STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 7/25/22 through 7/27/22. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID # TW5C11	E 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		7/28/22

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

Electronically Signed | 08/08/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 657	Continued From page 1 Based on record review and staff interview, the facility failed to review care plans for 1 of 5 residents (Resident #11) reviewed for unnecessary medications. Findings Included: Resident #11 was admitted to the facility on 12/16/20 with diagnoses including Alzheimer ' s Disease and depression. Resident #11 was care planned for being dependent for meeting emotional, intellectual, physical, and social needs, communication problem, impaired cognitive function, risk for falls and use of psychotropic medications. All care plans were last updated 2/28/22. Record review revealed a care conference had been conducted regarding Resident #11 on 3/9/22. A quarterly Minimum Data Set (MDS) was completed on 6/1/22. Record review revealed a care conference was completed on 6/8/22. An interview was conducted with Nurse #2 on 7/27/22 at 2:00 PM and she stated she was responsible for reviewing the care plans. She stated Resident #11 ' s care plan should have been reviewed in June after she completed the MDS. She stated she just forgot.	F 657	• How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: Response: Resident #11 care plan was reviewed and updated on 7/27/2022 • How the facility will identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken: Response: All other current resident care plans were reviewed for timeliness by MDS Registered Nurse. No other residents were found to be affected. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Response: Inservice initiated on 7/28/2022 by Director of Nursing providing education to MDS Registered Nurse on the regulation to update resident care plans following comprehensive and quarterly MDS' as well as with order changes impaction plan of care. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Response: Director of Nursing will initiate a monitoring schedule to audit care plans for timeliness of review and completion in accordance with state regulations weekly for 8 weeks then monthly for 4 months. Results of audits will be submitted to QAPI with interventions if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 657	Continued From page 2	F 657	• Date of Correction 7/28/2022 This Plan of Correction is submitted to be in compliance with certain state and federal regulations. Its submission does not indicate that the facility agrees with the findings	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 13 of 206 days reviewed from 1/1/22 through 7/25/22 for staffing. Findings Included: A review of the facility ' s staffing sheets revealed no RN coverage for 01/22/2022, 01/23/2022, 2/12/22, 2/13/22, 2/26/22, 2/27/22, 3/12/22, 3/13/22, 3/20/22, 3/26/22, 3/27/22, 7/23/22, and 7/24/22.	F 727	• How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: Response: No residents affected and unable to correct past compliance for 8-hour RN coverage. • How the facility will identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken: Response: A full time RN was hired on 4/21/2022 to fulfill missing weekend	7/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 727	Continued From page 3 During an interview with the Director of Nursing on 7/27/22 at 3:55 PM, she stated she does the nursing schedule and on 01/22/2022, 01/23/2022, 2/12/22, 2/13/22, 2/26/22, 2/27/22, 3/12/22, 3/13/22, 3/20/22, 3/26/22, 3/27/22, 7/23/22, and 7/24/22 there was no RN coverage. The DON stated she reached out to staff for coverage and tried to get a RN from staffing agencies. She stated she was aware of the requirement to provide an RN for 8 consecutive hours each day and we did the best we could to get coverage.	F 727	8-hour RN compliance. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Response: Inservice initiated on 7/28/2022 by Director of Nursing providing education to nursing administration team on actions to be taken if there is no RN for weekend shifts. Step #1 is to reach out to Cardinal RN floor staff for RN coverage, step #2 is to reach out to contract agency for RN coverage, step #3 is to notify Director of Nursing of non-coverage. Director of Nursing or designee will provide facility in person RN 8-hour coverage when necessary. