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	04/22/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of the use of supplemental oxygen and dialysis (Resident #39), the use of hypoglycemic medication (Resident #9), and hospice services (Resident #29). The deficient practice was for 3 of 26 residents whose MDS assessments were reviewed. The findings included: 1. Resident #39 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease with dependence on dialysis and chronic obstructive pulmonary disease (COPD). Resident #39 had the following physician orders: 11/20/25 oxygen flow at 3 liters per minute (LPM) via nasal cannula (NC) to keep oxygen saturation greater than 90% every shift for hypoxia. 11/21/25 for dialysis on Monday, Wednesday, and Friday. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #39 had severe cognitive impairment and was not coded for the use of supplemental oxygen and dialysis while a resident at the facility. The MDS Nurse was interviewed on 4/22/26 at 9:36 am and revealed she completed the MDS assessments by reviewing physician orders, observations, and a review of nursing progress notes. The MDS Nurse stated she was aware of Resident #39's use of supplemental oxygen and dialysis but she just miscoded the assessment. During an interview with the Administrator on 4/22/26 at 2:51 pm she reported that the MDS Nurse was responsible for coding Resident #39's assessment correctly to be an accurate reflection of the care the resident received. 2. Resident #9 was admitted to the facility on [DATE] with diagnoses which included diabetes and long-term use of insulin. Resident #9 had a physician order dated 10/28/25 for insulin glargine (long-acting insulin) to inject 80 units subcutaneously (under the skin) at bedtime for diabetes. Review of the Medication Administration Record (MAR) for January 2026 revealed Resident #9 received the insulin glargine as ordered. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #9 was not (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coded for the use of a hypoglycemic medication which included insulin. An interview was conducted on 4/22/26 at 9:41 am with the MDS Nurse who revealed she would review physician orders and the MAR to complete the medication portion of the MDS assessment. The MDS Nurse stated she just miscoded Resident #9's quarterly assessment for insulin use. The Administrator was interviewed on 4/22/26 at 2:51 pm. The Administrator stated the MDS Nurse was responsible for coding Resident #9's assessment correctly to be an accurate reflection of the care the resident received. 3. Resident #29 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, heart disease, and diabetes. A Physician's order dated 03/03/26 stated to continue hospice services in the long-term care facility. A hospice care plan was initiated on 03/03/26 and included the following interventions spiritual care consult, notify Physician of significant changes, and provide medication per Physician orders. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #29 was coded as not receiving hospice care while a Resident at the facility. An interview was completed on 04/22/26 at 12:34pm with the MDS Nurse. The MDS Nurse stated she mistakenly coded Resident #29 as not receiving hospice care while a resident on the 03/06/26 MDS assessment. The MDS Nurse verified Resident #29 should have been coded as receiving hospice care while a resident. An interview was completed on 04/22/26 at 3:03pm with the facility's Administrator. The Administrator stated the Resident's MDS should be an accurate reflection of the Resident when the assessment was completed.

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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. Based on observation, record review, and staff interviews, the facility failed to implement their infection prevention program policies and procedures when Nurse Aide (NA) #3 failed to apply personal protective equipment (PPE) when activities of daily living (ADL) care was performed for a resident on Enhanced Barrier Precautions (EBP). This deficient practice was for 1 of 3 staff members observed for infection control practices (NA #3).The findings included:The facility's Infection Prevention and Control Program (IPCP) last revised April 2023 stated that the IPCP was designated to establish and maintain an effective program that provided a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The facility's Enhanced Barrier Precautions (EBP) policy last revised 4/01/23 read in part that EBP was utilized in conjunction with standard precautions when performing high-contact resident care activities and included the use of both gowns and gloves. The policy noted in part that EBP applied to all residents with an indwelling medical device, such as an indwelling catheter. The policy further noted that resident care activities that were considered high-contact included dressing and transferring.An observation on 4/21/26 at 10:04 am revealed Resident #2 had signage posted at the entrance of the room that alerted staff that the resident was on enhanced barrier precautions. The signage noted that providers and staff must wear gloves and a gown for the following high-contact resident care activities which included dressing. A