STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/8/23 through 5/11/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RJVU11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/8/23 through 5/11/23. Event ID# RJVU11. The following intakes were investigated: NC00200802, NC00201477 and NC0000200222 2 of the 8 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interview the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 4 residents (Resident #28) reviewed for medication administration. Findings included: Resident #28 was admitted to the facility on 9/24/2019 with a diagnosis of hypertension. A review of Resident #28's quarterly Self Administration of Medications assessment dated	F 554	Corrective Action for the Resident Affected On 05/10/2023, the Director of Healthcare Services, (DHS), interviewed resident #28 to determine if the resident wanted to administer her own medications. The resident stated that she would like the Licensed Nurses to give her the medications ordered by her physician. Action for the Residents Potentially Affected	6/8/23

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

Electronically Signed | 05/29/2023

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F 554	Continued From page 1 11/25/22 revealed Resident #28 did not wish to administer her own medications and the plan of care was the facility would administer them for her. A review of Resident #28's quarterly Minimum Data Set (MDS) assessment dated 2/24/23 revealed she was cognitively intact. Resident #28's medical record did not reveal a physician's order to self-administer medication. On 5/8/23 at 10:04 AM Resident #28 was observed to have a medicine cup containing 6 pills at her bedside. She stated these were her morning medications. She went on to say she usually took her medications right away when the nurse provided them to her but this morning she had not had enough water in her pitcher and was waiting on the nurse aide (NA) to bring her some before taking them. On 5/8/23 at 10:06 AM Nurse #2 was observed at the medication cart approximately 3 rooms away from Resident #28. Resident #28 was out of Nurse #2's line of sight. An interview with Nurse #2 indicated she provided Resident #28 with her medication cup that morning which contained amlodipine (an antihypertensive medication), hydrochlorothiazide (a fluid pill), metformin (a blood sugar medication), Mucinex (a medication which thins mucous), metoprolol (an antihypertensive medication) and losartan (an antihypertensive medication). She stated she was not aware of Resident #28 having a physician's order to self-administer her medications. She went on to say Resident #28 usually took her medications right away when she gave them to her. She further indicated she had not stayed to	F 554	On 05/18/2023, the Director of Health Care Services (DHS) reviewed all other residents with a BIMS score of 13 and above to see if the residents preferred to have their medications at the bedside. Out of 15 residents, 15 preferred to continue having their medications given to them by the licensed Nurses. Systemic Changes On 05/24/2023, Nurse #2 was in-serviced by the DHS on the 6 rights of medication administration. On 05/23/2023, the DHS and or the Assistant Director of Healthcare Services, (ADHS) initiated an in-service to the Licensed Nurses on the 6 rights of medication administration. Staff that are not in-service by the compliance date of June 8, 2023, will receive the in-service prior to their next shift worked. Any newly hired licensed nurses will receive the in-service during orientation. Quality Assurance The DHS and or ADHS will conduct random audits of medications being passed to ensure the licensed nurses are administrating medications using the 6 rights of medication administration, 3 times a week for 4 weeks, then 1 time a week for 4 weeks, then monthly utilizing the QA monitoring tool for self-administering medications. The results of these medication audit	

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F 554	Continued From page 2 observe Resident #28 take her medications that morning. Nurse #2 stated she usually did but could not say why she had not today. On 5/10/23 at 11:50 AM an interview with the Director of Nursing (DON) indicated Resident #28 had not had an assessment completed to determine if she could safely self-administer her own medication. She went on to say Resident #28 did not have a physician's order in place to do that. She stated she had been told by Nurse #2 on 5/8/23 that Resident #28 might want to keep her medications at her bedside to take a few at a time so she was in the process of completing this assessment before putting a physician's order in place.	F 554	reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: June 8, 2023	
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 observations, record review and interviews with facility staff the facility failed to accurately code the Minimum Data Set (MDS) Assessment accurately in the areas of oxygen use (Resident #23), pressure ulcers (Resident #29), and discharge destination (Resident #51) for 3 of 18 resident assessments reviewed. The findings included: 1. Resident #23 was admitted to the facility on 7/01/2021. His diagnosis included laryngectomy with tracheostomy.	F 641	Corrective Action for the Resident Affected On 05/23/2023, resident #23 MDS assessment was modified for oxygen administration in section O by the MDS nurse. On 05/11/2023, an order was obtained from the resident□s physician for oxygen administration. On 05/11/2023, resident #29□s MDS assessment was modified for a healed	6/8/23

