STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 11/18/2021

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EMERALD HEALTH & REHAB CENTER	**54 RED MULBERRY WAY LILLINGTON, NC 27546**

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E 000	Initial Comments An unannounced recertification survey was conducted 11/15/2021 through 11/18/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# RYBS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted 11/15/2021 through 11/18/2021. Event ID: #RYBS11. One of nine allegations was substantiated resulting in a deficiency.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have an accurate Minimum Data Set (MDS) assessment in the areas of tube feeding (Resident #13), falls and hospice (Resident #21) and discharge (Resident #70). This was for 3 of 18 residents reviewed for MDS accuracy. Findings Included: 1). Resident #13 was admitted on 09/09/2019 with diagnoses which included cerebrovascular accident (CVA) and gastrostomy. A review of the active physician orders dated 09/02/2021, revealed Resident #13 would receive continuous tube feeding at a rate of 60 milliliters	F 641	#1- Resident #13, Resident #21, and Resident #70 have had the errors in coding corrected with assessment modifications. These modifications were submitted and accepted on 12/10/2021 #2-How will the facility identify other like residents? Residents who have fallen, who are on hospice, or receive nutrition via tube feeding are at risk for this issue. There will be an audit of the latest comprehensive or significant change assessments for each of the current residents with these issues. This will be completed by the Administrator or designee. This will be completed by 12/8/2021	12/13/21

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

Electronically Signed | 12/10/2021

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F 641	Continued From page 1 (mLs) per hour. This order was active during the 7-day look back period. Review of the quarterly Minimum Data Set (MDS) dated 11/01/2021 revealed Resident #13 was not coded to receive tube feedings. An observation of Resident #13 on 11/15/2021 at 10:40 am revealed Resident #13 was receiving a nutritional supplement via tube feeding at the rate of 60 mLs per hour. An interview with the MDS Nurse on 11/17/2021 at 4:15 pm revealed Resident #13 should have been coded for tube feeding and the mistake was an oversight on her part. An interview with the Administrator on 11/18/2021 at 10:55 am revealed all MDS assessments should be correctly coded according to resident status. 2. Resident #21 was admitted to the facility on 3/16/21 with diagnoses that included dementia and hyperlipidemia. A progress note dated 7/28/21 revealed Resident #21 was sent to a local hospital after a fall which resulted in a laceration to his head. Resident #21's discharge Minimum Data Set (MDS) assessment dated 8/3/21 revealed no falls since his last MDS assessment. During an interview with the MDS nurse on 11/17/21 at 12:39 PM who stated Resident #21's	F 641	#3-What will you do to prevent this from recurring? To prevent this from recurring, the Regional Reimbursement Specialist has reeducated the nurses responsible for completing the MDS assessments in compliance with the guidelines concerning the expectation that all assessments are accurate. Every MDS new hire will undergo OBRA training during orientation and will be educated on the responsibility for completing the MDS assessments in compliance with the guidelines concerning the expectation that all assessments are accurate. This will be completed by 12/8/2021 #4-How will you monitor and maintain ongoing compliance? To monitor and maintain ongoing compliance, the Administer will review comprehensive and significant change assessments for accuracy with falls, hospice, and nutrition via tube feeding. This will be documented for at least 1 assessment a month for a resident who has had a fall, a resident who is on hospice, and a resident that is receiving nutrition via a tube feeding system. This will be monitored for 3 months.	

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F 641	Continued From page 2	F 641		

assessment should have been coded to reflect the fall with minor injury. She stated it was an oversight.

An interview was conducted with the Administrator on 11/18/21 at 10:05 AM who stated Resident #21's MDS assessment dated 8/3/21 should have been coded accurately to reflect his fall.

3. Resident #21 was admitted to the facility on 3/16/21 with diagnoses that included dementia and hyperlipidemia.

Review of physician's orders revealed an order to admit Resident #21 for hospice dated 9/17/21.

Resident #21's significant change Minimum Data Set (MDS) assessment dated 9/20/21 revealed no hospice services received while in the facility.

During an interview with the MDS nurse on 11/17/21 at 12:39 PM who stated Resident #21's assessment should have been coded to his hospice status. She stated the significant change was admission to hospice and the error was an oversight.

