STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

(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 was conducted on 3/27/2023 through 3/30/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RJBL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 3/27/2023 through 3/30/2023. Event ID#RJBL11. The following intakes were investigated NC00188600, NC00190482, and NC00191636. 2 of the 17 complaint allegations resulted in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/26/23

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

Electronically Signed | 04/27/2023

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a resident's dignity by dressing the resident in a gown with a brown stain across the neckline that extended below the chest area for 1 of 3 residents (Resident #38) reviewed for dignity. A reasonable person would expect to be treated with dignity and be dressed in apparel that was not stained. The findings included: Resident #38 was admitted to the facility on 1/11/2018. A review of the quarterly Minimum Data Set (MDS) dated 3/17/2023 for Resident #38, revealed she had severe cognitive impairment and required extensive assistance of one staff	F 550	The stained gown was removed from resident #38 and a clean, unstained gown was replaced on 3/27/23 by CNA. CNA #1 was re-educated to the importance of maintaining the resident's dignity through not using stained gowns/clothing/linens. On 3/31/23 the Director of Nursing and the Executive Director performed a quality review of all residents in the facility to identify any other dignity issues as related to stained gowns/clothing/linen. No other issues were identified. A quality review was completed by the Housekeeping Supervisor and Executive Director to identify any other linen with stains on 3/31/23. Linen identified with stains removed and disposed of on 3/31/23. Once the stained linens were removed, a	

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F 550	Continued From page 2 member with personal hygiene and dressing. A review of Resident #38's care plan, dated 3/20/2023, revealed a focused area that read, the Reside nt had an activity of daily (ADL) self-care performance deficit related to activity intolerance, disease process, and impaired balance. The interventions identified the Resident was totally dependent on one staff member to assist her with dressing. An observation was conducted on 3/29/2023 at 11:01 a.m. of Resident #38 lying in bed with a gown that had a brown stain across the neckline and extended below the chest area. An interview was conducted with Nursing Assistant (NA) #1 on 3/29/2023 at 11:02 a.m. and she stated she had just conducted activities of daily living care for Resident #38 that included placing a clean gown on the Resident and was finished providing care. She had a bag of dirty linen in her hand that contained the gown that had been removed. When asked if she had observed the stain on the gown Resident #38 was wearing, she stated yes. She revealed there had been an increase in stained linens, to include gowns, over the past few months and she had reported it to the hall nurses. When asked why the Resident was wearing a gown at 11:02 a.m. the NA replied, the Resident preferred a gown when in bed and the facility staff only got her out of bed every other day as tolerated. When asked what would be done regarding the stained gown, she then stated she would get another gown that had no stains for Resident #38. An interview was conducted with the	F 550	count of all clean linens was completed to ensure the proper PAR level was on hand. An ADHOC Quality Assurance Performance Improvement Committee will be held on 4/7/23 to formulate and approve a plan of correction for the deficient practice. The Executive Director and/or the RN Educator educated the Housekeeping Supervisor, Laundry personnel and nursing staff the importance of maintaining the resident's dignity by identifying stained linen and disposing of before it gets in circulation for resident use by 4/12/23. Newly hired Housekeeping Supervisors, laundry personnel and nursing staff will recieve the same education during their orientation. The Executive Director, the Discharge Planner, Human Resources or Activity Director will conduct random Quality reviews by observation of 9 residents and their room as related to maintaining the resident's dignity related to clean gowns/clothing/linens as follows: 5 times a week for 8 weeks, then 3 times a week for 4 weeks, 1 time weekly for 8 weeks, then 2 times monthly for 8 months. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 550	Continued From page 3 Administrator on 3/30/2023 at 2:34 p.m. and she revealed the staff had made her aware of an increase in stained linens, that included gowns, around a month prior. She had completed an investigation that revealed the chemicals used for the stains had been changed by the contracted laundry company and the incorrect settings were being used on the washing machine. This resulted in the chemicals not working effectively. She added the settings had been corrected and the facility was still working on removing stained linens from the facility. She revealed it was her expectation that the residents at the facility be provided stain free linens and clothing and that a clothing item be replaced with an unstained item, if excessive staining had been identified by a staff member.	F 550		
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 resident and staff interviews and record reviews, the facility failed to accurately code cognition and fall history on the Minimum Data Set (MDS) assessments for 2 of 20 residents (Residents #79, and #23) reviewed for MDS accuracy. Findings included: 1. Resident #79 was admitted to the facility on 2/28/23. Diagnosis included, in part, aphasia. The admission MDS assessment dated 2/28/23	F 641	Resident #23 Minimum Data Set (MDS) was corrected in the area of falls to accurately reflect the resident and submitted by the MDS Nurse on 3/29/23. Resident #79 MDS was corrected in the area of cognition to accurately reflect and submitted by the MDS Nurse on 4/24/23. The Executive Director completed a quality review was on the current residents' most recent full MDS assessments in the areas of cognition (section C) and of falls (section J) to	4/26/23