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F 641	Continued From page 3 The quarterly MDS dated 4/7/23 coded Resident #23 was not receiving oxygen. On 5/8/23 at 2:45 PM Resident #23 was observed to have a tracheostomy. He was receiving oxygen at 5 liters per minute. During an interview with Nurse #1 on 5/11/23 at 10:15 AM she stated Resident #23 had received oxygen during his whole time at the facility. On 5/11/23 at 1:24 PM the MDS nurse said Resident #23 did not have a doctor's order for oxygen when she was completing his MDS, so she was not aware he was receiving oxygen. She stated she did not code it in the MDS. She said if she had been aware he was receiving oxygen she would have indicated the oxygen use on the MDS. On 5/11/23 at 2:10 PM the Director of Nursing said the MDS should have coded Resident #23 was receiving oxygen because he was receiving oxygen during the assessment look back period. 2. Resident #29 was admitted to the facility on 12/6/2019 with diagnoses which included Parkinson's disease and cerebral infarct. A review of the quarterly MDS dated 3/10/23 indicated Resident #29 had one unstageable pressure ulcer with suspected deep tissue injury which was not present on admission or reentry. A review of the wound nurse's wound treatment documentation dated 11/16/22 revealed the deep tissue pressure injury (DTPI) to the right heel was identified on 11/14/22.	F 641	pressure ulcer in section M by the MDS nurse. On 05/10/2023, resident #51□s MDS assessment was modified to reflect the resident was discharged to a home setting in section A by the MDS nurse. Action for the Residents Potentially Affected On 05/11/2023, the MDS nurse reviewed orders for residents on oxygen. Of the 5 with orders 5 orders were noted. Of the 5 MDS, section 0 was properly assessed. On 05/25/2023, the MDS nurse reviewed the resident with pressure ulcers going back 30 days. Approximately 15 residents had pressure ulcers that had healed, and assessments updated as needed. On 05/25/2023, the MDS nurse reviewed residents that had been discharged from the facility over the past 30 days. Of the 17 residents discharged, those discharged with return not anticipated, were 2 home, 2 were discharged to acute hospital, 2 were discharged to another skilled facility and 1 discharged to assisted living. Those discharged with return expected, 9 were discharged to an acute hospital with 1 discharged to the ER and returned. All 17 were coded appropriately in the MDS. Systemic Changes On 05/18/2023, the Clinical Reimbursement Consultant in-serviced the MDS nurse, Interdisciplinary Team,	

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F 641	Continued From page 4 The wound nurse's note documented the area to the right heel was resolved on 2/19/23. During an interview with the Wound Treatment Nurse on 5/10/23 at 3:52 PM she stated the wound was healed months ago and her notes indicated it was healed on 2/19/23. On 5/11/23 at 1:31 PM the MDS nurse stated Resident #29 had a DTPI on her heel and the note dated 2/19/23 indicated the heel had a dark area. She said the note dated 2/19/23 was not during 7 days of the look back period for the 3/10/23 MDS assessment so the DTPI indicated on the 3/10/23 MDS was coded in error. On 5/11/23 at 2:17 PM the Director of Nursing stated the 3/10/23 quarterly MDS was incorrect for recording the DTPI which was healed in February. She said a modification to the MDS was completed today. 3. Resident #51 was admitted to the facility on 10/22/2022 with diagnoses that included Muscle weakness, Dysphagia, and Acute respiratory failure. Review of the discharge Minimum Date Set (MDS) dated 4/1/2023 indicated Resident #51 was discharged to an acute hospital. A review of the Nurse's note in the discharge summary dated 4/1/2023 indicated Resident #51 was discharged home with his family. During an interview with the MDS Nurse on 5/10/2023 at 11:19 a.m. she confirmed the MDS entry was incorrect. The MDS nurse explained the entry was coded in error.	F 641	and the Administrator on proper coding of the MDS and accuracy of assessments. On 05/24/2023, the Administrator in-service the DHS, ADHS, the Therapy Coordinator, Social Worker, and Activity Director on MDS coding and accuracy of assessments. The facility has reviewed its MDS Assessment Accuracy Policy with no revisions needed. Quality Assurance Director of Healthcare Services and/or Assistant Director of Healthcare Services will review the accuracy of 3 assessments per week x4 weeks and then 5 assessments per month for 3 months, utilizing the QA Monitoring Tool for Accuracy of Assessments. The results of the MDS accuracy reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: June 8, 2023	

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F 641	Continued From page 5 An interview was conducted with the Director or Nursing (DON) on 5/11/2023 at 11:03 a.m. She stated the MDS nurse was required to enter the correct assessment for Resident #51 in the MDS to reflect the correct discharge.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		6/8/23

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F 656	Continued From page 6 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to develop the comprehensive care plan in the area of anticoagulant (blood thinning) medication (Resident #39). This deficient practice was for 1 of 13 residents whose comprehensive care plans were reviewed. Findings included: Resident #39 was admitted to the facility on 6/2/22 with a diagnosis of pulmonary emboli (blood clot in the lungs). A review of the annual Minimum Data Set (MDS) assessment for Resident #39 dated 4/3/23 revealed she was cognitively intact. She received anticoagulant medication on 7 of 7 look-back days of the assessment. A review of Resident #39's medical record revealed a physician's order dated 3/22/23 for	F 656	Corrective Action for the Resident Affected On 05/11/2023, resident #39□s comprehensive care plan was updated in the area of anticoagulant (blood thinner) care plan was updated by the MDS nurse. Action for the Residents Potentially Affected On 05/11/2023, the MDS nurse reviewed comprehensive care plans for residents on anticoagulants (blood thinners). Of the 49 residents in the facility, approximately 12 residents were on anticoagulants and 12 were care planned. Systemic Changes On 05/18/2023, the Clinical Reimbursement Consultant in-serviced	

