STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345409	A. BUILDING _____ B. WING _____	C 07/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBROKE CENTER	310 E WARDELL DRIVE PEMBROKE, NC 28372

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey and complaint investigation were conducted on 07/17/22 through 07/25/22. The facility was found to be in compliance with CFR §483.73, Emergency Preparedness. Event ID # YJKG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 07/17/22 through 07/25/22. Event ID# YJKG11. The following intakes were investigated: NC00184237, NC00190748, NC00191040, NC00190675, NC00190431, NC00188010, NC00187235, NC00185731, and NC00183648. 20 of the 20 complaint allegations were not substantiated.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights,	F 551		8/4/22

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

Electronically Signed | 08/12/2022

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 551	Continued From page 1	F 551		

except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the

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F 551	Continued From page 2 representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a resident with severe cognitive impairment had documentation in the medical record that designated a resident representative as chosen by the resident to act on their behalf to support the resident in decision-making for 1 of 1 resident (Resident #63) reviewed for resident representative designation. The findings included: Resident #63 was admitted to the facility on 02/10/22. The admission documentation dated 2/10/22 revealed Resident #63's spouse completed the paperwork on behalf of the resident. Review of Resident #63's quarterly Minimum Data Set (MDS) dated 06/17/22 revealed the resident had severe cognitive impairment. Review of Resident #63's medical record revealed Resident #63 and his spouse were both listed as responsible for the billing statement. There was no documentation that indicated who the resident designated as their Responsible Party (RP) and/or their Power of Attorney (POA) for health/financial. In an interview on 07/21/22 at 10:15 AM with the facility's Admission Coordinator (AC) she stated	F 551	F551 Rights Exercised by Representative 1. Resident #63's resident profile, listed in the electronic medical record was updated on 8/4/2022 by Admissions Director, to reflect the Resident□s Representative who signed the Resident Representative Designation Form. In the facility□s electronic medical record (Point Click Care), this is titled under the heading, Responsible Party. 2. All residents have the potential to be affected. On 8/04/2022, 100% of all current residents' medical records were audited by the Admissions Director to ensure a signed Resident Representative Designation Form was completed and accurately reflected in the electronic medical record. All issues identified during the audit were immediately corrected on 8/4/2022. 3. On 8/04/2022, the Regional Director of Business Development completed training with the Admissions Director on appropriately completing the Resident Representative Designation Form and then inputting this information accurately in the resident's medical record. 4. 100% Resident Representative Designation Form medical records audits	

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F 551	Continued From page 3 on admission she was responsible for ensuring a Resident Representative Designation Form was completed to signify who the resident delegated as their representative/responsible party. She revealed this form was not completed for Resident #63 on admission. The AC explained without this documentation she did not have proof to establish legal authority for resident's spouse to act on his behalf. The AC further explained she was new to the facility and could not determine why the Resident Representative Designation form was not completed with supporting documentation attached when the resident was admitted. She indicated she had not previously realized the Resident Representative designation form was not completed or that there was no RP listed for Resident #63 in the medical record. In an interview on 07/21/22 at 10:55 AM with the Director of Nursing (DON), she indicated Resident #63's medical record did not list a RP for Resident #63 and should have. The DON stated Resident #63's medical record indicated both him and his spouse were responsible only for financial billing and the facility did not have any documentation delegating her as the RP or financial /health care power of attorney. However, the facility was still contacting the spouse for decision making needs for the resident as well as any significant changes in condition. In an interview on 07/21/22 at 1:49 PM the Administrator stated he was unaware Resident #63 did not have a RP or health care POA listed in resident's medical record. The Administrator said he expected the Admission Coordinator to ensure all resident medical records include a	F 551	will be completed by Admissions Director and/or Administrator on all new admissions weekly x 12. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The facility Nursing Home Administrator will be responsible for implementation of the plan. 5. Date of Compliance: 08/04/2022.	

