STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING ______ B. WING ______	C 01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/23/23 through 1/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MRLB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/23/23 through 1/27/23. Event ID# MRLB11. The following intakes were investigated NC00193740 , NC00196022 , NC00194845, NC00196860, NC00192036 and NC00197268. 5 of the 20 complaint allegations were substantiated resulting in deficiencies. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a surety bond which named the residents of the facility as the obligee for 43 of 43 residents who had personal funds accounts with the facility. The findings included: The facility surety bond dated 1/1/23 titled "Patient Trust Funds Bond Surety Bond" revealed	F 570	F570-C Surety Bond – Security of Personal Funds 1) Administrator contacted the Governing Body to correct the Surety Bond. The Surety Bond was corrected on 2/21/2023 to reflect the residents of Elizabeth City Health and Rehab 2) All residents who have a personal funds account have the potential of being	2/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/23/2023

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 570	Continued From page 1 the principal was listed as Elizabeth City Health and Rehabilitation, LLC and the obligee was listed as State of North Carolina. An interview with the Administrator on 1/25/23 at 1:32 PM revealed she was not aware that the State of North Carolina was the obligee and she would be following up with corporate.	F 570	impacted by this deficient practice. 3) The Regional Operations Manager in serviced the Administrator on F 570 regulations on 2/22/2023 4) Annually the Administrator will audit the Surety Bond for the correct obligee. Administrator will submit the findings from the audit to the QAPI (Quality Assurance Performance Improvement) . committee for review and any further recommendations. 5) Compliance 2/22/2023	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.	F 577		2/13/23

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F 577	Continued From page 2 (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to inform the residents of the location and availability of the facility's survey results. This failure affected all residents in the facility. The findings included: During an initial tour of the building on 1/23/2023 at 11:09am, survey results were unable to be located. No signage was observed posted regarding the availability and location of survey results. Resident council interview was conducted on 1/24/2023 at 2:30pm. During the meeting 7 of 7 residents, (Residents #19, 123, 108, 88, 24, 41, and 67) and Resident Council members stated they did not know where the survey results were located and had not seen any signage that directed residents to the location. Residents #19 and #24 stated they would wish to review the state survey results binder but did not know its location. During an interview with the Activities Director (AD) on 1/24/2023at 10:22am she stated she reviews with residents the location of the state survey results regularly. She stated she did not know where the state survey results were moved to from the main lobby. In an interview with the Director of Nursing on 1/24/2023 at 11:03am, she stated the survey binder was usually located at the main lobby on a	F 577	F577-C 1) On 1/24/2023 the Administrator immediately placed the survey binder on the table in the lobby. Signage was also replaced by the administrator on 1/30/2023. 2) Administrator was immediately educated by the Regional Operation Manager on 1/27/2023 regarding survey binder requirement to be available at all times to residents and visitors. Process was put into place by administrator to ensure daily check for survey binder. 3) Manager on Duty leadership team and front desk education completed on 2/13/2023 by the Administrator to include on their weekend checklist confirmation that survey binder is in lobby available to all residents and visitors. The activity director will remind Resident Council monthly where the residents can locate the Survey binder and will be noted in the minutes. 4) Administrator/Designee to audit daily five days a week for 4 weeks to ensure survey binder is located in lobby available to all residents and visitors. Resident Council Minutes to be audited monthly by Administrator/designee for three months to reflect informing residents where they can locate survey binder. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 3 consecutive meetings. The Quality	

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F 577	Continued From page 3 desk but was not aware of its current location. During an interview and observation conducted with the Administrator on 1/24/2023 at 11:10am she stated survey inspection results binder was moved during the remodeling of the main lobby. She stated she was responsible for the binder. She stated she overlooked returning binder to where it was accessible by the residents and their families. She located the binder behind the reception desk.	F 577	Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance 2/13/2023.	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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. (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 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (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. (ii) Notice must be made as soon as practicable	F 623		2/6/23

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F 623	Continued From page 4 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is 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. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (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	F 623		

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F 623	Continued From page 5 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. §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. §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 staff interviews, the facility failed to notify the Ombudsman in writing when 6 of 6 residents (Residents #1, #143, #55, #110, #51, and #102) transferred to the hospital. The findings included: a. Resident #1 was admitted to the facility on	F 623	F623-C 1) Social worker submitted the discharge notification for resident #1, #143, #55, #110, #51 and #102 to the Ombudsman on 2/6/2023. 2) All residents that discharge from the facility have a potential of being impacted by this practice. Social worker pulled the	