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F 656	Continued From page 7 Eliquis (an anticoagulant medication) 5 milligrams (mg) twice daily for pulmonary emboli. A review of Resident #39's May 2023 Medication Administration Record revealed she received Eliquis twice daily as prescribed. A review of Resident #39's current comprehensive care plan last revised on 5/1/23 did not reveal any care plan focus area or interventions related to receiving an anticoagulant medication. On 5/8/23 at 2:16 PM an interview with Resident #39 indicated she was currently receiving anticoagulant medication. She stated she had not experienced any unusual bleeding or bruising. On 5/11/23 at 10:00 AM an interview with the MDS Nurse indicated Resident #39's care plan should address anticoagulant medication so staff caring for her would be aware she was receiving it. She stated receiving anticoagulant medication put Resident #38 at risk for side effects like bleeding and bruising. She went on to say when she coded Resident #38 as receiving anticoagulant medication on the MDS assessment dated 3/22/23, this should have alerted her to address the medication on Resident #38's care plan but she had not. She further indicated it had just been an oversight on her part. On 5/11/23 at 10:14 AM an interview with the Director of Nursing (DON) indicated anticoagulant medication was a high-risk medication. She stated it should be addressed in Resident #38's comprehensive care plan so all staff caring for her would be aware she was at risk for side	F 656	the MDS nurse and the Administrator on completing a comprehensive care plan utilizing the company policy. On 05/24/2023, the Administrator in-service the DHS, ADHS, the Therapy Coordinator, Social Worker and Activity Director on completing a comprehensive care plan utilizing the company policy. Quality Assurance Director of Healthcare Services and/or Assistant Director of Healthcare Services will review 3 residents comprehensive care plans weekly x□s 4 weeks and then 2 residents comprehensive care plans assessments monthly x□s 3 months ensuring development and completion of the comprehensive care plan utilizing the QA Monitoring Tool for comprehensive care plans. The results of these QA Monitoring Tool reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: June 8, 2023	

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F 656	Continued From page 8 effects like bleeding or bruising.	F 656		
F 677 SS=E	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 record review, observation, resident, and staff interviews the facility failed to provide bathing to residents who were dependent on staff for activities of daily living (ADL) care for 2 of 2 residents (Resident #8 and Resident #24) reviewed for ADL care. Findings included: 1. Resident #8 was admitted to the facility on 7-18-17 with multiple diagnoses that included diabetes, vascular dementia, and muscle weakness. The annual Minimum Data Set (MDS) dated 4-14-23 revealed Resident #8 was severely cognitively impaired and required total assistance with one person for bathing. The MDS did not document Resident #8 refusing care. Resident #8's care plan dated 4-26-23 revealed Resident #8 was at risk for deterioration in ADL care self-performance due to muscle weakness and vascular dementia. The goal for Resident #8 was not to have deterioration in self-performance care. The interventions were documenting any deterioration, do not rush the resident, and aid with ADL care.	F 677	Corrective Action for Residents Affected. Resident # 8 and # 24 ADLs were completed and documented on 05/09/2023. Action for the Resident□s Potentially Affected. On 05/22/2023 the Director of Health Services and Nurse□s completed a review of all resident ADL care and documentation. The audit identified the documentation was not in place for 100% of the residents. Systemic Changes The Director of Health Services (DHS) and/or Nurse Managers began to in-service all nursing staff effective 05/25/2023. The DHS and/or Nurse Managers in-service staff on the importance of providing and documentation of ADL care for our residents, as well as the process for documenting a refusal of ADL Care. If a resident makes the decision to refuse ADL	6/8/23

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F 677	Continued From page 9 Review of Resident #8's bathing documentation from March 2023 through May 2023 revealed no documentation of Resident #8 receiving a bath or shower on the following days: March 2, 4, 5, 16, 18, 20, 25, and 26. April 2, 4, 5, 7, 8, 9, 10, 11, 13, 16, 17, 26, 29, and 30. May 3, 6, and 7. Review of the nursing documentation for the above dates revealed no documentation of Resident #8 refusing care. Resident #8 was interviewed on 5-8-23 at 9:51am. Resident #8 discussed not receiving a bath every day and stated she would like to have a bath every day. The resident was observed to have oily hair and a slight body odor. Observation of ADL care occurred on 5-9-23 at 7:00am with Nursing Assistant (NA) #3. The resident's hair was observed to be oily, and the resident had a slight body odor prior to the full bed bath. NA #3 was interviewed on 5-10-23 at 10:09am. The NA confirmed she had been assigned to Resident #8 on 3-5-23, 3-18-23, 4-4-23, 4-10-23, and 4-17-23. NA #3 stated when she was assigned to Resident #8, she tried to provide the resident with a full bed bath but explained some days the resident may refuse, or she did not have time to complete a bath. Upon reviewing the documentation for the dates listed, the NA stated she could not confirm she had provided a bath to Resident #8 nor could she confirm if the resident refused. NA #3 explained if a resident refused care, she should document the refusal and inform	F 677	care, the Nurse will be notified, and the refusal will be documented in the resident clinical chart. The Certified Nursing Assistants (CNA) will document care given in the Care Assist electronic charting program and or the refusal in the Care Assist electronic charting program. The CNA will then notify the nurse and complete the resident shower form. The nurse will need to document in the clinical chart and the nurse is required to follow up on the refusal with resident or Responsible Party. Nursing staff not educated by 6/8/2023 will be educated prior to their next scheduled shift. All newly hired direct care staff will receive the in-service during orientation. Quality Assurance The Director of Health Services and/or Nurse Managers will observe the resident, review the resident shower sheets and electronic ADL documentation to ensure the ADL care was provided and documented appropriately. Director of Health Services and Administrative nurses will review the accuracy of 5 residents ADL observation and documentation daily for 5 days then, 10 residents weekly for 4 weeks, then 20 residents monthly thereafter. The analysis of the ADL observation and documentation will be presented by the Administrator and/or Director of Health Services to the QA monthly for 3 months or until sustained compliance is maintained for 3 consecutive months then	

