STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

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F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on-site on 08/09/21 through 08/12/21 and completed remotely on 08/13/21. 4 of 32 complaint allegations were substantiated with deficiency. Event ID# T85M11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		9/14/21

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

Electronically Signed | 09/02/2021

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to cover the urinary drainage bag with a privacy cover to maintain dignity for 1 of 2 residents observed for incontinence care. (Resident #6) Findings included: Resident #6 was admitted to the facility on 07/28/21. Diagnoses included, in part, dementia without behaviors. The Minimum Data Set quarterly assessment dated 06/11/21 revealed the resident was moderately cognitively impaired. The resident required extensive assistance with two staff physical assistance with bed mobility, transfers, dressing, and toileting and was always incontinent of bowel and had an indwelling catheter. An observation of incontinence care for Resident #6 was conducted on 08/10/21 at 6:00 AM with NA #3. The resident was noted to be lying in bed with a urinary drainage bag hanging on the side of the bed closest to the door and could be	F 550	F 550 Resident Rights/Exercise of Rights CFR(s): 483.10 (a)(1)(2)(b)(1)(2) On 8/10/2021, the Unit Manager provided resident # 6 a privacy cover to the Foley drainage bag to maintain resident dignity. Resident # 6 no longer resides at the facility. On 8/10/2021, the Unit Manager initiated a 100% audit of all residents with Foley or Supra Pubic catheter to include resident # 6. This audit is to ensure all Foley drainage bags were covered with privacy cover to maintain resident dignity. The Director of Nursing will address all concerns identified during the audit. Audit will be completed by 8/10/2021. On 8/10/2021, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants to include agency nurses and nursing assistants in regard to Dignity-Foley/Supra Pubic Catheter with emphasis on ensuring Foley drainage bags are covered with privacy cover to maintain resident dignity. Inservice will be completed by 9/14/2021.	

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F 550	Continued From page 2 visually observed from the hall. The drainage bag was covered with a blue privacy bag. NA #3 proceeded to remove the privacy bag and drained the urine in the urinal. NA #3 was observed leaving the privacy bag on the floor. An interview was conducted with NA #3 on 08/10/21 at 6:27 AM. The NA reported she did not know what a privacy bag was. NA #3 stated she never heard of a such a thing and reported she had received training on emptying urinary drainage bags, but never knew of anything called a privacy bag. She stated when she removed the blue cover from the urinary drainage bag she thought it was just part of the urinary drainage bag. NA #3 stated when she first started at the facility she was oriented to several things and she believed one of the topics was dignity. An interview with the SDN on 08/10/21 at 9:21 AM revealed NA #3 received in services regarding maintaining a catheter bag and she believed it included covering the urinary drainage bag with a cover to maintain privacy. The SDN was unable to provide documentation specific to this training and stated that when she completed in services regarding maintaining a catheter she included to ensure the urinary drainage bag was covered to maintain the resident's privacy and dignity. An interview with the Director of Nursing (DON) on 08/12/21 at 5:40 PM. The DON stated she expected her nursing staff to make sure all the urinary drainage bags were covered to maintain privacy and dignity for the residents.	F 550	All newly hired nurses and nursing assistants will be in-serviced during orientation by the Staff Development Coordinator in regard to Dignity-Foley/Supra Pubic Catheter. The Unit Managers will complete observations of all residents with Foley catheters or Super Pubic catheters weekly x 8 weeks then monthly x 1 month utilizing the Foley Audit Tool. This audit is to ensure all Foley drainage bags are covered with a privacy cover to maintain resident dignity. The Unit Managers will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Foley Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will present the findings of the Foley Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Foley Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		9/14/21

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F 583	Continued From page 3 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide full personal privacy for a resident while providing	F 583	F 583 Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	

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F 583	Continued From page 4 incontinence care when she exited the room to get additional help and left the resident undressed and exposed for 1 of 2 residents observed for incontinence care, (Resident #6). Findings included: Resident #6 was admitted to the facility on 07/28/21. Diagnoses included, in part, dementia without behaviors. The Minimum Data Set quarterly assessment dated 06/11/21 revealed the resident was moderately cognitively impaired. The resident required extensive assistance with two staff physical assistance with bed mobility, transfers, dressing, and toileting and was always incontinent of bowel and had an indwelling catheter. An observation of incontinent care for Resident #6 was conducted on 08/10/21 at 6:00 AM with Nurse Aide (NA) #3. The resident was noted to be lying in bed close to the wall. The window was near the bed and the blind was closed. The urinary drainage bag was hanging on the side of the bed which was covered with a blue privacy bag. NA #3 proceeded to inform the resident that she was going change her. She lifted up the resident ' s nightgown and laid the nightgown over the resident's chest. She removed the resident's brief and proceeded to instruct the resident to turn. She was unable to have the resident reposition and stated, "I need to go and get help." NA #3 left the resident lying on her back, with the nightgown pulled up over her chest and the brief off. NA #3 did not close the privacy curtain, nor did she cover the resident with her bed sheets prior to leaving and left the door wide open when she proceeded to find assistance. NA #3 was out	F 583	On ¿¿¿8/10/2021, NA # 3 was retrained on providing personal privacy for a resident while providing incontinence care by the Director of Nursing. Resident # 6 no longer resides at the facility. On 8/10/2021, 100% audit of all residents to include resident # 6 was completed by the Medical Records Manager/Nursing Assistant to ensure that all residents were provided personal privacy to include while being provided incontinence care. There were no additional identified areas of concern during the audit. On 8/10/2021, 100% in-service to include return demonstration was initiated by the Staff Development Coordinator on with all nurses and nursing assistants regarding providing personal privacy to include providing personal privacy for a resident while providing incontinence care. All newly hired nurses and nursing assistants to include agency nurses and nursing assistants will be in-serviced by the Staff Development Coordinator during orientation in regard to personal privacy. In-service will be completed by 9/14/2021. 10% observation of ADL resident care to include providing personal privacy for a resident while providing incontinence care for all residents will be completed by the Assistant Director of Nursing, Unit Managers weekly x 8 weeks then monthly x 1 month utilizing Privacy Audit Tool. This audit is to ensue residents were provided personal privacy to include while receiving incontinence care. Any areas of identified concern will be addressed by the Assistant Director of Nursing, Unit Managers to include providing privacy	

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F 583	Continued From page 5 of the room for 6 minutes and staff were observed walking by the resident ' s room during this time. NA #3 returned with NA #4 and they proceeded to assist Resident #6 with her incontinent care. An interview was conducted with NA #3 on 08/10/21 at 6:27 AM. NA #3 stated when she returned from the resident's room with additional staff, she did not notice anything she may have missed prior to leaving the resident ' s room to get assistance. NA #3 stated she did not realize she left the resident exposed and the door open. NA #3 stated she believed she had received training and education regarding providing residents with privacy while doing care when she was first hired about a month ago. NA #3 stated she should not have left Resident #6 uncovered before she left the room, and she should have provided privacy for her. An interview was conducted with the Staff Development Nurse (SDN) on 08/10/21 at 9:21 AM. The SDN provided documentation of an in service that was completed for orientees in June 2021. She stated the power point presentation had a specific slide for right to privacy. The in service included discussion to provide privacy in resident ' s room, during care, and privacy with other facility residents. The SDN provided a completed check off list for NA #3 to indicate providing privacy for a resident was taught. An interview was conducted with the Director of Nursing (DON) on 08/12/21 at 5:40 PM. The DON stated she expected the nurse aides to provide privacy when doing care on a resident at all times.	F 583	and/or additional staff training. The Director of Nursing will review and initial the Privacy Audit Tools weekly x 8 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will present the findings of the Privacy Audit Tools to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Privacy Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 584	Continued From page 6	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		9/14/21