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F 623	Continued From page 6 11/10/2017. Resident #1 was discharged to the hospital on 3/5/2022 and returned to the facility on 3/8/2022. Resident #1 was discharged to the hospital on 10/21/2022 and returned to the facility on 10/25/2022. Resident #1 was discharged to the hospital on 1/17/2023 and returned to the facility on 1/17/2023. b. Resident #55 was admitted to the facility on 2/25/2020. Resident #55 Resident #55 was discharged to the hospital on 10/25/2022 and returned to the facility on 11/01/2022. Resident #55 was discharged to the hospital on 11/26/2022 and returned to the facility on 12/09/2022. Record review of the Nursing Progress Note dated 10/17/2022 at 2:32pm revealed Resident #55 was admitted for further evaluation for infection of the abdomen. Record review of the Nursing Progress Note dated 11/26/2022 at 9:12am revealed Resident #55 was having a fever and was admitted with a diagnosis of COVID and Septic. c. Resident #143 was admitted to the facility 9/26/22. Resident #143 was discharged to the hospital on 12/15/22. Review of the Nursing Home Notice for Transfer/Discharge revealed that Resident #143	F 623	past 90 days with the correct Electronic Medical Record report and sent via email to Ombudsman on 2/6/2023. 3) Social worker team was educated on1/31/2023 by the administrator as to the correct way to pull the discharge facility report and what information that must be sent. 4) Administrator/Designee will audit a sample of residents monthly for two months from the discharge report for three months to ensure that the correct discharge information is included for both discharged residents and those with potential of returning to the facility. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance 2/6/2023	

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F 623	Continued From page 7 was discharge to the hospital and transferred to an assisted living facility on 1/18/23. d. Resident #102 was admitted to the facility on 1/26/22. Resident #102 was discharged to the hospital on 10/24/22 and readmitted to the facility on 11/8/22. Review of a nursing progress note dated 10/24/22 revealed Resident #102 was transferred to the hospital after the results of a right hip Xray. Resident #102 was sent to the emergency department and later admitted. e. Resident #110 was admitted to the facility on 10/08/22. Resident #110 was discharged to the hospital on 11/21/22 and returned to the facility on 11/23/22. Record review of the Nursing Progress Note dated 11/21/22 at 10:32 am revealed Resident #110 was sent to the emergency room for further evaluation. f. Resident #51 was admitted to the facility on 11/30/22 Resident #51 was discharged to the hospital on 12/13/22 and returned to the facility on 12/19/22. Resident #51 was discharged to the hospital on 12/26/22 and returned to the facility on 12/30/22. During an interview on 1/26/23 at 12:58 pm the Social Worker revealed she did not send discharge information to the Ombudsman office for those residents that were sent to the hospital. The Social Worker reported she was not aware	F 623		

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F 623	Continued From page 8 she had to send the information for those residents sent to the hospital to the Ombudsman. During an interview on 1/26/23 at 1:10 pm the Regional Clinical Director of Operations revealed the Social Worker was not aware she needed to submit both the discharge return anticipated as well as the discharge return not anticipated to the Ombudsman. During an interview on 1/27/23 at 1:20 pm the Administrator revealed she was informed the Social Worker was not submitting the correct Ombudsman discharge report.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to code the Minimum Data Set assessment accurately for 1 of 5 sampled residents (Resident #51) reviewed for nutrition. The findings included: Resident #51 was admitted to the facility on 11/30/22 with multiple diagnoses that included chronic heart failure, chronic obstructive pulmonary disease, dysphagia and failure to thrive. The quarterly Minimum Data Set dated 1/02/23 indicated Resident # 51 was on a physician-prescribed weight loss regimen.	F 641	F641 1) Resident # 51 MDS(Minimum Data Set) assessment section K dated 1/2/2023 was corrected on 2/23/2023 by the MDS nurse to reflect the resident is not on a weight loss program. 2) All residents have the potential to be impacted by this deficiency. Any identified concerns would be complete by 2-10-23) 3) The Administrator provided education on 2/8/2023 to the MDS Coordinators and Dietary Manager on coding Section K. 4) The Director of Nursing/designee will audit of Section K to ensure accurate coding for three residents weekly for 6 weeks. The Administrator will bring the	2/27/23

