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	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Nursing and Rehabilitation Center	Hwy 305 North Jackson, NC 27845

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, and Responsible Party (RP) interview, the facility failed to hold a care plan meeting and invite the resident and the RP to participate in the care planning process for 1 of 3 residents reviewed for care planning (Resident #76). The findings included: Resident #76 was admitted to the facility on [DATE]. Review of the Care Plan General Note dated 8/22/24 by the Social Worker revealed Resident #76 had a care plan meeting held with the Responsible Party (RP) via telephone. Review of Resident #76's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #76 or the RP was invited to participate in a care plan meeting after the 8/22/24 meeting. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #76 had moderate cognitive impairment. A telephone interview was conducted with Resident #76's RP on 1/21/25 at 3:02 pm who revealed he had not been invited to participate in a care plan meeting or notified that a meeting was held for Resident #76. An interview was conducted on 1/23/25 at 2:04 pm with the Social Worker who reported the MDS Nurse provided her with a list of the residents that were due for a care plan meeting, and she was responsible for scheduling and inviting the resident and RP to the meetings. The Social Worker stated Resident #76 was not listed on the care plan meeting list provided by the MDS Nurse for November 2024, so Resident #76's care plan meeting was not scheduled. During an interview on 1/23/25 at 3:06 pm the MDS Nurse reported she provided the Social Worker with a list of residents that required a care plan meeting every month along with a date range that the meetings should be scheduled. The MDS nurse confirmed Resident #76 was on the list provided to the Social Worker for November 2024 to have a care plan meeting scheduled. The MDS Nurse stated the Social Worker was responsible for the coordination of the care plan meeting. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted with the Social Worker on 1/24/25 at 8:02 am who revealed she reviewed the November 2024 list provided by the MDS Nurse and she did see that Resident #76 was listed and should have been scheduled for a care plan meeting. The Social Worker stated she just missed Resident #76's name on the list and no care plan meeting was held. An interview was held on 1/24/25 at 5:39 pm with the Administrator who revealed the Social Worker was responsible for scheduling Resident #76's care plan meeting.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations, record review, and resident and staff interviews, the facility failed to revise the care plan in the area of indwelling urinary catheter (Resident #36) and use of side rails (Resident #67) for 2 of 3 residents reviewed for care plan revision. The findings included: 1. Resident #36 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #36 has severe cognitive impairment and was always incontinent of bladder. Review of Resident #36's care plan last reviewed 11/26/24 revealed no care plan for use of an indwelling urinary catheter. Resident #36 had a physician order dated 1/11/25 to place an indwelling urinary catheter until further notice for decreased urine output. The nursing progress note dated 1/11/25 at 2:35 pm by the Nurse Supervisor revealed Resident #36 had an indwelling urinary catheter placed and the resident tolerated the procedure. An observation was conducted on 1/21/25 at 10:37 am of Resident #36 who was observed to have an indwelling urinary catheter in place. A telephone interview was conducted on 1/24/25 at 11:16 am with the Nurse Supervisor who revealed she obtained a physician order to place Resident #36's indwelling urinary catheter but she did not start a care plan because she believed the Resource Nurse would make sure a care plan was put in place. An interview was conducted on 1/24/25 at 1:49 pm with the Resource Nurse who revealed Resident #36 should have had a care plan started and the care guide should have been updated for the use of an indwelling urinary catheter when it was placed. She stated that either the Nurse Supervisor or the MDS Nurse should have revised Resident #36's care plan to reflect the use of the indwelling urinary catheter. The Resource Nurse stated resident orders would have been reviewed during the next clinical meeting and if no care plan was noted the MDS Nurse would start the care plan based on the orders. The Resource Nurse stated she was not responsible to ensure Resident #36 had a care plan in place for the indwelling urinary catheter. During an interview on 1/24/27 at 2:47 pm with the MDS Nurse she revealed the nurse that obtained the order and placed the indwelling catheter should have revised Resident #36's care plan. The MDS Nurse stated she would assist nursing with care plans when asked but she did not recall discussing Resident #36's new indwelling urinary catheter during the clinical meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 1/24/25 at 3:08 pm who revealed the Nurse Supervisor who placed Resident #36's indwelling urinary catheter was responsible for revising the care plan. The DON stated all new resident orders were reviewed in the clinical meetings. She stated she recalled seeing the new order and discussing in the clinical meeting and she thought the MDS Nurse revised the care plan but must have been sidetracked. An interview was conducted with the Administrator on 1/24/25 at 5:41 pm. The Administrator stated that the missing care plan should have been identified during the clinical meeting. 