STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345475	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TSALI CARE CENTER	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.

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and the facility policy titled, Transfers and Discharges, the facility failed to notify the Ombudsman of transfers to the emergency department for one (1) of one (1) resident (Resident #45). The findings include: Resident #45 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was transferred out of the facility to the emergency department on 06/08/2020, 07/09/2020 and 07/31/2020. There was no documentation in the medical record that reflected the Ombudsman was notified of the transfers. During an interview on 08/28/2020 at 9:48 a.m., the Administrator confirmed there was no documentation that supported the Ombudsman was notified of Resident #45's transfer to the emergency department as aforementioned. The Administrator stated a notice for each resident is sent at the time of the transfer via email, but she was unable to locate the notifications for Resident #45 related to the June and July 2020 hospital transfers. Review of the facility policy, Transfers and Discharges, revised 08/20/20, did not include a provision for contacting the Ombudsman when residents were transferred out of the facility related to an urgent medical need.
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** Based on resident interview, staff interview, record review and review of the facility policy entitled Comprehensive Care Plans, the facility failed to invite residents to participate in the care plan meeting or to have a note in the medical record indicating why it was not practicable for the resident to participate in the care plan meeting for two (2) of eleven (11) residents interviewed (Resident #s 23, 13). The facility also failed to have evidence that a member of the food and nutrition services staff, a Registered Nurse and Certified Nursing Assistant with responsibility for the resident, participated in the development, review and revision of the care plan for two (2) of eleven (11) residents interviewed (Resident #s 23, 13). The findings include: Resident #23 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum (MDS) data set [DATE] revealed Resident #23 was cognitively intact. During an interview with Resident #23 on 08/25/2020 at 10:59 a.m., he stated that he used to be invited to care plan meetings but he missed one that had been at 9:00 a.m. and missed the last one because he wasn't invited and didn't know when it was being held. He indicated he would like to attend his care plan meeting. Review of the Care Plan Attendance Record for Resident #23 dated 05/26/2020 revealed the resident signature line was blank. The following members of the Interdisciplinary Team (IDT) signed the attendance form: Minimum Data Set Coordinator #1 (MDS Coordinator #1), the Activities Coordinator, a Physical Therapy Assistant, two Social Workers, the Wound Care Nurse and the Nurse Practitioner. Further review of the form revealed there was no evidence indicating a member of the food and nutrition services staff attended or that a Nurse and Certified Nursing Assistant with responsibility for the resident attended. Review of the Care Plan Attendance Form for Resident #23 dated 08/18/2020 revealed Resident Invited to CP (Care Plan) meeting and Resident Attended CP Meeting were both checked No. RP (Responsible Party) Invited to CP Meeting and RP Attended CP Meeting were both checked No. In addition the following members of the Interdisciplinary Team (IDT) signed the attendance form: MDS Coordinator #1, a Physical Therapist, a Physical Therapy Assistant, two Social Workers and the Nurse Practitioner. Further review of the form revealed there was no evidence indicating a member of the food and nutrition services staff attended or that a Nurse and Certified Nursing Assistant with responsibility for the resident attended. Review of the IDT meeting plan of care notes for Resident #23 dated 05/26/2020 and 08/18/2020, written by MDS Coordinator #1, revealed there was no documentation indicating a rationale for not inviting Resident #23 to the care plan meeting. Further review of the plan of care note and progress notes revealed there were no notes from food and nutrition services staff or a Nurse with responsibility for the resident indicating they participated in developing the plan of care with the resident and responsible party. In addition there was no evidence that a Certified Nursing Assistant with responsibility for the resident had been involved in care planning for Resident #23. Review of care plan meeting invitation letters provided by MDS Coordinator #1 revealed letters regarding the 05/26/2020 and 08/18/2020 care plan meetings for Resident #23. Further review of the letters revealed that although the letters were To (name of resident) and Family the body of the letter was written as an invitation to family, not an invitation to the resident. It read The development of the best possible care plan for your loved one can only be achieved with your involvement in this process The meetings are held between 9:00 AM and 12 PM Please call to schedule a time that is convenient for you. Review of the admission face sheet for Resident #23 dated 08/28/2020 revealed that Resident #23 was his own responsible party. Resident #13 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment revealed Resident #13 was moderately cognitively impaired but able to make himself understood, could understand others and had no behaviors, disorganized thinking or inattention. During an interview with Resident #13 on 08/23/2020 he stated that he had not been invited to a care plan meeting. Review of the Care Plan Attendance Form for Resident #13 dated 06/30/2020 revealed Resident Invited to CP (Care Plan) meeting and Resident Attended CP Meeting were both checked No. RP (Responsible Party) Invited to CP Meeting and RP Attended CP Meeting were both checked Yes. In addition the following members of the Interdisciplinary Team (IDT) signed the attendance form: Minimum Data Set Coordinator #1 (MDS Coordinator #1), a Physical Therapist, a Physical Therapy Assistant, the Activities Coordinator, two Social Workers and the Nurse Practitioner. Further review of the form revealed there was no evidence indicating a member of the food and nutrition services staff attended or that a Nurse and Certified Nursing Assistant with responsibility for the resident attended. Review of the IDT meeting plan of care note for Resident #13 dated 06/30/2020, written by MDS Coordinator #1, revealed there was no documentation indicating a rationale for not inviting Resident #13 to the care plan meeting. Further review of the plan of care note and progress notes revealed there were no notes from food and nutrition services staff or a Nurse with responsibility for the resident indicating they participated in developing the plan of care with the resident and responsible party. In addition there was no evidence that a Certified Nursing Assistant with responsibility for the resident had been involved in care planning for Resident #13. During an interview with MDS Coordinator #1 on 08/27/2020 at 4:00 p.m., she stated that prior to COVID-19 they used to invite residents to care plan meetings but due to COVID-19 they no longer invited the resident to attend the meeting, since the conference room was small and they didn't want the resident to be crowded in the room with the IDT Members that attended. Instead of inviting residents to care plan meetings she said she met separately with the resident before the meeting to discuss any concerns and then reported back to the resident after the care plan meeting but did not document this anywhere. MDS Coordinator #1 acknowledged that a member of food and nutrition services staff had not been attending the care plan meetings routinely, although she had sent the meeting schedule to the Food Services Manager