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F 641	Continued From page 9 Review of the care plan dated 1/24/23 revealed Resident #51 had significant weight loss related to diuretics resolving fluid issues. Staff were to provide supplements as ordered. Review of the physicians' orders revealed Resident #51 was to receive a No added Salt, mechanical soft diet. An interview with MDS nurse #1 on 1/27/23 at 1:18 PM revealed the resident was not on a prescribed weight loss diet and was coded inaccurately on the current MDS assessment. An interview with the Dietary Manager on 1/27/23 at 1:30 PM revealed he looked at the resident's diuretic use and inadvertently chose the weight loss button. He stated Resident #51 was not on a physician-prescribed weight loss program.	F 641	results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance date 2/27/2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide Activities of Daily Living (ADL) care for 1 of 3 residents (Resident #30) who was dependent on facility staff for ADL care. The findings included: Resident #30 was admitted to the facility on 11/3/20 with diagnoses that included	F 677	F677-D 1) The CNA (certified nursing assistant) provided facial shaving on 1/27/2023 for resident #30 2) The unit managers completed an observation audit of all current residents for facial hair or in need of shaving on 2/8/2023. All care needed was rendered at that time. 3) The staff development	3/1/23

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F 677	Continued From page 10 polyneuropathy (A condition the affects the nervous system and causes problems with sensation and coordination). A review of the Minimum Data Set (MDS) dated 11/2/22 revealed Resident #30 was cognitively intact and was totally dependent on staff for personal hygiene. Resident #30 ' s care plan last reviewed 11/7/22 revealed a goal that Activities of Daily Living/Personal Care would be provided by staff due to resident ' s impaired mobility. An observation and interview with Resident #30 on 1/24/23 at 9:30 AM revealed she had facial chin hair. Resident #30 stated that she liked to keep the hair on her chin shaved. She stated that staff usually shaved her chin when giving her a bath. An observation was conducted of Resident #30 on 1/24/23 at 4:37 PM. The chin hair was still visible on Resident #30. An observation and interview were conducted on 1/25/23 at 10:11 AM with Resident #30. Resident #30 stated that she had received her bath. She was observed to have chin hair approximately one-half inch long. An interview was conducted with Nursing Assistant #9 on 1/26/23 at 1:07 PM. NA #9 stated that she had not noticed that Resident #30 had facial chin hair. NA #9 stated she would take care of shaving Resident #30. An observation and interview were conducted on 1/26/23 at 1:18 PM with Nurse #7. Nurse #7	F 677	nurse/designee provided the nursing staff with education regarding providing facial care for all resident male and female completed on 3/1/2023. Staff that have not received the in-service training will not start their next scheduled shift without completing the training. 4) The Unit Managers/Designee will conduct observation audits on five residents a week for 6 weeks to ensure facial hygiene is provided. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance date 3/1/2023	

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F 677	Continued From page 11 observed Resident #30 and agreed that she needed to be shaved. An interview was conducted with the Director of Nursing on 1/26/23 at 4:10 PM. The DON stated that she expected staff would provide ADL care as needed.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Responsible Party (RP) interview, the facility failed to provide an ongoing resident centered activities program that include one on one (1:1) activities to meet the interests of a resident that did not participate in group activities for 1 of 2 residents reviewed for activities (Resident #110). Findings included: Resident #110 was admitted to the facility on 10/08/22 with a diagnosis of Parkinson's. Record review of the Activity Progress Note dated 10/14/22 at 12:32 pm revealed the Activities	F 679	F679-E 1) Resident #110 was provided 1:1 activity time and added to activity calendar on 1/25/2023. 2) All residents requiring 1:1 activity programming have the potential of being impacted by this practice. Activity Director evaluated all current residents on 1/25/2023 for current activity programming appropriate for each resident. No other issues were found. 3) The Administrator educated Activity Director and activity staff on meeting the social, emotional, and recreational needs of every resident on 1/25/2023. The	2/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING ______ B. WING ______	C 01/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 679 Continued From page 12

Director met with Resident #110 and she reported she enjoyed animals, playing games, keeping up with the news, listening to country music, and watching television. Activity staff were to encourage group and independent activities and monitor for resident's individual activity needs.

The Minimum Data Set (MDS) Admission Assessment dated 10/14/22 revealed Resident #110 had moderate cognitive impairment. Resident #110 reported it was very important to her to listen to the music she liked, do the activities she liked, and to participate in religious services or programs.

During an interview on 1/23/23 at 10:57 am Resident #110's Responsible Party (RP) revealed the family was present every day for extended periods of time and had not seen anyone from the activity department offer activities or engage in activities with Resident #110.

During an interview on 1/25/23 at 9:08 am the Activity Director revealed that she was responsible to review group activity logs for those residents that did not participate, and she will set up for 1:1 in room visits. The Activity Director stated the 1:1 in room visits were scheduled 4 times per week, and stated she believed Resident #110 was on the list. Upon review of the 1:1 activity logs, the Activities Director reported that Resident #110 was not on the 1:1 activity log and had not received any in room visits since admission. The Activity Director stated she just missed adding her for 1:1 in room visits somehow, she just dropped the ball on Resident #110 but would add her to the list immediately.