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F 677	Continued From page 10 the nurse who would also write a nursing note. The Director of Nursing (DON) was interviewed on 5-10-23 at 1:16pm. The DON discussed the process for the NAs when they had completed ADL care on a resident was to document what care had been provided in their tablet and if the resident had refused care, the NA should also document the refusal and inform the nurse on duty. She stated the nurse would document in the resident's progress notes the refusal of care. The DON stated she did not know why there was no documentation of ADL care for Resident #8 and could not speak to whether the resident had received a bath. The Administrator was interviewed on 5-11-23 at 2:26pm. The Administrator discussed residents should be receiving or at least offered a full bed bath daily and staff were responsible for documenting the care in their tablet. She stated if a resident was refusing a bath, the NA should document the refusal in their tablet and share the information with the nurse, but the nurse did not necessarily need to document in the progress notes the resident refusal. The Administrator stated she did not know why there was no documentation of Resident #8 receiving a bath, but she expected staff to provide the resident with at least a full bed bath daily. 2. Resident #24 was admitted to the facility on 11-4-22 with multiple diagnoses that included dementia without behavioral disturbances. The quarterly Minimum Data Set (MDS) dated 2-10-23 revealed Resident #24 was severely cognitively impaired and required total assistance with two people for bathing. The MDS did not	F 677	quarterly thereafter After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date of compliance: June 8, 2023	

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have any documentation of Resident #24 refusing care.

Resident #24's care plan dated 4-11-23 discussed Resident #24 was at risk for a decline in ADL functioning. The goal was for Resident #24 to have his ADL needs met and independence maximized within constraints of disease. The intervention for the goal was to aid with ADL care.

Review of the Nursing Assistant (NA) documentation for ADL care/bathing for Resident #24 from March 2023 through May 2023 revealed no documentation of Resident #24 receiving a bath for the following days.

March 2, 3, 4, 5, 8, 14, 16, 19, 20, 25, and 26.
April 7, 8, 9, 10, 11, 16, 28, and 29.
May 2, and 6.

Review of the nursing documentation for the above dates revealed no documentation of the resident refusing a bath.

Resident #24 was interviewed on 5-8-23 at 10:00am. The resident was observed to have an orange substance dried on his face, his hair was uncombed, and he had a brown/black substance caked under his fingernails. Resident #24 discussed not receiving a bath every day and stated he would like to have a bath every day.

Observation of ADL care occurred on 5-9-23 at 9:50am with Nursing Assistant (NA) #3. The NA was observed to provide Resident #24 with a full bed bath.

NA #3 was interviewed on 5-10-23 at 10:09am. NA #3 confirmed she was assigned to Resident

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#24 on 3-19-23, 4-11-23, and 4-16-23. The NA stated she did not know why there was no documentation for Resident #24's ADL care and that she could not confirm she had provided a bath to the resident. She explained the night shift sometimes provided the resident with a bath but confirmed there was no documentation of the night shift providing a bath to Resident #24 on the above dates. The NA said the resident would refuse ADL care and she was able to document refusals but stated she could not confirm he refused a bath on the above dates since there was no documentation.

The Director of Nursing (DON) was interviewed on 5-10-23 at 1:16pm. The DON discussed the process for the NAs when they had completed ADL care on a resident was to document what care had been provided in their tablet and if the resident had refused care, the NA should also document the refusal and inform the nurse on duty. She stated the nurse would document in the resident's progress notes the refusal of care. The DON stated she did not know why there was no documentation of ADL care for Resident #24 and could not speak to whether the resident had received a bath.

A telephone interview occurred on 5-10-23 at 2:46pm with NA #5. NA #5 confirmed she had been assigned to Resident #24 on 3-16-23. She stated she had not provided the resident with a bath or shower on 3-16-23. NA #5 discussed Resident #24 would "sometimes" try to "fight" staff when providing him with a bath or shower. The NA stated she had not attempted to provide a bath or shower to Resident #24 on 3-16-23.

The Administrator was interviewed on 5-11-23 at

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F 677	Continued From page 13 2:26pm. The Administrator discussed residents should be receiving or at least offered a full bed bath daily and staff were responsible for documenting the care in their tablet. She stated if a resident was refusing a bath, the NA should document the refusal in their tablet and share the information with the nurse, but the nurse did not necessarily need to document in the progress notes the resident refusal. The Administrator stated she did not know why there was no documentation of Resident #24 receiving a bath, but she expected staff to provide the resident with at least a full bed bath daily.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with facility staff and record review the facility failed to obtain a physician's order for the use of supplemental oxygen for 1 of 1 resident (Resident #23) reviewed for respiratory care. The findings included, Resident #23 was admitted to the facility on 7/01/2021. His diagnosis included laryngectomy with tracheostomy.	F 695	Corrective Action the Resident Affected On 05/11/2023, an order was written for resident #23 for oxygen. Action for the Residents Potentially Affected On 05/11/2023, the MDS nurse reviewed residents with oxygen orders and residents that were receiving oxygen to	6/8/23