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F 551	Continued From page 4 designated RP, with all supporting documentation to establish authority to act and make financial and/or health care decisions.	F 551		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/12/22

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F 584	Continued From page 5 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to repair the damaged drywall that was scratched and peeling off the wall behind the resident's bed, and on the wall in front of the residents bed, and failed to repair paint that was scratched and peeling away from the wall on multiple areas of the adjacent walls in the residents room and failed to provide a homelike environment and remove the TV power cords hanging from the wall in front of the residents bed or provide pictures on the walls in 1 of 1 resident rooms reviewed for homelike environment (Room 201). Findings included: An observation was conducted on 07/17/22 at 1:00 PM of room 201. The drywall on the wall behind the resident's bed was damaged with scratched areas of the drywall that had peeled away from the wall. The wall in front of the residents bed also had damaged scratched drywall with paint peeling off the wall. The remaining walls in the room also had peeling brown paint and scratches throughout the room. The TV power cords were observed hanging high up on the wall directly in front of the resident's bed however there was no TV in the residents room. The walls were bare with no pictures or visual stimulation for the resident. The resident	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. TV provided and mounted as well as pictures hung in room 201 on 7/20/22. Drywall was repaired on 7/20/22 with painting completed on 8/12/22. 2. All residents have the potential to be affected. Maintenance Director completed whole house audit of facility rooms to include which rooms needed TV, TV mounts, damaged walls, peeling paint/paint needed to be repaired on 8/4/2022. TV mounts ordered by Licensed Nursing Home Administrator (LNHA) on 8/8/22. Pictures/decorative items for rooms purchased for facility rooms 7/20/22. 3. Facility wide education initiated on 7/19/2022, regarding Policy "OPS 200 Accommodation of Needs" and "How to create a work order in TELS", with completion date of 8/12/2022. 4. 1 room designated per week for completion of Home-like environment repairs by Maintenance Director. Weekly audit for completion to be conducted by	

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F 584	Continued From page 6	F 584		

was lying in bed with eyes opened and stated she would like to have something to look at.

An interview was conducted on 07/20/22 at 11:45 AM with Nurse #3 the unit manager. She stated room 201 needed the sheetrock repaired and pictures hung on the walls to provide a more stimulating homelike environment for the resident. She stated she would notify the Administrator.

An interview was conducted on 07/20/22 at 11:53 AM with the Administrator. He stated the drywall needed repairing and the entire room needed to be painted once the drywall was repaired. He stated the TV power cords hanging from the wall in front of the resident's bed were for a TV and the resident did not have a TV but stated he could check to see if they had a TV available for her. He stated pictures could be provided to hang on the walls. He stated he would have the Maintenance Director start repairing the damaged drywall immediately.

An interview was conducted on 07/20/22 at 12:14 PM with the Maintenance Director. He stated there was a plan to repair the damaged drywall and paint the resident's room at some point he had just not gotten to it yet. He stated he would start repairing the drywall and get the walls painted. He was observed setting up a TV in the resident's room and hanging pictures on the wall.

An interview was conducted on 07/21/22 at 2:00 PM with the Administrator along with the Director of Nursing (DON). The Administrator stated they had planned to start repairing and painting one resident's room every two weeks but had not started room 201 yet. He agreed the damaged

LHNA and/or designee.

Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

Licensed Nursing Home Administrator will be responsible for the implementation of this plan.

5. Date of compliance: 08/12/2022

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F 584	Continued From page 7 drywall was in disrepair and multiple scratched areas on the walls of the room needed repairing. He stated pictures were hung and a TV was put into room 201.	F 584		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff and resident interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of speech (Resident # 75), dental (Resident #25) and eating (Resident #15) for 3 of 27 residents reviewed for MDS. The findings included: 1. Resident #75 was admitted to the facility on 7/27/21 with expressive aphasia. The annual MDS dated 6/28/22 indicated Resident #75 was cognitively impaired and she had clear speech. The plan of care for Resident #75 with revised date 6/29/22, included the focus area of impaired communication as evidenced by difficulty making self-understood (expressive aphasia). The interventions included: Resident will express needs through nonverbal communication; use short phrases that require yes or no answers. An observation and interview was conducted with Resident #75 on 7/18/22 at 2:15 PM. She was	F 641	F641 Accuracy of Assessments 1. An observation and interview was conducted with resident #75 on 7/18/22 at 2:15 PM. She was only able to communicate with yes and no answers. MDS was corrected on 7/18/22 by MDS Nurse. Resident # 25 had MDS corrected on 7/21/22 by MDS Nurse. Resident #15 had MDS corrected 7/21/22 by MDS Nurse 2. All residents have the potential to be affected. A whole house audit was conducted by MDS Coordinator on 8/4/22 on all residents regarding speech assessments, oral assessments, and dining assessments. All deficiencies corrected on 8/4/2022 3. Education provided to MDS Coordinator by Director of Nursing (DON) regarding accuracy of MDS assessments	8/12/22

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F 641	Continued From page 8	F 641		

only able to communicate with yes and no answers.