During an interview on 1/27/23 at 1:19 pm the

F 679

activity director implemented a weekly Activity team huddle to review all residents for appropriate activity programming beginning week of 1/30/2023.

4) Administrator / Designee to audit a sample of residents weekly for 6 weeks to ensure they are receiving activity programming that meets their recreational needs. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed.

5) Compliance date 2/13/2023

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F 679	Continued From page 13 Administrator revealed the Activity Department reports on which residents received 1:1 in room visits but she did not ask for who was actually scheduled for the day. She stated the Activity Department was responsible to provide Resident #110 with 1:1 in room activity visits.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and physician interviews, the facility failed to provide the care for ear wax removal as recommended by a physician for 1 of 1 resident reviewed for communication (Resident #123). Findings included: Resident #123 was admitted to the facility on 10/11/22. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 11/8/22 revealed Resident #123 was cognitively intact and had adequate hearing without a hearing aid or other device. Record review on the Physician Visit note dated	F 684	F684 Quality of Care-D 1) An order was obtained from the nurse practitioner for debrox on 1/27/2023 for resident #123 An appointment was scheduled for an ENT (Ear, Nose & Throat) visit on 2/27/2023. 2) A review by the Assistant Director of Nursing was conducted of orders written by the PA to ensure they have been implemented in the past 7 days beginning 2/27/2023 and completed 2/7/2023. No other issues noted. 3) The Director of Nursing provided education to all providers regarding the process for entering and communicating orders completed on 2/13/2023. New	3/1/23

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F 684	Continued From page 14 1/09/23 revealed Physician Assistant (PA) #1 assessed Resident #123's reported ear wax buildup and determined her to have wax impaction in both ears. PA #1's treatment recommendation was Debrox (ear wax removal drops) and irrigation. Record review of PA #1's email correspondence to in-house providers revealed no communication regarding Resident #123's ear wax buildup and recommendation for Debrox and irrigation. Record review of Resident #123's physician orders revealed no order for the Debrox drops or irrigation. During an interview on 1/23/23 at 2:01 pm Resident #123 revealed she had reported to the nurse a few weeks ago that her left ear had wax buildup that was interfering with her hearing. She stated she did not have any pain or discomfort just trouble hearing out of the left ear. During an interview on 1/25/23 at 12:36 pm Nurse #2 revealed she was notified by Resident #123 a few weeks ago about the ear wax. Nurse #2 stated she notified the Social Worker because the audiologist was at the facility that day and thought the Social Worker would be able to have her seen. Nurse #2 stated Resident #123 had not mentioned the ear wax buildup since the initial report, so she thought it was taken care of. During an interview on 1/25/23 at 12:41 the Social Worker stated she was notified of the ear wax buildup for Resident #123 on 1/09/23 and she notified PA #1 while she was at the facility. The Social Worker stated PA #1 saw Resident #123 that day but was not aware of the outcome.	F 684	providers will be inserviced before they begin to see residents. 4) All providers will meet prior to the clinical morning meeting to review recommendations and new orders. The Providers (Nurse Practitioners and Physicians Assistants) will bring recommendations to the morning clinical meeting and review with the clinical team. The Administrator will audit provider morning huddle 3 times a week for 6 weeks. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance date 3/1/2023	

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F 684	Continued From page 15 During an interview on 1/25/23 at 2:07 pm PA #1 revealed she assessed Resident #123 on 1/09/23 but she does not write orders. PA #1 stated she notified the in-house providers at the facility of her assessment and recommendation but was not sure who was responsible to enter the order after her recommendations were sent to the in-house providers. PA #1 stated she may have reported her findings in person to an in-house provider but was unable to state who she spoke to. A telephone interview was conducted on 1/25/23 at 3:31 pm with PA #2, an in-house provider, revealed she was not notified by PA #1 about her recommendation for Resident #123. PA #2 stated she was not aware of Resident #123's reported issue and was not notified by staff or the resident during her recent visit. A telephone interview was conducted on 1/25/23 at 3:39 pm with PA #3, an in-house provider, revealed she did not receive notification from staff or PA #1 regarding ear wax buildup for Resident #123. PA #3 stated she saw Resident #123 on 1/12/23 and she did not report a concern about ear wax at the time of her visit. During an interview on 1/24/23 at 1:59 pm the Medical Director revealed he was not aware of Resident #123's ear wax buildup. The Medical Director stated the normal protocol for treatment for Resident #123 would be Debrox drops and light irrigation or the ear. During an interview on 1/27/23 at 1:23 pm the Administrator reported PA #1 was responsible to communicate with the appropriate staff or medical provider to ensure the treatment	F 684		