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Response: Director of Nursing will initiate a monitoring schedule to audit care plans for daily RN 8- hour coverage in accordance with state regulations weekly for 8 weeks then monthly for 4 months. Results of audits will be submitted to QAPI with interventions if needed. • Date of Correction 7/28/2022 This Plan of Correction is submitted to be in compliance with certain state and federal regulations. Its submission does not indicate that the facility agrees with the findings	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		8/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 758	Continued From page 4 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 758	Continued From page 5 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement a 14-day stop date for as needed psychotropic medications for 2 of 2 residents reviewed for unnecessary medications, (Resident #9 and Resident # 10). Findings included: 1. Resident #9 was admitted to the facility on 03/02/22 with diagnoses which included anxiety. Resident #9 ' s physician order dated 03/07/22 revealed she was ordered Alprazolam 0.25 mg every six hours as needed (PRN) for anxiety. The order had a start date of 03/07/22 with a stop date of 03/07/2032. A review of the Medication Administration Record (MAR) for Resident #9 revealed she received Alprazolam 0.25 mg thirteen times in March, zero times in April, one time in May, four times in June and one time in July. An interview on 07/26/22 with Nurse #2 at 11:52 am revealed she wasn ' t sure why the stop dates were not set to 14 days instead of 10 years. An interview with Pharmacist #1 on 07/26/22	F 758	• How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: Response: Resident's # 9, and #10 had clarification orders written to provide stop dates or discontinuation of PRN psychotropic medications. • How the facility will identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken: Response: All other current resident medications were reviewed for stop dates on PRN psychotropics by Registered Nurse on 7/27/2022. Clarification orders were written for 1 additional identified resident. • What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Response: Inservice initiated on 8/8/2022 by Pharmacy Manager of Clinical Operations, providing education to pharmacist on the regulation to provide stop dates for any PRN psychotropic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 758	Continued From page 6 01:27 PM revealed the computer system used for order entry automatically added a 10 year stop date unless someone manually added a different stop date on the order. Pharmacist #1 added the facility ' s pharmacy should have gotten clarification from the physician to ensure the PRN order of Alprazolam had a stop date of no more than 14 days from the written date and the medication would have then fallen off Resident #9 ' s profile. An interview with the Physician on 07/26/2022 at 12:08 am revealed he was aware of the regulation for PRN psychotropic medications to be written for no more than 14 days and Resident #9 ' s order for Alprazolam must have been on oversight. The Physician stated the pharmacy usually alerted him if there was an order written for psychotropic medications which did not have a stop date within 14 days after the original order was written. He stated Resident #9 ' s order should have only been written for 14 days from its original written date. 2. Resident #10 was admitted to the facility on 03/03/22 insomnia. Resident #10 ' s physician order dated 03/20/22 revealed she was ordered Diazepam 5mg at bedtime as needed for insomnia. The order had a start date of 03/20/22 with a stop date of 03/20/2032. An interview on 07/26/22 with Nurse #2 at 11:52 am revealed she wasn ' t sure why the stop dates were not set to 14 days instead of 10 years. An interview with Pharmacist #1 on 07/26/22 01:27 PM revealed the computer system used for order entry automatically added a 10 year stop	F 758	medications. Inservice initiated on 7/28/2022 by Director of Nursing to order approving licensed nurses, providing education of necessary components of order review in EMAR. Inservice initiated on 8/3/2022 by Director of Nursing to Medical providers providing education of stop dates and re-evaluation for PRN psychotropic medications. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Response: Pharmacist will review medications monthly Director of Nursing or designee will initiate a monitoring schedule to audit PRN psychotropic medications for stop dates weekly for 8 weeks then monthly for 4 months. Results of audits will be submitted to QAPI with interventions if needed. Date of Correction 8/8/2022 This Plan of Correction is submitted to be in compliance with certain state and federal regulations. Its submission does not indicate that the facility agrees with the findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 758	Continued From page 7 date unless someone manually added a different stop date on the order. Pharmacist #1 added the facility ' s pharmacy should have gotten clarification from the physician to ensure the PRN order of Diazepam had a stop date of no more than 14 days from the written date and the medication would have then fallen off Resident #10 ' s profile. An interview with the Physician on 07/26/2022 at 12:08 am revealed he was aware of the regulation for PRN psychotropic medications to be written for no more than 14 days and Resident #10 ' s order for Diazepam must have been on oversight. The Physician stated the pharmacy usually alerted him if there was an order written for psychotropic medications which did not have a stop date within 14 days after the original order is written. He stated Resident #10 ' s order should have only been written for 14 days from its original written date.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 8	F 880		

§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.
