STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/04/22 through 04/08/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3GFX11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 4/4/22 through 4/8/22. Event ID #3GFX11. 6 of the 6 complaint allegations were not substantiated. Intake #s: NC00183465, NC00181092, NC00182644.	F 000		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the Resident Trust Fund Accounts, the Surety Bond, and staff interviews, the facility failed to provide a surety bond that covered the total balance for 62 of 62 residents with funds deposited in the resident trust account. The findings included: A record review of the facility trust account on 4/7/22 revealed 62 residents had a total of $49,200.27 in the trust account. A review of the facility Surety Bond read in part:	F 570	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F570	5/24/22

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

Electronically Signed | 05/05/2022

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F 570	Continued From page 1 "Residents of Liberty Common Nursing and Rehabilitation of Warren County 7/19/2019 in the just and full some of $45,000. " An interview was conducted with the Administrator on 4/7/22 at 4:18 PM. The Administrator stated she was unaware that the surety bond had expired. The Administrator stated that the corporate office of the facility was responsible for renewing the surety bond for the facility. The Administrator stated that a request had been submitted to increase the surety bond amount up to $50,000.	F 570	The facility failed to purchase a surety bond to assure the security of all personal funds of residents deposited with the facility. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/07/2022 the Liberty Mutual Surety policy increase was obtained, bringing the bond amount from $45,000 to $50,000 along with a standing surety bond supplements in the amounts of $10,000 and $25,000 with the respective effective dates of 5/2/2022 and 7/19/2022. The bond total amount covers the $49,200.27 within the trust account as of 4/7/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. The facility trust account is one balance that includes 100% of the facility Skilled Nursing population. On 04/07/2022 the Liberty Mutual Surety policy increase was obtained, bringing the bond amount from $45,000 to $50,000 along with a standing surety bond supplements in the amounts of $10,000 and $25,000 with the respective effective dates of 5/2/2022 and 7/19/2022. The bond total amount covers the $49,200.27 within the trust account as of 4/7/2022. 3. Systemic changes. Beginning on 04/27/2022 facility Nursing Home Administrator was educated by the Regional Director of Operations on the organization□s Surety Bond policy and the process supplement for the Administrator to review the resident trust	

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F 570	Continued From page 2	F 570	account against the surety bond limit in order to ensure that the total amount is covered. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor this utilizing the F570 QA Tool for Monitoring Surety Bond Quality Assurance Tool for Monitoring. The Administrator assess that the surety bond assures the security of all personal funds of residents deposited with the facility in compliance with facility policy. This will be completed by auditing the amounts of the resident trusts against the bond limit monthly x 4 months. The Administrator will present the report to the Quality Assurance Committee and any trends/concerns will be immediately addressed and monitored by the QA Committee. Reports will be presented to the weekly QA committee by the Administrator or designee to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 5/24/2022	

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F 688	Continued From page 3	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to place palm protector to hand for contracture management for 1 of 2 residents observed for range of motion. (Resident #23). Findings included: Resident #23 was admitted to the facility on 11/01/16 with diagnoses which included stroke, contracture of left hand, and left sided hemiparesis (weakness on one side of body). Record review of Resident #23 ' s care plan dated 5/27/21 revealed care plan for alteration in musculoskeletal status related to contracture of	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F688 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	5/24/22