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F 684	Continued From page 16 recommendation was ordered for Resident #123.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide care safely when a resident (Resident #295) was provided with incontinence care. Resident #295 fell from the bed during care and sustained a 2.5-centimeter (cm) laceration to her head with bleeding and she reported pain in her back and head post fall. Resident #295 was sent to the hospital and required 3 staples to close the laceration. This was for 1 of 8 residents reviewed for accidents (Resident #295). Findings included: Resident #295 was admitted to the facility on 3/09/21 with diagnoses which included Alzheimer's and contractures. The Minimum Data Set (MDS) Annual Assessment dated 4/05/22 revealed Resident #295 had severely impaired cognition, was incontinent of bowel and bladder, and was dependent on 2 staff members for bed mobility.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 17 Record review of Resident Care Guide (no date) revealed Resident #295 was non-ambulatory, had contractures, and was dependent on staff for bathing and transfers by 2 staff members. Resident #295 was dependent upon staff for bed mobility but did not list how many staff members were needed for turning and positioning in bed. A Nursing Progress note dated 4/18/22 at 3:00 am by Nurse #5 revealed she was called to Resident #295's room and observed her to be on the floor between the wall and the bed, on her left side. Nurse #5 stated Nurse Aide (NA) #6 reported he provided care, and he turned on her right side and Resident #295 fell from the bed. Resident #295 was assessed and was noted to have a laceration to the left temple area which measured approximately 2.5 cm with blood present and reported pain to her head and back. Resident #295 was transferred to the hospital for further evaluation. A Nursing Progress note dated 4/18/23 at 7:09 am by Nurse #5 revealed Resident #295 returned to the facility with 3 staples to left side of head. During a telephone interview on 1/25/23 at 1:41 pm NA #5 revealed she was working with NA #6 at the time of the fall. She stated they entered Resident #295's room to provide care to her and the roommate. NA #5 reported she was bathing the roommate and NA #6 was bathing Resident #295 when she heard him call out and when she turned around, she saw Resident #295 on the floor. She stated Resident #295 was not able to assist with turning and repositioning because she had contractures and was very stiff. NA #5 reported the resident care guide had the information needed to provide care for residents	F 689		

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F 689	Continued From page 18	F 689		

and was located at the nursing station.

Attempts to interview NA #6 on 1/25/23 at 2:27 pm and 1/26/23 at 9:20 am were unsuccessful.

A telephone interview was conducted on 1/26/23 at 11:26 am with Nurse #5 who was assigned to Resident #295 at the time of the fall. Nurse #5 stated when she entered the room Resident #295 was on the floor and NA #6 reported he was providing care at the time of the fall. Nurse #5 stated that Resident #295 was not able to assist with turning and repositioning due to her severe contractures.

During an interview on 1/27/23 at 10:36 am the MDS Nurse #1 revealed the coding of total dependence by two staff members for Resident #295's was based off the documentation by staff that reported two staff members were needed for her bed mobility. She stated the information was available for NAs on the resident care guide.

During an interview on 1/27/23 at 12:38 pm the Director of Nursing (DON) revealed that staff were educated at orientation that a resident that was dependent for bed mobility required two staff members to turn and reposition during care.

An interview on 1/27/23 at 1:24 pm the Administrator revealed the resident care guide was implemented upon admission and updated as needed. The Administrator was unable to state why the resident care guide was not completed to instruct staff how many staff members were required to positioning for Resident #295.

The facility provided the following corrective

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F 689 Continued From page 19 F 689

action plan with a completion date of 6/09/22.

1. On 6/03/22 the Regional Operations Manager completed an audit of the past 30-day event reports and identified root cause analysis and resident care guides were not completed or updated.

2. All residents in the facility were identified to be at risk.

3. The Regional Operations Manager educated the Administrator and Director of Nursing (DON) on event reporting, root cause analysis, and resident care guide completion on 6/03/22. The DON was responsible to provide the education to nursing staff. The staff education began on 6/03/22 and was completed on 6/09/22 by the DON. Any staff that did not receive the education by 6/09/22, was educated prior to their next shift by the DON or designee. Resident care guide education will be included in orientation for newly hired staff beginning 6/03/22.

4. The Regional Operations Manager completed an audit of event reports for root cause analysis and the resident care guide for completion weekly for 4 weeks. The findings of the Regional Operations Manager's audits were provided to the Administrator and DON weekly for required follow-up. The Administrator and DON will continue the audits for event root cause analysis and resident care guide completion monthly for 3 months. The results of the monthly audits will be brought to the Quality Assurance and Performance Improvement (QAPI) meeting monthly for 3 months to monitor for effectiveness of the corrective action plan and determine the need for further monitoring as applicable.