An interview was conducted with the Administrator on 11/18/21 at 10:05 AM who stated Resident #21's MDS assessment dated 9/20/21 should have been coded accurately to reflect services received.

4. Resident #70 was admitted on 10/11/21 and discharged on 10/26/21. He had diagnoses of bilateral foot wounds and uncontrolled pain.

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F 641	Continued From page 3 A review of the discharge return anticipated Minimum Data Set (MDS) dated 10/26/21 revealed Resident #70 was discharged to the community. A nursing note written by Nurse #1 dated 10/26/21 indicated Resident #70 was discharged to the hospital. A physician's note dated 11/5/21 was reviewed and indicated Resident #70 was seen by the physician on 10/26/21. The note revealed after the bedside exam, emergency medical service arrived and transported Resident #70 to the hospital. On 11/17/21 at 1:33 PM an interview was conducted with Nurse #1 and she stated Resident #70 was discharged to the hospital on 10/26/21. An interview was conducted with MDS Nurse #2 on 11/17/21 at 1:40 PM. She read the nursing note written by Nurse #1 dated 10/26/21 and stated the MDS was coded incorrectly. She stated it was an error on her part. An interview with the Administrator was conducted on 11/18/21 at 10:55 AM and she revealed all MDS assessments should be correctly coded according to resident status.	F 641		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/13/21

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F 880	Continued From page 4	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 5 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to clean and disinfect a manual blood pressure cuff and sphygmomanometer in between uses for 2 of 2 residents reviewed during medication administration, (Resident #21 and Resident #55). Findings included: A review the facility's infection control policy dated 06/24/2021 labeled "Cleaning and Disinfection of Resident Care Equipment" revealed reusable non-critical resident-care equipment, including blood pressure cuffs, would be cleaned, and disinfected between resident use. An observation on 11/18/2021 at 8:00 am	F 880	#1-Corrective action for affected resident: Residents #21 and #55 were assessed for temperature and questions related to signs and symptoms of infection that after the blood pressure cuff was used for both residents without disinfecting between uses. They had no signs or symptoms of infection at that time. #2-How will the facility identify other like residents? Current residents are at risk for exposure to the spread of infection related to this issue. Current residents are being assessed daily for temperature and questions related to signs and symptoms of	

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F 880	Continued From page 6 revealed Nurse #3 at Resident #21's bedside obtaining a blood pressure reading via manual blood pressure cuff and sphygmomanometer and exited the room. The continued observation included Nurse #3 used an alcohol-based hand sanitizer and proceeded to Resident #55's room and reused the same blood pressure cuff and sphygmomanometer without cleaning or disinfecting. An interview with Nurse #3 on 11/18/2021 at 8:10 am revealed she should have cleaned and disinfected the blood pressure cuff and sphygmomanometer between residents but "forgot to do it." An interview with the Director of Nursing (DON) on 11/18/2021 at 10:30 am revealed manual blood pressure cuffs and sphygmomanometers would be cleaned and disinfected between residents.	F 880	infection. Chart reviews focused on the presence of infection looking back 14 days will be completed for current residents to identify infection. If there is a pattern of a specific diagnosis of infection that has spread between residents, a root cause analysis will be completed. A new plan will be developed if the root cause was not related to medical equipment disinfection.--Completed by 12/8/2021 #3-What will you do to prevent this from recurring? To prevent this from recurring, Current staff will be reeducated concerning the Cleaning and Disinfection of Resident Care Equipment policy by the Director of Nursing or designee. There will be equipment present for demonstration of the disinfection process for commonly used medical equipment. This education will be completed by 12/8/2021 by the Director of Nursing or designee. Any staff member that cannot be reached within the initial reeducation time frame will not take an assignment until they have received this reeducation. Agency staff and newly hired facility staff will have this education during their orientation. #4-How will you monitor and maintain	

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F 880	Continued From page 7	F 880	ongoing compliance? To monitor and maintain ongoing compliance, the Director of Nursing or designee will perform observation of disinfection between uses of medical equipment between residents. This will be documented for 5 residents a day for 7 days, 5 residents a day 5 days a week for 3 weeks, and then 5 residents a week for 8 weeks. DPOC, Education Attestation, and Root Cause Analysis have been uploaded.	