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F 584	Continued From page 7 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: 1a) remove a black greenish substance from ceiling vents in 9 of 15 resident rooms (200, 206, 208, 300, 302, 306, 311, 315, and 400), 4 of 4 shower rooms, and 5 of 6 lobby entrance ceiling vents, 1b) failed to remove the black greenish substance from the commode base caulking in 5 of 15 resident rooms (110, 112, 208, 300, and 306), and 1c) failed to ensure the ceilings were free from damaged drywall in 2 of 4 shower rooms (400 and 500 halls), 1d) failed to replace 3 of 19 broken or missing toilet paper dispensers in resident rooms (112, 208, and 306), 1e) repair 7 of 19 resident's overhead lights that were either non-functioning, missing a light cover, or had broken covers in rooms (200, 204, 209, 300, 306, 621, and 627), 1f) failed to repair leaking commode bases in 4 of 19 resident rooms (208, 301, 308, and 310), and 1g) failed to unclog 1 of 1 resident room commodes (112). Findings included: 1a. An observation on 08/09/21 at 1:00 PM revealed 9 of 15 ceiling vents in resident rooms (200, 206, 208, 300, 302, 306, 311, 315, and 400), 3 of 4 shower room ceiling vents (300-1, 300-2, and 500 hall), and 5 of 6 lobby ceiling vents were noted to have black greenish substance on them. 1b. An observation on 08/09/21 at 1:00 PM revealed 5 of 11 resident commodes (110, 112,	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10 (i)(1)-(7) The black greenish substance from ceiling vents in room # 200, 206, 208, 300, 302, 306, 311, 302, 306, 311, 315, 400 and 4 of 4 shower rooms and 5 of 6 lobby entrance celling vents was cleaned by the Housekeeping Director on August 11, 2021. The black greenish substance from was cleaned from the commode base caulking in room # 110, 112, 208, 300, and 306 was cleaned by the housekeeper on August 10, 2021. The black greenish substance from ceiling vents in room # 200, 206, 208, 300, 302, 306, 311, 302, 306, 311, 315, 400 and 4 of 4 shower rooms and 5 of 6 lobby entrance celling vents was cleaned by the Housekeeping Director on August 11, 2021. The damaged ceilings drywall was repaired in the 400 and 500 hall shower rooms by the Hilco Repair Crew on September 2, 2021. The broken and missing toilet paper dispensers in room # 112, 208 and 306 was repaired/replaced by the Hilco Repair Crew on August 1, 2021. The overbed lights that were either non-functioning, missing a light cover, or had broken covers in rooms in room #	

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F 584	Continued From page 8 208, 300, and 306), were noted to have black greenish substance located around the base of the commodes. 1c. An observation on 08/09/21 at 1:00 PM revealed 2 of 4 facility shower rooms (400 and 500 halls) were noted to have damaged ceiling drywall. 1d. An observation on 08/09/21 at 1:00 PM revealed 3 of 19 toilet paper dispensers were either missing, broken, or not attached to the wall (112, 208, and 306). 1e. An observation on 08/09/21 at 1:00 PM revealed 7 of 19 resident room overhead lighting were either non-functioning, missing a light cover, or had broken covers (200, 204, 209, 300, 306, 621, and 627). 1f. An observation on 08/09/21 at 1:00 PM revealed 4 of 19 resident room commodes were leaking at their bases with white bath towels wrapped around them in rooms (208, 301, 308, and 310). 1g. An observation on 08/09/21 at 1:00 PM revealed 1 of 1 resident room comode was noted to be clogged and full of unflushed feces (112). An interview was conducted with NA #1 on 08/09/21 at 4:10 PM revealed she did not know what the TELS work order system was. NA #1 said, when she had a maintence concern, she would report her concern verbally to her nurse or the Maintenance Director (MD). A follow-up observation on 08/10/21 at 8:55 AM for the remaining 1 of 4 shower rooms (400 hall)	F 584	200, 204, 209, 300, 306, 621, and 627 was repaired/replaced by the Hilco Repair Crew on August 29, 2021. The leaking commode bases in room # 208, 301, 308 and 310 was repaired by the North Chase Maintenance Staff on August 11, 2021 The clogged commode in room # 112 was unclogged by the North Chase Maintenance Department on August 9, 2021. 100% observation of the facility to include all resident□s rooms to include rooms # 110, #112, #200, # 204, #206, #208, #209, #300, #301, #302, #306, #308, #310, #311, #315, #400, #621, #627 and 400 and 500 hall shower rooms was completed on August 10, 2021 by the Housekeeping Director and the Maintenance Director to ensure all areas and rooms are in good repair. Work orders were completed on August 10, 2021 by the Administrative and Maintenance Staff for notification to Maintenance for any identified areas of concern. The Maintenance Director will correct all identified areas of concerns from the audit by September 8, 2021. The Maintenance Director was in-serviced by the Administrator on August 10, 2021 regarding ensuring rooms are in good repair. All license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers were in-service by the staff development coordinator and Administrator on September 2, 2021 to notify Maintenance of any areas in the	

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F 584	Continued From page 9 and 9 resident rooms (108, 112, 200, 204, 208, 301, 308, 315, and 400) revealed black greenish substance around the base of 5 resident commodes (110, 112, 208, 300, and 306), clogged commode (rooms 112), leaking around the base of 4 resident commodes (208, 301, 308, and 310), lighting fixtures in disrepair to include not working, missing bulbs, and had missing or broken covers of 6 resident rooms (200, 204, 206, 209, 306, and 627). The Maintenance Director (MD) indicated the facility utilized an electronic work order system (TELS) which was a building management platform disigned for senior living with integrated asset management, life safety, and maintenance solutions. He stated he checked TELS work orders every morning, and added that most of the facility's repair needs were communicated by the staff through verbal communication and not electronically. He stated he did not routinely complete routine walk-throughs of the facility to address any additional maintenance needs that were not addressed in TELS. He stated he priortized work order requests based on resident safety concerns. MD stated he did not have a system in place to track regular scheduled facility maintenance, and also could not provide documentation of completed or pending work orders that still needed to be addressed. The Housekeeping Supervisor (HS) was interviewed on 08/10/21 at 11:00 AM. The HS stated he was not aware of of the black greenish substance around the base of the resident's commodes, and in shower rooms. He stated housekeeping staff were responsible for checking toilets daily (and as needed), and he was not sure why any of those areas had a black greenish substance on them. The HS stated he never	F 584	facility in need of repair or painting to include resident rooms by completing a work order in TELS system or by using the forms available near each nurse□s station. All newly hired license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers will be in-serviced by the Staff Development Coordinator regarding to notify Maintenance of any areas in the facility in need of repair or painting to include resident□s rooms by completing a work order in TELS during orientation. The Maintenance Staff & Housekeeping Director will monitor all areas of the facility to include 100% of all resident rooms, to include rooms # 110, #112, #200, # 204, #206, #208, #209, #300, #301, #302, #306, #308, #310, #311, #315, #400, #621, #627 and 400 and 500 hall shower rooms to ensure rooms are in good repair weekly x 8 weeks then monthly x 1 utilizing a Homelike Environment QI Audit tool and complete a work order in TELS for all identified areas of concerns. The Maintenance Director will immediately address any identified areas of concern during the audit. The Administrator will review the Home like Environment QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Homelike Environment QI Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include	

