will be scheduled for resident #266 by 10/6/2022. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with moderate or highly impaired hearing impairment have the potential to be affected by the alleged deficient practice. On 9/29/2022, the Nurse Management team completed an audit of all current residents. The audit consisted of assessing each residents ear canal for any signs of wax buildup or infection that may affect hearing ability. This was completed by using an Otoscope to inspect each residents ear canal. Findings were then shared with the facility Medical Director on 9/29/2022 and new orders initiated as indicated. In addition, on 9/30/2022 the Nurse	

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F 685	Continued From page 2 was content with these activities in her room. During an interview on 9/7/22 at 2:40 PM, the Social Worker revealed she spoke with Resident #266 weekly, and she had not mentioned wanting hearing aids. She did indicate Resident #266 was hard of hearing. The Social Worker revealed she was new to the facility and was unsure if Resident #266 had seen a hearing specialist in the past. During an interview on 9/8/22 at 9:00 AM, Nurse Aid #1 indicated that Resident #266 was hard of hearing but could communicate without difficulty. She did not recall Resident #266 having trouble understanding or making her needs known. During an interview on 9/8/22 at 1:20 PM, the MDS nurse indicated that she had marked "yes" for a referral to another specialist but had not discussed with Resident #266 a referral to a hearing specialist. She indicated she should have discussed this with Resident #266 and gotten a referral if requested. The MDS Nurse indicated that she worked with the social worker to get appointments with the facility's hearing specialist or an outside agency. During an interview on 9/8/22 at 4:45 PM, the Administrator revealed if a resident triggered in the MDS for a hearing problem, they should be referred to a hearing specialist. The MDS nurse and the social worker worked together to get appointments as needed.	F 685	Consultant audited all current resident Care Area Assessment at Section Communication to identify if any resident should have been referred to another specialist. If a referral was indicated, one will be scheduled. This was completed by 9/30/2022. Systemic changes In-service education began on 9/29/2022 and was provided to all full time, part time, and as needed nurses including agency. Topics included: • Problems with hearing can contribute to sensory deprivation, social isolation, and mood and behavior disorders. • Unaddressed communication problems related to hearing impairment can be mistaken for confusion or cognitive impairment. • Hearing is assessed quarterly with the MDS assessment and as needed should concerns arise. Residents with difficulty hearing should be assessed for cause to include but not limited to wax build up, infection, and or need for hearing aide equipment or repair of current equipment. • The provider should be notified of any wax build up for interventions. • If the resident needs an audiology consult, contact the provider for an order and notify transportation of the consult request. This information has been integrated into the standard orientation training and the required in-service refresher courses for all Nurses and will be reviewed by the Quality Assurance process to verify that	

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F 685	Continued From page 3	F 685	the change has been sustained. Staff that have not received the education by 10/6/2022 will not be allowed to work. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor tag F685 using the Hearing Assessment QA tool for auditing a sample of residents for hearing impairment to ensure hearing needs are addressed and any previous interventions were carried out. Audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Completion date: 10/6/2022	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		9/30/22

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F 761	Continued From page 4 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure a medication for one of four medication carts observed (medication cart #1). Findings included: On 9/7/22 at 10:30 AM through 10:36 AM, a continuous observation was made. Nurse #1 was observed preparing medications. The nurse locked medication cart #1, leaving a bottle of Fluticasone Spray (nasal spray) on top of medication cart #1. Nurse#1 stated she had to store the nasal spray in another medication cart (medication cart #2). Nurse #1 was observed left the bottle of Fluticasone spray on top of the medication cart #1 and then proceeded to go into a resident's room where medication cart #1 was	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 A corrective action for failing to secure a medication for one of four medication carts observed (medication cart #1).	

