STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345323	A. BUILDING _____ B. WING _____	C 02/08/2024

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WALLACE REHABILITATION AND HEALTHCARE CENTER	647 S EAST RAILROAD STREET WALLACE, NC 28466

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/5/2024 through 2/8/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1WW411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/05/2024 through 02/08/2024. Event ID #1WW411. The following intakes were investigated NC00199476, NC00200252, NC00202676, NC00203053 and NC00206641. 1 of the 16 complaint allegations resulted in deficiency.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		2/22/24

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

Electronically Signed | 02/22/2024

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F 577	Continued From page 1 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to display survey results in a location accessible to residents during 3 of 3 observations of the facility. Findings included: During a tour of the facility on 2/5/24 at 9:45 AM, the survey results were not located in the building. An observation of the front lobby revealed a desk area near the entrance. On the desk there was a visitor sign in book, a red plastic bin that contained facemasks, and written information about infection control. Tours of the facility on 2/5/24 at 2:36 PM and 2/6/24 at 1:00 PM revealed the survey results were not located in the building. A Resident Council group meeting was conducted on 2/6/24 at 2:00 PM. During the meeting, the residents indicated they did not know where the survey results were located. The Resident Council President shared she had been at the facility for a year and did not know the location of the survey results. Resident #60 stated she also did not know the location of the survey results book.	F 577	F 577 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on observations, resident and staff interviews, the facility failed to display survey results in a location accessible to residents during 3 or 3 observations of the facility. The facility survey binder was located behind the reception desk and placed in an area accessible to residents and secured to the location to prevent it from being moved. No adverse outcomes were identified. Element #2 All residents have the potential to be affected by the deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3	

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F 577	Continued From page 2 An interview was completed with the Receptionist on 2/6/24 at 2:21 PM. He explained the survey results book was located behind his desk. The book was not visible when a resident or visitor faced the front of the receptionist's desk. The Receptionist said the book had been on his desk 2/5/24 and 2/6/24. He thought someone may have updated the survey results book and placed it on the desk instead of on the coffee table in the front lobby area where it was usually kept for residents/visitors. In an interview with the Director of Nursing (DON) on 2/06/24 at 2:43 PM, she explained the survey book was typically on the coffee table in the front lobby. She said there was a sign posted on a cabinet in the activities room/office that identified the location of the survey results. She said the activities room/office was unlocked 24 hours a day. The DON stated there was also a sign on the desk in the front lobby area where visitors signed in that identified the location of the survey results. During the interview, an observation of the desk with the DON revealed the sign had been covered up by a red plastic bin that contained facemasks. On 2/08/24 at 1:09 PM an interview was conducted with the Administrator. She said the survey results book was always on the bottom shelf of the coffee table in the front lobby. The Administrator stated she was unsure if "in the hustle and bustle" of the survey process, the Receptionist moved it from the coffee table.	F 577	The Activity Director informed all facility residents on the location of the facility survey binder on 2/6/2024. Education was provided to facility staff by the Administrator on the location of the facility survey binder and that the facility survey binder must be accessible to residents. Education was provided to the facility Administrator by the Regional Vice President of Operations on 2/6/2024 on Resident Rights to include that the facility survey binder must be accessible to residents. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits weekly x 12 weeks to ensure the facility Survey Binder is accessible to residents. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 2/22/2024	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		2/22/24