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F 584	Continued From page 10 tested the black greenish substance to see what it was and he would do the daily visually checks in the residents' bathrooms, but he could not provide documentation in the system that the facility utilized to verify that they were visually checked daily. An interview was conducted with NA #2 on 08/10/21 at 11:37 AM revealed she did not know of the TELS work order system. NA #2 said, when there was a maintence concern, she would report the concern verbally to the Maintenance Director (MD) or her nurse. An interview was conducted with the Maintenance Director (MD) on 08/10/21 at 2:00 PM. The MD stated the ceiling vents needed to be cleaned. He stated he would get his assistant to clean the black greenish substance areas. He also stated he never assessed the black greenish substance on any of their ceiling vents, and he did not know what the black greenish substance actually was. MD said housekeeping was responsible to cleaning the base of the commodes, and that maintenance was responsible for cleaning the ceiling vents. An interview interview was conducted with the Regional Vice President (RVP) and Administrator on 08/10/21 at 4:45 PM. He stated they identified areas of concern, which they identified during their own tour of the facility, shower rooms, and resident rooms on 08/10/21 and 08/11/21., which included: complete all outstanding maintenance work orders, repair and paint all resident rooms, clean all ceiling vents, replace all facility toilet paper dispensers and commodes, replace or repair all overhead lighting, repair or replace resident drawers and cabinets, and repair or replace any other identified physical physical	F 584	continued frequency of monitoring x 3 months.	

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F 584	Continued From page 11 plant concerns during the renovation. The RVP stated it was his expectation for all the residents to have a safe and homelike environment that was clean and in good repair. An interview was conducted with the Administrator, Regional Vice President (RVP), and the Corporate Regional Consultant on 08/12/21 at 5:40 PM. They all expected all facility ceiling vents, comode caulking, shower rooms, to have been free of this black greenish substance which was evident in 9 of 19 resident rooms (200, 206, 208, 300, 302, 306, 311, 315, and 400), 4 of 4 shower rooms, and 5 of 6 facility's lobby entrance.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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).	F 656		9/14/21

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F 656	Continued From page 12 (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 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to develop a comprehensive care plan for a resident with a known history of hoarding for 1 of 5 residents reviewed for clean, homelike environment, (Resident #10). Findings included: Resident #10 was admitted to the facility on 02/26/18 with diagnoses that included paranoid schizophrenia with behavioral disturbances and a history of hoarding. A nursing progress note dated 03/22/21 at 3:59 PM revealed Resident #10 continues with paranoid behavior, was suspicious of anyone who	F 656	F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) Resident # 10 Care Plan was reviewed and revised on 8/19/2021 by the Minimum Data Set (MDS) nurse with oversite by the Director of Nursing (DON) to reflect known history of hording. A 100% audit of all care plans was initiated on ¿¿¿8/19/2021 by the Director of Nursing (DON), including care plans for residents # 10 and residents with known history of hording to ensure that all areas of the care plan reflect the resid¿¿¿ent□s individual needs. Any care plans with areas of concerns will be updated by the MDS Nurse by 9/10/2021 with oversight	

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F 656	Continued From page 13	F 656		

looked at him or went near his room. Resident #10's room was cluttered with wood projects he is working on, multiple open juice containers, soda and milk cartons, and refused to let staff remove the items. Writer offered to clear room of old drinks and containers, which he refused stating, "No, I need it, so leave it be."

A psychotherapy progress note dated 03/23/21 revealed Resident #10 was seen as a coordination of care session with consultation with nursing staff and social services regarding this patient's recent behaviors and progress. Resident #10's room was extremely cluttered with some art supplies and crafts that he was working on, but it also included old milk cartons and other cups or used containers. Resident #10 refused to allow staff to clean this up and his room was becoming quite cluttered.

A quarterly Minimum Data Set dated 07/26/21 indicated Resident #10 was alert and oriented. Resident was cognitively aware and demonstrated behaviors, including refusal of care.

A care plan dated 07/26/21 revealed Resident #10 with paranoid/suspiciousness behavior related to diagnosis of paranoid schizophrenia. There was no specific care plan in place related to the resident's hoarding or refusal to let staff assist with cleaning the room.

Observation on 08/09/21 at 1:00 PM revealed Resident #10's room and bathroom was noted to be extremely cluttered with personal items, multiple food trays, many opened snack and juice containers, and an excessive amount of trash. Resident's room was noted to be extremely

from the Director of Nursing, to reflect the known history of hording.
An in-service will be completed by ¿¿¿¿9/14/2021 by the MDS Consultant and DON with the interdisciplinary care plan team members and hall nurses: Minimum Data Set (MDS) Coordinator, Dietary Manager (DM), Social Worker (SW), Staff Facilitator, Quality Improvement Nurse, Activities Director and 100 % of nurses on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed.
An audit will be completed of 10% of all resident□s care plans that with a known history of hording to include care plans for resident # 10 weekly x 8 weeks then monthly x 1 month by the Director of Nursing to ensure that the care plans accurately reflects the residents utilizing the Care Plan Audit Tool. The interdisciplinary care plan team members or hall nurses will be retrained and the care plan will be revised immediately by DON for any identified areas of concern. The Administrator will review and initial the Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.
The DON will present the findings of the Care Plan Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Care Plan Audit Tool to determine trends and/or issues that may

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F 656	Continued From page 14 cluttered, with mutipble personal items piled up on the residdnt's bed, night stand, bedside tables, the floor and bathroom counter. The bed was piled high with personal items, and the floors, sink, and toilet were filthly. An interview was conducted with Housekeeper #1 on 08/11/21 at 10:08 AM. Housekeeper #1 revealed Resident #10 let her in his room for the first time that morning to start the process of de-cluttering and cleaning his room and bathroom. Housekeeper #1 reported she was half-way through with the trash removal and cleaning and so far had removed 13 large trash bags of trash and has yet to start on his bathroom. Housekeeper #1 stated she was still in the process of thawing out his refrigerator. The housekeeper had attempted to clean his room several times in the past, but the resident refused to let her in. An interview was conducted with the Director of Nursing (DON) on 08/11/21 at 10:03 AM. The DON revealed Resident #10 had hoarding behaviors and would not let nursing or housekeeping staff clean his room. The DON stated the resident was alert and oriented, was his own Responsible Party (RP), kept his door closed, and liked his cluttered room. The DON revealed Resident #10 was not care planned for hoarding behavior and should have been, due to his refusal to have his room cleaned. An interview was conducted with the Regional Vice President (RVP) and Administrator on 08/12/21 at 5:40 PM. RVP revealed it was their expectation that Resident #10 should have been care planned for his hoarding behaviors, and was not, due to his his continued refusal to have staff	F 656	need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 656	Continued From page 15 clean his room.	F 656		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 755	F 755 Pharmacy	9/14/21

