STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/20/23 through 3/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #46SZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted on 3/20/23 through 3/23/23. Event ID# 46SZ11. The following intakes were investigated NC00189442, NC001996551. None of the allegations resulted in deficiency.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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	F 812	DISCLAIMER: Preparation and/or	4/14/23

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

Electronically Signed | 04/14/2023

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F 812	Continued From page 1 facility failed to ensure food preparation knives ready for use were clean. This practice had the potential to affect food served to residents. Findings included: On 3/22/23 at 11:55 AM an observation of the kitchen revealed two food preparation knives ready for use in the knife storage rack contained visible dried debris on the sides of the blades. The cook was present when the observation was made. On 3/22/23 at 12:54 PM the Dietary Manager (DM) stated the knives were assigned to be cleaned by the cook after use and were placed in the knife rack by the cook. The DM said the knives should have been cleaned and stored without dried debris on them and were overlooked before storing them. The cook was interviewed on 3/22/23 at 1:13 PM and stated the cooks were responsible to wash, clean and sanitize the knives after use. He said the knives were checked for cleanliness before placing them into the storage rack for use. The cook said he believed the 2 knives were overlooked when they were cleaned. The Administrator stated on 3/23/23 at 2:14 PM that the knives should have been cleaned prior to storing them in the knife rack.	F 812	execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F812 The facility ensures that food safety requirements are met at all times. On 3-22-23, the 2 kitchen preparation knives were cleaned and sanitized immediately before replacing them back on the drying rack. Dietary Manager immediately on 3-22-23 did re-education to the cook assigned to that shift to ensure that any kitchen preparation utensils including knives were properly cleaned and inspected before placing them in the drying rack. By 4-13-23 all dietary staff will be in-serviced by the Food and Nutrition Director on properly cleaning silverware intended for the meal service. Any staff members who do not receive the training by 4-13-23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 4-13-23 the process for the physical sorting of the silverware was	

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F 812	Continued From page 2	F 812	changed to ensure all silverware was cleaned prior to meal service. The cook on each shift is responsible for ensuring that this task is complete and in compliance. Beginning 4-14-23, Food and Nutrition Director and/or designee will audit properly cleaned silverware for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion date for this area of concern is 4/14/23	
F 867 SS=D	QAPI/QAA Improvement Activities 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	F 867		4/30/23

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F 867	Continued From page 3	F 867		

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 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

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F 867	Continued From page 4	F 867		

(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 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

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F 867	Continued From page 5 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 observation and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 6/10/21 recertification survey. The failure related to two deficiencies that were originally cited during the 6/10/21 recertification survey and was cited on the current recertification and complaint survey of 3/20/23. The recited deficiencies were in the areas of infection prevention and control and food safety requirements and store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program. The Findings included: This tag is cross referenced to: F-880 Based on observations, record review and	F 867	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F867 The facility maintains Quality Assessment and Assurance Committee (QAPI) with members including the Administrator, Director of Nursing, Medical Director, Infection Preventionist, and at least three additional staff from nursing and/or Interdisciplinary team. On 5/5/23 a special communication was provided to the QAPI Committee. This included the survey results and the Plan of Correction defining the training and monitoring. Further follow-up discussion	

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F 867	Continued From page 6 staff interviews the facility failed to implement their policy for Infection Prevention when 1 of 1 staff (Nurse Aide #1) failed to put on gloves and a gown before entering a resident's room for 1 of 2 residents on contact precautions (Resident #6). During the recertification survey of 6/10/21 the facility was cited for F-880. The facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 3 staff members (Staff #1) failed to discard her N95 mask and disinfect her goggles after leaving a quarantine room and before going to a non-quarantine room, 1 of 3 staff members (Staff #2) had no eye protection while in the quarantine room, and 1 of 3 staff members (Staff #3) wore a surgical mask and had no eye protection while in a quarantine room. These practices affected 4 of 4 residents reviewed for infection control. These failures occurred during a COVID-19 pandemic. F-812 Based on observations and staff interviews the facility failed to ensure food preparation knives ready for use were clean. This practice had the potential to affect food served to residents. During the recertification survey of 6/10/21 the facility was cited for F-812. The facility failed to dispose of expired perishable food items in 1 of 1 cooler. Staff drinks were observed to be stored alongside resident food items in the kitchen freezer. The facility also failed to dispose of expired foods and date individual cartons of juice and bottled drinks in 1 of 2 resident nourishment rooms.	F 867	will be included on the agenda of the next scheduled QAPI Committee meeting, which takes place on 5/25/23. On 5/5/23, through this special communication, the QAPI members were trained by the Administrator on the expectations for sustaining an effective Quality Assurance Program. Corrective Action: F812 The facility ensures that food safety requirements are met at all times. On 3-22-23, the 2 kitchen preparation knives were cleaned and sanitized immediately before replacing them back on the drying rack. Dietary Manager immediately on 3-22-23 did re-education to the cook assigned to that shift to ensure that any kitchen preparation utensils including knives were properly cleaned and inspected before placing them in the drying rack. By 4-13-23 all dietary staff will be in-serviced by the Food and Nutrition Director on properly cleaning silverware intended for the meal service. Any staff members who do not receive the training by 4-13-23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 4-13-23 the process for the physical sorting of the silverware was	