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F 688	Continued From page 4 the left hand with interventions which included resident to wear palm protector daily. Remove only when bathing. A physician order dated 8/03/21 for palm protector to left hand at all times, may remove to wash. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 1/28/22 revealed Resident #23 had moderately impaired cognition, impairment of upper/lower extremity x 1 side, and was not coded for behaviors. An observation on 4/04/22 at 11:45 AM Resident #23 was in bed and did not have the palm protector in place on the left hand. The palm guard was not observed on bed, bedside table, or floor. An observation on 4/05/22 at 11:39 AM revealed Resident #23 was in bed and did not have the palm protector in place on the left hand. The palm guard was not observed on bed, bedside table, or floor. During an interview on 4/05/22 at 3:41 PM Nurse Aide (NA) #1 stated Resident #23 had the ability to remove the palm protector but did not recall if the palm protector was in place during her shift. During an interview on 4/05/22 at 3:52 PM Support Nurse #1 revealed she placed the palm guard on Resident #23 in the morning but was not able to state why it was not in place at time of observation. An observation on 4/06/22 at 8:23 AM revealed Resident #23 was sitting in wheelchair and did	F 688	cited: The facility failed to place palm protector to hand for contracture management for range of motion for Resident #23. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/7/2022 the palm protector was placed on the left hand as ordered by the Director of Nurses for resident #23. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 04/8/2022 the nurse management team audited all current residents with orders for splint use to ensure that splints are in place. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint the nurse manager ensured the device was in place, had an MD order, CNA task, and care plan. This process was completed a s of 04 /8/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 04/27/2022, the Director of Nurses/Staff Development Coordinator began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: " The importance for applying splints as ordered by the MD. " Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown.	

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F 688	Continued From page 5 not have the palm protector in place on the left hand. The palm guard was not observed on bed, bedside table, or floor. During an interview on 4/06/22 at 1:48 PM Nurse #1 revealed Resident #23 refused the palm protector when she asked but did not have a chance to attempt to place palm protector later. During an interview on 4/06/22 at 1:57 PM the Rehab Director revealed Resident #23 had the ability to attempt to remove the palm protector from her left hand and stated the staff needed to ensure the splint was in place properly on her left hand. She stated the Nurses and NA ' s have been educated on how to properly apply the palm protector. The Rehab Director reported she was not notified Resident #23 was not compliant with the palm protector. An observation on 4/07/22 at 8:36 AM revealed Resident #23 was in bed and did not have the palm protector in place on the left hand. The palm guard was not observed on bed, bedside table, or floor. During an interview on 4/07/22 at 9:19 AM the Director of Nursing (DON) revealed she was notified the palm protector was not in place for Resident #23. The DON stated she was unable to locate the palm protector but was able to obtain one from therapy and placed it on Resident #23. During an interview on 4/07/22 at 11:40 AM NA #2 stated Resident #23 did not refuse to wear the palm protector and she did not observe her remove it once in place.	F 688	" What to do when the device cannot be located. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 05/23, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F688 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Monitoring will be rotated in order to include all ordered shifts and weekends. The Director of Nursing or designee will monitor splint application and compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for	

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F 688	Continued From page 6 During a phone interview on 4/07/22 at 12:28 PM the Physician stated he expected the order to be followed as written. During an interview on 4/07/22 at 4:33 PM the Administrator revealed a physician order or recommendation was to be in place and followed by staff.	F 688	compliance with splint application. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 05/24/2022	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to hold blood pressure medication when blood pressure was below parameters as ordered by physician for 1 of 1 resident reviewed for medication administration. (Resident #66). Findings included: (1) Resident #66 was admitted to the facility on 11/27/20 with diagnoses which included bradycardia (low heart rate), hypertension, and chronic systolic and diastolic congestive heart failure. A physician order dated 12/14/20 for hydralazine HCl (blood pressure medication) 50 milligram (mg) tablet by mouth every 8 hours; hold for systolic blood pressure (SBP) less than 100 millimeters of mercury (mmHg) or diastolic blood pressure (DBP) less than 70 mmHg.	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 The facility failed to hold a blood pressure medication when blood pressure was below parameters as ordered by the physician for resident #66. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/07/2022 the attending physician was notified of the medication error by the Director of Nurses and the physician	5/24/22

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F 760	Continued From page 7	F 760		

Record review of Resident #66 ' s MAR for March and April 2022 revealed the order parameters for the hydralazine HCl were listed on the MAR and required the blood pressure to be entered before documentation of the medication administration. The MAR record report revealed the hydralazine HCl was administered 20 times with DBP below order parameters on following dates and times:

