

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2024
NAME OF PROVIDER OR SUPPLIER Tsali Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Echota Church Road Cherokee, NC 28719	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40542</p> <p>Based on observations, interviews, and review of facility Resident's Rights document, the facility failed to ensure the resident's dignity was maintained during medication administration for one (1) of two (2) residents reviewed (Resident #8). Additionally, the facility failed to ensure staff did not call out from across the room to prompt/encourage residents to eat for four (4) of nine (9) sampled residents (Resident #s 2, 3, 4, and 8); and did not engage in personal conversation or discuss another resident, while assisting Resident #5 with her meal.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Resident #5 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's and non-traumatic brain dysfunction. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident's cognition was severely impaired. <p>During an observation on [DATE] at 12:27 PM, Certified Nursing Assistant (CNA) #1 assisted Resident #5 with lunch and simultaneously discussed funeral arrangements for Resident #1 (who had expired on the Memory Care unit the preceding Saturday) with Registered Nurse (RN) #1 and the Activity Assistant (AA). CNA #1 placed the fork with food up to Resident #5's mouth, then inquired to RN #1 and the AA, Does anyone know anything about the arrangements for (stated resident's first name). It is sad. I miss her. She was here a long time. RN #1 responded, We should get something soon. The AA added to the conversation with . My husband is doing better . etc. The conversations were loud enough to have been heard from the room's entry doorway. Resident #s 2, 3, 4, 6, 7, 8, 9, and 11 were present in the room but were not engaged in the conversation.</p> <p>During an interview on [DATE] at 12:28 PM, RN #1 confirmed Resident #1 had passed away earlier; and had interacted with the other residents in the Memory Care unit.</p> <ol style="list-style-type: none"> Resident #4 was admitted to the facility on [DATE] with diagnoses that included Parkinsons and cognitive deficient. Review of the MDS dated [DATE] revealed the resident's cognition was severely impaired. Resident #2 was admitted to the facility on [DATE] with diagnoses that included non-traumatic brain dysfunction and insomnia. Review of the MDS dated [DATE] revealed the resident's cognition was severely impaired. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Resident #3 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's and insomnia. Review of the MDS dated [DATE] revealed the resident's cognition was severely impaired.</p> <p>During an observation [DATE] at 12:30 PM, RN #1, was seated behind the nurse's desk, which was approximately 15 feet away, when she called out to prompt/encourage Resident #4 to Pick up your fork and eat. RN #1, while seated behind the nurse desk and within a ,d+[DATE]-minute observation window, also called out to prompt/encourage Resident #s 2 and 3 to Pick up your fork and eat.</p> <p>5. Resident #8 was admitted to the facility on [DATE] with diagnoses that included oropharyngeal phase (voluntary movement of the bolus from the oral cavity into the oropharynx), type 2 diabetes mellites, and dementia. Review of the MDS dated [DATE] revealed the resident's cognition was severely impaired.</p> <p>During an observation on [DATE] at 12:45 PM, CNA #1 called out to Resident #s 4 and 8, who were approximately 8 feet away, to Wake up and eat, while she assisted Resident #5. CNA #1 confirmed Resident #8 could talk and was able to make her wishes known.</p> <p>During a medication administration observation on [DATE] at 11:30 AM, Resident #8 was seated in the Memory Care Unit's dining room, when RN #1 instructed the resident to lift her shirt. RN #1 simultaneously pulled down the top of Resident #8 pant, exposed her left abdomen, and administered an insulin injection. RN #1 did not provide privacy, which resulted in Resident #8's exposure and visibility to Resident #s 2, 3, 4, 5, 6, 7, 8, 9, and 11, Licensed Practical Nurse (LPN) #1, CNA #2, and the AA-all were present in the Memory Care Unit's dining room</p> <p>During an interview on [DATE] at 12:15 PM, CNA #1 confirmed she had engaged in discussions with her co-workers about a deceased resident's arrangements and unrelated family matters, while she assisted Resident #5 with her lunch. CNA #1 stated, I reminded Resident #s 8 and 4, to wake up and eat, but should have finished with Resident #5 or gone over to each of them, get down to their level-face to face-to encourage them to eat.</p> <p>During an interview on [DATE] at 01:00 PM, RN #1 confirmed she had engaged in conversation with her co-workers about a recently deceased resident's arrangements, while the residents ate lunch. RN #1 stated. We probably should not have discussed another resident or personal family matters in front of or over other residents. Also, I should not have called out Resident #s 2, 3 and 4 to 'pick up their forks and eat,' from behind the nurse's desk. I should have gone over, assisted and encouraged each of them to eat.