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F 755	Continued From page 16 facility failed to: 1. a, b, and c) ensure an accurate narcotic count during the shift change count of narcotic medications between two nurses on 3 out of 21 controlled substance count records and; 2) failed to accurately document the time and date on the monthly Medication Administration Record (MAR) 12 out of 177 times when a prescribed as needed pain medication was removed from the narcotic dispensing card for 1 of 3 residents reviewed for misappropriation (Resident #3). Findings included: Resident #3 was admitted to the facility on 02/25/21. Diagnoses included, in part, traumatic fracture, wedge compression fracture of third lumbar vertebra, and contracture left hip and right hip. The Minimum Data Set quarterly assessment dated 07/16/21 revealed the resident was cognitively aware and received scheduled pain medication and as needed (PRN) pain medication. 1a) Physician's order written on 04/20/21 for Oxycodone HCL Immediate Release (narcotic pain medication) 5 milligrams (mg) give 1 tablet by mouth every 4 hours as needed for mild to moderate pain or 2 tablets by mouth every 12 hours as needed for moderate to severe pain. The Controlled Substance Count Record (CSCR) dated 05/23/21 - 05/29/21 which was utilized to maintain an accurate countdown of the narcotic medication when it was removed from the medication cart for Resident #3 revealed the CSCR for Oxycodone 5mg on 05/28/21 at 8:20 PM remaining amount was recorded as 5. On 05/29/21 at 9:00 AM, Nurse #2 recorded she had	F 755	Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) Resident # 3 Controlled Substance count sheets and Medication Administration Records (MARs) was audited, and Controlled Substance declining count sheet was corrected by the Director of Nursing on 8/19/2021. 100% audit of all current residents Medication Administration Records (MARs) and Controlled Substance count sheets form 8/1/2021-8/31/2021 who received Controlled Substances, to include Resident #3 was initiated on 8/30/2021 by the Director of Nursing, Assistant Director of Nursing, Unit Managers to ensure the nurse or medication aide signed out the narcotics on the residents Control Substance Declining Count Sheet to include Quantity Start, Date Given, Time Given, Quantity Given, Given By or Destroyed By Quantity Destroyed, Method Destroyed, Witnessed By if Destroyed, Quantity Left as necessary at the time of removing the Controlled Substance and electronically initialed the Electronic Medication Administration Record (EMAR) also that the controlled substance was administered and that documentation was completed of the EMARs for all as needed medications (PRN), to include date/hour, medication/dosage, route, reason, nurse initials, results, response, and nurse initials and will be completed by 9/14/2021. The Director of Nursing, Assistant Director of Nursing, Unit Managers will immediately address all	

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F 755	Continued From page 17 given two tablets and recorded the remaining amount as 3, however, on 05/29/21 at 5:00 PM, Nurse #2 recorded she had taken one tablet but recorded the remaining amount 4 (should have been 2). On 05/29/21, at a time that was not legible but had the PM circled on the record, Nurse #2 recorded she removed 2 tablets but recorded the amount remaining as 2 (should have been 0). The documentation revealed Nurse #2 would do the shift change narcotic medication count with Nurse #3. On 05/29/21 at 8:00 PM, Nurse #3 recorded on the CSCR she had removed two tablets of Oxycodone 5 mg, but the remaining amount was recorded as 0 (there should have been none to remove). An interview was conducted with Nurse #2 via phone on 08/13/21 at 2:26 PM. Nurse #2 stated on 05/29/21 at 5:00 PM she added the one tablet she removed instead of subtracting it and confirmed the count should have been 2 not 4. Nurse #2 did not know why she added instead of subtracting the dose. Nurse #2 stated she was very confused as to why the documentation would say she withdrew 2 tablets around an (illegible time) PM dose when her shift ended at 7:00 PM. Nurse #2 added, but the record should have shown on 05/29/21 at the illegible PM time the remaining amount should have been 0. Nurse #2 stated she added the medication back in to equal 4 and that was inaccurate, and it should have been 3, and when she removed the 5:00 PM dose, she should have documented 2 and when that illegible time PM dose was given it would have completed the countdown to equal 0. Nurse #2 stated she always counted off with the on coming nurse and they should have identified this	F 755	identified areas of concern by 9/14/2021. 100% in-services was initiated on 8/10/2021 by Staff Development Coordinator with all Nurses and Medication Aides to include Nurse # 1, Nurse #2, Nurse # 3, Nurse #4, Nurse #5, Nurse #7, Nurse #8, Nurse #9, and Nurse #10 documenting on the Shift Change Controlled Substance Count Check sheet the Date, Time of Count, Signature of Staff On, Signature of Staff Off, Total # of Count Sheets, Count change Reason Code at each shift change and on the residents Control Substance Declining Count Sheet the Quantity Start, Date Given, Time Given, Quantity Given, Given By or Destroyed By, Quantity Destroyed, Witnessed By if Destroyed signature, Quantity Left at time of pulling Controlled Substance, and documentation of PRN medication to include date/hour, medication/dosage, route, reason, nurse electronic initials, results, response, and nurse electronic initials which is signed post administration to evaluate the effectiveness of PRN medication and will be completed by 9/14/2021. All newly hired nurses and medication aides will be in serviced during orientation by the Staff Development Coordinator regarding documenting on the Shift Change Controlled Substance Count Check sheet the Date, Time of Count, Signature of Staff On, Signature of Staff Off, Total # of Count Sheets, Count change Reason Code at each shift change and on the residents Control Substance Declining Count Sheet the Quantity Start, Date Given, Time Given, Quantity Given, Given	

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F 755	Continued From page 18 problem during the count. She stated it was an error that she added the one pill back into the count which left the number remaining 4 and that she could not explain how there was any medication left to be given for Nurse #2 at 8:00 PM on 05/29/21 when there should have been none left at the illegible time PM on 05/29/21. Nurse #2 stated that her and Nurse #3 should have identified there was a problem with the count when they counted off. An interview was conducted with Nurse #3 via phone on 08/13/21 at 7:38 AM. Nurse #3 did not know how there could have been 2 tablets to remove from that count sheet when the last recorded time before she documented her 8:00 PM time the count should have been 0. Nurse #3 stated if she documented she removed 2 tablets then there were two tablets in the card. Nurse #3 stated without looking at the count sheet she was not certain where the error had occurred and stated that her and Nurse #2 should have identified any discrepancies when they were doing the shift change count. 1b) The CSCR dated 05/30/21 - 06/04/21 for Resident #3 for Oxycodone 5mg revealed on 06/02/21 at 9:00 PM, Nurse #5 recorded she had removed 1 tablet and recorded 9 as the remaining amount. On 06/03/21 at 8:45 AM, Nurse #4 recorded he removed 2 tablets but recorded the remaining count as 6 (should be 7), and on 06/03/21 he removed one tablet at 12:45 PM but recorded the remaining count as 5 (should be 6). The documentation revealed Nurse #4 would do a narcotic medication count with Nurse #5 at change of shift on 06/03/21. On 06/03/21 at 9:00 PM, Nurse #5 recorded on	F 755	By or Destroyed By, Quantity Destroyed, Witnessed By if Destroyed signature, Quantity Left at time of pulling Controlled Substance, and documentation of PRN medication to include date/hour, medication/dosage, route, reason, nurse electronic initials, results, response, and nurse electronic initials which is signed post administration to evaluate the effectiveness of PRN medication. The Unit Mangers and Assistant Director of Nursing will audit 10% of residents that receive controlled substances to include Resident # 3 Controlled Substance Declining Count Sheets and Electronic Medication Administration Records (EMAR) 5 times a week x 8 weeks then monthly x 1 month utilizing the Controlled Substance Audit Tool. This audit is to ensure accurate narcotic count during shift change and accurate documentation on the EMAR for as needed pain medication is removed from the narcotic dispensing card. Re-training and Physician notification will be conducted by the Unit Mangers and Assistant Director of Nursing immediately for any identified areas of concern. The Director of Nursing will review and initial the Controlled Substance Audit Tool weekly times 8 weeks then monthly times 1 months for completion and to ensure all areas of concern were addressed. The Director of Nursing will present the findings of the Controlled Substance Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI)	