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F 689	Continued From page 20 The facility had an alleged date of compliance 6/09/22. An observation of repositioning for Resident #87 was conducted on 1/24/23 at 8:30 am by 2 staff members. Review of the resident care guide revealed Resident #87 required 2 staff members for bed mobility. An observation of incontinence care and pressure ulcer treatment for Resident #45 was completed on 1/25/23 at 9:18 am by 1 staff member. Review of the resident care guide revealed Resident #45 was an extensive assist from 1 staff member for bed mobility. An observation of bathing for Resident #110 was completed on 1/25/23 at 10:30 am by 2 NA's. Review of the resident care guide revealed Resident #110 required extensive assistance from 2 staff members for bed mobility. The corrective action plan was verified through record review of the education logs, audit reports of the event reporting, root cause analysis, resident care guides audits, and resident care observations. Based on the observations and record review the facility's compliance date of 6/09/22 was verified.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		3/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 21 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 observation and staff interviews, the facility failed to remove expired medications stored in 1 of 2 medication rooms observed (Sycamore Medication Room). Findings included: During an observation on 1/26/23 at 12:10 pm of the Sycamore Medication Room with the Assistant Director of Nursing (ADON) the following expired medication were observed. The expiration dates were confirmed by the ADON prior to removal of the medications. 1 box with 60 Heparin lock flush solution syringes with expiration date of 9/2021.	F 761	F761-E Label/Store Drugs and Biologicals 1) The expired medications were immediately removed from the medication room on 1/27/2023 by the Director of Nursing. 2) All residents have the potential of being impacted by this practice. The Director of Nursing/Assistant Director of nursing checked the other medications rooms and medication carts and no other expired or discontinued medications were found on 1/27/2023. 3) The staff development nurse/designee will provide the licensed nurses, medication aides and Unit	

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F 761	Continued From page 22 1 box with 19 Heparin lock flush solution syringes with expiration date of 7/2022. 1 box with 60 Heparin lock flush solution syringes with expiration date of 9/2022. 1 box with 60 Heparin lock flush solution syringes with expiration date of 11/2022. 1 box with 30 Heparin lock flush solution syringes with expiration date of 11/2022. During an interview on 1/26/23 at 12:10 pm the ADON stated the Unit Manager was responsible to ensure the expired medication was returned to pharmacy. During an interview on 1/26/23 at 12:29 pm the Unit Manager stated the syringes were not supposed to be stored in the bottom cabinet so she did not see them in there. She stated she checked the room weekly for expired medications. The Unit Manager stated that when the nurse discharged the resident or when the medication was discontinued the items should have been returned to the pharmacy. An interview on 1/27/23 at 12:43 pm with the Director of Nursing (DON) stated the Unit Manager was responsible to ensure the medication rooms did not have any medication that was expired. During an interview on 1/27/23 at 1:29 pm the Administrator revealed the Unit Manager was required to check the medication room for expired medications.	F 761	Managers education related to medication storage regulations and maintaining compliance completed by 3/1/2023. Staff that have not received the in-service training will not start their next scheduled shift without completing the training. This information will also be added to new hire orientation as of 2/23/2023. 4) The Assistant Director of Nursing/Unit managers will complete audits on the medication rooms and medication carts twice weekly for 8 weeks. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed. 5) Compliance date 3/1/2023	
F 867 SS=E	QAPI/QAA Improvement Activities	F 867		3/1/23

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ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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F 867	Continued From page 23 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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	345036	A. BUILDING ______ B. WING ______	C 01/27/2023

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F 867	Continued From page 24	F 867		

prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms

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F 867	Continued From page 25 that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and the facility ' s Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the	F 867	F867 QAPI/QAA Improvement Activities-E 1. The facility Quality Assurance	

