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 02/08/2023

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
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 02/07/23 through 02/08/23. Event ID# 75MU11. The following intakes were investigated: NC00194189, NC00197726, NC00197798, NC00194664, NC00194271, and NC00194199. 1 of 22 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	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	F 584		2/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 02/23/2023

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 584	Continued From page 1 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 and staff interviews the facility failed to: 1a) failed to repair drywall wall damage in 7 of 25 resident rooms (202, 205, 209, 300, 302, 303, 304, and 402), 1b) failed to repair drywall wall damage in 10 of 25 resident bathrooms (107, 115, 201, 203, 205, 207, 210, 301, 310, and 401), 1c) failed to remove the black greenish substance from the commode base caulking in 13 of 25 resident rooms (107, 115, 116, 201, 203, 206, 207, 210, 213, 301, 305, and 310), 1d) failed to repair a broken bedside cabinet handle in 2 of 25 resident rooms (103 and 300), 1e) failed to replace rough, worn, splintered resident hallway door of 9 of 25 resident hallway doors (107, 108, 206, 209, 211, 213, 302, 303, and 304), 1f) failed to replace rough, worn, splintered resident bathroom door of 5 of 25 resident bathroom doors (112, 201, 203, 205, and 207), 1g) and failed to replace broken floor tile and missing grout in 1 of 3 resident shower rooms (200-Hall).	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1a) Senior Maintenance Director entered work orders into Facility□s Computerized Maintenance Management System (TELS) to initiate/track progress of drywall wall damage in need of repair. Work Orders entered on 2/20/2023 for resident rooms 202, 205, 209, 300, 302, 303, 304, and 402. 1b) Senior Maintenance Director entered work orders into TELS to initiate/track progress of drywall wall damage in need of repair. Work Orders entered on 2/20/2023 for resident room bathrooms 107, 115, 201, 203, 205, 207, 210, 301, 310, and 401. 1c) Senior Maintenance Director entered work orders into TELS to initiate/track progress of removing black greenish	

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F 584

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Findings included:

1a. An observation on 02/08/23 at 9:45 AM revealed 7 of 25 resident rooms were noted to have drywall wall damage (202, 205, 209, 300, 302, 303, 304, and 402). 1b. An observation on 02/08/23 at 9:45 AM revealed 10 of 25 resident bathrooms were noted to have drywall wall damage (107, 115, 201, 203, 205, 207, 210, 301, 310, and 401). 1c. An observation on 02/08/23 at 9:45 AM revealed 13 of 25 resident commodes (107, 115, 116, 201, 202, 203, 206, 207, 210, 213, 301, 305, and 310), were noted to have black greenish substance located around the base of the commodes. 1d. An observation on 02/08/23 at 9:45 AM revealed broken bedside cabinet handle in 2 of 25 resident rooms (103 and 300). 1e. An observation on 02/08/23 at 9:45 AM revealed 9 of 25 resident hallway doors (107, 108, 206, 209, 211, 213, 302, 303, and 304), were rough, worn, with multiple splintered/chipped off areas and/or holes in the door. 1f. An observation on 02/08/23 at 9:45 AM revealed 5 of 25 resident bathroom doors (112, 201, 203, 205, and 207), were rough, worn, with multiple splintered/chipped off areas and/or holes in the door. 1g. An observation on 02/08/23 at 9:45 AM revealed broken floor tile and missing grout in 1 of 3 resident shower rooms (200-Hall).

An interview and facilty tour of the 100, 200, 300 and 400 halls was conducted with the Maintenance Director (MD) and Assistant Director of Nursing (ADON) on 02/08/23 at 10:30 AM. The MD and ADON stated there were still multiple areas on the 100, 200, 300 and 400 halls that needed to be addressed, repaired, or replaced. MD stated he had had no assistant, but was still able to keep up with faclity repairs. He said he

F 584

substance from commode base caulking. Work Orders entered on 2/20/2023 for resident room bathrooms 107, 115, 116, 201, 203, 206, 207, 210, 213, 301, 305, and 310.

1d) Senior Maintenance Director entered work orders into TELS to initiate/track progress of broken bedside cabinet handles in need of repair. Work Orders entered on 2/20/2023 for resident rooms 103 and 300.

1e) Senior Maintenance Director entered work orders into TELS to initiate/track progress of rough, worn, splintered resident hallway doors of resident hallways in need of replacement and/or repair. Work Orders entered on 2/20/2023 for resident hallway doors 107, 108, 206, 209, 211, 213, 302, 303, and 304.