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the CSCR for Resident #3 she removed two tablets of Oxycodone 5mg but recorded the remaining amount as 3 (should be 4). Documentation revealed Nurse #5 would do a narcotic medication count with Nurse #6 at change of shift on 06/04/21.

On 06/03/21 at 9:00 AM, Nurse #6 recorded on the CSCR for Resident #3 she removed 2 tablets but recorded the remaining count at 1 (should have been 2). On 06/04/21 at 3:35 PM, Nurse #6 recorded she removed 1 tablet and recorded the remaining amount as 0 (should be 1).

Nurse #5 was unable to be reached for a phone interview. Attempted a call on 08/13/21 at 2:50 PM and left message on the voice mail.

An interview was conducted with Nurse #4 via phone on 08/13/21 at 2:25 PM. Nurse #4 revealed the count should have been recorded as 7 after he removed two tablets at 8:45 AM on 06/03 and the count should have been 6 after he removed one tablet at 12:45 PM on 06/03. Nurse #4 stated he did not know how the count could have been messed up or how it occurred. He stated a count between two nurses happened every time he worked, and he would not take a cart unless the count was accurate. He stated if the count was inaccurate, then he and Nurse #5 should have identified it. He stated he knows he gave the medication to Resident #3, but he did not know how the count got so messed up.

Nurse #6 no longer worked at the facility and was unable to be reached via phone on 08/13/21.

1c) The CSCR dated 06/04/21 - 06/09/21 for Resident #3 for Oxycodone 5mg revealed on

committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Controlled Substance Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring

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06/07/21 at 9:20 PM, Nurse #1 recorded he removed 2 tablets and recorded the remaining amount as 11. Documentation revealed Nurse #1 would do a medication count at shift change with Nurse #9 on 06/08/21.

On 06/08/21 at 5:00 AM, Nurse #9 recorded she removed one tablet, but recorded the amount remaining as 11 (should be 10). On 06/08/21 at 5:00 AM, Nurse #9 recorded she removed another tablet, but recorded the amount remaining as 10 (should be 9). Documentation revealed Nurse #9 would do a medication count at shift change with Nurse #4 on 06/08/21.

On 06/08/21 at 11:00 AM, Nurse #4 recorded he removed two tablets, but recorded the amount remaining at 8 (should be 7). On 06/08/21 at 4:50 PM, Nurse #4 recorded he removed one tablet but recorded the amount remaining as 7 (should be 6). Documentation revealed Nurse #4 would do a medication count at shift change with Nurse #8.

On 06/08/21 at 8:00 PM, Nurse #8 recorded she removed two tablets, but recorded the amount remaining as 5 (should be 4). On 06/09/21 at 5:00 AM, Nurse #8 recorded she removed one tablet but recorded the amount remaining as 4 (should be 3). Documentation revealed Nurse #8 would do a medication count at shift change with Nurse #10.

On 06/08/21 at 8:55 AM, Nurse #10 recorded she removed 2 tablets, but recorded the amount remaining as 2 (should be 1). On 06/09/21 at 2:25 PM, Nurse #10 recorded she removed 1 tablet, but recorded the amount remaining as 1 (should be 0). Documentation revealed Nurse

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#10 would do a medication count at shift change with Nurse #7.

On 06/09/21 at 9:00 PM, Nurse #7 recorded she removed one tablet, but recorded the amount remaining as 0 (there should not have been any left to remove).

An interview with Nurse #9 on 08/12/21 via phone at 1:25 PM revealed she recalled working the evening of 06/07 going into 06/08. She stated she was on the 300 hall from 7:00 PM to 11:00 PM and then went to the 600 hall and did shift change narcotic count with Nurse #1 and the count was accurate. Nurse #9 confirmed the starting count was 11. She stated on 06/08/21 when she removed one tablet she should have recorded 10 and not 11 and when she removed the additional tablet also at 5:00 AM she should have recorded 9 and not 10. Nurse #9 stated she counted off at shift change with Nurse #4 and she did not know why she and Nurse #4 did not identify the discrepancy. Nurse #9 stated her error caused the remaining count to be inaccurate and it should have been identified and fixed during the shift change on the morning of 06/08/21. She stated a medication count was always done at each shift change. She added the nurse that was going off the shift would read the amount remaining on the CSCR and the nurse coming on the shift would look at the actual dispensing cards to confirm the number of pills remaining. Nurse #9 stated usually the nurse going off the shift would have the CSCR record beside the nurse who was reading the dispensing cards to view.

An interview with Nurse #4 via phone on 08/13/21 at 2:25 PM revealed the count should have been

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recorded as 7 after he removed two tablets at 11:00 AM on 06/08 and the count should have been recorded as 6 after he removed one tablet at 4:50 PM on 06/08. Nurse #4 stated he did not know how the count could have been messed up or how it occurred. He stated a count between two nurses happened every time he worked, and he would not take a cart unless the count was accurate. He stated if the count was inaccurate, then he and Nurse #9 should have identified it in the morning when he took over the medication cart or at the end of the shift when he did a narcotic medication count with Nurse #8 on 06/08.

An interview with Nurse #8 via phone on 08/13/21 at 10:19 AM revealed a narcotic medication count was always done at shift change. Nurse #8 stated when she came on to her shift and took over a cart she would be the nurse counting the number of pills in the dispensing cards and the nurse going off the shift would read from the CSCR. She stated she and Nurse #4 should have identified any discrepancies during the count on 06/08/21 when she arrived, or she and Nurse #10 should have identified any discrepancies on 06/09/21 when she was reading from the CSCR and Nurse #10 was counting the actual number of pills remaining. Nurse #8 could not say how the discrepancies occurred or how they were not identified.

Nurse #10 was unable to be reached for a phone interview. Attempted call on 08/13/21 at 2:53 PM.