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F 641	Continued From page 4 revealed Resident #79 was coded as usually understands others and was usually understood by others. He was coded as "not assessed" for the resident's cognitive status interview. Additionally, the staff assessment for cognition was also coded as "not assessed." A note in the medical record, authored by Social Worker (SW) #1 read, "Resident BIMS (Brief Interview for Mental Status) cannot accurately be assessed due to diagnosis of expressive aphasia. When asked to repeat words he thinks he is saying the correct words, however, they come out as different words." Resident #79 was interviewed on 3/27/23 at 11:44 AM. During the interview, the resident's speech was clear, and he responded with accurate wording during the conversation. Resident #79 shared he had some trouble with "remembering things." During an interview with SW #1 on 3/29/23 at 9:54 AM, she verified she completed the cognition section of the MDS assessment. She stated the resident had aphasia and at the time of the assessment, she didn't think he could accurately be assessed for memory. She added, because of Resident #79's aphasia, she couldn't complete the resident interview and didn't complete the staff assessment of his cognition. The MDS Coordinator was interviewed on 3/29/23 at 10:43 AM. He assessed Resident #79's communication ability when he completed the admission MDS assessment. He said the resident "processed information but it didn't come out the way he wanted it to" and so the MDS Coordinator coded the communication section as	F 641	validate the most recent MDS assessment have been coded to accurately reflect the status of the residents by the MDS nurse on 4/12/23. Of the Minimum Data Sets reviewed no further issues identified related to coding of cognition. There were 2 MDS assessments that required modification in the coding of falls. Those modifications were completed on 4/24/23. The Executive Director completed a quality review on current residents who had been re-admitted from the hospital in the last 90 days regarding triggering Section J, Item number J1700 for completion. The audit revealed that 4 MDS assessments were incorrect and those assessments were modified on 4/24/23. An ADHOC Quality Assurance Performance Improvement Committee will be held on 4/7/23 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the MDS Coordinator and Social Services on accurately coding of cognition (Section C) and falls (Section J) on 4/6/23. The Executive Director educated the MDS Coordinator on ensuring that section J, item J1700 was triggered for completion on the first full assessment after a resident was re-admitted to the facility. The MDS Coordinator educated the newly promoted MDS Coordinator on accurately coding of cognition (Section C) and falls (Section J) on 4/24/23. The MDS Coordinator educated the newly promoted	

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F 641	Continued From page 5 usually understood by others and usually understands others. He added Resident #79 was able to intermittently make his needs known by gestures and pointing or if he used a communication board. The MDS Coordinator stated SW #1 wrote a note that she attempted to assess the resident's cognition and when SW #1 asked the resident to repeat back 3 words she said to him, he stated 3 different words, and so she coded the resident interview for cognitive ability as not assessed. The MDS Coordinator explained SW #1 should have coded the resident's response as incorrect on the assessment instead of "not assessed." During an interview with the Administrator on 3/30/23 at 11:46 AM, she explained SW #1 was not familiar with assessing a resident who had expressive aphasia and education was provided by the MDS Coordinator. 2. Resident #23 was originally admitted to the facility on 10/11/21 with diagnoses which included: cerebral vascular accident and hemiplegia affecting the left nondominant side. Resident #23 fell on 1/10/23 and was discharged to the hospital. The resident was diagnosed with a displaced fracture of the left femur. She was re-admitted to the facility on 1/16/23 after hospitalization. The quarterly minimum data set (MDS) dated 1/18/23 indicated Resident #23 did not have a history of falls or any fracture related to a fall in the 6 months prior to her re-entry date of 1/16/23. During an interview on 3/29/23 at 3:15 p.m., after	F 641	MDS Coordinator on ensuring that section J, item J1700 was triggered for completion on the first full assessment after a resident was re-admitted to the facility. The Executive Director will conduct random Quality reviews of 5 residents' MDS assessments in the areas of cognition (Section C) and falls (Section J) to ensure MDS coded accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will review full assessments on current residents who have been readmitted in the area of section J, item J1700 regarding completion, 2 times a week for 8 weeks and then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 641	Continued From page 6 reviewing Resident #23's 1/18/23 MDS, the MDS Coordinator indicated due to software error, the MDS inaccurately indicated this was not the first assessment since the resident's re-entry to the facility; thereby, disabling the fall history questions.	F 641		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to	F 761	¿ Medication removed from bedside of resident #40 on 3/28/23. Nurse #2 and	4/26/23