1f) Senior Maintenance Director entered work orders into TELS to initiate/track progress of rough, worn, splintered resident bathroom doors in need of replacement and/or repair. Work Orders entered on 2/20/2023 for bathroom doors in resident rooms 112, 201, 203, 205, and 207.

1g) Senior Maintenance Director entered work orders into TELS to initiate/track progress of broken floor tile and missing grout in need of replacement. Work Orders entered on 2/20/2023 for resident shower room located 200-Hall.

2. All residents have the potential to be affected. Maintenance Director and/or designee completed whole house audit of facility to identify which areas need of

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did not know what the black greenish substance actually was around the base of some of the residents' commodes and caulking in the 200-hall shower room. MD said housekeeping was responsible for cleaning the base of the commodes, and that maintenance was responsible for repairing or replacing items in the facility including re-caulking around the base of commodes. The ADON said she identified additional areas of concerns she observed during the tour of the facility, the shower room, and resident rooms on the 100, 200, 300 and 400 halls. She stated many of the residents' rooms were currently not home-like. She said her additional concerns included: outstanding maintenance work orders, repair and paint needed in resident rooms/bathrooms, repair or replace of commodes, repair or replace of broken cabinet handles, drywall damage, stained toilet seats, hallway doors, and bathroom doors in need of repair or replacement. The ADON and MD stated it was their expectation for all the residents to have a safe and homelike environment that was in good repair.

A follow-up interview was conducted with the ADON and MD on 02/08/23 at 10:35 AM. ADON stated they may need additional maintenance personnel pulled from other sister facilities to address the additional facility concerns she identified.

An interview was conducted with the Director of Nursing (DON) on 02/08/23 at 10:50 AM. She was aware that many of the residents rooms were not home-like, and needed to be updated. The DON stated it was her expectation for all the residents to have a safe and homelike environment that was in good repair.

F 584

drywall repair, removal of greenish substance at base of commode, broken bedside cabinet handle repair, rough/worn/splintered door replacement and broken floor tile replacement. Audits completed on 2/23/2023, with all areas of concern entered into TELS.

3. Maintenance Director educated by Licensed Nursing Home Administrator (LNHA) on the importance of Policy "OPS 200 Accommodation of Needs" and the importance of completing TELS Tasks (Maintenance work orders) timely on 2/16/2021. Facility wide education initiated on 2/16/2023, regarding Policy "OPS 200 Accommodation of Needs" and "How to create a work order in TELS", with the completion date of 2/22/2023.

4. Temporary Maintenance Assistant position opened and advertised on 2/14/2023 by Genesis Recruiting Team, to focus on repairing/replacing audit identified areas and ongoing TELS Tasks (Maintenance Work Orders). 1 room designated per week for completion of Home-like environment repairs by Maintenance Director. Work Orders will be entered into TELS for weekly selected room. Licensed Nursing Home Administrator and/or designee will Aduit weekly room to verify completion. Weekly audit for x12 for completion to be conducted by LHNA and/or designee.

Results of these audits will be brought

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F 584	Continued From page 4 An interview was conducted with the Corporate Clinical Lead (CCL) on 02/08/23 at 11:15 AM. She spoke with the ADON aware that many of the residents rooms were currently not home-like. The CCL stated it was her expectation for all the residents to have a safe and homelike environment in good repair. The facility's Administrator was not available for interview due to being out sick.	F 584	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: 2/23/2023.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		2/23/23

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F 623	Continued From page 5 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623		

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F 623	Continued From page 6 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the family when a resident with severely impaired cognition (Resident #3) was transferred from the facility to a hospital for 1 of 3 residents reviewed for notification of transfer.	F 623	F623 Notice Requirements Before Transfer/Discharge 1. Resident #3 transferred to Hospital on	

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F 623

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Findings included:

Resident #3 was admitted to the facility on 04/21/22 with diagnoses that included altered mental status, vascular dementia, metabolic encephalopathy and hemiplegia and hemiparesis following a stroke.

Review of a quarterly Minimum Data Set assessment dated 12/28/22 documented Resident #3 had severely impaired cognition. She required extensive to dependent assistance from staff for all activities of daily living.

Review of a Grievance/Concern Form dated 01/04/2023 revealed the family had reported they had not been notified Resident #3 had been transferred to the hospital. An investigation was conducted by the facility and education was provided to staff regarding Responsible Party notification of hospital transfers on 01/04/23 by the Director of Nursing.