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F 695	Continued From page 14 The quarterly MDS dated 4/7/23 coded Resident #23 was moderately cognitively impaired. Resident #23's care plan updated 4/19/23 revealed Resident #23 required oxygen therapy via trach collar. The interventions included monitor oxygen saturation via pulse oximetry every shift. On 5/8/23 at 2:45 PM Resident #23 was observed to have a tracheostomy. He was receiving oxygen at 5 liters per minute. A review of the physician's orders for April and May 2023 revealed there was no current order for Resident #23 to receive oxygen. A review of the Medication Administration Record (MAR) for April and May 2023 revealed no documentation for ensuring Resident #23 received oxygen or the rate of the oxygen being administered. There was an order with an original date of 6/26/22 which read to check the pulse oxygen (level) every shift. The order for the pulse oxygen level was signed off by the nursing staff each shift on the April and May 2023 MAR. On 5/10/23 at 2:25 PM an observation of tracheostomy care with Nurse #1 was conducted. During the observation an interview with Nurse #1 was conducted. She stated Resident #23 was receiving oxygen via his tracheostomy site at 5 liters per minute. On 5/11/23 at 10:14 AM Nurse #1 said she Resident #23 had received oxygen daily at 5 liters per minute for the last 4 months since she had worked with him.	F 695	ensure orders were written. Of the 5 residents on oxygen, 5 had orders for oxygen. Systemic Changes On 05/25/2023, the Director of Healthcare Services (DHS) in-serviced nurse #1 on ensuring if a resident is on oxygen, there is an order and or if a resident has a written order for oxygen that they have oxygen, and that it is being administered at the prescribed liters. On 05/25/2023, the Director of Healthcare Services (DHS) and or Assistant Director in-serviced the licensed nurses on ensuring if a resident is on oxygen, there is a written order and or if a resident has an order for oxygen that they have oxygen, and that it is being administered at the prescribed liters. Quality Assurance Director of Healthcare Services and/or Assistant Director of Healthcare Services will randomly monitor 1 resident weekly times 4 weeks, then 2 residents monthly times 3 months to ensure they have orders for oxygen and that it is being administered per orders utilizing the QA Monitoring Tool for Respiratory/Tracheostomy Care and Suctioning. The results of these oxygen reviews will be submitted to the Quality Assurance Performance Improvement (QAPI)	

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F 695	Continued From page 15 On 5/11/23 at 10:30 AM the Director of Nursing (DON) stated a physician's order was required for any resident receiving oxygen therapy. The DON said she failed to enter Resident #32's oxygen orders when he returned from the hospital. She said his oxygen rate was increased from 4 liters to 5 liters in November 2022 when he returned. She added since there were no orders the nursing staff would not know the rate of the oxygen Resident #23 should be receiving.	F 695	Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: June 8, 2023	
F 813 SS=C	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a policy regarding outside food brought in to residents by family or visitors that allowed for the safe storage of the foods which were brought in for residents. This had the potential to affect all residents. The findings included: A review of the policy titled "Patients/Residents Personal Food" revised on11/11/22 read; "It is the policy of (named corporate organization) to allow the patient/resident's family to provide food items for patient/resident consumption. The following process includes measures that (named corporate organization) is taking to prevent and control potential infectious diseases such as food-born illnesses and SARS-CoV-2. The procedure included: 5. Leftovers will not be	F 813	Corrective Action for the Resident Affected On 05/12/2023, PruittHealth Corporation reviewed and revised the Personal Food Policy to include use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption. Action for the Residents Potentially Affected On 05/26/2023, the Administrator-in-training and Social Worker conducted a Resident Council Meeting to discuss the revised Personal Food Policy. For residents that were unable to attend the resident council meeting, and BIMS score is 13 and	6/8/23

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F 813	Continued From page 16 refrigerated or reheated by the facility." During an interview with the Dietary Manager on 5/10/23 at 11:20 AM she stated the facility provided a refrigerator located in the dining room for residents to store foods brought into the facility that required refrigeration. On 5/10/23 at 2:50 PM Nursing Assistant (NA) #2 said food from outside for any resident at the facility was to be stored in a container in refrigerator in the dining room. She added the container must have the resident's name and the date it was brought in written on the outside of the container. The Administrator was interviewed on 5/11/23 at 10:30 AM She reported she had contacted the corporate office to determine if there was a different policy for the storage of resident's food brought in by outside sources. She stated this was the current policy. She acknowledged the policy did not allow for the safe storage of residents' foods. The Administrator said she was unaware of how the residents were informed of the policy. On 5/11/23 at 11:45 AM the corporate Nurse Consultant stated she had contacted the corporate office and this policy was the current policy.	F 813	above, the Activities Director reviewed the policy with them on an individual basis. On 05/25/2023, letters were mailed to current responsible parties explaining the revised Personal Food Policy. Systemic Changes On 05/22/2023, the Administrator in-serviced the Administrator-in-training, Dietary Manager, Director of Healthcare Services, Assistant Director of Healthcare Services, Financial Coordinator, Therapy Manager, Admission/Social Worker, MDS Nurse, Maintenance Director, Activities Director, and Housekeeping Manager on the revised Personal Food Policy. On 05/24/2023, the Dietary Manager, Director of Healthcare Services, Assistant Director of Healthcare Services, Therapy Manager and Housekeeping Manager initiated an in-service to their staff on the revised Personal Food Policy. Any employee not receiving the in-service by the 06/08/2023 will not be allowed to work until they have received the training. New orientee□s will receive the training upon hire. On 05/22/2023, the Administrator in-serviced the Admissions Coordinator/Social Worker on providing the revised Personal Food Policy to new admissions and or their responsible party. Quality Assurance	

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F 813	Continued From page 17	F 813	The Administrator-in-training and or Administrative Nurses will randomly monitor 2 employees weekly times 4 weeks, then monthly times 3 months to ensure they are familiar with the revised Personal Food Policy, utilizing the QA Monitoring Tool for Personal Food Policy. The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator-in-training for review by the Interdisciplinary Team members monthly or until compliance is sustained. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: June 8, 2023	
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F 847		6/8/23