3/1/22 at 12:00 am DBP was 61 mmHg.
3/3/22 at 12:00 am DBP was 69 mmHg.
3/12/22 at 12:00 am DBP was 54 mmHg.
3/13/22 at 12:00 am DBP was 56 mmHg.
3/14/22 at 12:00 am DBP was 63 mmHg.
3/15/22 at 8:00 am DBP was 61 mmHg.
3/16/22 at 4:00 pm DBP was 60 mmHg.
3/17/22 at 12:00 am DBP was 60 mmHg.
3/18/22 at 12:00 am DBP was 57 mmHg.
3/19/22 at 4:00 pm DBP was 64 mmHg.
3/22/22 at 12:00 am DBP was 58 mmHg.
3/23/22 at 12:00 am DBP was 52 mmHg.
3/28/22 at 12:00 am DBP was 66 mmHg.
3/31/22 at 12:00 am DBP was 62 mmHg.
4/01/22 at 12:00 am DBP was 58 mmHg.
4/02/22 at 8:00 am DBP was 62 mmHg.
4/02/22 at 4:00 pm DBP was 65 mmHg.
4/03/22 at 8:00 am DBP was 65 mmHg.
4/03/22 at 4:00 pm DBP was 64 mmHg.
4/06/22 at 12:00 am DBP was 52 mmHg.

Record review of Resident #66 ' s medical record from 3/1/22 through 4/6/22 revealed no negative outcome related to hydralazine being administered outside of parameters.

During an interview on 4/7/22 at 2:06 pm Medication Aide #1 revealed she was aware of Resident #66 ' s blood pressure medication parameters and was unable to state why she reviewed the recorded blood pressures. The resident□s order with parameters was updated with parameters removed for the medication by the physician.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 04/08/2022 the Director of Nursing and nurse managers audited all resident orders with parameters for the last 30 days for compliance with the administration of the medication following the ordered parameters. Results: Medical Director was notified of all identified areas of deficient practice and they were corrected on 4/8/2022.

3. Systemic changes.
Beginning on 04/27/2022 all nurses including agency nurses and medication aides, full time, part time and as needed will be educated by the Director of Nurses/ Staff Development Coordinator on prevention of medication errors and medication safety to include facility policy on compliance with medication orders that contain parameters for administration. Education will be completed by 05/23/2022.
The Director of Nurses will ensure that any of the above identified staff who does not complete the in-service training by 5/23/2022 will not be allowed to work until the training is completed.
This in-service was incorporated into the new employee facility orientation for the above identified staff.

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F 760	Continued From page 8 administered the medication on 3/19/22. Medication Aide #1 stated she took the blood pressure before the medication was administered, but she may have been rushed when she gave the medication to Resident #66. During an interview on 4/7/22 at 2:16 PM Nurse #3 revealed she was aware of the blood pressure parameters for Resident #66 ' s blood pressure medications. Nurse #3 stated she may have given the medication because Resident #66 ' s SBP was usually high when she checked it before giving the medications, but she was unable to state for sure why she administered the medications on 3/3/22, 3/12/22, 3/13/22, 3/14/22, 3/16/22, 3/17/22, 3/18/22, 3/22/22, 3/23/22, 3/28/22, 4/1/22 and 4/6/22. She stated the facility had provided education on blood pressure medication and monitoring for parameters which included taking the blood pressure before giving the medication. Attempts to contact Nurse #1 and Nurse #2, who administered medication to Resident #66 on 3/1/22, 3/15/22, 3/31/22, 4/2/22, and 4/3/22 were not successful. During an interview on 4/7/22 at 12:05 pm the Director of Nursing (DON) revealed the Nurses were expected to follow physician orders as written. She stated the medications should have been held when the parameters were not met. During an interview on 4/7/22 at 12:22 pm the Physician revealed the blood pressure parameters were ordered for Resident #66 for his severe diastolic heart failure. The Physician stated the parameters were expected to be followed by the Nurses and he stated if the Nurse	F 760	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Staff Development Coordinator will monitor this utilizing the F760 QA Tool for Medication Error Prevention/Medication Parameters Quality Assurance Tool for Monitoring. The Director of Nurses/Staff Development Coordinator will audit for compliance with the administration of medications with ordered parameters by randomly observing two medication passes to include all shifts and weekends weekly x 2 weeks and then monthly for 3 months or until resolved by the Quality Assurance (QA) Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 5/24/2022	

