STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

(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 and complaint investigation survey was conducted on 08/22/22 through 08/25/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4M0K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/22/22 through 08/25/22. There were 9 complaint allegations investigated and one was substantiated resulting in a deficiency. Event ID# 4M0K11. Intakes NC 00192274, NC00189785, NC00188857, and NC00192091.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and staff, the facility failed to provide access to control the light fixture behind the bed for 1 of 1 resident reviewed for accommodate of needs (Resident #96). The findings included: Resident #96 was admitted to the facility on 06/23/22. Review of the admission Minimum Data Set	F 558	University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction as required by Federal and State regulations and statutes applicable to long term care providers. This plan does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of this plan does not constitute an agreement by the facility that the surveyor's findings or	9/26/22

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

Electronically Signed | 09/18/2022

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F 558	Continued From page 1 (MDS) dated 07/15/22 assessed Resident #96 with moderate impairment in cognition. Review of Resident #96's medical records revealed she had moved to the current room on 08/04/22. During an observation conducted on 08/22/22 at 12:42 PM the cord attached to the light fixture behind Resident #96's bed to control the light was broken. It extended approximately 2.5 inches from the light fixture and approximately 60 inches above the floor. The cord was too short for the resident to reach making the light inaccessible. During an interview with Resident #96 on 08/22/22 at 12:45 PM she stated the switching cord for the light fixture had been broken since the first day she moved into this room. She had difficulty standing up to reach the switching cord to control the light according to her choices. She had been totally dependent on the staff to control the light fixture for the past 3 weeks. It was very inconvenient to her, and she was frustrated why none of the staff would do something to fix the problem. Subsequent observation conducted on 08/23/22 at 3:47 PM and 08/24/22 at 11:12 AM revealed the cord remained out of the resident's reach. During a joint observation conducted with Nurse #2, Nurse Aide (NA)#2, and the Maintenance Manager on 08/25/22 at 10:14 AM, the cord remained broken. An interview conducted with the Maintenance Manager on 08/25/22 at 10:16 AM revealed he walked through the facility daily to identify repair	F 558	conclusions are accurate, that the findings constitute a deficiency, or the scope or severity regarding any of the deficiencies cited are correctly applied. Corrective action has been accomplished for the alleged deficient practice regarding light cord not being long enough for resident to reach to turn over bed light on. Root cause: Maintenance Supervisor did not notice the light cord was too short for resident to reach while in bed. In addition, no staff or the oriented resident reported the call light cord not within reach to the resident while in bed. On 8/25/22 the Maintenance Supervisor repaired the over bed light cord extending the light cord ensuring resident #96 could reach the light cord while in bed. All residents have a potential to be affected by this deficient practice. 08/26/2022 the Maintenance Supervisor completed a 100% audit to ensure all over bed light cords were long enough for all residents to reach while in bed. Any light cords not long enough for residents to reach while in bed were corrected at the time of the audit. On 8/26/22 Facility Administrator conducted and completed education with Maintenance Supervisor and Department Heads to ensure all over bed light cords are long enough for all residents to reach while in bed during room rounds. Beginning 8/26/22 the Maintenance Supervisor will be responsible to complete monitoring of all over bed light cords are long enough for all residents to reach while in bed 3xweekly for 2 weeks, then	

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F 558	Continued From page 2 needs. He also depended on staff to report repair needs through work order. He had been checking the work order boxes located at each nurse station and his office door at least once daily. His priority was the safety of the residents, then the needs of residents and other cosmetic issues. He stated he had missed the broken cord for light fixture in Resident #96's room during the daily walk through. He acknowledged that it was too short and needed to be fixed. A joint interview was conducted with Nurse #2 and NA #2 on 08/25/22 at 10:32 AM, both stated they did not notice the cord was broken. Otherwise, they would have notified the maintenance staff for repair. During an interview conducted on 08/25/22 at 12:25 PM, the Unit Manager (UM) expected nursing staff to be more attentive to resident's living environment and reported all the repair needs as indicated to the maintenance staff in timely manner. During an interview conducted on 08/25/22 at 3:31 PM, the Administrator stated it was her expectation for the staff to notify the maintenance staff for all repair needs in timely manner to accommodate residents' needs.	F 558	2xweekly for 2 weeks, then weekly for 8 weeks. Beginning 8/26/22 the Maintenance Supervisor will be responsible to report the findings of this monitoring to the Intradisciplinary Team weekly and as needed for any additional changes/updates needed to ensure facility compliance of all over bed light cords are long enough for all residents to reach while in bed for 3 months. Beginning September 2022 during monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Maintenance Supervisor will be responsible of reporting cumulative results of monitoring for facility compliance of all over bed light cords are long enough for all residents to reach while in bed for 3 months. Date of Completion: 9/26/22	
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.	F 584		9/26/22