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F 584	Continued From page 3	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to maintain walls in good repair in 4 of 8 rooms (Rooms 203-2, 207-1, 207-2, 214-1, and 215-1) on the 200 hallway. Findings included: a. During tours of Room 203-2 on 2/5/24 at 11:30 AM and 2/7/24 at 1:30 PM, an observation revealed scratches on the wall and missing paint behind the resident's bed. An interview was conducted with the resident in Room 203-2 on 2/8/24 at 10:48 AM. She stated she had resided in her room for 1 ½ years and the wall behind her bed had always been scratched with missing paint. She shared she would like for the wall to be patched and repainted. b. During tours of Room 207-1 on 2/5/24 at 11:11 AM and 2/7/24 at 1:33 PM, an observation revealed scratches on the wall and missing paint behind the resident's bed. An interview was conducted with the resident in Room 207-1 on 2/5/24 at 11:12 AM. He acknowledged there were scratches on the wall behind his bed and said, "Every room has them." c. During tours of Room 207-2 on 2/5/24 at 11:02 AM and 2/7/24 at 1:34 PM, an observation revealed scratches on the wall and missing paint behind the resident's bed.	F 584	F 584 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on observations, resident and staff interviews, the facility failed to maintain walls in good repair in 4 of 8 rooms (Rooms 203-2, 207-1, 207-2, 214-1, and 215-1) on the 200 hallway. Resident rooms identified in 2567 have had the walls repaired. All resident rooms were audited to identify any additional rooms that are in need of wall repair. The facility will implement a schedule to complete wall repairs on any additional rooms identified. No adverse outcomes were identified. Element #2 All residents have the potential to be affected by the deficient practice. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 Education was provided to facility staff by the Administrator on the process for	

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F 584	Continued From page 5 An interview was conducted with the resident in Room 207-2 on 2/5/24 at 11:03 AM. He stated the scratches on the wall had been there since he resided in the room (about 3 years). He said he had not told any of the facility staff about the scratches on the wall. d. During tours of Room 214-1 on 2/5/24 at 11:23 AM and 2/7/24 at 1:34 PM, an observation revealed gouges in the wall and exposed sheetrock behind the resident's bed. e. During tours of Room 215-1 on 2/5/24 at 3:02 PM and 2/7/24 at 1:35 PM, an observation revealed scratches on the wall and missing paint behind the resident's bed. The Maintenance Director was interviewed on 2/08/24 at 10:20 AM. He explained there was a clipboard at the nurse's station where staff wrote down repair issues that needed to be addressed and he checked the clipboard throughout the day. He added staff also called or texted him with repair needs. The Maintenance Director shared he walked through the building daily and if he saw something that needed to be repaired, he took care of it. He stated he had not routinely audited rooms for repairs. He said he was currently working on installing wall boards behind residents' beds. He did not have a specific schedule for when the wall boards would be installed, rather, he did them as he "got to them." He said he was the only maintenance employee and had worked on installing the wall boards for the past six months. A tour of rooms 203-2, 207-1, 207-2, 214-1 and 215-1 was conducted with the Maintenance Director and Administrator on 2/8/24 at 10:30 AM.	F 584	reporting any room repairs needed when observed on 2/16/2024. Education was provided to the Facility Maintenance Director by the facility Administrator on 2/16/2024 on Safe/Clean/Comfortable/Homelike Environment to include that the facility will maintain resident room walls. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits weekly x 12 weeks to ensure resident room walls are in good repair. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Compliance Date: 2/22/2024	

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F 584	Continued From page 6	F 584		

The Maintenance Director explained the scratches/gouges in the walls were from the beds hitting the walls which then removed the paint from the walls. The Administrator verified the walls should be repaired so that each resident's room maintained a homelike environment.

In an interview with the Vice President of Clinical Operations on 2/08/24 at 11:00 AM, she explained that on 1/3/24 rooms 203, 207, 214 and 215 had been noted in the computer system that repairs were needed. She added some of the walls were chronic issues where the bed was moved so staff could operate a mechanical lift and subsequently scratched the wall.

On 2/08/24 at 11:40 AM, observations of rooms 203, 207, 214 and 215 were conducted with Medication Aide #1. In an interview with Medication Aide #1 on 2/8/24 at 11:42, she shared the scratches on the wall behind the bed of Room 203-2 been there "for at least the last few months." She further stated the walls in Rooms 207, 214, and 215 had been scratched/gouged for at least the last two months. She said the scratches on the wall came from the bed being pushed up against the wall.

