STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Compass Healthcare and Rehab Hawfields, Inc	2502 S NC 119 Mebane, NC 27302

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on record review, resident and staff interviews, the facility failed to treat a resident with dignity and respect when a nurse aide was witnessed yelling at a resident during an interaction in the resident's room for 1 of 4 residents reviewed for dignity (Resident #75). A reasonable person expects to be treated with respect and dignity by their caregivers in their home environment. Findings included: Resident #75 was admitted on [DATE]. Review of Resident 75's quarterly Minimum Data Set 3/26/24 revealed Resident #75 was cognitively intact. Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident # 75 was involved in an altercation with Nurse Aide #1 on 3/27/24 in which Therapy Assistant #1 heard Nurse Aide #1 shouting at Resident #75 but unable to determine the exact words spoken at that time. Review of the facility provided schedules revealed Nurse #1 was assigned as the hall nurse the day of the incident and Nurse Aide #2 was assigned to Resident #75 on the day of the incident. Nurse Aide #2 was assigned to Resident #75's hall but on another assignment. An interview with Resident #75 was completed on 10/8/24 at 9:23 AM. Resident #75 had no recollection of the event and stated she felt safe at the facility. Resident #75 did not report any issues or concerns at that time An interview with Nurse Aide #1 was conducted on 10/9/24 at 12:21 PM revealed she worked on first shift on 3/27/24 but was not assigned to Resident #75. She further revealed that she recalled during first shift on 3/27/24 that she heard Resident #75 hollering, so she went in to see why Resident #75 was hollering and if she needed anything. Resident #75 voiced that she just wanted someone to sit with her and she tried to explain that she had other residents that needed care, but she would come back, and Resident #75 continued to holler out. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Therapy Assistant #1 on 10/9/24 at 12:25 PM revealed she was working on the first shift on 3/27/24 with another resident across the hall from Resident #75's room when she overheard Nurse Aide #1 yelling at Resident #75. She further revealed that she was not able to determine the words that were spoken by Nurse Aide #1 but felt that the level of Nurse Aide #1's voice was not respectful. An attempt was made to reach Nurse # 1 by telephone however the facility was not able to provide a working telephone number. An interview with the Unit Manager #1 on 10/10/24 at 9:14am revealed she worked the day of the incident and Resident #75 reported to her around shift change that Nurse Aide #1 told Resident #75 to shut up. She further revealed that when she interviewed Therapy Assistant #1, she was informed that Nurse Aide #1 was yelling at Resident #75 who was working in a room across the hall. An interview with Nurse Aide #2 on 10/10/24 at 9:48 AM revealed she did recall this incident. An interview with the Administrator on 10/10/24 at 11:40 AM revealed that the investigation revealed Nurse Aide #1 spoke to Resident #75 in a tone that was not acceptable or respectful and therefore Nurse Aide #1 was terminated. He further revealed that all residents should be treated with dignity and respect.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on observations, staff interviews and record reviews, the facility failed to apply signage indicating the use of oxygen outside residents' rooms with supplemental oxygen for 1 of 2 residents reviewed for respiratory care (Resident # 79). The findings included: Resident # 79 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. A physician's order for Resident # 69 dated 9/20/24 read oxygen at 3 liters per minute via nasal canula continuously. Review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident # 79 was cognitively intact and coded for the use of oxygen. During an observation on 10/7/24 at 2:38 PM of Resident #79's room, there was no signage for oxygen use found anywhere near Resident # 79's room entrance. Resident #79 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 79's room. During an observation on 10/10/24 at 8:37 AM there was no signage for oxygen use found anywhere near the entrance of Resident # 79's room. Resident #79 was observed wearing oxygen via nasal cannula at 3 liters per minute (LPM). The oxygen concentrator was observed in Resident # 79's room. During an interview with Nurse #2 on 10/10/24 at 08:40 AM she stated that Resident #79 received oxygen continuously and nursing staff made sure oxygen was applied to Resident #79 and he was monitored. Nurse #2 further revealed that she did not know for sure why Resident #79 was missing the signage, but it should have been posted outside his door. An interview occurred on 10/10/24 at 08:44 with the Director of Nursing (DON). She stated it was the nursing staff's responsibility to put up the oxygen in use sign on the resident's door and if the signage is missing the nurse should have it replaced. An interview on 10/10/24 at 1:37 PM occurred with the Administrator. The Administrator indicated that Resident #79 should have had signage posted outside the room to indicate the use of oxygen.