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F 760	Continued From page 9 had a question about administering the medication, they were able to call him at any time. During an interview on 4/7/22 at 4:35 pm the Administrator stated the staff were expected to follow Resident #66 ' s physician orders as written.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the	F 761	The statements made on this plan of	5/24/22

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F 761	Continued From page 10 facility failed to discard expired medications for 2 of 2 medication carts reviewed for medication storage. (Middle Hall Med Cart, 300 Hall Med Cart) Findings included: 1. During an observation of the Middle Hall medication cart for medication storage on 4/6/22 at 12:13 PM, an opened and accessed Advair Discuss with an opened date of 2/19/22 was in the drawer. The manufacturer's label revealed that medication was to be discarded 30 days after opening. An interview was conducted with Medication Aide #2 on 4/6/22 at 12:27 PM. Medication Aide #2 stated that she was unaware that the medication had expired. Medication Aide #2 stated she reordered medication when the medications ran out. An interview was conducted with Nurse #4 on 4/6/22 at 12:32 PM. Nurse #4 stated that medication carts were to be checked by night shift for expired medications. An interview was conducted with the Director of Nursing (DON) on 4/6/22 at 4:12 PM. The DON stated night shift nurses were responsible for checking the medication carts for expired medication. The DON stated cart checks were part of the night shift nursing duties. 2. During an observation of the 300 Hall Medication Cart on 4/7/22 at 9:04 AM, a bottle of opened and accessed Combigan eye drops had an open date of 12/23/21. The manufacturer's instruction stated to discard opened medication 4	F 761	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 The failed to discard expired medications for 2 of 2 medication carts reviewed for medication storage. (Middle Hall Med Cart, 300 Hall Med Cart) 1. The expired medications were removed from each of the 2 carts on 04/6/2022 by the assigned nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Audits of all medication carts and the medication storage room was completed on 04/7/2022 by the Director of Nurses and Support Nurses with no other expired medications found. 3. Systemic changes. Beginning on 4/27/2022 all nurses including agency nurses and medication aides will be re-educated by the Director of Nurses/ Staff Development Coordinator on the facility Medication Storage policy, this will be completed by 05/23/2022. The pharmacist consultant was notified of the	

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F 761	Continued From page 11 weeks after opening. An opened and accessed bottle of Xalatan was in the drawer with an open date of 1/27/22. The manufacturer's label stated to store opened medication at room temperature for 6 weeks. An opened and accessed bottle of Olapatidine Solution .02% (an eye medication) had an opened date of 2/14/22. The medication label read "2 drops to both eyes twice daily for 14 days. An interview was conducted with Support Nurse #1 on 4/7/22 at 9:20 AM. Support Nurse #1 stated that night shift was responsible for checking the medication carts nightly for expired medication. An interview was conducted with the Director of Nursing on 4/7/22 4:12 PM. The DON stated that she expected that expired medications would be removed from the medication cart and discarded. 3. An observation of the 300 Hall Medication Cart on 4/7/22 at 9:04 AM, 17 pills (different sizes, shapes, color) and 3 half pills (white in color) were loose in the medication cart. An interview was conducted with Support Nurse #1 on 4/7/22 at 9:20 AM stated that she was not aware that the loose pills were in the cart. Support Nurse #1 stated that night shift was responsible for checking the medication carts nightly for expired medication. An interview was conducted with the Director of Nursing (DON)on 4/7/22 at 4:12 PM. The DON stated night shift nurses were responsible for checking the medication carts for expired medication.	F 761	survey findings on 04/8/2022 and will perform monthly audits of the medication carts and medication room to assist the facility in discarding and monitoring of expired medications. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or Support Nurses will audit all medication carts weekly for 2 weeks and then monthly for 3 months for compliance with monitoring for the presence of expired medications. The Pharmacist Consultant will also submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Date of Compliance: 5/24/2022	

