STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 and complaint investigation was conducted on 9/27/22 through 9/30/22. The facility was found in compliance with the requirement CFR483.73, Emergency Prepardeness. Event ID # PRBM11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 9/27/22 through 9/30/22. Event ID # PRBM11. The following intake was investigated: NC00190947. 3 of the 3 complaint allegations were not substantiated.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use 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;	F 758		10/31/22

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

Electronically Signed | 10/21/2022

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F 758	Continued From page 1 §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 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 reviews, staff interviews, Physician interview, and Pharmacy Consultant interview, the facility failed to ensure Physician's orders for PRN (as needed) psychotropic medications were time limited in duration for 1 of 5 Residents (Resident #16) reviewed for unnecessary medications. The findings included: Resident #16 was admitted to the facility on	F 758	Northampton Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Northampton Nursing and Rehabilitation	

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F 758	Continued From page 2 6/8/22 with diagnoses that included Parkinson's disease and Lewy Body dementia. The admission Minimum Data Set (MDS) assessment dated 6/15/22 revealed the Resident was moderately cognitively impaired. He was not coded as having any behaviors during the assessment period. A care plan was last revised on 8/29/22 for use of psychotropic medication use. Interventions included administer medications as ordered by the Physician and monitor and notify Physician of any side effects related to the medication. A Physician order dated 6/8/22 indicated Lorazepam 0.5 milligrams (mg) 1 tab by mouth every 4 hours as needed (PRN) for anxiety was ordered without a stop date. A Physician order dated 8/27/22 indicated Haldol 0.5 mg 1 tab every 6 hours PRN for hallucinations was ordered without a stop date. A telephone interview was completed on 9/29/22 at 1:06 pm with the Pharmacy Consultant. She indicated PRN psychotropic medications required an initial 14 day stop date. The Pharmacy Consultant continued to state the Physician then reevaluated the Resident for continued use of the medication and documented the rationale for extending the medication. An interview was conducted on 9/29/22 at 3:25 pm with the Director of Nursing (DON). She indicated she was aware all PRN psychotropic medications required an initial 14 day stop date, and the Physician then reevaluated the resident at the end of the medication regimen for	F 758	Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Northampton Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F758 Free from Unnecessary Psychotropic Meds/PRN Use On 9-29-22, the Director of Nursing clarified the stop date for the PRN antianxiety medication order for resident #16. The order was updated in the electronic record. On 10-20-22, the Director of Nursing initiated an audit of all PRN psychotropic medications to ensure PRN psychotropic medications for all residents to include resident # 16 were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical record and indicated the specific duration. The DON or designee will address all concerns identified during the audit to include clarifying order with the physician and updating the electronic record for appropriate stop date. The audit will be completed by 10-31-22 On 10-20-22, the DON initiated an	

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F 758	Continued From page 3 continued use. An interview was completed on 9/29/22 at 4:43 pm with the Administrator. She stated it was her expectation all PRN psychotropic medications have a stop date included in the order. A telephone interview was completed on 9/30/22 at 8:20 am with the Physician. He revealed all PRN psychotropic medications were ordered for 14 days. The Physician stated he then revaluated the resident and extended the medication for a time frame he felt appropriate. The Physician indicated he did not recall being notified Resident #16's medications did not include stop date and planned to reevaluate the Resident during his next visit for continued use.	F 758	in-service will all nurses and providers regarding PRN Psychoactive Medication Monitoring with emphasis on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for the extended time period in the medical record and indicates the specific duration. In-service will be completed by 10-31-22. After 10-31-22, any nurse or provider who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and/or providers will be in-serviced during orientation regarding PRN Psychoactive Medication Monitoring. 10% audit of all residents to include resident # 16 physician orders for PRN psychotropic medications will be reviewed by the DON and/or Administrative nurses weekly x 4 weeks then monthly x 1 month utilizing the Psychoactive Medication Audit Tool. This audit is to ensure that the duration of the psychotropic medication is limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical records. The DON or designee will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit. The Administrator will review the Psychoactive Medication Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 758	Continued From page 4	F 758	The Administrator will present the findings of the Psychoactive Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Psychoactive Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain the area surrounding the dumpster free of debris for 2 of 2 dumpsters observed. The findings included: During an observation of the dumpster area with the dietary manager (DM) and dietary consultant on 9/27/22 at 10:12 AM, approximately 400 square feet of debris was behind and to the right of dumpster #1 and dumpster #2. Debris items included: Styrofoam containers, plastic lids, plastic cups, straws, napkins, rubber gloves, a cookie wrapper, a paper straw box, aluminum cans, etc. The DM stated a lot of racoons and cats occupy this area. The dietary consultant stated the dumpster area should be a lot cleaner than observed, and the dumpsters were shared by all departments.	F 814	F814 Dispose Garbage and Refuse Properly On 9-29-22, the Dietary Consultant cleaned up trash and debris to include Styrofoam containers, plastic lids, plastic cups, straws, napkins, rubber gloves, a cookie wrapper, a paper straw box, and aluminum cans around dumpster #1 and dumpster #2. On 10-20-22, the Maintenance Director initiated an audit of surrounding exterior areas to include dumpsters #1 and #2 to ensure areas were free of trash and debris. The Administrator addressed all concerns identified during the audit. The audit will be completed by 10-31-22. On 10-20-22, the Administrator initiated	10/31/22