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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** 38077 Based on observations, and staff interviews, the facility failed to store food in the walk-in freezer not open to air and without freezer burn. The facility failed to discard foods past their use-by date, failed to label and date food placed in the nourishment refrigerator in 1 of 2 nourishment refrigerator/freezers reviewed for food storage (E/F hallway). The facility also failed to hold cold foods in a safe temperature range during tray line observation. These practices had the potential to affect food being served to the residents. Findings included: An observation of the walk-in freezer on [DATE] from at 9:30 AM to 9:45 AM revealed the following were located on shelves below the compressor: 1 a. An opened brown cardboard box labeled Chicken -10 lbs. that had ice on top of the box. Inside the box was an opened plastic bag containing 7 pieces of breaded chicken tenders with ice on them. There was no label or date on the bag. 1b. An opened brown cardboard labeled Chicken -10 lbs. that had ice on it. Inside the box was an opened plastic bag containing 5 pieces of chicken patties with no label or date on the bag. 1c. An opened white cardboard that had ice on it. Inside the box was an opened plastic bag with no label or date containing 24 Manicotti (type of pasta) with freezer burn. 1d. An opened brown cardboard labeled beef steak fritters - 71 pieces that had ice on top of the box. Inside the box was an opened plastic bag containing approximately 50 portions of meat with ice on plastic bag. The plastic bag was not labeled or dated. 1e. An opened brown box with 2 unopened bags labeled Italian Sauage - 2 lbs. that had ice on the box. The sausages inside the bags had freezer burn with ice crystals on them. 1f. An opened white cardboard box labeled Breaded Cod -10 lbs. that had ice on the box. Inside the box was an opened plastic bag containing 9 pieces of breaded fish that had freezer burn. There was on label or date on the plastic bag. During an interview on [DATE] at 9:45 AM the Dietary Manager indicated the freezer's compressor was having some issues and was repaired recently by maintenance. He stated when the freezer defrosted, it over cooled causing ice on the food placed on the shelves under the compressor and causing food to have freezer burn. He stated the food placed in the freezer should be properly closed and labeled. The Dietary Manager stated that all dietary staff were responsible to check the walk-in freezer temperature and ensure food packages were properly closed, labeled after use and ensure food had no freezer burn. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An observation of the nourishment refrigerator/freezer on the E-F Hallway on [DATE] at 9:58 AM revealed a blue green thermal lunch bag with no name or date in the nourishment refrigerator. The freezer contained a 16-ounce (oz) Styrofoam cup with lid. Inside the cup was frozen pink colored liquid. There was no label or date on the Styrofoam cup. There were four (4) Nutritional supplement ice creams with a use by date of [DATE]. During an interview on [DATE] at 10:00 AM the Dietary Manager stated all food brought in by a resident's family should be labeled and dated by the nursing staff. Employees should not be placing their personal food in the nourishment refrigerator. The Dietary Manager stated he was unsure to whom the insulated lunch bag belonged. to. The Dietary Manager stated all food that had expired should be discarded by the dietary staff when stocking the nourishment refrigerator. The Dietary Manager indicated the Nutritional supplement ice cream were served on the residents' meal tray during meals. The nursing staff may have placed them in the nourishment refrigerator when these were not consumed. During an interview on [DATE] at 10:05 AM Unit Manager #1 stated all resident's food brought in the facility by their family should be labeled by nursing staff prior to be placed in the nourishment refrigerator. The label should have the resident's name and date when the food was placed in the nourishment refrigerator. 3. Tray line observation was made on [DATE] from 11:20 AM - 12:00 Noon. The temperatures of foods on the tray line were taken by the Dietary Cook. Coleslaw was the vegetable option on the menu for the lunch meal. The coleslaw was placed in individual cups and was in an insulated cart near the tray line. The temperature of the coleslaw was taken with a calibrated thermometer, and it read 44 degrees Fahrenheit (F). There were 7 individually wrapped plated containing salad with meat for residents who requested alternate option. The temperature of the salad plate with meat was 49 degrees Fahrenheit (F). The Dietary Manager removed the food from the tray line and placed them in the refrigerator until the internal temperature of these foods reached below 40 degrees F. The food was later placed on the tray line over ice and the Dietary Manager rechecked the temperature of the foods to ensure they were below 40 degrees F. During an interview on [DATE] at 11:50 AM, the Dietary Manager indicated the coleslaw and salads were prepared prior to lunch and were placed in the refrigerator until tray line started. While setting up for the tray line, the dietary aide had placed the individual cups of coleslaw and salad plates in the insulated cart instead of placing them on ice on the table beside the steam table. The insulated cart could not maintain the cold temperature, resulting in the temperature of the food going over the recommended level. The Dietary Manager stated the cook was responsible for checking temperature of food before the food was placed on the steam table for tray line and plated. If the cold foods temperature were not the recommended level of 41 degrees or below, then they should be placed back in the refrigerator until the required temperatures were reached. He stated the cold food should be placed in the cold side of the table with ice to maintain their internal temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:02 PM, the Administrator indicated he was unaware that kitchen freezer was having issue with the compressor. The Administrator stated all dietary staff should ensure all opened boxes and bags were properly closed and opened packages were labeled. He further stated that food served to the residents should be maintained at proper temperatures. The Administrator indicated the dietary staff were responsible for nourishment refrigerator/ freezer. The dietary staff should be checking for any expired food items and cleaning the refrigerator/ freezer when stocking it with snacks and food daily. Nursing staff should be labeling and dating food brought in by families, however the dietary staff should be cross checking to ensure the food was dated, labeled and discarded as needed.