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 9 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 and staff interviews, the facility failed to disinfect a glucometer (used to measure a resident ' s blood glucose level) after use per the manufacturer ' s recommendation which resulted in the potential cross contamination for 1 of 1 nurse (Nurse #1) observed for medication administration. Findings included: A review of the facility ' s policy "Glucometer Cleaning" read in part; clean the glucometer surface after each use and when visible blood or bloody fluids are present by following the manufacturer recommended procedure, and alcohol should never be used to clean a glucometer because it can damage the glucometer. The recommended cleaning and disinfecting instructions for the meter used was reviewed. Instructions included using an Environmental Approved Agency wipe and wiping the surface of the meter to clean blood and other body fluids and dispose of wipe and then obtain a second wipe and wipe the entire surface to remove any	F 880	" How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: Response: Both glucometers on med cart were cleaned using Sani Cloth bleach disinfecting wipe and separated into separate boxes labeled with individual resident name on 7/27/2022. " How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Response: Nurse #1 was re-educated on proper glucometer technique using proper disinfecting wipes, appropriate time frame for disinfecting process and individual resident glucometers. " What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Response: A Root Cause Analysis was conducted as described: (see attached) Problem Statement: Registered Nurse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 10 bloodborne pathogens. The surface must remain wet for the wipes recommended contact time. The wipes used by the facility recommend a surface wet time of 4 minutes. On 7/27/22 at 9:10 AM Nurse #1 was observed obtaining a blood sugar on Resident #15 and returning to the med cart. Nurse #1 placed the glucometer on top of the medication cart and obtained an alcohol wipe. Nurse #1 picked up the glucometer and proceeded to wipe it down for less than 15 seconds. Nurse #1 placed the glucometer back on the medication cart to air dry and then placed it in a plastic box next to a second glucometer. At 9:40 AM on 7/27/22 and interview was conducted with Nurse #1, and she stated the glucometer was a multiuse glucometer and used on other residents. She stated she was told she could clean the glucometer with an alcohol wipe. An interview was conducted with Nurse #2, who is also the Infection Preventionist, and she stated Nurse #1 was trained to clean the glucometer per the manufacturer ' s instructions. She stated if the glucometer was soiled it needed to be cleaned with a manufacturer approved wipe and get another wipe to disinfect the glucometer with a contact time of 4 minutes. Nurse #2 also stated the manufacturer approved wipes are in the medication cart for cleaning the glucometers and Nurse #1 has been re-educated on the cleaning procedure. On 7/27/22 at 4:05 PM the Director of Nursing was interviewed, and she stated the glucometers should be cleaned per the manufacturer recommendations.	F 880	noted to not follow proper protocols for disinfecting glucometer. We followed The 5 W's methodology for analysis: Why? Registered Nurse noted that the screen of the glucometer was cloudy when using the disinfecting wipes. Why? Registered Nurse thought that the alcohol wipe would be an approved disinfectant for the glucometer. Why? Registered Nurse forgot that she was trained on how to properly clean glucometers. The Root Cause was that the Registered Nurse took it upon herself to use an unauthorized product to clean the glucometer due to cloudiness on the glucometer screen. To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented? Answer: Yes Response: Inservice initiated on 7/28/2022 by Infection Preventionist Registered Nurse providing education all licensed nurses on proper glucometer technique using proper disinfecting wipes, appropriate time frame for disinfecting process and individual resident glucometers. Please find Attestation Statement. Letter of Attestation for Completion of Training for Glucometer Cleaning and Disinfection (see attached) Date: 8/10/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 11	F 880	This statement is to confirm that all licensed nurses were trained on how to clean and disinfect glucometers. That training included use of Sani Cloth Bleach Disinfectant Wipes and to leave the product on glucometers for 4 minutes. Training also included The Cardinal practice of single resident use Glucometers and single storage containers. Training was initiated on 7/28/2022 and completed on 8/9/2022. I declare that the above training was completed by Mary Williams RN Infection Preventionist for The Cardinal at North Hills Theresa Weigand RN DON The Cardinal