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F 761	Continued From page 7 secure medications for 1 of 1 resident (Resident #40) observed with medications at bedside. Findings included: Resident #40 was admitted to the facility on 8/28/19. Diagnoses included, in part, hypertension and diabetes. The Admission Data Collection assessment, dated 1/9/23, indicated Resident #40 was assessed as not self-administering medications. The quarterly Minimum Data Set assessment dated 1/11/23 revealed Resident #40 had moderately impaired cognition. An observation of Resident #40's room was completed on 3/27/23 at 11:31 AM. The resident was alert and lying in bed. A medication cup that contained nine pills was on the overbed table next to the resident's bed. During an interview with Resident #40 on 3/27/23 at 11:35 AM, he stated he did not know what the medications were for but said sometime during the morning, the nurse brought them in and left them on the table for him to take. He added normally the nurse watched him swallow his medications before she left his room. Nurse #2 was interviewed on 3/27/23 at 12:35 PM. She explained when she gave medication to a resident she watched the resident swallow the medication before she left the room. She verified she was Resident #40's nurse for the day and shared the resident typically took his medication with a spoon and only took one to two pills at a time, so it took a while to administer his medications. She had not noticed a cup of pills	F 761	Unit Manager #1 were re-educated on 3/28/23 to ensure resident takes all medication before leaving room or to take the medication back out of the room to discard and document as refused. ¿ A quality review was completed by the Director of Nursing and Nurse Managers to ensure no medication was left at bedside unsecure on 3/28/23. No other unsecured medication was identified during review. An ADHOC Quality Assurance Performance Improvement Committee will be held on 4/7/23 to formulate and approve a plan of correction for the deficient practice. ¿ The Director of Nursing and or the RN Nurse Educator re-educated licensed nursing staff to include medication aides on ensuring medication is not left at bedside and resident takes all of medication before leaving resident's room by 4/14/23. Nurses and medication aides not re-educated will not be allowed to work their next scheduled shift prior to being re-educated. All newly hired nurses or medication aides will have the same education during their orientation period. The Director of Nursing and/or the RN Nurse Educator provided education to the leadership team, nursing staff, housekeeping staff, activity staff, therapy staff and maintenance to take any noted medications found and take them to the nurse by 4/14/23. All newly hired leadership team members, nursing staff, housekeeping staff, activity staff, therapy staff and maintenance will have the same	

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F 761	Continued From page 8 on his overbed table when she gave him the medications earlier in the day. She said the cup of pills on his overbed table were not left by her. On 3/28/23 an interview was conducted with Nursing Assistant (NA) #2. She worked with Resident #40 during the day on 3/27/23. She recalled she delivered his breakfast tray and said she had not seen a cup of pills on his overbed table. She shared sometimes Resident #40 didn't want to take his medications or told the nurse he wanted the medications left on his table. In an interview with Unit Manager #1 on 3/28/23 at 11:03 AM, she stated she was the nurse who worked with Resident #40 on 3/26/23 during the evening shift and gave him medications. She recalled she gave Resident #40 a cup of pills; the resident swallowed all the medications at once and she took the plastic cup out of the room when he was finished. Unit Manager #1 added sometimes Resident #40 took medication one at a time or wanted the medication placed in pudding or applesauce. Typically when she administered medication she watched the resident swallow the medication before she left the room. She stated it was never appropriate to leave medications with the resident and added Resident #40 was not capable of self-administering medications. During an interview with the Director of Nursing on 3/29/23 at 2:49 PM, she expressed staff were supposed to stay with a resident until all medications were swallowed and then leave the room. She said Resident #40 was not capable of self-administering his medications. She added the resident's pattern of taking medications frequently changed; at times he wanted to take	F 761	education during their orientation period. ¿ The Director of Nursing, RN Educator, Executive Director, Discharge Planner, Human Resources or Activity Director will conduct random Quality reviews of 9 residents rooms to ensure no medication left at bedside 5 times a week for 8 weeks, 3 times a week for 4 weeks, 1 time weekly for 8 weeks, then 2 times a month for 8 months. The Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 761	Continued From page 9 his pills one at a time, sometimes he wanted them in applesauce and other times he wanted staff to leave the medications in the room. She stated it was not appropriate for staff to have left the medication in his room and she had been unable to determine which staff member left the cup of pills on the overbed table in Resident #40's room.	F 761		
F 867 SS=D	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,	F 867		4/26/23