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F 847	Continued From page 18 §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review, resident representative and staff interviews, the facility failed to explain the arbitration agreement to the resident representatives prior to having them sign the agreement. This occurred for 3 of 4 residents (Resident #203, Resident #104, and Resident	F 847	Corrective Action for the Resident Affected On 05/19/2023, resident #203□s responsible party (RP) was contacted by the Admissions Director and the	

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F 847	Continued From page 19 #253) reviewed for arbitration. Findings included: Review of the facility's "Arbitration Agreement" which was not dated, revealed documentation that the resident and/or the resident's representative acknowledged they had read and understood the agreement and that the agreement had been adequately explained to them in plain language. a. Resident #203 was admitted to the facility on 4-26-23. The medical record for Resident #203 did not have a Minimum Data Set (MDS) available. Review of Resident #203's arbitration agreement revealed the resident's representative had signed the agreement on 4-27-23. A telephone interview occurred with Resident #203's representative on 5-9-23 at 10:44am. The resident representative stated the arbitration agreement had not been explained to her and she had not read the agreement. She explained she had been "overwhelmed" with the amount of paperwork, so she just signed each place she was instructed to sign. b. Resident #104 was admitted to the facility on 4-27-23. The medical record for Resident #104 did not have a Minimum Data Set (MDS) available. Review of Resident #104's arbitration agreement revealed the resident's representative had signed	F 847	arbitration agreement was reviewed. RP verbalized understanding of the agreement and chose to keep it in place. On 05/17/2023, resident #104□s responsible party (RP) was contacted by the Admissions Director and the arbitration agreement was reviewed. RP verbalized understanding of the agreement and chose to keep it in place. On 05/10/2023, resident #253□s responsible party (RP) was contacted by the Admissions Director and the arbitration agreement was reviewed. RP verbalized understanding of the agreement and chose to revoke the agreement. Action for the Residents Potentially Affected On 05/10/2023, the admissions Coordinator initiated calling and or speaking with current residents and or their responsible parties about the Arbitration Agreement. Out of 48 current residents, approximately 2 families decided to rescind their original approval to have the arbitration agreement, 1 family member refused to accept or decline signing the agreement, 1 resident expired, and 42 families/resident kept the agreement in place. Several attempts were made to contact 2 families without success, certified letters sent out with return receipt requested.	

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F 847	Continued From page 20 the agreement on 4-28-23. During a telephone interview with Resident #104's representative on 5-9-23 at 10:47am, the representative stated the arbitration agreement had not been explained to her and she did not fully understand the agreement when she read it but said she was unable to proceed with the admission process on the computer unless she signed the form. c. Resident #253 was admitted to the facility on 5-2-23. The medical record for Resident #253 did not have a Minimum Data Set (MDS) available. Review of Resident #253's arbitration agreement revealed the resident's representative had signed the agreement on 5-2-23. A telephone interview occurred with Resident #253's representative on 5-10-23 at 12:04pm. The representative explained she had not read the arbitration agreement and the agreement had not been explained to her. She stated she was provided with a lot of papers to sign, and she just signed them. Once the arbitration agreement was explained to her, the representative stated she would not have signed the form and questioned who she could speak with to have the agreement voided. The Admissions Coordinator was interviewed on 5-10-23 at 1:00pm. The Admissions Coordinator explained the admissions process was completed using an electronic system. She stated the admissions packet which contained the arbitration agreement would be emailed to the residents'	F 847	Systemic Changes On 05/18/2023, the Administrator re-educated the Admissions Coordinator/Social Worker on arbitration agreements, including that the agreement must be discussed with the resident and or responsible party in a language they understand. Quality Assurance The Administrator and or Administrator-in-training will randomly audit 2 admissions weekly for 4 weeks, then 1 monthly to ensure that the arbitration agreement has been discussed with the resident and or responsible party in a language the understand utilizing the QA Monitoring Tool for Arbitration agreements. The results of these Arbitration agreement reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or the Administrator-in-training for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: June 8, 2023	

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F 847	Continued From page 21 representative or if the resident/resident representative were present, then she would sit with them and review the admissions paperwork with them and have them sign the forms electronically. The Admissions Coordinator said when she emailed the admissions packet to the residents' representative, she would inform them to call her if they had any questions. She acknowledged that she did not follow up with the representatives once she received the admissions packet to ensure the representatives understood the arbitration agreement and stated she was unaware she had to ensure the representatives understood what they were signing when they signed the arbitration agreement. The Director of Nursing (DON) was interviewed on 5-10-23 at 1:16pm. The DON stated she was not familiar with the arbitration agreement other than the agreement was completed by the Admissions Coordinator. The Administrator was interviewed on 5-11-23 at 2:26pm. The Administrator stated she expected the arbitration agreement to be explained to the resident and/or the resident representative in a language they can understand.	F 847		
F 867 SS=F	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	F 867		6/8/23

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PRUITTHEATH-FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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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 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

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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 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

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F 867	Continued From page 24 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 observations, record review and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 2/23/21 focused infection control and complaint investigation survey, the 1/27/22 recertification and complaint investigation survey and the 11/30/22 complaint investigation survey. This was for one deficiency in the area of F880 Infection Prevention and Control that was cited on the 2/23/21 focused infection control and complaint investigation survey, 2 deficiencies in	F 867	Corrective action for the resident affected On 05/25/2023, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT)to discuss the 3 repeat tags, F656, F670 and F880. It was determined through the Root Cause Analysis, that the facility has gone through increased turnover in leadership and ownership in these identified areas.	