at North Hills " How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Response: Director of Nursing or designee will initiate a monitoring schedule to audit med pass observations, including glucometer cleaning 3 times weekly for 4 weeks then, three times monthly for 3 months. Results of audits will be submitted to QAPI with interventions if needed. Date of Correction 8/10/2022 This Plan of Correction is submitted to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880	in compliance with certain state and federal regulations. Its submission does not indicate that the facility agrees with the findings	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		8/8/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 883	Continued From page 13 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and review of facility policy, the facility failed to administer the pneumococcal vaccine to 1 of 5 residents reviewed for immunizations, (Resident #9). Findings included: A review of the facility ' s policy dated October 2019 labeled "Pneumococcal Vaccine" read in part, "assessments of pneumococcal vaccine status will be conducted within five (5) working days of the resident ' s admission. Administration of the pneumococcal vaccines will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations	F 883	• How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice: Response: Order and consent obtained to administer Pneumococcal vaccine to Resident #9 on 7/27/2022. Vaccine was administered on 7/28/2022 • How the facility will identify other resident's having the potential to be affected by the same deficient practice and what corrective action will be taken: Response: All other current residents were reviewed for Influenza and Pneumococcal vaccines and were found to be fully vaccinated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 883	Continued From page 14 at the time of the vaccination. A review of the CDC recommendations dated January 24, 2022, read in part, "age 65 years or older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23. Resident #9 was admitted to the facility on 03/07/2022 with diagnoses to include Alzheimer's disease and dementia, A review of the Minimum Data Set (MDS) dated 06/01/2022 assessed Resident #9 to be severely cognitively impaired. The MDS documented the pneumococcal vaccine was not up to date. A review of the medical record for Resident #9 revealed a consent to administer pneumococcal (PVC13 and/or PPSV23) vaccine. The form was dated 03/10/2022 and signed by the resident representative and the option "Yes, I wish to receive the Pneumococcal (PPSV23) vaccine of indicated" was selected. The immunization record for Resident #9 was reviewed and no PPSV23 vaccine was documented as given. An interview with the Infection Preventionist (IP) on 07/25/22 at 2:18 pm revealed during Resident #9 ' s initial treatment team meeting on 03/10/22, Resident #9 ' s resident representative was asked if she wanted Resident #9 to receive the pneumococcal vaccine and she said yes. The IP	F 883	• What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Response: Inservice initiated on 7/28/2022 by Director of Nursing to Medical Providers and Infection Preventionist on vaccine review and order requirements. • How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. Response: Director of Nursing or designee will initiate a monitoring schedule to audit new admissions for vaccine administration weekly for 8 weeks then, monthly for 4 months. Results of audits will be submitted to QAPI with interventions if needed. Date of Correction 8/3/2022 This Plan of Correction is submitted to be in compliance with certain state and federal regulations. Its submission does not indicate that the facility agrees with the findings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345572	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARDINAL AT NORTH HILLS	311 GARDEN AT NORTH HILLS STREET RALEIGH, NC 27609

(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 883	Continued From page 15	F 883		

stated she notified the facility ' s medical provider, about the pneumococcal vaccine request for Resident #9 but never received a response. The IP added there was no other follow up by the facility ' s medical provider regarding Resident #9 ' s need for the pneumococcal vaccine and Resident #9 never received the vaccine. The IP added there had been some communication issues with their previous medical provider and the facility had a new medical director as of 7/18/2022 and hoped the communication would work much better.

An interview with the Director of Nursing (DON) on 7/20/22 at 3:47 pm revealed Resident #9 had not received the pneumococcal vaccine since admission on 03/07/2022. The DON stated her expectations would be for the physicians to have responded to the facility ' s IP ' s request regarding Resident #9 ' s pneumococcal vaccine. The DON stated Resident #9 should have received the pneumococcal vaccine.