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F 867	Continued From page 26 committee put into place following the 1/19/21 focused infection control and complaint investigation survey and the 11/18/21 recertification survey. This was for 2 recited deficiencies on the current recertification and complaint investigation survey of 1/27/23 in the areas of infection control (F880) and label/store drugs and biologicals (F761). The continued failure during two or more federal surveys of record shows a pattern of facility ' s inability to sustain an effective QAA committee. The findings included: This tag was cross referenced to: a. F880: Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures (1) when Nurse Aide (NA) #1 failed to remove isolation gown and gloves and perform hand hygiene before exiting a COVID-19 isolation room, (2) Nurse #1 failed to replace oxygen tubing that was on floor before placing in residents' nose (Resident #87), and (3) failed to perform hand hygiene between 4 of 4 residents when passing meal trays (Resident #101, Resident #70, Resident #62, Resident #115). During the focused infection control and complaint investigation survey dated 1/19/21 the facility was cited at F880 for failing to implement interventions for a wandering resident during a COVID-19 outbreak to prevent the resident from wandering in and out of other resident room. During the recertification survey dated 11/18/21 the facility was cited at F880 for failing to implement its personal protective equipment	F 867	Performance Improvement (QAPI) Committee held a meeting on 2/24/2023 to review the purpose and function of the QAPI committee and to review the on-going compliance issues. The Administrator, Director of Nursing, Assistant Director of Nursing, Unit Coordinator, MDS Coordinator, Medical Records, Housekeeping Manager, Maintenance Manager, CNA, Dietary Manager, and either Regional Operators Manager or the Regional Clinical Manager will attend QAPI committee meetings. Corrective action has been taken for the identified concerns related to repeat deficiencies. (F880, F761) On 2/24/2023 the Administrator provided the Medical Director with updates regarding the plan of correction. 2. All residents have the potential to be affected by this practice. 3. On 2/22/2023 the Regional Operations Manager provided the Administrator and Director of Nursing with in-servicing related to the appropriate function of the QAPI committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F880 infection control and F761 med storage. The facility QAPI committee will continue to identify other areas of quality concern through the quality improvement processes and tools. 4. The QAPI committee will meet monthly to review and identify issues related to quality assessment and assurance activities as needed and will develop appropriate corrective measures for any identified concerns related to	

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F 867	Continued From page 27 policy. b.F761: Based on observation and staff interviews, the facility failed to remove expired medications stored in 1 of 2 medication rooms observed (Sycamore Medication Room). During the recertification survey dated 11/18/21 the facility was cited at F761 for failing to: secure prepared medications that were left on top of the medication cart, remove expired medications stored in medication storage rooms, and ensure the medication cart was secured while unattended. An interview was conducted with the Administrator and Corporate Nurse Consultant on 1/27/23 at 2:54 PM. The Administrator stated that the QAPI (Quality Assurance and Performance Improvement) Meeting was held monthly and consisted of herself, the Director of Nursing, Medical Director, Infection Preventionist, Minimum Data Set (MDS) Nurse, and Regional Operations Manager. She stated that morning huddles (meetings that review resident status changes and staffing challenges) were instituted from the QAPI meetings. The Administrator further stated that the QAPI initiatives were a large focus and the facility had involved staff to reach their goals. The Administrator stated that the Infection Preventionist was new to the facility and they were in the process of working on any improvement that were needed	F 867	facility concerns. The Medical Director will continue to attend the QAPI meeting monthly to review and make recommendations related to the compiled QAPI report information. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 2 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training and observations to determine if the continuation of audits is needed 5. Compliance date 3/1/2023	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/1/23

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F 880	Continued From page 28 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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,	F 880		

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F 880	Continued From page 29 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures (1) when Nurse Aide (NA) #1 failed to remove isolation gown and gloves and perform hand hygiene before exiting a COVID-19 isolation room, (2) Nurse #1 failed to replace oxygen tubing that was on floor before placing in residents' nose (Resident #87), and (3) failed to perform hand hygiene between 4 of 4 residents when passing meal trays (Resident #101, Resident #70, Resident #62, Resident #115).	F 880	F880-E Infection Prevention and Control 1) On 1/25/2023 the Registered Nurse manager immediately provided re-education for CNA #1 related to proper hand hygiene and proper donning and doffing upon exiting any isolation room. Nurse #1 was educated by the Staff Development Nurse on 1/30, regarding infection control practices related to oxygen tubing and nasal cannula and	

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F 880	Continued From page 30 Findings included: The facility was in COVID-19 outbreak status as of 1/12/23. Record review of the prior four-week period of COVID-19 facility testing revealed 4 staff and 13 residents had tested positive. The dates of the most recent staff and resident positive COVID-19 results were 1/11/23, 1/19/23, 1/20/23, and 1/21/23. Record review of the facility policy titled "Policies and Practices Infection Control" dated 10/2022 revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 1. Rooms 704 and 703 had signage posted on the door that alerted staff that the residents were on special airborne contact precautions and required a staff to clean hands before entering and when leaving the room, wear a gown when entering the room and remove before leaving, and wear gloves when in room and they were to be removed prior to exiting the room. On 1/25/23 at 8:21 am an observation was made of Nurse Aide (NA) #1 exiting room 704 wearing an isolation gown and gloves on with two meal trays in her hands and continued to walk across the hall to place the meal trays in the meal cart outside room 705. NA #1 then removed the isolation gown and gloves and placed in them in a trash can in room 703 and performed hand hygiene. During an immediate interview on 1/25/23 at 8:22	F 880	preforming hand hygiene between residents. Resident # 87 tubing was replaced by the Director of Nursing on 1/25/2023. CNA #2 was educated by the Staff Development Nurse on 1/30/2023 on hand hygiene between passing meal trays. 2) All residents have the potential to be impacted by this deficiency. 3) The Staff Development Nurse / Designee provided the facility staff with education regarding proper hand hygiene, donning and doffing PPE (Personal Protective Equipment) and infection control practices for oxygen tubing and nasal cannulas. Inservice to begin on 1/31/2023 and completed by 3/1/2023. Staff that have not received the in-service training will not start their next scheduled shift without completing the training. Personal Protective Equipment and Infection Control education added to all new hire orientation on day one beginning 1/31/2023. 4) The Infection preventionist/designee will conduct random observations related to proper hand hygiene and proper use of PPE and observation rounds on residents with oxygen orders to identify any issues with infection control practices related to oxygen tubing and nasal cannulas five times a week for four weeks, followed by twice a week for four weeks and weekly for four weeks. The Administrator will bring the results of the above audits to the monthly Quality Assurance Committee meeting x 3 consecutive meetings. The Quality Assurance Committee will evaluate the effectiveness of the training	