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F 761	Continued From page 5 out of direct sight of Nurse #1. Nurse #1 returned to medication cart #1 and the bottle of Fluticasone Spray (nasal spray) was still observed on top of medication cart #1. An interview with Nurse #1 was conducted on 9/7/22 at 10:36 AM. Nurse #1 stated the bottle of nasal spray should not have been left on top of medication cart #1 unattended. Nurse #1 proceeded to pick up the bottle and gave it to Medication Aide #1 to store in medication cart #2. An interview with the Director of Nursing (DON) on 9/7/22 at 3:40 PM was conducted. The DON stated medications should not be left unattended on top of medication carts. During an interview conducted on 9/8/22 at 11:51 AM, the Administrator stated nurses should complete their medication pass in compliance with medication administration and medication storage.	F 761	Nurse #1 removed the medication from a top the medication cart and secured it in the locked medication cart #1. This was completed on 9/7/2022. Immediate education was provided to Nurse #1 by the Nurse Consultant. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 9/28/22, 9/29/2022, and 9/30/2022, the Nurse management team completed an audit observing all current medication carts for the following: observed to ensure the medication cart was locked and audited to ensure no medications were left unattended on the cart. This was completed by 9/30/2022. Systemic changes In-service education began on 9/29/2022 and was provided to all full time, part time, and as needed nurses and medication aides including agency nurses. Topics included: • Medication cart must be kept locked when out of sight of the Nurse or Medication Aide. • Medications cannot be left unattended on top of the medication cart at any time. This information has been integrated into the standard orientation training and the required in-service refresher courses for all Nurses and Medication Aides and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Staff that have not	

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F 761	Continued From page 6	F 761	received the education by 10/6/2022 will not be allowed to work. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor tag F761 using the Med Cart QA tool for auditing medication cart locked when not attended by a nurse or medication aide and audit for medications being left unattended on the medication cart. Audits will be completed weekly x 2 weeks then monthly x 3 months. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Completion date: 10/6/2022	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		9/30/22

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F 812	Continued From page 7 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 date leftover food stored for use in one of one kitchen walk-in refrigerator and failed to date leftover food in one of one nourishment room (300 hall) refrigerator. This had the potential to effect 70 of 70 residents. Findings included: 1. A tour was conducted on 9/6/22 at 9:50 AM with the facility's cook of the kitchen walk-in refrigerator. Observations were made of a large container of tomato sauce with no label, a large container of tomato soup with no label, and a bag of cheese with no label. During an interview on 9/6/22 at 9:55 AM, the cook indicated staff should be labeling everything in the walk-in refrigerator with the date opened and the discard date. Staff monitored the refrigerators daily. An observation was made on 9/7/22 at 9:50 AM of the walk-in refrigerator with the dietary manager present of a container of mixed	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 9/6/2022 and 9/7/2022. During initial walk through of the kitchen and follow-up observation, it was noted dietary services had failed to properly label and date a container of tomato soup, bag of cheese, and bag of vegetables. During observation of the nourishment room refrigerator/freezer a Styrofoam	

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F 812	Continued From page 8 vegetables with no label. During an interview on 9/7/22 at 9:55 AM, the dietary manager revealed the cook should check the refrigerators daily and sign off on the task list. Staff should label every item placed in the walk-in refrigerator with the date it was opened and the discard date. During an interview on 9/8/22 at 9:35 AM, the Administrator revealed the dietary manager should be monitoring the walk-in refrigerator to ensure items are labeled and dated. 2. A tour was conducted on 9/6/22 at 10:15 AM of the facility's 300 hall nourishment room with the cook present. Observations were made of a Styrofoam to-go box of food with a resident's name and room number with no date, another Styrofoam to-go box of food with a resident's room number and no date, a bag of meat with a resident's name and room number with no date. During an interview on 9/6/22 at 10:15 AM, the cook revealed housekeeping staff was responsible for discarding food from the nourishment room refrigerator. Nursing staff was responsible for labeling with the resident's name and date. During an interview on 9/7/22 at 3:30 PM, the housekeeping manager revealed housekeeping staff monitored the nourishment room refrigerators daily and should discard any food that was not dated. He revealed he had not audited the nourishment room in about a month. During an interview on 9/8/22 at 9:35 AM, the Administrator revealed the housekeeping manager should be monitoring the nourishment	F 812	to-go box and a bag of meat were to be without resident names and dates. On 9/7/2022 the Dietary Service Director discarded any improper closed food and non-labeled/dated food items in the kitchen and nourishment fridges. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 9/7/2022, the Dietary Service Director and Maintenance Director completed a kitchen and nourishment walk through to ensure all food items were within their dates and dated properly. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff on 9/21/2022. Topics included: • Storage and dating policies and regulations. • Kitchen inspections completed each shift to ensure properly labeled/dated items, to observe all food are within their dates, and to toss if out of date items. • Nourishment room inspections to be completed each shift by all staff that have access to nourishment room (dietary, nursing, and environmental staff) to ensure properly labeled/dated items, to observe all food are within their dates, and to toss if out of date items.	