supply holder was observed hung on the door and was stocked with PPE, which included disposable gowns and disposable gloves.A continuous observation of resident care for Resident #2 was conducted on 4/21/26 at 10:05 am through 10:12 am with NA #3. NA #3 was observed to have gloves on and put Resident #2's shirt and pants on while the resident was on the bed. NA #3 then assisted Resident #2 to turn onto the left side and she pulled the shirt down to cover the resident's back and pulled the resident's pants up. The NA then assisted the resident to turn onto the right side and completed dressing Resident #2. NA #3 then had Resident #2 turn onto his back and then straightened the shirt and pants and moved the indwelling urinary catheter bag onto the bed in between the resident's legs without a disposable gown in place. NA #3 was then observed to remove the disposable gloves and perform hand hygiene with hand sanitizer. NA #3 failed to wear a gown during the resident care observation. An immediate interview was conducted with NA #3 on 4/21/26 at 10:12 am. NA #3 stated she was not aware she needed to wear a gown when she provided the care to Resident #2. NA #3 confirmed the signage and PPE supplies were present at the entrance of Resident #2's room but she stated she had not read the sign before she provided the care. The Infection Preventionist (IP) was interviewed on 4/22/26 at 1:29 pm. The IP stated that NA #3 was required to wear a gown and gloves when she provided care to Resident #2 related to the indwelling urinary catheter. The IP stated that all staff had received education regarding EBP and the use of PPE when providing specific care duties. The IP further stated that each resident who was on EBP had the signage and PPE supplies on the door that provided information about the requirement for gown and glove use when providing specific resident care. An interview was conducted on Director of Nursing (DON) on 4/22/26 at 2:43 pm. The DON stated that all staff had been educated regarding EBP and the use of PPE when resident care was provided. The DON stated NA #3 should have worn a gown when she provided care to Resident #2. During an interview with the Administrator on 4/22/26 at 2:52 pm she revealed EBP education was provided to all staff and the EBP signage was posted for Resident #2. The Administrator stated NA #3 should have worn the required PPE when she provided care to Resident #2.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, record reviews, and staff interviews, the facility failed to post an updated daily nurse staffing sheet for residents and visitors for 1 of 4 days during the survey period (4/19/26).The findings included:On 4/19/26 (Sunday), during the initial tour of the facility at 9:40 AM the daily nurse staffing sheet posted near the facility entrance was dated 4/16/26 (Thursday). The daily nurse staffing sheet was not updated to reflect the current date, census, and staffing information.During an interview on 4/19/26 at 10:15 AM, Nurse #1 stated the Scheduler prepared the daily nurse staffing sheets and placed them in a binder on Fridays at the nurses' station for nurses to update and post on the weekends. Nurse #1 indicated she worked on 4/18/26 (Saturday) and the day of the interview (4/19/26) and had not noticed the daily nurse staffing sheet posted near the facility entrance had not been updated since 4/16/26.During an interview with the Scheduler on 4/19/26 at 2:01 PM, the Scheduler confirmed she completed and posted the daily nurse staffing sheets. The Scheduler explained she had last worked on Thursday (4/16/26) and had given the completed daily nurse staffing sheets for 4/17/26, 4/18/26, and 4/19/26 to the Assistant Director of Nursing before leaving work. The Scheduler further stated the facility nurses usually ensured the daily nurse staffing sheet was current and updated to reflect the actual staff working in the facility.During an interview with the Assistant Director of Nursing (ADON) on 4/19/26 at 2:33 PM. The ADON stated the Scheduler had given her the daily nurse staffing sheets for 4/17/26, 4/18/26, and 4/19/26 on 4/16/26. The ADON stated that she placed the daily nursing staffing sheets in the green staffing binder that was kept at the nurse's station. The ADON stated the nurses usually ensured the daily nurse staffing was current and updated. She did not know what happened to the documents that she had placed in the binder.During an interview with the Director of Nursing (DON) on 4/19/26 at 11:24 AM, the DON stated facility charge nurse was responsible for ensuring that the daily nurse staffing sheets were posted. The DON verified that Nurse #1 was the charge nurse that weekend and would have been responsible for updating and posting the staffing sheets. During an interview on 4/19/25 at 3:37 PM, the Administrator stated that it was the Scheduler's responsibility to complete the daily nurse staffing sheet Monday through Friday. The Administrator stated nurses were responsible for posting the daily nurse staffing sheets on weekends. The Administrator stated the charge nurse should have updated the daily nurse staffing sheet to reflect the current date, current census and staffing information and posted the document so it clearly visible to residents and visitors.