2. Resident #67 was admitted to the facility on [DATE]. Review of the physical device use evaluation dated 11/15/24 revealed Resident #67 was assessed for the use of 1/4 assist side rails for mobility. The side rails were noted as used daily for enhanced independence. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #67 had moderate cognitive impairment and required assistance by staff for turning, repositioning, and transfers. Review of Resident #67's care plan last reviewed 11/27/24 revealed no care plan was in place for use of side rails for mobility. An observation and interview were conducted with Resident #67 on 1/21/25 at 10:49 am who revealed he had the side rails on his bed since he was admitted to the facility, and he stated he just received a new bed the other day that did not have side rails and he had the nurse put the side rails on the new bed. An interview was conducted with the Resource Nurse on 1/24/25 at 1:54 pm who revealed a care plan was required for a resident that used side rails for mobility. She stated Resident #67 would have been reviewed in the clinical meeting upon admission and the MDS Nurse would have put in a care plan. The Resource Nurse stated she was not responsible for the care plan, and she was unable to state why a care plan was not in place for Resident #67's side rails. An interview was conducted on 1/24/25 at 2:49 pm with the MDS Nurse who reported the nursing staff were responsible to revise Resident #67's care plan for side rails when they were placed on his bed. She stated she would assist with care plans when asked but she would not know about Resident #67's use of side rails if she was not told by nursing. During an interview on 1/24/25 at 3:14 pm the Director of Nursing (DON) stated Resident #67's use of side rails for mobility should have been added to his care plan. She stated Resident #67 had side rails since admission. The DON stated a care plan should have been in place for Resident #67's use of side rails, but she stated it must have been missed during the clinical meeting. An interview was conducted with the Administrator on 1/24/25 at 5:41 pm. The Administrator stated that the missing care plan should have been identified during the clinical meeting.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observation, record review, and staff interviews, the facility failed to obtain physician orders for the management of an indwelling urinary catheter for 1 of 3 residents reviewed for urinary catheter (Resident #36). The findings included: Resident #36 was admitted to the facility on [DATE] with diagnoses which included stroke. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #36 had severe cognitive impairment and was coded as always incontinent of bladder. Resident #36 had a physician order dated 1/11/25 to place an indwelling urinary catheter until further notice for decreased output. Review of Resident #36's electronic medical record revealed no physician orders regarding what size of catheter, how many cubic centimeters (cc) of fluid to anchor the catheter, the time frame to change the indwelling urinary catheter, and time frame to change the indwelling catheter bag. The nursing progress note dated 1/11/25 at 2:35 pm by the Nurse Supervisor revealed Resident #36 had an 18 french (size of the catheter) 5 cubic centimeters (amount of fluid placed in the bulb to anchor the catheter) indwelling urinary catheter placed and tolerated the procedure well. A physician order dated 1/12/25 to monitor and record indwelling urinary catheter output every shift. An observation was conducted on 1/21/25 at 10:37 am revealed Resident #36 had an indwelling urinary catheter in place. A telephone interview was conducted on 1/24/25 at 11:16 am with the Nurse Supervisor who revealed she obtained a physician order for the indwelling urinary catheter for Resident #36, and she entered the order she received. She stated she did not enter any other orders for the management of Resident #36's indwelling urinary catheter, because she believed the Resource Nurse would enter any other orders that were needed. An interview on 1/24/25 at 1:49 pm with the Resource Nurse revealed when a resident had an indwelling urinary catheter physician orders were required for the catheter to be in place, the size of the catheter, how often to change the indwelling catheter and the catheter bag, and monitoring urine output. The Resource Nurse stated the Nurse Supervisor was responsible for entering all standing orders that were associated with the indwelling urinary catheter management. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 1/24/25 at 3:08 pm who revealed the nurse who obtained the physician order and placed the indwelling urinary catheter for Resident #36 was responsible for implementing all the standing orders that were required for the catheter. The DON stated Resident #36 should have had orders for the size of the catheter, changing the catheter, and how often to change the catheter bag. The DON stated she was not aware Resident #36 was missing physician orders for the management of the catheter, but she must have missed it when the orders were reviewed. The Administrator was interviewed on 1/24/25 at 5:42 pm who revealed the nurse who obtained the order was responsible for entering associated orders for Resident #36's indwelling urinary catheter.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations and staff interviews, the facility failed to date opened leftover food items in 2 kitchen refrigerators (the walk-in refrigerator and the free-standing refrigerator), failed to remove an expired food item stored for use from the dry goods storage room, and failed to remove a plastic measuring cup from the sugar storage bin located near the tray line. The plastic measuring cup was resting in the sugar which has the potential for cross-contamination. These practices had the potential to affect food served to residents. The findings included: During the initial observation of the kitchen on [DATE] at 9:36 am with the Dietary Manager the following was observed: a. The walk-in refrigerator, located near the dry goods storage room, was observed to have the following: 1 open plastic bag of shredded lettuce without a date. b. The free-standing refrigerator, located near the tray line, was observed to have an open, large box of grated parmesan cheese without a date. c. The dry goods storage room, located in the kitchen near the walk-in refrigerator, was observed to have one box of hard taco shells with an expiration date of [DATE]. d. A plastic measuring cup was observed inside the large sugar storage bin resting in the sugar. The Dietary Manager confirmed all findings and removed identified items from the refrigerators, dry goods storage room, and the sugar storage bin. During an interview on [DATE] at 1:53 pm with the Dietary Manager she revealed all items placed in the refrigerator were to be dated when opened. The Dietary Manager stated the measuring cup was to be washed after being used and was not to be left inside the bin. She stated she must have missed the hard taco shells when she checked the dry goods storage room for expired items. The Dietary Manager stated she was responsible for ensuring food items were stored properly in the kitchen. An interview was conducted with the Administrator on [DATE] at 5:35 pm who revealed the Dietary Manager was responsible for ensuring food items were dated, labeled, and stored properly in the kitchen.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on a review of the facility arbitration agreement and staff interviews, the facility failed to provide an arbitration agreement that explicitly granted the resident or their representative the right to rescind the agreement within 30 days of signing it. The deficient practice was for 3 of 3 residents reviewed for arbitration (Resident #63, Resident #76, and Resident #33). The findings included: A review of the facility's arbitration agreement titled, Arbitration Agreement, dated 7/15/24 was conducted. The Arbitration Agreement read in part that the agreement may be rescinded by written notice to the facility from the Resident within thirty (30) days of signature. The arbitration agreement did not include the statement that the resident or his or her representative has the right to rescind the agreement within 30 days of signing it. a. Resident #63 was admitted to the facility on [DATE]. Resident 63's arbitration agreement revealed the resident representative signed the agreement on 10/29/24. b. Resident #76 was admitted to the facility on [DATE]. Resident #76's arbitration agreement revealed Resident #76 signed the agreement on 7/30/24. c. Resident #33 was admitted to the facility on [DATE]. Resident #33's arbitration agreement was signed by the resident representative on 9/18/24. An interview was conducted on 1/24/25 at 8:35 am with the Admission Director who revealed she was responsible for reviewing the arbitration agreement with the Resident or the Representative at the time of admission. The Admission Director stated she was provided with the document by the facility and had no knowledge of what was required to be included. During an interview on 1/24/25 at 5:33 pm with the Administrator she revealed she was new to the facility and was not familiar with the facility's arbitration agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772 Based on observation, record review, and staff interviews, the facility failed to implement its infection prevention and control program when 1 of 1 facility staff (Nurse Aide #1) failed to perform hand hygiene before donning and after removing gloves for 4 of 4 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]). The facility also failed to implement its Personal Protective Equipment (PPE) policy when 2 of 2 staff (Wound Treatment Nurse, Nurse Aide #2) failed to wear isolation gowns while in a resident's room on Enhanced Barrier Precautions (EBP). The findings included: The facility's Infection Prevention and Control Program policy last updated 4/2023 read in part: The infection Prevent and Control Program of this facility of designated to establish and maintain an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and transmission of disease. The Objective was to ensure proper utilization of standard precautions and or when needed, transmission-based precautions which should be the least restrictive for a resident under the given circumstances. Review of the facility's hand hygiene policy last updated 4/2023 indicated personnel are to wash their hands after each direct or indirect resident contact to include between resident contacts. 