</p> <p>During an interview with the Director of Nursing (DON), Corporate Clinical Nurse, and the Administrator, on [DATE] at 01:50 PM, the DON stated, Staff is expected to treat the residents with dignity and respect and to ensure the resident's privacy when administering an injection. The nurse should have taken the resident to a private location before exposing the resident's abdomen. It is also the expectation that staff not discuss their private business or another resident's (present or not) business, in the presence of other residents.</p> <p>Review of the facility's Resident Rights document revealed, The facility will protect and promote your rights to . Be treated with consideration, respect, and dignity, recognizing each resident's individuality.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40542</p> <p>Based on observations, interviews and review of the facility's policies, titled Handwashing and Hand Hygiene and Cleaning of Glucometer, the facility failed to ensure staff cleaned and disinfected the glucometers prior to use for two (2) of two (2) residents observed (Resident #s 3 and 8). The facility also failed to ensure staff washed/sanitized their hands between direct contact with four (4) of nine (9) sampled residents (Resident # 2, 3, 4, and 5), and assisted residents with hand hygiene before and after the meal for nine (9) of nine (9) residents in the Memory Care Unit's dining room, (Resident #s 2, 3, 4, 5, 6, 7, 8, 9 and 11).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #5 was admitted on [DATE] with diagnoses that included Alzheimer's and non-traumatic brain dysfunction. Review of the MDS dated [DATE] revealed Resident #5's cognition was severely impaired, and the resident was fully dependent on staff for personal hygiene . Including washing/drying face and hands . 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included Parkinsons and cognitive deficiency. Review of the MDS dated [DATE] revealed Resident #4's cognition was severely impaired, and the resident was fully dependent on staff for personal hygiene . Including washing/drying face and hands . 3. Resident #3 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #3's cognition was severely impaired, and the resident required partial/moderate assistance from staff for personal hygiene, Including washing/drying face and hands . 4. Resident #2 was admitted to the facility on [DATE] with diagnoses that included non-traumatic brain dysfunction. Review of the MDS dated [DATE] revealed Resident #2's cognition was severely impaired, and the resident required substantial/maximum assistance from staff for personal hygiene . Including washing/drying face and hands . <p>During an observation on 04/15/24 at 12:30 PM, Certified Nursing Assistant (CNA) #1 did not wash or sanitize her hands between direct contact with Resident #s 5 and 4. Specifically, CNA #1 paused with feeding Resident #5 to attend to and reposition Resident #4's in her chair.</p> <p>On 04/15/24 at 12:35 PM, RN #1 donned gloves and assisted Resident #3. When finished RN #1 picked up a napkin from the floor, wrapped it inside and removed the contaminated glove from her right hand. RN #1 did not wash or sanitize her hands before she immediately turned and repositioned Resident #2's glass, by the rim, with the ungloved right hand.</p> <p>During the lunch meal observation in the Memory Care Unit's dining room, on 04/15/24 from 12:30 PM to 01:00 PM, CNA #1, RN #1, and the AA were not observed to have assisted Resident #s 2, 3, 4, 5, 6, 7, 8, 9 and 11 with hand hygiene before or after the meal.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Handwashing and Hand Hygiene revealed, . TCC considers hand hygiene the primary means to prevent the spread of infections . Employees must perform appropriate handwashing/hand hygiene . Before and after direct contact with residents . assisting resident with meals . before applying non-sterile gloves . after removing gloves . and change gloves between patient contacts.</p> <p>5. Resident #8 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellites and dementia. Review of the MDS dated [DATE] revealed Resident #8's cognition was severely impaired, and the resident was fully dependent on staff for personal hygiene . Including washing/drying face and hands .</p> <p>During an observation and interview on 04/16/24 at 11:30 AM and 11:40 AM, Registered Nurse (RN) #1 did not clean or disinfect Resident #s 8 or 3's individual glucometers, prior to performing both resident's blood glucose tests with their respective devices. RN #1 confirmed she had not cleaned either of the monitors prior to use. She stated, This is the way we have always done it. It makes sense that it should be cleaned before and after use, because we can't be sure the person that last used it cleaned it. We will do better.</p> <p>During an interview on 04/16/224 at 1:35 PM, the Infection Control Preventionist (ICP) confirmed, staff is expected to follow the policy for cleaning of glucometer, which provides for cleaning and disinfecting the resident's glucometer before and after each use. The ICP stated, Although residents do not share glucometers, staff is expected to clean and disinfect the glucometer before and after each use, no exception. The ICP also confirmed that staff were trained to always assist the residents with hand hygiene before meals and to wash/sanitize their hands between resident contact, before and after putting on and removing gloves.</p> <p>Review of the facility's Cleaning of Glucometer policy dated 11/29/17, revealed It is the policy . to clean and maintain glucometers in a safe and sanitary manner that prevents cross contamination . The glucometer must be cleaned before and after each use .</p>		