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F 584	Continued From page 3 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; §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, record review, resident and staff interviews, the facility failed to keep a sanitary environment in a shared bathroom for 2 of 2 residents reviewed for homelike environment	F 584	Corrective action has been accomplished for the alleged deficient practice regarding trashcan in shared bathroom was dirty with brown substance.	

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F 584	Continued From page 4 (Residents #35 and #70). The findings included: Resident #35 was admitted to facility on 3/16/22 and her quarterly Minimum Data Set (MDS) dated 6/14/22 indicated she was cognitively impaired. An interview with resident #35 on 8/22/22 at 11:05 AM revealed she and her roommate shared a bathroom with two residents in the next room. A resident in the next room had a bowel movement and placed the soiled paper towels in the unlined bathroom trash can about one week prior. She could not recall the exact date. She further revealed the smell from the soiled paper towels permeated the bathroom and her room for days. The smell bothered her. Housekeeping did not clean the trash can before placing trash bag liners in the trash can. She complained to housekeeping when the incident first occurred (one week prior) and was told it would be taken care of, but the trash can remained soiled with dried brown matter and dried paper towels since one week ago. Resident #70 was admitted to facility on 1/31/20 with a MDS dated 7/3/22 indicated she was cognitively intact. An interview with Resident #70 on 8/22/22 at 11:30 AM indicated she became nauseous when she smelled the odor from the bathroom after housekeeping did not clean the brown stained trash can. An observation on 8/22/22 at 11:15 AM and 8/24/22 10:55 AM of the inside the trash can (bottom and side) revealed dried brown	F 584	Root cause: Housekeeping staff misconception of maintenance was to clean trashcans, therefore housekeeping aide put a trashcan liner in the trashcan and did not clean the brown substance observed on the trashcan. On 8/25/22 the Housekeeping Supervisor completed 100% audit & pressure washed/cleaned all trash cans in the facility including resident rooms and bathrooms. All residents have a potential to be affected by this deficient practice. On 8/26/22 the Facility Administrator and Housekeeping Supervisor completed education to housekeeping department of ensuring housekeeping is to clean any observed dirty trashcans prior to putting a trashcan liner back in a trashcan. In addition, housekeeping department is to empty trash/clean trashcans if reported by a resident of any concern of dirty/odor trashcan. No housekeeping staff, newly hired housekeeping staff, or contracted housekeeping staff will be allowed to work until he/she has received this education. On 8/26/22 Facility Administrator conducted and completed education with Department Heads report any observed dirty/odor trashcans during daily room rounds during Intradisciplinary Team Meeting to assist in assuring facility compliance of Safe/Clean/Comfortable/Homelike Environment failed to keep sanitary environment; facility trashcans are clean & no odor. Beginning 8/26/22 the Housekeeping Supervisor will be responsible to complete	