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F 867	Continued From page 25 the areas of F656 Develop and Implement Comprehensive Care Plan and F880 Infection Prevention and Control that were cited on the 1/27/22 recertification and complaint investigation survey and 1 deficiency in the area of F677 Activities of Daily Living Care that was cited on the 11/30/22 complaint investigation survey. These deficiencies were recited on the current recertification and complaint investigation survey of 5/11/23. The continued failure of the facility during two or more federal surveys of record show a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to: F656: Based on record review and resident and staff interviews the facility failed to develop the comprehensive care plan in the area of anticoagulant (blood thinning) medication (Resident #39). This deficient practice was for 1 of 13 residents whose comprehensive care plans were reviewed. During the recertification and complaint investigation survey on 1/27/22 the facility was cited for failing to develop and implement a comprehensive care plan. F677: Based on record review, observation, resident, and staff interviews the facility failed to provide bathing to residents who were dependent on staff for activities of daily living (ADL) care for 2 of 2 residents (Resident #8 and Resident #24) reviewed for ADL care.	F 867	Corrective action for residents potentially affected On 5/23/2023 The Administrator and Regional Nurse Consultant educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys. On 05/22/2023, the Administrator reviewed surveys for 02/23/2021, 01/27/2022 and 11/30/022 to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI meetings. Systemic Changes The Area Vice President of Operations for Coastal North Division and or the Regional Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly times 6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI process. Quality Assurance The results of these ongoing survey trend reviews are to be submitted in the QAPI meeting and placed in the QAPI minutes for review. The Quality monitoring schedule will be modified based on the findings of the monitoring review. The	

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F 867	Continued From page 26 During the complaint investigation survey on 11/30/22 the facility was cited for failing to provide a full bed bath which included brushing teeth, washing or brushing hair, nail care, and failed to rinse soap from a resident's skin during a bed bath. F880: Based on record review and staff interviews the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 49 of 49 residents in the facility. During the focused infection control and complaint investigation on 2/23/21 the facility was cited for failing to ensure residents were offered or provided hand hygiene during meals. During the recertification and complaint investigation survey on 1/27/22 the facility was cited for failing to follow Infection Control practices when entering an enhanced droplet isolation room and failing to perform hand hygiene between rooms. On 5/11/23 at 3:09 PM an interview with the Administrator indicated she could not speak to what happened in the facility prior to this year because she was not present in the facility. She went on to say there had been a lot of turnover of management staff in the facility and the facility had been using a lot of agency staff. The Administrator stated she felt as a result of that there had not been a lot of consistency or accountability. She stated she was currently precepting a new Administrator and hoped that with her onboard the facility could get back on track.	F 867	QAPI Committee will evaluate and modify the monitoring schedule as needed. Compliance Date: June 8, 2023	

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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 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:	F 880		6/8/23

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F 880	Continued From page 28 (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 record review and staff interviews the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 49 of 49 residents in the facility. Findings included: The facility's "Infection Prevention and Control Surveillance" policy reviewed on 4-6-23 documented the Infection Preventionist (IP)	F 880	Corrective action for the resident affected The facility hired a Registered Nurse to assume the role of the Infection Preventionist (IP) Nurse with a start date of 05/15/2023. The roles and responsibilities include tracking and analyzing infections within the facility. Corrective action for residents potentially affected	

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F 880	Continued From page 29 conducts surveillance of all infections among residents and partners including tracking and analysis of outbreaks of infections. The Infection Preventionist (IP) nurse was interviewed on 5-11-23 at 11:12am. The IP nurse discussed tracking and analyzing infections in the facility by using an approved tracking form. She explained the form was computerized, so she did not have a paper copy for review. After requesting the IP nurse retrieve the last three months of her tracking for infections on her computer for review, the IP nurse stated she did not have the information. She explained she had not tracked or analyzed any infections in the facility since her arrival in January 2023. The IP nurse also stated during the facility's monthly management meeting with the Physician, she will discuss any infections residents may have but she stated she had not documented the information. A telephone interview occurred with the facility's Medical Director on 5-11-23 at 2:06pm. The Medical Director stated she attended the monthly management meeting and residents who currently had an infection were discussed. She stated she did not know if there was any documentation but said she expected the IP nurse to track the trends in resident infections. The Administrator was interviewed on 5-11-23 at 2:26pm. The Administrator explained the IP nurse was responsible for infection surveillance and was unaware the IP nurse had not been tracking and analyzing the residents' infections. She stated she expected the IP nurse to perform infection surveillance on all the residents who were present with an infection.	F 880	The Director of Health Services and/or Infection Preventionist reviewed the history of antibiotic usage for the past sixty days with tracking and trending analysis including epidemiology, trace mapping and outbreak. The Infection Surveillance will continue daily by the Infection Preventionist. Systemic Changes On 05/23/2023, the Regional Nurse Consultant educated the Administrator, Administrator-in-training and Administrative Nurses on the Infection Preventionist (IP) Nurses role to include tracking and analyzing infections within the facility. The facility Infection Preventionist Nurse will maintain the Infection Control Program including surveillance of all infections among residents and partners including tracking and analysis of outbreaks of infections. The Administrator will ensure the facility has a designated Registered Nurse in the role of the Infection Preventionist monthly. Quality Assurance The Infection Preventionist will present the analysis of the tracking of infections to the Quality Assurance and Performance Committee meeting members monthly for three consecutive months then quarterly thereafter for review and revision as needed. The QAPI Committee will evaluate and modify monitoring	