A follow up interview was conducted with the Vice President of Clinical Operations and the Maintenance Director on 2/08/24 at 11:46 AM. The Vice President said the facility had sent environmental room audits weekly to the corporate office. She explained each time the audit was completed, the facility reiterated to the corporate office that a work order needed to be approved for an outside contractor to come in and repair the walls. She said the facility had sent 4-6 work order notices to the corporate office

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F 584	Continued From page 7 regarding wall repair. The Maintenance Director added if it were just paint issues, he could install a wall board, but if there were gouges, the wall needed to be repaired first before it could be painted.	F 584		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to place signage indicating oxygen was in use outside resident rooms for 2 of 3 residents reviewed for oxygen use (Resident #228 and Resident # 69). Findings included: 1. Resident #69 was admitted to the facility on 12/12/2023, and diagnoses included congestive heart failure. Resident #69 was discharged from the facility on 1/27/2024 to the hospital and was readmitted to the facility on 2/1/2024. The admission Minimum Data Set (MDS) assessment dated 12/19/2023 indicated Resident #69 was cognitively intact, was not experiencing shortness of breath and was not receiving oxygen therapy.	F 695	F 695 What corrective action will be accomplished for those residents found to have be affected by the deficient practice: Element #1 Per the 2567, based on record review, observations and staff interviews the facility failed to place signage indicating oxygen was in use outside resident rooms for 2 of 3 residents reviewed for oxygen use (Resident #228 and Resident #69). Signage was immediately placed on the resident rooms identified. No Adverse outcomes were identified. Element #2	2/22/24

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F 695	Continued From page 8 Physician orders dated 1/8/2024 included an order for oxygen at 2 liters per minute via nasal cannula as needed to keep oxygen saturations greater than 90%. On 2/1/2024, Resident #69's re-admission physician orders included oxygen at 2 liters per minute via nasal cannula continuously every shift for congestive heart failure and hypoxia (low oxygen in the blood). A physician note dated 2/2/2024 recorded Resident #69 was still requiring oxygen therapy, and Resident #69 was receiving oxygen via nasal cannula. On 2/5/2024 at 2:40 p.m., Resident #69 was observed wearing oxygen via nasal cannula at 2 liters per minute. There was no warning signage observed indicating oxygen was in use located outside the room or on the door frame. On 2/6/2024 at 8:28 a.m., there was no warning signage observed indicating oxygen was in use located outside the room or on the door frame. On 2/6/2023 at 2:16 p.m. in an interview with Unit Nurse Manager #1 and Unit Nurse Manager #2 (the assigned nurse on re-admission), Unit Nurse Manager #2 stated after reviewing Resident #69's electronic medical record, she could not positively say Resident #69 was using oxygen when readmitted to the facility. Unit Nurse Manager #1 explained based on the hospital's discharge summary it was reported Resident #69 was using oxygen on arrival to the facility, and Resident #69 was to continue the use of oxygen until weaned off oxygen at the facility. Unit Nurse Manager #1 stated the facility used red "Oxygen in Use. No Smoking" magnetic signage outside the room on	F 695	An audit was completed on 2/16/2024 to ensure all residents with oxygen in use had appropriate signage on the outside of their resident room. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Element #3 On 2/16/2024 current licensed nursing and licensed agency staff were educated by the Director of Nursing on ensuring signage is placed on the resident door when oxygen is in use. Licensed Agency staff and New Licensed Nursing Hires will be educated signage being placed outside of the resident room when oxygen is in use during orientation by the Director of Nursing or Designee. How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing and/or designee will conduct random compliance audits weekly x 12 weeks to ensure signage is in place for resident rooms when oxygen is in use. The facility will provide education on any areas of concern. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been	