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F 867	Continued From page 7 On 3/23/23 at 2:32 PM the Administrator was interviewed and explained the incidents were isolated. The infection control incident broke down because the staff was not paying attention. The facility had been focused on infection control for 3 years and had improved infection control procedures with lots of training and staff education. The kitchen knives were overlooked and should have been cleaned. Quality assurance committee met monthly, and the goal was to be and remain in compliance with CMS regulations.	F 867	changed to ensure all silverware was cleaned prior to meal service. The cook on each shift is responsible for ensuring that this task is complete and in compliance. Beginning 4-14-23, Food and Nutrition Director and/or designee will audit properly cleaned silverware for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Corrective Action: F 880 The facility ensures that an infection control prevention and control program is designed and followed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. On 3-21-23 immediate education was provided to the 1 staff member identified during the survey to ensure that she was understanding of the current policies and procedures with PPE use. Education was also provided to other nursing staff on proper PPE usage and completed on 3-22-23. Beginning 4-12-23, facility Infection Preventionist will conduct in-services with nursing staff, EVS staff, Food and	

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F 867	Continued From page 8	F 867	Nutrition Director, Administrative staff, and Maintenance staff utilizing CDC infection control training modules. Any staff members who do not receive the training by 5-1-23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 4-3-23, a systemic change of Infection Control Policies and Procedures Enhanced Barrier was implemented to ensure compliance. On 4-13-23, the facility completed a Root Cause Analysis (RCA) with the assistance of the Corporate Performance Improvement, Corporate Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee of the facility and Governing Body to develop the intervention plan. Beginning 4-17-23, facility Infection Preventionist and/or designee will audit proper use of PPE for 12 weeks observing 5 observations a week times 4 weeks and 10 observations a month times 2 months. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion Date for QAPI tag 867 is 4-30-23	

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F 880	Continued From page 9	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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;	F 880		4/30/23

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F 880	Continued From page 10 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to implement their policy for Infection Prevention when 1 of 1 staff (Nurse Aide #1) failed to put on gloves and a gown before entering a resident's room for 1 of 2 residents on contact precautions (Resident #6). The findings included:	F 880	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	

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F 880	Continued From page 11 The facility's policy entitled, "Infection Prevention ...Contact, Contact Enteric ..." read in part, "Isolation precautions will be used ...when standard precautions alone are not adequate to eliminate or minimize occupational exposure to communicable disease ...contact precautions are indicated for patients who are known or suspected to be infected with microorganisms that can be transmitted by direct contact with the patient or indirect contact with environmental surfaces ...personal protective equipment (PPE) including gloves and gown are worn to enter a patient's room. Perform hand hygiene with soap and water when leaving room." Resident #6 was admitted to the facility on 3/30/23 with current diagnoses of Clostridioides diffcile (C-diff), a bacterium that causes an infection of the large intestines, and Methicillin-resistant Staphylococcus Aureus (MRSA), a bacteria that can cause serious infections that can lead to sepsis or death. An observation of the 300-hall on 3/20/23 at 12:20pm revealed Resident #6 was on contact precautions and the signage on the door instructed staff to clean their hands before entering the room, put on gloves before entering the room and put on a gown before entering the room. A continuous observation from 12:20pm to 12:22pm revealed NA #1 went into room 316 to deliver the lunch tray. NA #1 did not put on gloves or a gown before taking the meal tray into the resident. NA #1 adjusted the bedside table and pulled the curtain while in the resident's room. NA #1 exited the room, cleaned her hands with hand sanitizer and continued down the hall towards the meal cart.	F 880	F880 The facility ensures that an infection control prevention and control program is designed and followed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. On 3-21-23 immediate education was provided to the 1 staff member identified during the survey to ensure that she was understanding of the current policies and procedures with PPE use. Education was also provided to other nursing staff on proper PPE usage and completed on 3-22-23. Beginning 4-12-23, facility Infection Preventionist will conduct in-services with nursing staff, EVS staff, Food and Nutrition Director, Administrative staff, and Maintenance staff utilizing CDC infection control training modules. Any staff members who do not receive the training by 5-1-23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 4-3-23, a systemic change of Infection Control Policies and Procedures Enhanced Barrier was implemented to ensure compliance.	

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CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 An interview on 3/20/23 at 12:22pm with NA #1 revealed she was aware that Resident #6 was on contact precautions. She stated that since she was not handling the resident's urine, she did not need to put on gloves and a gown. She then stated she should have put on gloves and a gown to enter the resident's room when delivering the meal tray. An interview on 3/20/23 at 4:53pm with the Infection Preventionist (IP) revealed that when a resident was on contact precautions, gloves and a gown should be worn when entering the room, regardless of the reason for going into the room. NA #1 should have put on gloves and a gown before entering the resident's room regardless of the reason for going into the room. The IP stated there were plenty of personal protective equipment (PPE) supplies available and the PPE was provided outside the door of room 316. An interview on 3/21/23 at 3:45pm with the Director of Nursing (DON) revealed NA#1 should have put on gloves and a gown before entering room 316. The DON stated there were plenty of PPE supplies available and were provided outside the door of room 316. She further stated staff should don PPE before entering a room with contact precautions regardless of the reason for going into the room. An interview on 3/23/23 at 2:04pm with the Administrator revealed staff have been educated many times about using PPE when entering a room on contact precautions. The Administrator further stated that regardless of the reason, NA#1 should have donned gloves and a gown before she entered room 316.	F 880	On 4-13-23, the facility completed a Root Cause Analysis (RCA) with the assistance of the Corporate Performance Improvement, Corporate Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee of the facility and Governing Body to develop the intervention plan. Beginning 4-17-23, facility Infection Preventionist and/or designee will audit proper use of PPE for 12 weeks observing 5 observations a week times 4 weeks and 10 observations a month times 2 months. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion Date for F880 is 04-30-23	