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

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.

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) monthly. MDS Coordinator #1 also said that CNA's often could not attend care plan meetings because the staffing did not allow them to attend. She stated she typically asked the CNA for input on the day of the care plan meetings but had not documented this anywhere. During an interview with the Food Services Manager on 08/28/2020 at 10:15 a.m., she stated that she had not been able to attend care plan meetings because the day for care plan meetings had been changed to fit the schedule of the Nurse Practitioner. The care plan meeting day now conflicted with the day the Food Services Manager submitted the food service order. The Food Services Manager added that she was training someone else to do the food order so she could attend care plan meetings in future. During an interview with the Administrator on 08/28/2020 at 10:35 a.m., she indicated she was unaware residents were no longer being invited to care plan meetings due to COVID-19. She also confirmed it would be possible to conduct care plan meetings in the day room which was a larger space and could accommodate social distancing for any residents who wanted to attend their own care plan meeting. The Administrator also acknowledged that just because a resident had a Power of Attorney for Health Care Decisions or an RP this wasn't sufficient reason to exclude them from attending their own care plan meeting. Review of the undated facility policy entitled, Comprehensive Care Plans revealed the policy did not require a member of the food and nutrition services staff, as well as a a Nurse and CNA with responsibility for the resident to participate in care planning; as required by the regulation. The policy read: The comprehensive care plan is prepared by an interdisciplinary team (IT), including the attending physician, a registered nurse, and other appropriate staff in disciplines as required by the resident's needs. The policy also read: The development of the comprehensive care plan involves the participation of the resident and his or her family or legal representative.
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.** Based on observation, staff interview and review of the facility document entitled, Equipment Care and Storage, the facility failed to ensure a fan actively blowing in the dish washing area was clean and free from debris for one (1) of one (1) random observations in the kitchen; and failed to ensure kitchen service items were air dried after washing, and not dried with a dishtowel, for one (1) of one (1) random observations in the kitchen. The findings include: 1. On 08/24/2020 at 4:38 p.m., Cook Supervisor #1 was observed at the sink in the dishwashing area with the water running. A medium size (approximately 20 inches by 20 inches) portable, non-oscillating box fan was sitting to her right on the counter top beside the sink. The fan was turned on and blowing strait out across the dishwashing area towards the dirty dishes side of the dishwasher. It was plugged into an outlet behind the reach in refrigerator, which was on the back side of the wall that the sink was on. Upon inquiry Cook Supervisor #1 stated that the fan should not be on the countertop as it was a safety hazard. She then lowered the fan to the floor. The fan was observed to be visibly dirty with greasy, dusty looking brown and black buildup throughout the front and back gills of the fan cage. In addition, small hair like fibers were visible within the debris and inside the fan cage the base of the unit was completely covered by brown debris. Photographs of the fan were obtained. No active dishwashing was occurring during this observation and no clean dishes were observed waiting to be put away. There were (3) plate covers stacked up on several dishwashing racks that were directly in front of the fan and three cups on the dirty side of the dishwasher. During an interview with Cook Supervisor #1 on 08/24/2020 at 4:40 p.m., she confirmed that the fan was visibly dirty and needed to be cleaned said they she just hadn't gotten around to doing it. Upon inquiry, she stated that the plate covers in front of the fan were still dirty and waiting to be washed. Cook Supervisor #1 indicated that the fan had been on because the kitchen was too warm and air movement was needed to make the area tolerable to work in. Review of the undated facility policy entitled, Equipment Care and Storage revealed, Keep all work areas, the floor and dietary equipment as clean as possible throughout the work day. 2. On 08/27/2020 at 11:31 a.m., Dietary Aide #1 was observed using a towel to dry a food processor bowl and a food processor blade. She then placed these items on a cart with other already dry kitchen service items including five (5) measuring cups, a large knife and a large spoon. During an interview with Dietary Aide #1 on 08/27/2020 at 11:32a.m., she stated that she was aware that she should not be drying kitchen service items with a towel and that she should let them air dry. She added that she normally put kitchen items on a rack to air dry but she had some extra time and decided to use a towel to dry the last few items, so she could put them away and save time later. Upon inquiry Dietary Aide #1 acknowledged she had used the same dishtowel to dry all the kitchen service items observed on the cart. During an interview with the Food Services Manager on 08/27/2020 at 11:31 a.m., she confirmed that kitchen service items were supposed to be air dried and should not be towel dried according to the regulatory requirements. The Food Services Manager stated that she had purchased antimicrobial disposable towels as she thought would be acceptable for the staff to use, if needed, and indicated Dietary Aide #1 had been using one of the antimicrobial towels when drying the observed kitchen service items. The Food Services Manager added that she would have the towel dried items re-run through the dishwasher and air dried. During an interview with the Administrator on 08/28/2020 at 10:35 a.m., the Administrator indicated she expected the staff in the kitchen to air dry all dishware and kitchen service items.