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F 584	Continued From page 5 substance and brown soiled paper towels on the bottom of the trash can. No odor detected at time of observation. An interview with Housekeeping Aide on 8/24/22 at 10:58 AM revealed she was covering an assignment for another housekeeping staff for past two days. She further revealed she just cleaned the bathroom and changed the trash bag in the trash can. She stated she did not clean the inside of the trash can and that it was usually the responsibility of maintenance to clean the trash cans if housekeeping staff informed them of the need. After she agreed to observe the soiled trash by removing the trash can liner that she placed in the trash can, she stated she did not see the dried brown substance or dried paper towels in the bottom of the trash can. She then stated that it should have been cleaned when residents reported it to housekeeping one week prior. She had not informed maintenance or her supervisor. She stated she would inform maintenance, then stated she would clean it instead. An interview with the Housekeeping Supervisor on 8/25/22 at 10:10 AM indicated he worked at the facility since March and housekeeping staff should have cleaned the trash can when they clean the bathroom, instead of placing trash can liners over the soiled trash can or make the housekeeping supervisor aware the trash can needed to be cleaned. He further indicated housekeeping is short staffed at times and that he would follow-up to make sure the trash can was cleaned. An interview with the Administrator on 8/25/22 revealed she was unaware of the issue with	F 584	monitoring of ensuring all facility trashcans including resident rooms and bathrooms are clean and without odor 3xweekly for 2 weeks, then 2xweekly for 2 weeks, then weekly for 8 weeks. Beginning 8/26/22 the Housekeeping Supervisor will be responsible to report the findings of this monitoring to the Intradisciplinary Team weekly and as needed for any additional changes/updates needed to ensure facility compliance of all facility trashcans including resident rooms and bathrooms are clean and without odor for 3 months. Beginning September 2022 during monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Housekeeping Supervisor will be responsible of reporting cumulative results of monitoring for facility compliance of of Safe/Clean/Comfortable/Homelike Environment failed to keep sanitary environment; facility trashcans are clean & no odor for 3 months. Date of Completion: 9/26/22	

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F 584	Continued From page 6 housekeeping and that a floor tech worked until 9 PM. She expected housekeeping to clean the trash can when Resident #70 reported it to housekeeping staff.	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 observation, record review and interviews with residents and staff, the facility failed to accurately code the Minimum Data Set (MDS) related to tobacco use for 3 of 3 residents reviewed for smoking (Resident #3, #138, and #139). Findings included: 1. Resident #3 was admitted to the facility on 04/28/15 with diagnoses included nicotine dependent. Review of care plan for smoking revised on 09/01/19 revealed Resident #3 was a supervised smoker. The goal was to smoke safely in the designated areas through the next review date. Interventions included assisted Resident #3 to obtain smoking materials from the secured storage area upon request, evaluated continued ability to smoke safely on a consistent and regular basis, observed for potential violations of the smoking policy, and documented and reported observations to the Administrator. Review of smoking evaluation conducted on	F 641	Corrective action has been accomplished for the alleged deficient practice regarding Accuracy of Assessments: accurately code the Minimum Data Set (MDS) related to tobacco use. Root Cause: Mobile MDS Nurse failed to correctly code MDS for tobacco use on 3 residents due to MDs Nurse did not ask resident if he/she used tobacco. On 8/25/22 the Mobile MDS Nurse updated MDS Assessment to reflect tobacco use for residents #3, #138, and #139. All residents have a potential to be affected by this deficient practice. On 8/29/22 the Regional MDS Nurse Consultant educated Mobile MDS Nurse and Intradisciplinary Team on accuracy of Comprehensive MDS Assessments: tobacco use. This education was completed on 8/29/22, any department head, newly hired/contracted Department Head will not be allowed to work until he/she has received this education. On 9/6/22 100% Audit of current tobacco users was completed by Regional MDS	9/26/22

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F 641	Continued From page 7 08/19/21 indicated Resident #3 was an unsafe smoker and required direct supervision during smoking. The annual MDS dated 10/05/21 assessed Resident #3 with intact cognition. Further review revealed she was coded as a non-tobacco user. During an interview on 08/22/22 at 4:59 PM Resident #3 acknowledged that she had been smoking since admitted to the facility and denied she had ever tried to quit smoking so far. Resident #3 was observed smoking in the courtyard with 6 other smokers on 08/23/22 at 12:01 PM. During an interview on 08/23/22 at 12:05 PM nurse aide (NA)#1 who was supervising the smokers in the courtyard indicated Resident #3 had been smoking regularly since she started to work in the facility about 1 year ago. Interview conducted on 08/24/22 at 11:21 AM with the travelling MDS Coordinator revealed she had been working in this facility for about 1 month. She acknowledged that Resident #3 should be coded as a tobacco user for her annual MDS dated 10/05/21. She explained the MDS Coordinator who completed the annual assessments on 10/05/21 was no longer working in this facility. She planned to correct the affected MDS and resubmit it immediately. During an interview on 08/25/22 at 12:25 PM the Unit Manager attributed the coding error as an oversight by the former MDS Coordinator. It was her expectation for all the MDS assessments to be coded accurately.	F 641	Consultant and mobile MDS Nurse to ensure all present tobacco users were coded correctly for tobacco use on MDS Assessment. Any needed modification to Comprehensive MDS Assessments were made at this time. Director of Nursing, Assistant Director of Nursing, Unit Manager, Regional MDS Nurse Consultant, Regional Facility Clinical Consultant will monitor 50% of all Comprehensive MDS Assessments for accuracy in the areas of tobacco use x4 weeks, then 25% of MDS Assessments x4 weeks, then 10% x4 weeks to ensure compliance is maintained through current plan of correction or needed changes/updates. Beginning September 2022 during monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Director of Nursing or Facility Administrator will be responsible of reporting cumulative results of monitoring for facility compliance of accuracy for Comprehensive MDS Assessments: tobacco use for 3 months. Date of Completion: 9/26/22	