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F 761	Continued From page 12 4. An observation of the 300 Hall Medication Cart on 4/7/22 at 9:04 AM. A bottle of one daily multivitamin with minerals had an expiration date of 3/22. An interview was conducted with Support Nurse #1 on 4/7/22 at 9:20 AM. Support Nurse #1 stated that she was unaware that the medication was expired. She immediately discarded the medication. An interview was conducted with the night shift nurse (Nurse #6) on 4/7/22 at 4:00 PM. Nurse #6 stated that night shift had a checklist that they followed each night, and the checklist did include checking the medication cart for expired medication. Nurse #6 stated she could not recall the exact days for checking the medication cart but knew that it was assigned at least two days a week to check medication cart for expired medications. Nurse #6 stated it was the responsibility of the nurse administering the medication to check the expiration date prior to giving the medication. An interview was conducted with the Director of Nursing on 4/7/22 4:12 PM. The DON stated that she expected that expired medications would be removed from the medication cart and discarded.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		5/24/22

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F 812	Continued From page 13 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean 2 of 2 plate warmers. The findings included: During the meal observation on 4/06/22 at 11:35 AM the tray line area was observed. The first 3 cylinder well plate warmer was observed with dark black dried food particles inside each well and the middle well had crumpled up foil in the bottom. The second 3 cylinder well plate/pellet warmer was observed to have dark black dried food particles in each well and the middle well had ketchup packets in the bottom of the well. During a second observation of the kitchen on 4/07/22 at 9:46 AM the first 3-cylinder plate warmer was observed with dark black dried food particles inside each well and the middle well had crumpled up foil in the bottom. The second 3 cylinder well plate/pellet dispenser was observed to have dark black dried particles in each well and the middle well had ketchup packets in the	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 4/6/2022 and 4/7/2022. During initial walk through of the kitchen, it was noted dietary services had failed to keep equipment in sanitary condition and prevent cross contamination. 3 of 3 cylinder wells of the plate warmer were noted with debris and/or dried food particles. The Dietary Service Director	

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F 812	Continued From page 14 bottom. In an interview on 4/07/22 the Dietary Manager indicated they were transitioning from one contract dining service to another service and the cleaning schedules needed to be updated. He stated he would add the plate warmers to the weekly cleaning schedule and have staff clean the plate dispensers. In an interview on 4/07/22 the Administrator indicated she would want staff to clean all the kitchen equipment, including the plate dispensers.	F 812	removed the plate warmer and with the assistance of the maintenance team cleaned the wells of the plate warmer. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 4/7/2022, the Dietary Service Director updated the cleaning schedule to include a weekly deep cleaning of the plate warmer. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Sanitation and cross contamination prevention policies. " Inspections on shifts to observe wells of the plate warmer to ensure wells are without debris or food particles. " At least weekly cleaning of the plate warmer (and as needed cleaning) added to cleaning schedule. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure.	