An interview with Nurse #7 on 08/13/21 at 3:11 PM revealed when she arrived for her shift the off going nurse would open the narcotic medication draw and she would count the medications in the

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dispensing cards and the nurse going off the shift would read the counts from the CSCR. Nurse #7 added, both nurses go through each one by name of the resident and name of the medication and confirm how many pills are remaining. Nurse #7 stated, without looking at the CSCR, she was not able to understand how there could have been a discrepancy on 06/09/21 and was not able to explain how she withdrew one tablet when the actual amount of the medication should have been 0. Nurse #7 stated she and Nurse #10 should have identified any discrepancies when they completed the medication count at shift change on 06/09/21. Nurse #7 added, she knows if she recorded she removed a medication from the narcotic medication draw for Resident #3 then she administered it as ordered to Resident #3.

An interview was conducted with the Pharmacist of the pharmaceutical company the facility had used via phone on 08/11/21 at 11:10 AM. The Pharmacist reported the facility had no record of any drug diversion and followed the procedure for returning discontinued narcotics. She stated when the pharmacist was in the facility to complete monthly medication reviews, she would perform random audits to check narcotic count sheets. The Pharmacist was not aware of any inaccurate audits of the Controlled Substance Count Records.

An interview was conducted with the Director of Nursing (DON) via phone on 08/13/21 at 3:20 PM. The DON confirmed there were count discrepancies on the CSCR and stated 8 nurses completed the medication count between shift changes and did not identify any of the discrepancies. The DON reported her expectation of each nurse was to make sure when they were

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doing the narcotic medication count at the change of every shift the count should be accurate and match exactly what was recorded on the Controlled Substance Count Record.

2) The Controlled Substance Count Record (CSCR) for the month of May for Resident #3 for Oxycodone 5mg revealed on 05/14/21 at 10:45 AM and 05/19/21 at 3:50 PM, Nurse #4 recorded he removed one tablet on each day.

Review of the May Medication Administration Record (MAR) for Resident #3 revealed there was no documentation to indicate Nurse #4 administered the Oxycodone 5mg to Resident #3 on 05/14/21 at 10:45 AM or 05/19/21 at 3:50 PM.

The CSCR for the month of June for Resident #3 for Oxycodone 5mg revealed on 06/03/21 at 12:45 PM, 06/04/21 at 3:35 PM, 06/07/21 at 6:00 PM, 06/11/21 at 12:30 PM, 06/12/21 at 12:40 PM, and on 06/22/21 at 4:30 PM, Nurse #4 recorded he removed one tablet on each day except on 06/04/21 when Nurse #6 removed one tablet.

Review of the June MAR for Resident #3 revealed there was no documentation to indicate Nurse #4 administered the Oxycodone 5mg to Resident #3 on 06/03/21 at 12:45 PM, 06/07/21 at 6:00 PM, 06/11/21 at 12:30 PM, 06/12/21 at 12:40 PM, or on 06/22/21 at 4:30 PM. Additionally, there was no documentation to indicate Nurse #6 administered the medication on 06/04/21 at 3:35 PM.

The CSCR for the month of July for Resident #3 for Oxycodone 5mg revealed on 07/14/21 at 3:30 PM, 07/15/21 at 5:30 PM, 07/19/21 at 3:30 PM, and 07/24/21 at 2:30 PM, Nurse #4 recorded he

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removed one tablet on each day.

Review of the July MAR for Resident #3 revealed there was no documentation to indicate Nurse #4 administered the Oxycodone 5mg to Resident #3 on 07/14/21 at 3:30 PM, 07/15/21 at 5:30 PM, 07/19/21 at 3:30 PM, or 07/24/21 at 2:30 PM.

An interview was conducted via phone with Nurse #4 on 08/13/21 at 2:25 PM. Nurse #4 reported any time he removed the as needed pain medication from the medication cart for Resident #3, he administered the medication to the resident. He stated he very likely missed signing the medication off on the MAR for May, June, and July because he forgot, and added, that he should have made sure they were recorded on the MARs when he removed the narcotic and administered the medication to Resident #3.

Nurse #6 no longer worked at the facility and was unable to be reached for an interview via phone on 08/13/21.

An interview was conducted with the Director of Nursing (DON) via phone on 08/13/21 at 3:20 PM. The DON stated when an as needed (PRN) pain medication was administered a time stamp would appear on the MAR to keep track of when the residents received the medication. The DON stated her expectation of the nurses was to document on the MARs anytime they administered a PRN pain medication to keep an accurate record of what was administered and when the drug was administered to the residents. The DON stated the Medication Administration Record should reflect what was removed from the narcotic count sheet.

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to serve food that was palatable and at a preferable temperature during a lunch meal to 5 of 5 residents reviewed for food palatability (Resident #10, #11, #12, #13, and #14). Findings included. During the initial tour of the facility on 08/09/21 at 12:40 PM an observation of the 600-hall revealed the lunch meal tray cart sitting at the end of the hallway with 15 resident meal trays on the cart. 1 a. Resident #10 was admitted to the facility on 03/22/21. The quarterly Minimum Data Set (MDS) assessment dated 07/22/21 revealed Resident #10 was cognitively intact. An interview was conducted on 08/09/21 at 12:45 PM with Resident #10. She was observed sitting on her walker in the doorway of her room on the 600 hall. She was alert and oriented to person, place, and time. She stated the meal tray cart had been sitting at the end of the hallway since	F 804	F 804 Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60 (d)(1)(2) On 8/10/2021, the Assistant Administrator returned the 600-hall lunch tray to the kitchen and meals were replaced before distributing to the residents. On 8/10/2021 and 8/11/2021, the Quality Assurance Nurse, Assistant Director of Nursing and the Assistant A initiated a 100% audit of all resident□s meal tray service for breakfast, lunch and dinner to include Resident # 11, Resident 12, Resident # 13, and Resident # 14. This audit is to ensure all meal trays were served were palatable and at a preferred temperature. The Director of Nursing will address all concerns identified during the audit. Audit will be completed by 8/11/2021. On 8/10/2021, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants to include agency nurses and nursing assistants in	9/9/21

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F 804	Continued From page 27 approximately 12:10- 12:15 PM and stated staff walked by the meal cart and no staff member took the time to start passing out meal trays and she and the other residents had been waiting for 30 minutes to get their food. A follow up interview was conducted on 08/09/21 at 3:45 PM with Resident # 10. She stated she had lived at the facility since 03/22/21. She stated meal trays were routinely served cold, especially the breakfast trays. She stated the dinner meals were the hottest meals served because staff were trying to leave by 7:00 PM, and the nurse aides on the hall didn't care if the food was served cold. She reported the meals carts always left the kitchen on time, and the cold food was due to staff not passing out the meal trays in a reasonable time once the meal carts arrived on the hallway. She stated it didn't do any good to report the concerns because it wouldn't make a difference. b. An interview was conducted on 08/09/21 at 12:47 PM with a family member of Resident #11 who was on the 600 hall. She stated the meal tray cart was on the hall for a while and the trays were not passed out to the residents, so she was going to leave and go get lunch from outside of the facility for Resident #11. c. Resident #12 was admitted to the facility on 08/27/20. The annual MDS assessment revealed Resident #12 was cognitively intact. During an observation conducted on 08/09/21 at 12:48 PM Resident #12 was observed retrieving her tray from the meal cart and stated I know I'm not supposed to do this myself and stated the meal tray cart was left on the hall for longer	F 804	regard to ensuring meal trays are passed timely to ensure that resident meals are served palatable and at preferred temperature. Inservice will be completed by 9/14/2021. All newly hired nurses and nursing assistants will be in-serviced during orientation by the Staff Development Coordinator in regard to timely meal service to ensure meals are palatable and at preferred temperature. The Unit Managers, Quality Assurance Nurse and Assistant Director of Nursing will complete observations of all meal services 3 times a day x 5 days a week x 8 weeks then weekly x 1 month utilizing the Meal Service Audit Tool. This audit is to ensure meal trays are passed timely to ensure that resident meals are served palatable and at preferred temperature. The Unit Managers, Quality Assurance Nurse and Assistant Director of Nursing will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Meal Service Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Director of Nursing will present the findings of the Meal Service Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The Executive QAPI Committee will meet monthly for 3 months and review the Meal Service Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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periods at times, but it didn't happen frequently. Resident #12 put the tray back on the cart and walked away.