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F 641	Continued From page 8	F 641		

During an interview on 08/25/22 at 3:31 PM the Administrator expected all the MDS assessments to be coded accurately.

2. Resident #138 was admitted to the facility on 04/30/18 with diagnoses included nicotine dependent.

Review of care plan for smoking revised on 09/08/19 revealed Resident #138 was a supervised smoker. The goal was to smoke safely in the designated areas through the next review date. Interventions included evaluated Resident #138 for continued ability to smoke safely on a consistent and regular basis, observed for potential violations of the smoking policy, and documented and reported observations to the Administrator.

Review of smoking evaluation conducted on 02/10/21 indicated Resident #138 was an unsafe smoker and required direct supervision during smoking.

The annual MDS dated 05/06/22 assessed Resident #138 with intact cognition. Further review revealed she was coded as a non-tobacco user.

During an interview on 08/22/22 at 4:57 PM Resident #138 acknowledged that she had been smoking since admitted to the facility and denied she had ever tried to quit smoking so far.

Resident #138 was observed smoking in the courtyard with 6 other smokers on 08/23/22 at 12:01 PM.

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F 641	Continued From page 9	F 641		

During an interview on 08/23/22 at 12:05 PM NA#1 who was supervising the smokers in the courtyard indicated Resident #138 had been smoking regularly since she started to work in the facility about 1 year ago.

Interview conducted on 08/24/22 at 11:21 AM with the travelling MDS Coordinator revealed she had been working in this facility for about 1 month. She acknowledged that Resident #138 should be coded as a tobacco user for her annual MDS dated 05/06/22. She explained the MDS Coordinator who completed the annual assessments on 05/06/22 was no longer working in this facility. She planned to correct the affected MDS and resubmit it immediately.

During an interview on 08/25/22 at 12:25 PM the Unit Manager attributed the coding error as an oversight by the former MDS Coordinator. It was her expectation for all the MDS assessments to be coded accurately.

During an interview on 08/25/22 at 3:31 PM the Administrator expected all the MDS assessments to be coded accurately.

3. Resident #139 was admitted to the facility on 06/11/19 with diagnoses included nicotine dependent.

Review of care plan for smoking revised on 07/29/19 revealed Resident #139 was a supervised smoker. The goal was to smoke safely in the designated areas through the next review date. Interventions included assisting Resident #139 to obtain smoking materials from the secured storage area upon request, and notified physician of her interest in smoking

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F 641	Continued From page 10	F 641		

cessation if expressed.

Review of the smoking evaluation dated 09/05/21 indicated Resident #139 was an unsafe smoker and required direct supervision during smoking.

The annual MDS dated 04/11/22 assessed Resident #139 with intact cognition. Further review revealed she was coded as a non-tobacco user.

During an interview on 08/22/22 at 4:15 PM Resident #139 acknowledged that she had been smoking since admitted to the facility and denied she had ever tried to quit smoking so far.

Resident #139 was observed smoking in the courtyard with 6 other smokers on 08/23/22 at 12:01 PM.

During an interview on 08/23/22 at 12:05 PM NA #1 who was supervising the smokers in the courtyard indicated Resident #139 had been smoking regularly since she started to work in the facility about 1 year ago.

Interview conducted on 08/24/22 at 11:21 AM with the travelling MDS Coordinator revealed she had been working in this facility for about 1 month. She acknowledged that Resident #139 should be coded as a tobacco user for her annual MDS dated 04/11/22. She explained the MDS Coordinator who completed the annual assessments on 04/11/22 was no longer working in this facility. She planned to correct the affected MDS and resubmit it immediately.