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F 812	Continued From page 15	F 812	The Dietary Service Director or assignee will monitor procedures for proper sanitation and prevention of cross contamination weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that equipment is in sanitary condition. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
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,	F 880		5/24/22

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F 880	Continued From page 16	F 880		

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.
(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

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F 880	Continued From page 17 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment when 6 of 6 staff members (Nurse #4, Support Nurse #1, NA #3, NA #4, NA #5) were observed entering 3 of 7 resident's rooms on isolation precautions without wearing isolation gowns and gloves. (Rooms 628, 312) The findings included: Record review of the Infection Prevention and Control Standards Policy dated 5/2020 and last revised on 3/2021 revealed transmission-based precautions would be utilized for airborne isolation with appropriate use of Personal Protective Equipment (PPE). Observation of the 600 Hall isolation rooms on 4/4/22 at 1:05 PM revealed signs on the door for all healthcare personnel to follow the Special Airborne Contact Precautions for COVID-19 before entering the room. The instructions read in part to clean hands before entering room and when leaving the room, wear a gown when entering the room and remove before leaving,	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 The facility failed to implement their personal protective equipment policy for residents on special droplet contact precautions when staff did not don appropriate personal protective equipment when entering the room of a resident on enhanced precautions. 1. How corrective action will be accomplished for those residents found to have been by the deficient practice: On 4/4/2022 the Director of Nurses/Infection Control Preventionist educated Nurse #4, Support Nurse #1, NA #3,#4, #5 on facility policy related to	

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F 880	Continued From page 18 N95 or higher respirator before entering and remove after exiting, protective eyewear or face shield, and to wear gloves when entering room and remove before leaving the room. PPE including gowns, gloves and N95 masks were available outside the room doors. 1.On 4/4/22 at 1:06 PM Nurse #4 was observed entering an isolation room (Room 628) wearing a N95 mask and protective eyewear. An interview was conducted with Nurse #4 on 4/4/22 at 1:19 PM. Nurse #4 stated that she did not realize that the resident was on special airborne contact isolation. Nurse #4 stated that she should have had a gown and gloves on before entering the room. An interview was conducted with the Director of Nursing (DON) on 4/6/22 at 4:12 PM. The DON stated that isolation rooms had signage on the doors that instructed the staff on what personal protective equipment they needed when entering the room. The DON stated that residents on isolation are reviewed during shift-to-shift report. 2. During an observation on 4/04/22 at 11:00 AM Room 312 had an isolation precaution sign posted on door. There was not a isolation supply bin with required PPE outside of Room 312. The isolation signage posted on door of Room 312 stated the following: Special Airborne Contact Precautions All healthcare personnel must: Clean hands before entering and when leaving room.	F 880	following the isolation sign directions and appropriate PPE utilization at all times when in resident rooms who are on special droplet contact precautions. Root Cause Analysis was completed on 4/7/2022 with the following staff in attendance: Administrator, Director of Nurses/Infection Control Preventionist, Nursing Supervisor, Dietary Manager, House Keeping Manager, Therapy Manager and the Support Nurse. Root cause analysis was done related to staff not wearing the required Special Droplet Contact Precautions personal protective equipment in designated resident rooms that were on enhanced precautions. Upon interview of the staff person it was determined that the root cause for failure to follow facility policy was due to the door isolation signage not being visible when residents door was open. Appropriate isolation signs were placed, in addition to being on the residents room door, just outside the residents room on wall in hallway by rooms on 4/7/2022. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 4 /7/2022 the Director of Nurses/Administrator audited all resident rooms on special droplet contact precautions for staff compliance with wearing of the appropriate personal protective equipment when in resident room. Results: No other breaches in practice observed. 3. Address what measures will be put in	