An interview was conducted with the MDS Coordinator on 7/20/22 at 1:25 PM. She stated that Resident #75 did not have clear speech. She further stated that it was a coding error on the MDS.

An interview was conducted with the Director of Nursing (DON) on 7/20/22 at 4:50 PM. She stated that she expected the MDS assessments to be coded accurately.

An interview was conducted with the Administrator on 7/21/22 at 2:30 PM. He stated that he expected the MDS assessments to be coded correctly.

2. Resident #25 was admitted to the facility on 12/10/18.

The annual MDS dated 4/25/22 indicated Resident #25 was cognitively intact and did not have any problems with oral dental status.

The plan of care for Resident #25 revised on 4/27/22 included the focus area of exhibits or at risk for oral health or dental care problems related to broken, loose, or carious teeth.

An observation and interview was conducted with Resident #25 on 7/17/22 at 12:57 PM. He stated that he wanted to see a dentist because his teeth were in very bad condition. When Resident #25 opened his mouth the teeth he had left on the bottom were broken and jagged and he had 1 broken tooth on the top of his mouth. He stated that his teeth had been missing and broken for

on 8/4/22 to include accurate coding of speech oral and dining assessments.

4. The Director of Nursing (DON)/Assistant Director of Nursing (ADON) and/or designee will audit MDS assessments for accuracy weekly x4 weeks (starting 8/15/2022), bi-weekly x2 weeks, then monthly x1 month for accuracy of MDS assessments to reflect correct MDS assessments of residents.

Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance.

The facility Director of Nursing will be responsible for implementation of the plan.

5. Date of Compliance: 08/12/2022.

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over a year.

An interview was conducted with the MDS coordinator on 7/20/22 at 1:30 PM. She stated that Resident #25's natural teeth were broken and missing. She stated that it was a coding error on the MDS.

An interview was conducted with DON on 7/20/22 at 4:50 PM. She stated that she expected the MDS assessments to be coded accurately.

An interview was conducted with the Administrator on 7/21/22 at 2:30 PM. He stated that he expected the MDS assessment to be coded correctly.

3. Resident #15 was admitted to the facility on 05/27/20 with diagnoses that included congestive heart failure, acute kidney failure, and liver disease.

Review of an annual MDS assessment dated 04/21/22 revealed he had intact cognition. Coding in Section G of the assessment documented he required supervision with the assist of 2 staff members when eating.

In an interview with the MDS Coordinator on 07/21/22 at 11:45 AM she stated the MDS assessment had been coded incorrectly for eating. She confirmed Resident #15 ate independently with set up only. She explained Section G automatically populated from data entered by the nurse aides, but it was her responsibility to look at the data and ensure it was correct. She indicated she would correct the error by completing an assessment modification.

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F 641	Continued From page 10 In an interview with the DON on 07/21/22 at 2:15 PM she stated she expected the information recorded in the MDS assessment to be accurate. She concluded automatically populated data was to be reviewed by the MDS Coordinator and changed if incorrect.	F 641		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and wound Nurse Practitioner #1 interviews, the facility failed to provide or arrange foot care for a resident with thick and long toenails (Resident #6) for 1 of 1 resident reviewed for foot care. The findings included: Resident #6 was admitted to the facility on 12/07/20 with diagnoses that included diabetes (DM), peripheral vascular disease (PVD), and cerebral vascular accident (CVA). A review of the active physician orders included an order dated 12/07/20 for podiatry services as	F 687	F687 Foot Care 1. Resident #6 was immediately placed on podiatry list for podiatry next visit to facility. Resident #6 was seen by podiatry in-house on 7/25/22. 2. All residents have the potential to be affected. Whole house foot inspection completed by Skin Health Team Lead, RN(SHTL), Nurse Practice Educator, RN (NPE) and/or designee, this was completed 8/10/22, with nail care provided as needed and any residents with a need for podiatry added to podiatry list to be	8/12/22