During an interview on 08/25/22 at 12:25 PM the Unit Manager attributed the coding error as an

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F 641	Continued From page 11 oversight by the former MDS Coordinator. It was her expectation for all the MDS assessments to be coded accurately. During an interview on 08/25/22 at 3:31 PM the Administrator expected all the MDS assessments to be coded accurately.	F 641		
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 by: Based on observations, record review, and staff interviews, the facility failed to discard produce with signs of spoilage, remove expired food items and date leftover food stored ready for use in the walk-in cooler. These practices had the potential to affect food served to residents.	F 812	Corrective action has been accomplished for the alleged deficient practice regarding food procurement, store/prepare/serve-sanitary. Root Cause: Dietary Staff did not discard produce with signs of spoilage, remove expired food items and date leftover food	9/26/22

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	345142	A. BUILDING _____ B. WING _____	C 08/25/2022

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F 812	Continued From page 12 The findings included: An observation with the Dietary Supervisor of the walk-in refrigerator occurred on 8/22/22 at 10:08 AM with the following concerns identified: -A box of 10-12 dented and gray colored cantaloupes, recorded a manufacturer's expiration date of 7/26/22. -One large open container of leftover cucumber salad in its original container from the manufacturer with no expiration date. -Thirty-five 4 oz prune juice containers, unlabeled with no expiration date, and stored in a large gray utility box that was soiled with brown and black residue. An interview with the Dietary Supervisor on 8/22/22 at 10:30 AM revealed she began her supervisory role 9 years ago. She stated the refrigerated food items should have a label indicating the "date opened" or "use by" date. She instructed a Dietary Aide (DA) to discard the expired and unlabeled food items. She further revealed she was responsible for discarding expired foods and all Dietary Staff were responsible for dating refrigerated food items. She further stated the Dietary Manager transferred to another facility at the beginning of August and she had been performing various duties that the DM would normally be responsible for. An interview with the Corporate Dietician on 8/24/22 at 2:05 PM indicated the Dietary Supervisor was responsible for inventory of refrigerated foods that may be expired or not dated.	F 812	timely. On 08/22/2022 the Interim Dietary Manager completed a full audit of kitchen discarding any food with signs of spoilage, discarding expired food items, and ensuring all leftover foods were dated. All residents have the potential to be affected by this deficient practice. On 08/22/2021 the Administrator conducted 1:1 education with Interim Dietary Manager to include all food safety requirements for food procurement and food storage, preparation, distribution, and serving. On 8/22/22 Interim Dietary Manager & Facility Administrator began education with Dietary Department regarding food safety requirements (safe temperatures of food, discarding any food with signs of spoilage, discarding expired food items, date leftover food, etc). This education was completed on 8/25/22. No dietary staff to include contracted staff and/or newly hired staff will be allowed to work until he/she has completed this education on Food Safety/Procurement/Store/Disposal/Date. Beginning 8/25/22 (Interim) Dietary Manage will complete monitoring of Dietary Kitchen to ensure compliance of food safety requirements (safe temperatures of food, discarding any food with signs of spoilage, discarding expired food items, date leftover food, etc) 3xweekly for 2 weeks then 2x weekly for 2weeks, then weekly x2months. The (Interim) Dietary Manager will report the findings weekly and as needed to the Intradisciplinary Team weekly for any	