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F 695	Continued From page 9 the door frames to communicate oxygen was in use in the room. She stated Resident #69 was using oxygen, and nursing staff was responsible for placing and checking that the "Oxygen in Use. No Smoking" warning signage was outside the room on the door frame. When asked why Resident #69 did not have warning signage indicating oxygen was in use outside the room, she stated the warning signage was magnetic and could have gotten knocked off the door frame. On 2/7/2024 at 8:57 a.m. in an interview with the Director of Nursing, she stated Resident #69 should have an "Oxygen in Use. No Smoking" warning signage outside the room on the door frame due to receiving oxygen, and nursing staff were responsible for placing the warning signage outside the room on the door frame. She further stated checking the use of oxygen and ensuring placement of the warning signage on the door frame was a task for the nursing staff to observe for compliance when completing daily rounds on residents in the facility. She stated she did not have an explanation why a warning signage was not on Resident #69's door frame when observed on 2/5/2024 and 2/6/2024 and reported there were ambulatory confused residents on the hall where Resident #69 resided that would remove items off the walls and door frames at times. 2. Resident #228 was admitted to the facility on 1/20/2024, and diagnoses included chronic obstructive pulmonary disease (COPD) and pneumonia. Physician orders dated 1/20/2024 included oxygen via nasal cannula at 2 liters per minute to keep oxygen saturation greater than 91% as	F 695	achieved x 3 months. Compliance Date: 2/22/2024	

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F 695	Continued From page 10	F 695		

needed due to pneumonia.

Resident #228's care plan dated 1/20/2024 indicated Resident #228 was receiving oxygen therapy for a respiratory illness. Interventions included humified oxygen set at 2 liters per minute via nasal cannula continuously.

The admission Minimum Data Set (MDS) assessment dated 1/26/2024 indicated Resident #228 was cognitively intact and was receiving oxygen therapy.

Nursing documentation dated 2/5/2024 recorded Resident #228 was using oxygen.

On 2/5/2024 at 10:45 a.m., Resident #228 was observed receiving oxygen at 2 liters per minute via nasal cannula. There was no warning signage that oxygen was in use observed outside Resident #228's room on the door frame.

On 2/6/2024 at 8:30 a.m. there was no warning signage reporting oxygen was in use observed outside Resident #228's room on the door frame.

In an interview with Unit Nurse Manager #1 on 2/7/2024, she stated after completing an interview on 2/6/2023 at 2:16 p.m. related to oxygen and the use of warning signage, she asked other unit managers to assist her in conducting rounds to check to ensure residents receiving oxygen had a warning signage, "Oxygen in Use. No Smoking", outside the room on the door frame. She stated she recalled at some point Resident #228 having the warning signage, "Oxygen in Use. No Smoking" outside the room on the door frame and didn't know why the warning signage was not on the door frame on 2/5/2024 and 2/.6/2024.

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WALLACE REHABILITATION AND HEALTHCARE CENTER	647 S EAST RAILROAD STREET WALLACE, NC 28466

(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
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She explained unit nurse managers tried to check that the magnetic warning signage was outside the room on the door frame when completing daily rounds on the residents and explained sometimes unit nurse managers were pulled to complete other tasks which interrupted them from completing rounds on the residents.

In an interview with Unit Nurse Manager #3 on 2/7/2024, she stated on 2/6/2024, after an initial interview with Unit Nurse Manager #1 on 2/6/2024 at 2:16 p.m. about oxygen warning signage, she completed rounds on Resident #228 and placed the warning signage, "Oxygen in Use. No Smoking" outside Resident #228's room on the door frame.

On 2/7/2024 at 8:57 a.m. in an interview with the Director of Nursing, she stated Resident #228 should have an "Oxygen in Use. No Smoking" warning signage outside the room on the door frame due to receiving oxygen, and nursing staff were responsible for placing the warning signage outside the room on the door frame. She further stated checking the use of oxygen and ensuring placement of the warning signage on the door frame was a task for the nursing staff to observe for compliance when completing daily rounds on residents in the facility. She stated she did not have an explanation why a warning signage was not on Resident #69's door frame when observed on 2/5/2024 and 2/6/2024 and reported there were ambulatory confused residents on the hall where Resident #69 resided that would remove items off the walls and door frames at times.