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F 880	Continued From page 19 Wear gown when entering room and remove before leaving. Wear N95 or higher respirator before entering room and remove after exiting. Protective eyewear (face shield or goggles). Wear gloves when entering room and remove before leaving. During an observation on 4/04/22 at 11:10 AM a blue bag hung on each wall in middle of Hall 300 which had Personal Protection Equipment (PPE) supplies which included isolation gowns and gloves but did not have N95 masks or protective eyewear. During an observation on 4/04/22 at 12:58 PM Support Nurse #1 entered Room 312 without isolation gown or gloves to deliver lunch tray to resident. During an observation on 4/04/22 at 1:00 PM Nurse Aide (NA) #3 entered Room 312 without isolation gown, gloves, or N95 mask on. During an interview on 4/04/22 at 1:04 PM Support Nurse #1 revealed the residents in Room 312 were on isolation and PPE was required to be worn in the room. She stated she should have put the gown and gloves on before entering the room but just did not think about it since she was just delivering the tray. During an observation on 4/04/22 at 1:24 PM NA #4 entered Room 312 without isolation gown, gloves or N95 mask on. During an interview on 4/04/22 at 1:26 PM NA #4 revealed she was not aware Room 312 was on isolation precautions because she did not see the	F 880	place or systematic changes made to ensure that the deficient practice will not reoccur: On 4/5/2022 the Director of Nurses/ICP and RN Supervisor initiated education for all registered nurses, licensed practical nurses, certified nursing assistants, medication aides, housekeeping, maintenance, therapy, agency and department managers Full time, part time and as needed on: Covid 19 Program facility policy and following special droplet contact precautions to include adhering to appropriate personal protective equipment utilization(PPE donning and doffing) in all enhanced precaution identified resident rooms at all times. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. On 4/7/2022 the Administrator, Director of Nurses/Infection Control Preventionist/Staff Development Coordinator implemented IC rounds to include appropriate PPE utilization for residents on special droplet contact precautions. The training will be validated with return demonstration observed by the Director of Nurses/Infection Control Preventionist or RN Supervisor on: appropriate personal protective equipment utilization and practice for the above identified staff. Education and validation of skills will be completed by 5/23/2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 880	Continued From page 20 sign and there was not a bin in front of the door. She stated she did not work on the hall and was just talking to the other NA in the room. During an interview on 4/04/22 at 1:27 PM NA #3 revealed she was not aware Room 312 was on isolation precautions until she was in the room and overheard the conversation with other staff member. NA #3 stated when a resident was on isolation there was normally a cart outside of the room with the N95 masks. NA #3 stated she did not look for the sign before entering and did not see the sign until she left the room. During an observation on 4/05/22 at 8:11 AM NA #5 entered Room 312 without gown, gloves, or N95 mask on. During an interview on 4/05/22 at 8:16 AM NA #5 revealed she was not aware Room 312 was on isolation precautions because she did not see a sign before she entered. NA #5 stated she saw the isolation sign once she entered the room but just dropped off the breakfast tray and left the room. During an interview on 4/07/22 the Director of Nursing (DON) revealed Room 312 was on isolation precautions and the correct isolation precaution signage was posted on the door stating the isolation requirement. She stated the staff should have also received report about the isolation precautions. The DON stated the normal process was to place a bin with N95 masks and eye protection on each hall when needed but not at individual doors. The DON reported the blue isolation bags which were hung on the wall of each hall held the gowns, gloves, N95 masks, and eye protection. She stated all	F 880	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Infection Control Preventionist/Administrator or Staff Development Coordinator will audit will observe 2-day shift and 2 evening/night shift staff 3x a week with at least one of the observations to be on a Saturday or Sunday to assure that donning and doffing of PPE is done properly, that required PPE is utilized based on posted isolation signs on doors and wall and that hand hygiene practices are followed based on facility policy. Immediate resolution or coaching is required. Monitoring to be done weekly x 4 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing/Infection Control Preventionist, Minimum Data Set Coordinator, Therapy, Health Information Manager and Dietary Manager. A Directed Plan of Correction was completed on 4/20/2022 and alleged compliance will be in place by 5/24/2022.	

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WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

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F 880	Continued From page 21 staff were educated on where to locate supplies and all staff were able to obtain the supplies when needed. During an interview on 4/07/22 the Administrator revealed the correct isolation precautions signage was present and if supplies were needed all the staff would be able to obtain from storage closet on hall.	F 880		