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F 812	Continued From page 13 An interview with the Administrator on 8/25/22 at 4:18 PM indicated she was not aware of the expired foods and that expired foods should discarded as soon as possible. She further indicated she was in the process of hiring a Dietary Manager (DM) and stated the Dietary Supervisor had added responsibilities since DM transferred to another facility.	F 812	additional changes/updates to ensure compliance is maintained for Food Procurement, Store/Prepare/Serve/Sanitary. Beginning September 2022 during monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the (Interim) Dietary Manage will be responsible of reporting cumulative results of monitoring for facility compliance of Food Procurement, Store/Prepare/Serve/Sanitary x3months. Date of Completion: 9/26/22	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure garbage was contained in a closed dumpster and maintain a clean grease trap free of buildup. The findings included: An observation on 8/22/22 at 10:20 AM of the outdoor grease trap while on kitchen tour revealed the entire lid, front and sides were soiled with thick black layers of grease build-up. There was also exposed trash and an open gate to the outdoor trash dumpster. Flies were also present. The Dietary Supervisor (DS) indicated she was responsible for emptying used kitchen grease into the outdoor grease trap and the company who comes to empty it, was responsible for cleaning it.	F 814	Corrective action has been accomplished for the alleged deficient practice regarding cleaning the grease trap/bin. Root Cause: Maintenance Supervisor, Housekeeping Supervisor, and Interim Dietary Manager were unaware the facility was responsible to ensure the maintenance/cleaning of the dumpster and grease trap/bin area was the responsibility of the facility. On 8/23/22 the Maintenance Supervisor, Housekeeping Supervisor, and Interim Dietary Manager cleaned the area at the dumpster and grease trap/bin, closed all gates, and deep cleaned the outside area to ensure garbage was contained in a closed dumpster and grease trap/bin was clean and free of buildup and pests.	9/26/22

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F 814	Continued From page 14 An interview with the Maintenance Manager on 8/23/22 at 4:15 PM revealed he power washed the grease trap one year ago and the gate to the trash recycle receptacle should be closed. He further revealed the waste company usually cleaned the outside of the grease trap upon request of the facility. A phone interview with the grease trap removal company on 8/25/22 at 4:35 PM indicated the last grease pick up took place on 3/21/22. A review of the Pest Prevention Service Agreement indicated there was a continuous 12 visit provision in place. Recommendations were made to facility to remove debris around the dumpster area to prevent unsanitary conditions and attraction of pests. There was no indication outlined in the agreement that the pest service included cleaning the outside of the grease trap. The last inspection took place 8/8/22. An interview with the Administrator on 8/25/22 at 4:18 PM indicated she was not aware the grease trap had not been maintained and clean. She further indicated the garbage/recycle removal company was not responsible for the grease trap disposal. A grease trap removal company was responsible for emptying the grease. However, she was unaware if they were responsible for cleaning the outside of the grease trap.	F 814	All residents have a potential to be affected by this deficient practice. On 8/23/22 the Facility Administrator conducted education with Maintenance Supervisor, Housekeeping Supervisor, and Interim Dietary Manager on cleaned the area at the dumpster and grease trap/bin, closed all gates, and deep cleaned the outside area to ensure garbage was contained in a closed dumpster and grease trap/bin was clean and free of buildup and pests. This education was completed on 8/25/22. Beginning 8/25/22 Maintenance Supervisor, Housekeeping Supervisor, and/or Interim Dietary Manager will monitor the outside area to ensure garbage is contained in a closed dumpster and grease trap/bin is clean and free of buildup and pests 3xweekly for 2 weeks, then 2xweekly for 2 weeks, then weekly for 8 weeks. Any additional deep cleaning will be conducted as needed. Beginning 8/25/22 Maintenance Supervisor, Housekeeping Supervisor, and/or Interim Dietary Manager will report the findings of this monitoring to the Intradisciplinary Team weekly and as needed for any additional changes needed to ensure facility compliance of garbage is contained in a closed dumpster and grease trap/bin is clean and free of buildup and pests for 3 months. Beginning September 2022 during monthly Quality Assurance & Performance Improvement (QAPI) Committee Meeting the Maintenance Supervisor will be responsible of reporting cumulative results of monitoring for facility	

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F 814	Continued From page 15	F 814	compliance of garbage is contained in a closed dumpster and grease trap/bin is clean and free of buildup and pests for changes/updates needed for 3 months. Date of Completion: 9/26/22	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place on 12/27/19. This was for a deficiency in Accuracy of Assessments that was originally cited on the 11/22/19 recertification and complaint investigation survey. The QAA committee failed to maintain implemented procedures and monitor the interventions that the committee put into place on 07/19/21. This was for a deficiency in Food Procurement Store, Prepare, Serve, Sanitary that was originally cited on the 06/24/21 recertification and complaint investigation survey. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This citation is crossed referred to:	F 867	Corrective action has been accomplished for the alleged deficient practice regarding QAPI/QAA Improvement Activities: Accuracy of assessments & food procurement Root Cause: Administrator states she attributes the repeat deficiencies related to food procurement and accuracy of assessments to recent vacancies with MDS Staff and the Dietary Manager. On 8/26/22 the Regional Vice President of Operations (RVPO) and the Regional Facility Clinical Consultant (RFCC) reviewed the Quality Assurance & Performance Improvement (QAPI) process of Minimum Data Sets (MDS) accuracy and food procurement with the Administrator and noted no concern prior to vacancies of MDS staff and Dietary Manager. All residents have a potential to be affected by this deficient practice.	9/26/22