In an interview with the Unit Manager on 02/08/22 at 9:55 AM she stated on the morning of 01/04/23 she had received a call from a family member who stated a physician from the hospital had called and informed her the resident had been transferred and was at the hospital. The Unit Manager commented she told the family member all the details and apologized for night shift staff not calling her at the time of the transfer so that she could have met the resident at the hospital.

In an interview with the Director of Nursing on 02/08/23 at 11:15 AM he stated education was provided to staff on the morning of 01/04/23

F 623

1/4/2023. Resident #3□s Nurse spoke with family to notify of Resident□s transfer to Hospital on 1/5/2023.

2. All residents have the potential to be affected. An audit was completed on all current residents with a hospital transfer within the last 30 days by Licensed Nursing Home Administrator on 2/20/2023 to ensure Resident Representatives and/or Resident□s Responsible Party was notified of Residents□ transfer to Hospital. No additional deficiencies discovered.

3. Education provided to Resident #3□s Nurse on 1/5/2023 by Director of Nursing (DON) on notification of Resident Transfers (Policy OPS404 Discharge and Transfer). All Licensed Staff to include Full time, Part time, as needed and Agency were educated on notification of Resident Transfers (Policy OPS404 Discharge and Transfer) completed on 2/22/2023 by Director of Nursing (DON) and Nurse Practice Educator (NPE).

4. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or designee will audit Resident Transfers to ensure Resident Representatives and/or Resident□s Responsible Party Notification, daily (Monday to Friday) for 2 weeks (starting 2/20/2023), then weekly x4 weeks, then bi-weekly x2 weeks, then monthly x1

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F 623	Continued From page 8 regarding notification but reported no root cause analysis was discussed and no monitoring or auditing was conducted following the incident. He stated he thought because it was the nurse's first night on the job that she had forgotten to call the family. He concluded the facility should have established a plan of correction to monitor notifications, in this incident especially since the resident had severely impaired cognition and would not have been able to let her family know she had been transferred to the hospital. He stated anytime a resident was transferred to the hospital the family should be notified.	F 623	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. The facility Director of Nursing will be responsible for implementation of the plan. 5. Date of Compliance: 2/23/2023.	
F 641 SS=D	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 and staff interview, the facility failed to accurately code a Minimum Data Set (MDS) assessment for a resident who had an unstageable pressure ulcer on her sacrum during the assessment look back period (Resident #3) for 1 of 9 residents assessed. Findings included: Resident #3 was admitted to the facility on 04/21/22 with diagnoses that included Type 2 diabetes mellitus and hemiplegia and hemiparesis following a stroke. On 12/16/22 she	F 641	F641 Accuracy of Assessments 1. Resident #3 discharged facility on 1/22/2023. 2. All residents with pressure ulcers/wounds have the potential to be affected. On 2/22/2023, An Audit of all current residents with MDS assessments completed in the last 30 days was completed by the RN MDS Manager and	2/23/23

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developed a facility acquired unstageable sacral pressure ulcer.

Review of a quarterly MDS assessment dated 12/28/22 documented Resident #3 had severely impaired cognition. Section M of the assessment indicated Resident #3 had a pressure ulcer and had received pressure ulcer care but did not indicate a stage. Dashes were documented in the unstageable, eschar choice indicating the wound had not been assessed. All other entries in Section M for staging the wound were answered "0."

Weekly wound assessments were reviewed for 12/16/22, 12/29/22, 01/06/23, 01/11/23 and 01/18/23. Each assessment was complete with a photo, measurements, and description of the wound status and notifications.

In an interview with the MDS Nurse on 02/08/23 at 9:55 AM she stated when she completed the assessment dated 12/28/22 she had looked at the wound assessments that were done on 12/16/22 and 12/29/22. She knew the resident had a wound on her sacrum but neither assessment she reviewed fell within her look back period for the assessment. She did not interview the wound care nurse and did not assess the wound herself to enable her to code it correctly on the MDS assessment in Section M. She said if the documentation did not fall within the look back period she did not code the wound on the assessment even though she knew the wound existed. She said she had never interviewed nurses or looked at a wound herself when coding an MDS assessment. She concluded she would ask the wound care nurse to start completing Section M of the MDS

F 641

Director of Nursing (DON) to ensure that any skin concerns were accurately coded on Section M on MDS. All deficiencies corrected on 2/23/2023.