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F 812	Continued From page 9 room refrigerator to ensure items are labeled and dated. Nursing staff was responsible for labeling and dating items placed in the nourishment room refrigerator.	F 812	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/30/22

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F 880	Continued From page 10	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.

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F 880	Continued From page 11 (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 record review and staff interviews, the facility failed to develop and implement a Legionella Prevention program. This had the potential to effect 70 of 70 residents. Findings included: Review of the Emergency Preparedness and Infection Control Programs with review date 8/2/22 revealed the facility did not have a procedure or program for water safety management for Legionella. During an interview on 9/8/22 at 4:10 PM, the Maintenance Director indicated he had received an email from corporate with changes regarding water safety management for Legionella, but they	F 880	F-880 Infection Control DPOC/RCA Root Cause Analysis F880 Infection Control Completed by: DON/Infection Preventionist and Administrator QAPI Committee Members: Administrator, DON/Infection Preventionist, Medical Director, Maintenance Director, Social Worker, HIM, MDS, Pharmacist, Dietary Manager, Activities Director, Admission's Coordinator, Therapy Director Governing Board/Director of Operations: Liberty Healthcare/Amy Fann Chief Clinical Operator/Roxanne Thompson VP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	C 09/08/2022

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F 880	Continued From page 12 had not implemented the changes. The facility did not complete risk assessment as recommended by corporate. During an interview on 9/8/22 at 4:30 PM, the Administrator revealed she was not aware of the new requirement. She indicated the was involved in the Emergency Preparedness review in August 2022 but water safety management was not reviewed.	F 880	of operations. Define the problem/issue: The facility did not test for legionella bacteria in the water system. Why did it happen? The facility did not implement the policy or procedure to test for legionella in the water system, thus the water was never tested. Why is that? The facility failed to come up with a plan on when the facility would start testing the water for the presence of Legionella. Why is that? The facility failed to set up a start date on when the facility would start testing the water for the presence of Legionella. Analysis The corporate/governing body designed a policy/procedure which specified testing protocols and acceptance ranges for control measures, to include documentation of the results of testing and corrective actions taken when control limits are not maintained. The facility failed to come up with a plan and start date on when the facility would test the water for the presence of Legionella. Action The facility set a start date and has already started testing for legionella bacteria in water system per policy/procedure.	

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F 880	Continued From page 13	F 880	Governing Body: Liberty Health Care Management Chief of Clinical Operations: Amy Fann VP of Operations: Roxanne Thompson Specific staff involved implementing Corrective Action: Chief of Clinical Operations, VP of Operations, Medical Director, Infection Control Preventionist/DON, Maintenance Director, Administrator, Regional Maintenance Director. Identification of residents in the facility who may be included: All residents have the potential to be affected. Systemic Changes and Actions that need to be taken: On September 9, 2022, the facility's water management process was started along with the completion of a risk assessment. The Regional Maintenance Director reviewed the assessment and a diagram of the facility's water flow was completed. As soon as testing strips were made available, the water was tested on September 14, 2022 with all acceptable ranges per policy. On September 23, 2022 all department heads were educated by the DON/Infection Preventionist, Maintenance Director, and Administrator on the Water Management Program with updates for testing including: Control Points, Control Measures, Control Limits, Contingency Response, Corrective Action and Monitoring and the facility's risk assessment. On September 29, 2022 all QAPI team members were educated by	

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F 880	Continued From page 14	F 880		

the DON/Infection Preventionist, Maintenance Director, Medical Director, and Administrator on the Water Management Program with updates for testing including: Control Points, Control Measures, Control Limits, Contingency Response, Corrective Action, and Monitoring, and the facility's risk assessment. On September 29, 2022 the education for all staff was initiated with 10/6/2022 being the completion date of all staff education including agency.

Monitoring: The risk assessment will guide the facility on where to take samples from within the facility. Based on the risk assessment some samples will be taken weekly, monthly, or as needed and tracked in the TELS system/Hard Copy by the Administrator and Maintenance Director.

The Administrator or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Safe Water Policy/Testing. The monitoring will include reviewing the testing results. Additionally, results will be audited--- weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/ Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Dietary Manager, Social Worker, HIM,

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F 880	Continued From page 15	F 880	and Therapy Director.	