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F 687	Continued From page 11 needed. A quarterly Minimum Data Set (MDS) assessment dated 07/11/22 revealed the resident had moderate cognitive impairment, and needed supervision with bed mobility, personal hygiene, and bathing. Resident #6's active care plan included a focus area, initiated 07/12/22, revealed resident needed assistance for activities of daily living (ADL) care in bathing, grooming, personal hygiene, and toileting related to limited mobility, right above-the-knee amputation (AKA), and cerebrovascular accident (CVA). On 07/17/22 at 1:15 PM Resident #6 was observed lying in bed with his left foot from under the sheet cover. His left foot toes were observed to have very long, thick, jagged toenails, approximately 0.5 inches long, with blackish/brown colored area on the underside of his left-great-toe. During a skin care observation and interview with the wound treatment nurse and wound Nurse Practitioner (NP #1) on 07/21/22 at 8:10 AM, Resident #6 commented that his left foot toenails needed to be cut because neither himself nor the nurse could do them due to him being diabetic with PVD. The NP #1 stated resident's thick long toenails were too long but wasn't sure if he had been on the list for the podiatrist on 07/18/22 or not. NP #1 checked the 07/18/22 podiatry list and confirmed Resident #6's name was not placed on the list by his nurse but would write an order to have the resident's nurse place his name on the podiatry list to be seen at the next Podiatry visit. NP #1 further explained, he needed podiatry care	F 687	seen per facility protocol. 3. Skin Health Team Lead, RN(SHTL), Nurse Practice Educator, RN (NPE) and/or designee provided education to all RN/LPN/CMA/CNA staff, to include contracted/agency staff regarding Facility's Policies "OPS166 Foot Care" and "NSG239 Toe Nail Trimming". All Education completed by 8/12/22. 4. The facility Skin Health Team Lead (TLSH), Director of Nursing (DON) and/or designee will audit all new admit/readmit within 48 hours of admission to facility per facility policies/procedures for the need of podiatry. Weekly audits of new admit/re-admits beginning 8/15/22 x4 weeks, bi-weekly x4 weeks and monthly x1 month. Results of these audits will be brought before the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Director of Nursing is responsible for implementation of the plan. 5. Date of Compliance: 08/12/22	

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	345409	A. BUILDING _____ B. WING _____	C 07/25/2022

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F 687	Continued From page 12 and would have expected him to be placed on the 07/18/22 list and was not. The Director of Nursing (DON) was interviewed on 07/21/22 at 12:30 PM and stated the podiatrist came to the facility about every 3-months. The list of residents that needed podiatry services were compiled based on nursing staff, physician, and NP reported needs. She was unaware Resident #6 had podiatry needs when the podiatrist was in the facility on 07/18/22. She stated she would have expected Resident #6 to have been placed on the podiatry consult list by his nurse or have been told there was a need for a podiatry visit.	F 687		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		8/12/22