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F 867	Continued From page 16 F641: Based on observation, record review and interviews with residents and staff, the facility failed to accurately code the Minimum Data Set (MDS) related to tobacco use for 3 of 3 residents reviewed for smoking (Resident #3, #138, and #139). During the recertification and complaint survey completed on 11/22/19 the facility failed to accurately code the Minimum Data Set (MDS) in the areas of ostomy status on 2 consecutive assessments for Resident #12, Preadmission Screening and Resident Review (PASRR) for Resident #75, and discharge status for Resident #149. F-812: Based on observations, record review, and staff interviews, the facility failed to discard produce with signs of spoilage, remove expired food items and date leftover food stored ready for use in the walk-in cooler. These practices had the potential to affect food served to residents. During the recertification and complaint survey completed on 06/24/21 the facility failed to remove expired items in the refrigerator in 1 of 4 nourishment rooms and failed to label and date opened food items stored for use in 3 of 4 nourishment rooms. An interview with the Administrator occurred on 08/25/22 at 5:07 PM and revealed that the during each QAA monthly committee meeting, the committee reviewed prior deficiencies and continued to monitor past deficiencies to identify how the committee could improve and if it was necessary to keep auditing for continued improvement. The Administrator stated that she	F 867	On 8/26/22 the RVPO educated the Administrator on continued compliance of previous identified facility deficiencies through QAPI meetings and updating/changing Plans of Correction. Beginning September 2022, the RVPO and/or the RFCC will attend the facility monthly QAPI committee meetings for 3 months to note any improvement/changes needed to assist in maintaining compliance of the facility's previous and/or present identified deficiencies. The RVPO and/or RFCC will submit a report of the QAPI meeting to the Corporate Director of Operations and Corporate Director of Clinical Services for additional guidance to ensure compliance of the QAPI/QAA Improvement Activities: Accuracy of assessments & food procurement. Date of Completion: 9/26/22	

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F 867	Continued From page 17 attributed the repeat deficiencies related to food procurement and accuracy of assessments to recent vacancies with MDS staff and the dietary manager.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to revise the activities of daily living (ADL) care plan for 1 of 5 sampled residents reviewed for ADL (Resident #90). The findings included: Resident #90 was admitted to the facility 4/25/22. Diagnoses included congestive heart failure, Alzheimer's disease, and adult failure to thrive, among others. The ADL care plan dated 4/25/22 indicated Resident #90 was independent with bed mobility. An admission Minimum Data Set (MDS) dated 5/1/22 assessed that Resident #90 required supervision, oversight or cueing of one staff person for bed mobility. A physician progress note dated 7/15/22 recorded that Resident #90 experienced a progressive decline and was dependent on staff for care related to ADL. A quarterly MDS, dated 7/19/22 assessed that Resident #90 required extensive staff assistance with weight-bearing support for bed mobility. A referral was made to physical and occupational therapy. The ADL care plan updated July 2022 was not revised to reflect this decline in bed mobility. An interview with Nurse Aide (NA) #3 occurred on 08/24/22 at 12:03 PM. NA #3 described that she assisted Resident #90 with her care since her admission to the facility. NA #3 stated that Resident #90 always required

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F 657	Continued From Page 1

some assistance but due to a recent decline, she currently required extensive to total staff assistance with her care and positioning while in bed.

During an interview with the MDS Coordinator on 08/25/22 at 4:09 PM, the MDS Coordinator stated that the care plan was updated by MDS staff after the MDS was completed. The MDS Coordinator also stated that the current care plan for Resident #90 should have been updated to reflect that she currently required extensive staff assistance with bed mobility after the quarterly MDS was completed.

An interview with the Administrator on 08/25/22 at 5:05 PM revealed that she expected the care plan to be updated to reflect the current MDS assessment.