1. A continuous observation was conducted on 1/21/25 at 12:02 PM. Nurse Aide (NA) #1 was observed to leave out of room [ROOM NUMBER] and walk down the hall to the clean linen cart where she retrieved a clothing protector. NA #1 returned to the room and placed a clothing protector on the resident. NA #1 was observed to leave the room without performing hand hygiene. NA #1 entered resident room [ROOM NUMBER] without performing hand hygiene. NA #1 donned gloves and assisted to slide resident in A bed up in the bed. NA #1 removed gloves and was observed to exit the room and retrieve meal tray for resident in the B bed from the meal cart without performing hand hygiene. NA #1 set the meal tray up for the resident and exited the room without performing hand hygiene. NA #1 walked to the meal cart and retrieved the meal tray for resident in room [ROOM NUMBER]. NA #1 placed the meal tray on the bedside table and exited the room. An interview was conducted with NA #1 on 1/21/25 at 12:16 PM. NA #1 stated she was supposed to perform hand hygiene when exiting each resident's room and between residents. NA #1 stated she was trying to get the trays out and didn't realize she had not performed hand hygiene. An interview was conducted with the Director of Nursing on 1/21/25 at 12: 22 PM. The DON stated she expected staff to perform hand hygiene and wear PPE as indicated. An interview was conducted with the Administrator on 1/24/25 at 5:49 PM. The Administrator stated hand hygiene was to be performed as warranted and staff were to perform hand hygiene techniques to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the EBP policy dated 4/1/24 stated EBP used in conjunction with Standard Precautions to reduce the risk of MDRO transmission during high-contact resident care. EBP included the use of gown and gloves. EBP was meant to be in place for the duration of the resident's stay or until resolution of the wound. Resident care activities that are considered high contact include but are not limited to dressing, bathing/showering, changing linens, wound care. During an observation of wound care on 1/24/25 at 9:32 AM, the Wound Treatment Nurse and Nurse Aide #2 completed wound care for Resident #17. Resident #17's room door had Enhanced Barrier Precautions signage that instructed staff to utilize Personal Protective Equipment when performing specific care which included wound care. The signage indicated everyone had to clean their hands before entering and after leaving the room. The signage further indicated that all healthcare personnel must wear gowns and gloves for all the following high-contact resident care activities to include wound care. A bin was observed hanging on the back of the door with PPE supplies readily available. The Wound Treatment Nurse and NA #2 were observed to perform hand hygiene and don gloves, no gown was used by either staff member. Resident #17 was positioned on her left side and the old dressing was removed by Wound Treatment Nurse. The Wound Treatment Nurse removed her gloves and hand hygiene was completed with hand sanitizer. Clean gloves were donned by the Wound Treatment Nurse and the wound bed was washed with soap and water. Gloves were removed and hand hygiene was completed using hand sanitizer. Clean gloves were donned, and calcium alginate (used to promote the formation of new granulation tissue) was applied to the wound bed and foam border dressing was applied over the calcium alginate. Resident #17's brief was applied and resident repositioned. Hand hygiene was completed prior to leaving Resident #17's room by the Wound Treatment Nurse and NA #2. An interview was conducted on 1/24/25 at 9:55 AM with the Wound Treatment Nurse who reported she was nervous during the wound care observation and realized she did not wear the PPE gown when providing wound care. The Wound Treatment Nurse stated she was nervous and just forgot to put the gown on. An interview was conducted on 1/24/25 at 10:25 AM with NA #2 who reported she was aware she did not wear the gown. NA #2 stated she told the Wound Treatment Nurse after they left the room, they had forgotten to wear their gowns. During an interview with the Infection Preventionist on 1/24/25 at 10:30 AM, she revealed when a resident is on EBP the staff were required to wear gowns when wound care was performed. The Infection Preventionist stated PPE was available in all residents that were on EBP. The Infection Preventionist reported both the Wound Treatment Nurse and NA#2 had been educated in the past regarding EBP on 12/23/24 -1/6/25. During an interview with the Director of Nursing on 1/24/25 at 3:24 PM, she stated staff were to wear proper PPE when providing wound care. During an interview with the Administrator on 1/24/25 at 5:38 PM, she stated the Infection Preventionist was responsible for ensuring all staff were educated.