3. Education provided to the RN Skin Health Team Lead (STHL) by Director of Nursing (DON) regarding accuracy of MDS assessments on 2/16/2023 to include accurate coding of wounds/pressure ulcers on section M. Education provided to RN MDS Manager by Director of Nursing (DON) regarding accuracy of MDS assessments on 2/20/2023 to include accurate coding of wounds/pressure ulcers on section M.

4. Facility transitioned RN to the RN MDS Manager role with the effective date of 2/20/2023. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or designee will audit MDS Section M assessments for accuracy weekly x4 weeks (starting the week of 2/20/2023), 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.

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F 641	Continued From page 10 assessment.	F 641	The facility Director of Nursing will be responsible for implementation of the plan. 5. Date of Compliance: 2/23/2023.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		2/23/23

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	345409	A. BUILDING ______ B. WING ______	C 02/08/2023

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development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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F 867	Continued From page 12 of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including	F 867		

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F 867	Continued From page 13 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility Quality Assurance & Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification and complaint survey on 07/25/22. This was for 2 deficiencies that were originally cited in the areas of safe, homelike environment and accurate coding of the minimum data assessments during a complaint investigation on 02/08/23. The continued failure during 2 surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F584: Based on observations and staff interviews the facility failed to: 1a) repair torn floor linoleum in 3 of 13 resident rooms (508, 600, and 603), 1b) failed to remove the black greenish substance from the commode base caulking in 4 of 13 resident rooms (506, 508, 510, and 615), 1c) failed to ensure the ceilings were free from damaged drywall in 2 of 4 shower rooms (500 and 600 halls), 1d) failed to repair a broken wall cabinet door in 1 of 13 resident rooms (502), 1e) failed to replace rough, worn, splintered hand-rails on the 500 and 600 halls, 1f) failed to repair leaking commode bases in 4 of 13 resident rooms (506, 508, 510, and 612). 1g) failed to repair drywall wall damage in 3 of 13 resident	F 867	F867 QAPI/QAA Improvement Activities 1. Facility received two repeat citations during recent complaint survey that were cited during prior survey. Revised plans have been developed to address those areas with ongoing monitoring by the Quality Assurance and Performance Improvement Committee (QAPI). Plans for F584 Safe/Clean/Comfortable/Homelike Environment and F641 Accuracy of Assessments. 2. All residents have the potential to be effected. On 2/22/2023, Root Cause Analysis completed by the interdisciplinary Quality Assurance Team for each of these deficiencies to determine the systemic break that led to the deficient practice with revised plans developed to address these areas. 3. Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Regional RN Nurse on 2/22/2023, regarding Quality Assurance and recognizing areas for Performance Improvement and how to report these findings to the QAPI Committee.	

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rooms (501, 508, and 615), 1h) failed to replace broken or missing floor tile in 8 of 13 resident rooms (502, 508, 600, 609, 610, 612, 614, and 615), and 1i) failed to replace broken window blinds in 2 of 13 resident rooms (600 and 613).

During the recertification and complaint survey completed on 07/25/22 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, failed to repair paint that was scratched and peeling away from the wall on multiple areas of the adjacent walls in the resident's rooms, and failed to provide a homelike environment and remove the TV power cords hanging from the wall in front of the resident's bed or provide pictures on the walls in 1 of 1 resident rooms reviewed for homelike environment (Room 201).

An interview was conducted with the Assistant Director of Nursing (ADON) on 02/08/23 at 10:30 AM. She said their current Quality Assurance and Performance Improvement Action (QAPI) Plan was not working and was not specific enough to address all of the residents' physical environment needs on the 100, 200, 300 and 400 halls.

2) F641: Based on record review and staff interview, the facility failed to accurately code a Minimum Data Set (MDS) assessment for a resident who had an unstageable pressure ulcer on her sacrum during the assessment look back period (Resident #3) for 1 of 9 residents assessed.

F 867

4. The Administrator will conduct a Quality Assurance and Performance Improvement Meetings weekly x4 weeks (starting 2/22/2023), bi-weekly x2 weeks, then monthly x1 month. The QAPI Committee will review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. 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: 2/23/2023.

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F 867	Continued From page 15 During the recertification and complaint survey completed on 07/25/22 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. In an interview with the Director of Nursing on 02/08/23 at 11:15 AM he stated he did not know why MDS had a repeat tag this year. The facility Administrator was not available for comment.	F 867		