An observation on 08/09/21 at 12:50 PM revealed the Corporate Nurse Consultant along with the Assistant Administrator approached the meal tray cart. They were informed that residents were complaining that the meal cart had been sitting on the hall for a while. The meal trays were sent back to the kitchen at that time and reheated before distributing to the residents.

d. Resident #13 was admitted to the facility on 04/07/21. The quarterly MDS assessment dated 07/15/21 revealed he was cognitively intact.

An interview was conducted on 08/09/21 at 3:55 PM with Resident #13. He was alert and oriented to person, place, and time. He stated he had lived at the facility for 5 months and cold food was served almost daily. He stated he went to dialysis three days a week and when he returned from dialysis, staff would reheat his meals, and most other days the food was usually cold. He stated the meal tray carts usually arrived on the hallway on time and the cold food was due to the meal cart sitting on the hallway for so long. He stated it didn't do any good to report it to anyone.

e. Resident #14 was readmitted to the facility on 02/19/21. The quarterly MDS assessment dated 05/12/21 revealed he was cognitively intact.

An interview was conducted on 08/09/21 at 4:30 PM with Resident #14. He was alert and oriented to person, place, and time. He stated he had been at facility since February 2021, and reported the food was served cold on many occasions. He

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stated for example the butter wouldn't melt on the mashed potatoes. He stated he usually told staff to take the tray away instead of reheating the food, and stated the food was cold due to the meal cart being left on the hallway for so long.

An interview was conducted on 08/09/21 at 4:05 PM with Nurse Aide #5. She stated when meal tray carts left the kitchen it was announced on the intercom and lunch meal trays usually arrived on the 600 hall between 12:00 -12:20 PM. She stated the meal trays were late getting passed out because she couldn't be everywhere at one time. She stated she started passing breakfast trays this morning around 8:00 AM and it took her 30 minutes to pass the trays for the 600 hall because no one helped her pass the trays and when she went in resident rooms to deliver the meal tray some residents would need help with set up and sitting up which delayed her more. She stated when the lunch tray cart arrived on the 600 hall, she was in a resident's room providing care and it took time getting him up to the bathroom. She stated she didn't tell anyone that she was with a resident and to start passing the trays and stated she didn't hear the intercom announcing the meal tray cart had arrived on the floor.

An interview was conducted on 08/09/21 at 4:40 PM with Medication Aide #6 for the 600-hall. She stated she was an agency medication aide, and she was passing medications during the lunch meal and Nurse Aide #5 was the only nurse aide she observed passing meal trays on the 600 hall during lunch. She stated there was another nurse aide (#7) assigned to the lower end of the hall that should have been available to help pass out the lunch meal trays to residents.

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An interview was conducted on 08/09/21 at 5:05 PM with Nurse Aide #7. She stated she normally worked on the 300 hall but was assigned to part of the 300 and part of the 600 hall that day. She reported when meal trays arrived on the floor it was all hands-on deck, and all nurse aides helped pass out meal trays, and lunch meal trays arrived on the hall at 1:00 PM daily. She stated she didn't hear the intercom announcing that lunch trays were on the 600 hall because she was providing care to a resident that had an appointment and the resident was to be picked up at 1:20 PM. She stated she went into his room around 12:40 PM to provide his care. The nurse aide was informed that the lunch meal trays were delivered to the 600 hall around 12:10 PM and were not passed out until after 12:50 PM. She stated she didn't hear the announcement called on the intercom.

An observation of the kitchen was conducted on 08/10/21 at 7:15 AM. The kitchen was clean and organized. Cook #1 was observed preparing breakfast and checking and recording food temperatures. The breakfast menu included pancakes, scrambled eggs with ham, grits, oatmeal, bacon, and sausage. The food temperatures were observed to be within the appropriate food temperature requirements for the regular, pureed, and ground foods. The 600-hall breakfast cart left the kitchen on time at 7:40 AM.

A breakfast meal test tray was sampled for palatability and required temperatures on 08/10/21 at 8:30 AM. The test tray was sampled immediately after the last resident in the facility received their breakfast tray (100 hallway). The test tray contained pancakes, scrambled eggs,

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grits, sausage, oatmeal, and milk. The scrambled eggs on the test tray were warm, the pancakes and sausage were warm, and the grits and oatmeal had steam coming off. There were no concerns identified.

An interview was conducted on 08/09/21 at 12:55 PM with the Dietary Manager along with the Assistant Administrator and the Corporate Nurse Consultant. The Dietary Manager stated the lunch cart for the 600 hallway left the kitchen on time and was delivered to the 600 hall between 12:10 - 12:15 PM. She tested the food temperatures using a calibrated thermometer on a sampled tray from the cart, the lunch tray included ground turkey, mashed potatoes, and green beans. She reported the food was not at the required temperatures for serving. She indicated the lunch meal trays would be replaced and another meal tray would be provided to the residents on the 600 hallway promptly.

A follow up interview was conducted with the Dietary Manager on 08/10/21 at 7:30 AM. She stated the meal trays left the kitchen on time daily. She stated the food temperatures were checked prior to plating foods during every meal and reported the food was at the appropriate temperatures when the meal trays left the kitchen.

An interview was conducted on 08/12/21 at 5:00 PM with the Administrator along with the Corporate Nurse Consultant. He stated the meal trays should not be left on the hallway for an extended period and the trays should be passed out utilizing all staff once the cart arrived on the hallway.