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F 880	Continued From page 30	F 880	requirements as needed. The Administrator will present the analysis of the Registered Nurse Infection Preventionist employment monthly at the Quality Assurance and Performance Improvement committee monthly until three months of sustained compliance is maintained, then quarterly thereafter. Compliance Date: June 8, 2023	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop an infection prevention and control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage, and duration of use of antibiotics. This was evident in 3 of 3 monthly surveillance data reviewed (February 2023, March 2023, and April 2023). Findings included: The facility's "Antibiotic Stewardship Program"	F 881	Corrective action for the resident affected The facility hired a Registered Nurse as the Infection Preventionist (IP) with a start date of 05/15/2023. Corrective action for residents potentially affected The Director of Nursing and Infection Preventionist reviewed the Antibiotic Stewardship program policy and implemented the infection prevention and	6/8/23

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F 881	Continued From page 31 policy revised on 2-8-23 documented the antibiotic stewardship program will monitor and review infections and antibiotic usage patterns on a regular basis, antibiogram reports for trends of antibiotic resistance, antibiotic resistance pattern for multidrug resistant organisms, number of antibiotics prescribed, and the number of residents treated each month. During an interview with the Infection Preventionist (IP) nurse on 5-11-23 at 11:12am, the IP nurse discussed the facility having an antibiotic stewardship program. Upon requesting to see the tracking of antibiotic use in the facility from February to April 2023, the IP nurse stated she did not have the information. She explained she had not completed any documentation of antibiotic use in the facility since she arrived in January 2023. The IP nurse confirmed there had been residents on antibiotics since her arrival in January 2023 and was able to state the cause for the antibiotics were urinary tract infections and osteomyelitis but could not remember any other infections, how long the residents were on the antibiotics, and what antibiotics they were prescribed. The IP nurse stated once a resident was having symptoms of an infection, she would contact the Physician and inform the Physician of the symptoms and request lab work but said she was not documenting any of the infections, lab work or antibiotics. The Medical Director was interviewed by telephone on 5-11-23 at 2:06pm. The Medical Director stated the nurse would contact her or the Physician on call to obtain orders for lab work if a resident was showing signs of an infection. She said she expected the IP nurse to be tracking trends of infections and the use of antibiotics so	F 881	control program that established an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage, and duration of antibiotic. Systemic Changes On 5/23/2023, the Regional Nurse Consultant educated the Infection Preventionist on the Antibiotic Stewardship Program that includes an antibiotic stewardship program with written protocols on antibiotic prescribing, documentation of the indication, dosage, and duration of antibiotics. (McGeer□s criteria). The Director of Healthcare Services (DHS) will monitor the Antibiotic Stewardship program to include the McGeer□s criteria, to ensure the Infection Preventionist is maintaining compliance monthly until three months of substantial compliance is maintained then quarterly thereafter. Quality Assurance The Infection Preventionist will present the analysis of the Antibiotic Stewardship program to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter or as designated by the QAPI committee. Date of Compliance: June 8, 2023	

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F 881	Continued From page 32 the facility could analyze the data and see if there were any trends of infections. The Administrator was interviewed on 5-11-23 at 2:26pm. The Administrator discussed the facility should be tracking trends of infection and the use of antibiotics. She confirmed the IP nurse was responsible for completing the task. The Administrator explained she was unaware the tracking of infections and antibiotic use were not being completed and stated she expected the IP nurse to follow the facility protocol for the antibiotic stewardship program.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to designate a qualified Infection	F 882	Corrective action for the resident affected	6/8/23

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F 882	Continued From page 33 Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. Findings included: The Administrator was interviewed on 5-9-23 at 2:35pm. The Administrator confirmed she had assigned all infection control activities to the Director of Nursing (DON). During an interview with the DON on 5-11-23 at 11:12am, the DON stated she was also the facility's Infection Preventionist (IP) and confirmed she was the only staff member responsible for the oversite of the infection control duties. The DON explained prior to being employed by the facility, she had been working on obtaining her specialized training for the IP position but was unable to complete the training. She stated since her arrival to the facility in January 2023, she had been "too busy" to complete any of the required training programs for the IP position. A further interview with the Administrator occurred on 5-11-23 at 2:26pm. The Administrator discussed working on hiring a nurse who had specialized training for the IP position. She also explained the DON was supposed to attend the last specialized training but had not attended. The Administrator said she was aware the IP nurse required specialized training but did not have any staff with the qualifications.	F 882	On 05/17/2023, the Infection Preventionist and the Director of Healthcare Services enrolled in the Center for Disease Control Nursing Home Infection Preventionist training Course. The Infection Preventionist will enroll in the Statewide Program for Infection Control and Epidemiology (SPICE) program when it becomes available to register in the summer of 2023 for class dated November 8 □ 10, 2023. Corrective action for residents potentially affected On 5/23/2023, the Regional Nurse Consultant educated the Interdisciplinary Team on the role of the Infection Preventionist. The Infection Preventionist and the Director of Health Services will be completed with the Center for Disease Control Nursing Home Infection Preventionist training Course by 05/29/2023. Systemic Changes The Director of Healthcare Services will ensure the Infection Preventionist registers for the upcoming Infection Preventionist will enroll in the Statewide Program for Infection Control and Epidemiology (SPICE) program and review monthly until completion of the program has been accomplished. The Administrator of the facility will ensure there is an Infection Preventionist with	

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F 882	Continued From page 34	F 882	specialized training in Infection Control always employed by the facility. Quality Assurance The Administrator will present the analysis of the Infection Preventionist specialized training to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. The QAPI Committee will evaluate and modify the monitoring schedule as needed. Compliance Date: June 8, 2023	