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and review of the facility policy entitled Coronavirus Disease 2019 (COVID-19) Plan and Protocols, the facility failed to ensure residents practiced social distancing and wore facial covering over their mouth and nose when in close proximity for two (2) of two (2) residents in the dayroom (Residents #s 24, 34). The facility also failed to ensure that two (2) of two (2) kitchen staff wore their facial covering over their mouth and nose while working in the kitchen, and performed hand hygiene, after touching their facial covering during two (2) random observations. The failures occurred during a COVID-19 pandemic. The findings include: 1. During an observation on 08/27/2020 at 10:01 a.m., Resident #s 24 and 34 were putting a puzzle together at the same table in the dayroom. The residents were close enough to touch each other. Licensed Practical Nurse (LPN) #1 was present during the observation. At 10:02 a.m., LPN #1 stated, Ladies are you okay? and exited the dayroom. Both residents continued in close proximity and were observed leaning forward toward each other, chatting and laughing. At 10:11 a.m., LPN #1 reentered the dayroom and confirmed that she was aware of the current COVID-19 pandemic. She confirmed Resident #s 24 and 34 were not [MEDICATION NAME] social distancing, nose and mouth were uncovered. LPN #1 stated she was aware of the aforementioned concerns when she exited the dayroom. She confirmed both residents get around the facility independently. During an interview on 08/27/2020 at 10:45 a.m., the Director of Nursing (DON) stated staff were expected to monitor residents as they departed from their rooms in the morning, in the hallways, and throughout the facility for adherence with social distancing and facial mask. At 11:15 a.m., the DON stated she expected the staff to remind and encourage residents observed not [MEDICATION NAME] social distancing or wearing facial masks, to do so. 2. During an observation on 08/24/2020 at 4:20 p.m., Cook #1 and Cook Supervisor #1 were both observed wearing their cloth face coverings under their chin with their mouth and nose exposed. Cook #1 was standing at the counter in the food preparation area where the ingredients for making sandwiches for residents were laid out. Cook Supervisor #1 was mopping the floor on the other side of the room and was greater than 6 feet from Cook #1 at this time. Upon being observed both Cook #1 and Cook Supervisor #1 pulled their cloth face coverings up over their mouth and nose. They did not perform hand hygiene after touching their masks. During an interview on 08/24/2020 at 4:40 p.m., Cook #1 acknowledged that both she and Cook Supervisor #1 had not been wearing their cloth face coverings, when observed upon entry into the kitchen. She stated that she was aware she should be wearing her mask at all times but it was so warm in the kitchen. She said she didn't think the air conditioning was working so she felt like she needed to take her mask off. The thermostat in the kitchen read 76 degrees Fahrenheit (F) at this time. On 08/26/2020 at 5:20 p.m., Cook #1 and Cook Supervisor #1 were both observed wearing their cloth face coverings under their chin with their mouth and nose exposed. They were standing on either side of the steam table, directly in front of each other and approximately three to four (3-4) feet apart. They were serving food for residents on the tray line during this observation. Upon being observed both Cook #1 and Cook Supervisor #1 pulled their cloth face coverings up over their mouth and nose. They did not perform hand hygiene after touching their masks. During an interview on 08/26/2020 at 5:52 a.m., Cook Supervisor #1 acknowledged that both she and Cook #1 had not been wearing their cloth face coverings when observed upon entry into the kitchen. She said that she had pulled her mask down to her chin

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) because it was so hot in the kitchen especially when working at the steam table. The thermostat in the kitchen read 79 degrees F at this time. During an interview on 08/27/2020 at 10:30 a.m., the Infection Preventionist stated that she had confirmed with the facility Medical Director that kitchen staff should wear a cloth face covering or surgical mask while working even though they were not interacting directly with residents. Review of the facility policy entitled, Coronavirus Disease 2019 (COVID-19) Plan and Protocols, Revised 8/27/20, revealed the following under the heading Screen Facility Entrants, Including All Staff: Anyone who enters the facility will be required to wear a facemask.