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F 812	Continued From page 13 by: Based on observations, and staff interviews, the facility failed to label and date thickened liquids and discard expired thickened liquids in 1 of 2 reach in refrigerators observed. This had the potential to affect multiple residents. Findings included: The initial tour of the kitchen was conducted on 07/17/22 at 12:30 PM. An observation of the reach in refrigerator revealed two 16-ounce opened containers of thickened sweet tea with lemon with no opened date. The attached manufacturers label instructed to discard 7 days after opening. A 16-ounce opened container of thickened apple juice was observed with no opened date. The attached label instructed to discard 7 days after opening. Two opened containers of thickened dairy drink dated 6/16/22 and 6/27/22 were observed with manufacturer's instructions to discard after 7 days. Three containers of Hydrolyte thickened water with opened dates of 07/01/22, 07/01/22, and 06/01/22 were observed. The manufacturers label instructed to discard 10 days after opening. An interview was conducted on 07/17/22 at 11:45 AM with the weekend Cook. She stated she only worked weekends and had not looked at the dates on the thickened liquids. She stated she was not aware thickened liquids had expiration dates within 7 - 10 days after opening. She discarded the liquids immediately. An interview was conducted on 07/20/22 at 2:15 PM with the Dietary Manager. She indicated she was aware thickened liquids had expiration dates from 7-10 days after opening. She stated they	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary 1. The unlabeled/undated and expired thickened liquids items were discarded immediately by dietary staff on 7/17/2022. 2. Multiple residents have the potential to be affected. Immediately on 7/17/2022, Certified Dietary Manager completed an audit to ensure there were no additional expired items in the kitchen. No addition deficiencies noted. 3. Education provided to Dietary Manager by Licensed Nursing Home Administrator on 7/19/22 on HCSG Policy 018 Food Storage: Dry Goods and HCSG Policy 019 Food Storage: Cold Foods. Education provided to dietary staff by Dietary Manager on HCSG Policy 018 and HCSG Policy 019 on 7/19/22. 4. Refrigerated items to be audited daily x4 weeks (Beginning 8/15/22), then weekly x4 weeks, then bi-weekly x2 weeks by HCSG Dietary Manager and/or designee. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Licensed Nursing Home Administrator will be responsible for the implementation of this plan.	

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F 812	Continued From page 14 should have been removed from the refrigerator once expired. She stated the refrigerators were to be checked for expired foods and drinks daily. An interview was conducted on 07/21/22 at 2:00 PM with the Director of Nursing. She stated she expected all expired foods and liquids to be discarded per the manufacturer's guidelines.	F 812	5. Date of compliance: 08/12/2022	
F 917 SS=B	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3) §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced	F 917		8/12/22

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F 917	Continued From page 15 by: Based on observation, staff interview and resident interview, the facility failed to allow private closet space accessible to residents to get to and reach her/his hanging clothing as well as items from shelves in the closets in 5 out of 14 resident rooms on the 300-hall (Room 303, 305, 307, 311, and 314). Findings included: On 07/17/22 at 1:20 PM, during the observation on 300-hall, there were 5-resident rooms 303, 305, 307, 311, and 314 which all had a dresser and a large cushioned chair pushed up against residents' private closets, blocking resident access, and preventing residents from reaching in and retrieving their hanging clothing as well as items from shelves in the closet. On 07/17/22 at 1:35 PM, during an interview, Resident #46 in room #314 indicated he wanted to get some of his hanging clean clothes out of his closet to wear for the day, but was unable to because nursing staff had blocked his closet with a large dresser and cushioned chair. On 07/19/22 at 8:15 AM, during an interview, the Maintenance Director indicated that nobody reported to maintenance concerning furniture blocking closet access in rooms 303, 305, 307, 311, and 314. The Maintenance Director stated if the resident was able to use a closet, they should be able to get to and reach her/his hanging clothing as well as items from shelves in the closet, which they were not able to do, due to furniture blocking closet access. On 07/19/22 at 10:15 AM, during an interview, the	F 917	F917 Resident Room/Bed/Furniture/Closet 1. Maintenance Director re-arranged furniture in rooms 303, 305, 307, 311, and 314 to provide accessible closet space on 8/5/22. 2. All residents have the potential to be affected. Maintenance Director completed whole house audit on 8/4/22 of facility rooms to identify which rooms furniture failed to allow accessible closet space for residents with corrections made as needed and completed on 8/5/22. 3. Maintenance Director completed whole house audit on 8/4/22 of facility rooms to identify which rooms furniture failed to allow accessible closet space for residents with corrections made as needed and completed on 8/5/22. Education initiated to on 7/19/2022 on Policy “OPS200 Accommodation of Needs” and "How to create a work order in TELS" to all staff with a completion of 8/12/22 by Director of Nursing. 4. 5 random resident room audits to be completed weekly x4 weeks (beginning 8/15/22), bi-weekly x2 week, then monthly x1 month by Maintenance Director and/or designee. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee	

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F 917	Continued From page 16 Administrator stated that his expectation was for Maintenance and nursing staff to keep all the furniture from blocking residents' access to their hanging clothing in their private closets.	F 917	monthly with the QAPI Committee responsible for ongoing compliance. Licensed Nursing Home Administrator will be responsible for the implementation of this plan. 5. Date of compliance: 08/12/2022	