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NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

(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 32	F 880		
F 880 SS=E	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		9/9/21

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F 880	Continued From page 33 (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 review, and staff interviews the facility failed to implement the facility's Infection Control Policy to 1) ensure staff followed infection control guidelines when a housekeeping aid (#2) was observed cleaning a resident's room (Resident #2) who was on contact precautions for clostridium difficile (a bacterium that causes loose stools and colitis (inflammation of the colon) and can be life	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Housekeeping Aide # 2 was in-serviced on proper donning and doffing personal protective equipment (PPE) for contact isolation rooms to include hand hygiene by the Staff Development Coordinator 8/10/2021. The DON removed the soiled linen from	

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F 880	Continued From page 34 threatening) without donning a gown prior to entering the room and failed to discard her gloves prior to leaving the room and perform handwashing. 2) ensure staff followed infection control guidelines for discarding soiled laundry when an observation revealed soiled clothing and linens lying on the floor in 2 of 2 resident rooms observed (Room #306, #106). Findings included: 1.) A review of the facility policy titled, "Contact Precautions", revised 03/10/20 revealed guidelines to wear gloves and a gown when entering the room, and remove gloves and perform hand hygiene with soap and water before leaving the resident area. Resident #2 was readmitted to the facility on 06/02/21. His diagnoses included in part, Cerebral Vascular Accident, and Urinary Tract Infection. The Minimum Data Set (MDS) annual assessment dated 07/23/21 indicated Resident #2 required set up to extensive assistance with toileting and had occasional incontinence. A nursing progress note dated 07/30/21 at 3:24 PM revealed Resident #2 tested positive for C. diff (clostridium difficile). Resident #2 was moved to room #609 and placed on Contact Precautions. An observation conducted on 08/09/21 at 3:40 PM revealed Housekeeping aide #2 cleaning Resident # 2's room. She was wearing gloves and a mask and was not wearing a gown. The housekeeping aide was observed going into the resident's bathroom to clean then exited the bathroom and continued cleaning the room. A sign was posted on the door that read, "Contact	F 880	room # 306 and room # 106 on 8/9/2021. On 8/10/2021, the Director of Nursing initiated an audit with return demonstration to ensure that all staff were wearing appropriate PPE in contact isolation rooms to include donning mask, gown, gloves prior to entering isolation room, as well doffing gloves, and preforming hand hygiene prior to exiting isolation room. The Unit Managers and Staff Development Coordinator will address all concerns identified during the audit to include education of the staff. Audit will be completed by 9/14/2021. On 8/10/2021, the DON completed a 100% audit of all resident rooms to ensure no solid linen was on the floor in residents rooms. The DON will addresses all identified areas of concern during the audit to include removing any solid linen from residents□ rooms. On 8/10/2021, the Staff Development Coordinator initiated an in-service with all staff regarding PPE to ensure that all staff were wearing appropriate PPE in contact isolation rooms to include mask, gown, gloves as well doffing gloves, and preforming hand hygiene prior to exiting isolation room. In-service will be completed by 9/14/2021. All newly hired staff will be in-serviced by the Staff Development Coordinator during orientation in regard to PPE/Handwashing with return demonstration. On 8/10/2021, the Staff Development Coordinator initiated an in-service with all staff regarding proper handling of soiled linen. The in-service will be completed by 9/14/2021. All newly hired staff will be	

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F 880	Continued From page 35 Precautions" with instructions to don gloves, gown, and mask prior to entering the room. A supply cart was located at the doorway entrance stocked with PPE (personal protective equipment) to include gloves and gowns. An interview was conducted on 08/09/21 at 3:40 PM with Housekeeping aid #2. She stated she was not aware Resident #2 was on contact precautions. She stated she did not look at the sign on the door and did not see the supply cart sitting in the hallway at the doorway of the resident's room. She stated she usually did not clean that hallway and was not familiar with who was on contact precautions. She stated she would be sure to wear full PPE when she went into the room. The Housekeeping aide then turned around and walked back into Resident #2's room to continue cleaning without donning a gown. An interview was conducted on 08/09/21 at 3:42 PM with Housekeeping aid #2. She stated she didn't think to put on a gown before going back into Resident #2's room to continue cleaning. She walked out of Resident #2's room at that time and moved her cleaning cart down to the next room on the hall without removing her gloves and washing her hands. She was instructed at that time by the surveyor to not enter the room and to remove her gloves and wash her hands with soap and water. An interview was conducted on 08/09/21 at 4:00 PM with the Director of Nursing (DON). She reported that housekeeping staff were trained on infection control measures. She stated her expectation was that all staff applied full PPE before entering a resident's room who was on	F 880	in-serviced by the Staff Development Coordinator during orientation in regard to proper handling of soiled linen. The Unit Mangers, Quality Assurance Nurse, Assistant Director of Nursing and Staff Development Coordinator will observe 20 resident care interactions weekly x 8 weeks and then monthly x 1 month to include all shifts and weekends utilizing the PPE/Handwashing Audit Tool. This audit is to ensure that all staff were wearing appropriate PPE in contact isolation rooms to include mask, gown, gloves as well as well doffing gloves, and preforming hand hygiene prior to exiting isolation room and proper handling of soiled linen. The Unit Mangers, Quality Assurance Nurse, Assistant Director of Nursing and Staff Development Coordinator will address all areas of concern during the audit to include providing staff with the appropriate PPE and prompting handwashing, removing soiled linen to include re-training of staff. The Director of Nursing will review the PPE/Handwashing Audit Tool weekly x 8 weeks and then monthly x 1 month to ensure all areas of concern are addressed. The Director of Nursing will forward the results of the PPE/Handwashing Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 month. The QAPI Committee will meet monthly x 3 months and review the PPE/Handwashing Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for	

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F 880	Continued From page 36 contact precautions and remove the PPE prior to exiting the room and perform handwashing. An interview was conducted on 08/10/21 at 10:56 AM with the Housekeeping Director. He stated the Housekeeping aid was not usually assigned to that hall. He stated housekeeping staff were notified of residents who were on isolation precautions and stated the Housekeeping aide should have identified that the resident was on contact precautions and worn the appropriate PPE. 2.) A tour of the facility on 08/09/21 at 1:00 PM with the Maintenance Director (MD) revealed soiled clothing laying on the floor inside the bathroom by the door of room 306. The MD stated the clothing should not have been left on the floor. He then texted on his phone for a Nurse Aide (NA) to take care of the soiled clothing. A follow-up tour of the facility on 08/09/21 at 2:00 PM with the Director of Nursing (DON) and Assistant Administrator revealed the same soiled clothes was observed on the floor inside room 306's bathroom by the door, which now had additional bed linen added to the pile. The DON stated the soiled linen should not have been placed on the floor in the bathroom of room #306 without being properly bagged and taken out of the room to be placed with soiled linen. She said it was an infection control concern, and staff would be re-educated on the proper handling of soiled linen. The DON then washed her hands, gloved, placed the soiled items into a clear plastic bag, tied the ends, and placed the bag in a covered soiled linen container. The DON stated it was her expectation that staff transported dirty	F 880	further and / or frequency of monitoring.	

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F 880	Continued From page 37	F 880		

linen in a plastic bag to be placed in a covered soiled linen container and not placed on the floor unbagged.

A follow-up tour of the facility on 08/10/21 at 8:55 AM with the Maintenance Director (MD) revealed a soiled shirt and soiled brief was observed laying on the floor inside the bathroom by the door of room 106. The MD stated the soiled shirt and brief should not have been placed on the floor in the bathroom of room #106 without being properly bagged and taken out of the room and placed with soiled linen. The MD then texted on his phone for a Nurse Aide (NA) to take care of the soiled clothing.

An interview conducted on 08/11/21 at 11:29 AM with the Infection Control Nurse (ICN) revealed the soiled clothing, linen, and adult brief found on the bathroom floor of 2 resident rooms (106 and 306) was an infection control concern and should not have been placed on the floor inside resident bathrooms, without being properly bagged and taken out of the room and placed with soiled linen. She stated it was an infection control concern, and that nursing staff would be re-educated on the proper handling of soiled linen.

An interview conducted with the Administrator on 08/12/21 at 6:05 PM revealed it was his expectation that soiled linen and clothes were bagged inside resident rooms and transported to the dirty utility room immediately.