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F 880	Continued From page 31 am NA #1 stated room 704 was on isolation for COVID-19 and she was supposed to remove the isolation gown and gloves and perform hand hygiene before she exited the room. NA #1 stated she should have had another staff member pick up the meal trays from the door so she could remove her gown and gloves and perform hand hygiene before she left the room. She stated she was not sure why she didn't follow the education she had been provided for residents on isolation for COVID-19. During an interview on 1/26/23 at 4:04 pm the Infection Preventionist revealed education had been provided to all staff regarding COVID-19 isolation requirements. She stated NA #1 was to remove her gown and gloves and then complete hand hygiene before she exited room 704. During an interview on 1/27/23 at 12:40 pm the Director of Nursing (DON) revealed she expected staff to follow the guidelines and signage posted for those residents on isolation for COVID-19. An interview on 1/27/23 at 1:27 pm with the Administrator revealed the staff member was to remove the isolation gown and gloves and wash her hands before leaving the room. 2. During an observation on 1/23/23 at 1:05 pm Resident #87's oxygen tubing was on the floor with the nasal prongs touching the floor. Nurse # 1 was observed to pick up the oxygen tubing from the floor and place the oxygen tubing into Resident #87's nares. Nurse #1 did not clean the oxygen tubing prior to placing on Resident #87. During an interview on 1/23/23 at 1:06 pm Nurse	F 880	and observations to determine if the continuation of audits is needed. 5) Compliance date 3/1/2023	

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F 880	Continued From page 32 #1 revealed she was assigned to care for Resident #87 and stated she should not have picked up the oxygen tubing from the floor and placed back in his nose. Nurse #1 stated she should have thrown the oxygen tubing in the trash and obtained new tubing for Resident #87. During an interview on 1/27/23 at 12:42 pm the Director of Nursing (DON) stated Nurse #1 should have obtained new oxygen tubing for Resident #87 when it was found on the floor. 3. On 1/23/23 at 12:45 PM Nursing Assistant (NA) #2 was observed to carry a meal tray into Resident # 101 ' s room. NA #2 prepared the resident ' s meal tray. She picked up the bed control off the floor and touched the footboard of bed A prior to exiting the room. NA #2 did not perform hand hygiene. On 1/23/23 at 12:48 PM NA #2 entered Resident #70 ' s room and positioned the resident ' s bedside table in front of her. She exited the room without performing hand hygiene. NA #2 walked to the meal tray cart to retrieve Resident #70 ' s tray. The NA setup the resident ' s meal and exited the room without performing hand hygiene. On 1/23/23 at 12:50 PM NA #2 retrieved Resident #62 ' s meal tray from the meal tray cart. She entered Resident #62 ' s room and set up her meal tray. NA #2 exited the room without performing hand hygiene. NA #2 entered Resident #70 ' s room to assist her with positioning the bedside table. NA #2 tapped Resident #70 ' s pant leg for her to lift her feet as she pushed the bedside table closer. NA #2 exited the room without performing hand hygiene.	F 880		

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F 880	Continued From page 33 On 1/23/23 at 12:53 PM NA #3 retrieved Resident #115 ' s meal tray from the meal tray cart. She entered Resident #115 ' s room and set up the meal tray. NA #2 exited the room without performing hand hygiene. NA #2 returned back to meal tray cart and proceeded to push the cart up the hall. An interview was conducted with NA #2 on 1/23/23 at 12:59 PM. NA #2 stated that she should have performed hand hygiene between residents. An interview was conducted with Director of Nursing (DON) on 1/23/23 at 1:10 PM. The DON stated she expected that NA #2 would have performed hand hygiene between residents.	F 880		