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F 814	Continued From page 5 An observation of the dumpster area conducted with the dietary consultant on 9/29/22 at 8:25 AM revealed the dumpster area to be in the same condition. The dietary consultant indicated that he spoke to the department heads about the excess debris yesterday afternoon, and they warned him of snakes in the area. He stated he thought the area would be picked up by now, but it looked the same. During a follow-up interview with the dietary consultant on 9/29/22 at 11:34 AM, he stated he had cleaned up the area around the dumpsters himself, and he was not sure who would be the point person to manage the area in the future. The Administrator was interviewed on 9/29/22 at 2:53 PM. She revealed that her expectation was to keep the dumpster area clean, and it was the housekeeping and dietary departments' responsibility to clean up after themselves. The Administrator stated she planned to assign an administrative staff member to oversee the cleanliness of the dumpster area going forward.	F 814	an in-service with all Department Heads, Maintenance staff, Housekeeping staff, Dietary staff and the Maintenance staff regarding Trash/Dumpsters with emphasis on the responsibility of each department to ensure dumpster areas are kept clean from trash and debris. In-service will be completed by 10-31-22. The Maintenance Director and/or Housekeeping Director will complete exterior environmental rounds weekly x 4 weeks then monthly x 1 month utilizing Environmental Rounds Audit Tool. This audit is to ensure all exterior areas are free of trash and debris. The Maintenance Director and/or Housekeeping Director will address all concerns identified during the audit to include cleaning areas of identified concern and re-education of staff. The Administrator will review the Environmental Rounds Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the Environmental Rounds Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Environmental Rounds Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		10/31/22

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F 880	Continued From page 6 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

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F 880	Continued From page 7 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to implement its personal protective equipment policy when 1 of 1 staff (Nursing Assistant #1) failed to remove an isolation gown before exiting a resident's room on isolation precautions. The findings included: Review of the Infection Control Policy last updated 5/22 read in part personal protective	F 880	F880 Infection Control On 9-29-22, the Staff Development Coordinator (SDC) verbally educated nurse aide #1 regarding donning/doffing personal protective equipment (PPE) with emphasis on removing PPE prior to exiting resident room and removal/changing N95 mask between isolation rooms.	

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F 880	Continued From page 8 equipment (PPE) was to be worn when performing tasks for residents on isolation precautions. The policy further stated that PPE should be removed and discarded in an appropriate container prior to exiting room. An observation was conducted of the 100 Hall on 9/29/22 at 8:30 AM. The room door had a sign that read to use eye wear, mask, gown, and gloves to protect residents on room restrictions. An observation was conducted of Nursing Assistant (NA) #1 on 9/29/22 at 8:35 AM. The room door had caution signage that indicated the resident was on isolation precautions and staff were required to use eyewear, mask, gown, and gloves when entering residents' room. NA #1 exited a resident's room that was on isolation precautions without removing her gown and gloves. NA #1 walked over to the meal cart and placed a tray on the cart. NA #1 then returned to the same resident's room and removed her gown and gloves. An interview was conducted with NA #1 on 9/29/22 at 8:48 AM. NA #1 stated that she was not aware that she could not wear her gown in the hallway. NA #1 stated that she had been educated on donning and doffing personal protective equipment. NA #1 stated that she had read the sign. An interview was conducted with the Director of Nursing (DON) on 9/29/22 at 9:10 AM. The DON stated that NA #1 should have discarded her gown and gloves in the waste receptable inside the room before exiting the resident's room.	F 880	On 10-20-22, the DON/Infection Preventionist initiated an audit of all staff currently working on use of PPE. This audit was to ensure staff don/doff PPE appropriately when entering/exiting quarantine rooms. The Director of Nursing will address all concerns identified during the audit. The audit will be completed by 10-20-22. On 10-20-22 the DON/Infection Preventionist initiated an in-service with return demonstration with all nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and maintenance staff regarding PPE Use. Emphasis is on appropriate donning/doffing PPE to include but not limited to gowns/gloves and use of PPE when enter resident rooms and/or quarantine rooms based on CDC guidelines. In-service will be completed by 10-31-22. After 10-31-22 any staff who has not received the in-service will be in-serviced upon next scheduled work shift. All newly hired staff will be in-serviced with return demonstration during orientation regarding facility PPE Use. On 10-20-22, the DON/Infection Preventionist initiated an in-service with all nurses, nursing assistants, therapy staff, dietary staff, housekeeping staff, Accounts Receivable, Administrator, Accounts Payable, medical records, receptionist, screener, social worker and	

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F 880	Continued From page 9	F 880	maintenance staff regarding Principle Covid 19 Guidelines with emphasis on source control measures. In-service will be completed by 10-31-22. After 10-31-22 any staff who has not received the in-service will be in-serviced upon next scheduled work shift. All newly hired staff will be in-serviced with return demonstration during orientation regarding Principle Covid 19 Guidelines. The Minimum Data Set (MDS) Nurse and/or nurse supervisor will complete 10 staff observations to include staff on all shifts weekly x 4 weeks then monthly x 1 month utilizing a PPE Audit Tool. This audit is to ensure staff donned/doffed PPE appropriately when entering/exiting resident room when isolation precautions were required. The MDS nurse and/or nurse supervisor will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the PPE Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing (DON) will present the findings of the PPE Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the PPE Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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