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F 867	Continued From page 10	F 867		

including the methodology and frequency for such 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;

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WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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consider the incidence, prevalence, and severity 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;

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F 867	Continued From page 12 (iii) Regularly review and analyze data, including 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, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 12/2/2021. This was for four deficiencies that were cited in the areas of resident rights (F550), notice requirements (F623), accuracy of assessments (F641), and label/store drugs and biologicals (F761). The four areas were recited on the current recertification and complaint survey of 3/30/2023. The duplicate citations during two federal surveys of record demonstrate a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: 1. F550 - Based on observations and staff interviews the facility failed to maintain a homelike environment when they failed to provide linens free from excessive stains in 1 of 2 residents (Resident #38) reviewed for clean laundry. During the recertification and complaint survey of 12/2/2021, the facility failed to maintain the dignity of a dependent resident as evidenced by two staff members use of the term "feeder" to describe a resident who needed assistance with eating for 1	F 867	The Executive Director held a Quality Assurance Performance Improvement meeting on 4/7/23 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director and Business Office Manager focusing on the areas of F584 Environment related to stained linens, F623 Transfer/Discharge notice providing written, F641 accuracy of Minimum Data Set in the areas of cognition (Section C) and falls (Section J) and F761 Label/store Drugs and Biologicals related to medications at bedside. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. During the Quality Assurance Performance Improvement on 4/7/23 the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis	

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F 867	Continued From page 13 of 4 residents reviewed for dignity. An interview was conducted with the Administrator on 3/30/2023 at 5:14 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing, Medical Director, executive director, minimum data set nurse, unit managers, nursing assistants, housekeeping supervisor, maintenance director, infection control nurse, human resources, admission coordinator, rehabilitation manager, medical records, activities director, pharmacy consultant, dietary manger, and the Social Worker. She stated the committee reviewed any areas of identified concerns in the mock survey, morning meetings, trends with grievances, staff retention, the admission process, dietary, nursing, vaccinations, wounds, falls, and antibiotic usage. She stated in regard to the environment and dignity issue, it was identified by the front-line staff previously and brought to the Administrator's attention. A plan of correction was put into place but had not been completed at the time of the survey. She added the team would continue to work on the issue with stained linens until it was resolved. 2. F623 - Based on staff interviews, interview with the Resident Representative and record review, the facility failed to provide the resident and resident representative a written notification for the reason for transfer to the hospital and failed to provide a copy of the transfer/discharge notice to the Ombudsman for 1 of 2 residents (Resident #79) reviewed for hospitalization. During the recertification and complaint survey dated 12/2/2021, the facility failed to notify the Ombudsman and provide the resident representative a written notification for the reason	F 867	identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Executive Director, Market Leader and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluate the effectiveness and amend as needed.	

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for transfer to the hospital for 2 of 2 residents reviewed for hospitalization.

An interview was conducted with the Administrator on 3/30/2023 at 5:14 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing, Medical Director, executive director, minimum data set nurse, unit managers, nursing assistants, housekeeping supervisor, maintenance director, infection control nurse, human resources, admission coordinator, rehabilitation manager, medical records, activities director, pharmacy consultant, dietary manger, and the Social Worker. She stated the committee reviewed any areas of identified concerns in the mock survey, morning meetings, trends with grievances, staff retention, the admission process, dietary, nursing, vaccinations, wounds, falls, and antibiotic usage. She stated the admission process had been improved with the plan of correction put into place by the QAA committee after the 12/2/2021 recertification. She added the nurse that completed the transfer/discharge identified during the 3/30/2023 recertification survey, was new to the facility and education would be provided.

3. F641 - Based on resident and staff interviews and record reviews, the facility failed to accurately code cognition and fall history on the Minimum Data Set (MDS) assessments for 2 of 20 residents (Resident #79 and #23) reviewed for MDS accuracy.

During the recertification and complaint survey, dated 12/2/2021, the facility failed to accurately code urinary incontinence, failed to accurately code a prognosis of less than six months and failed to accurately code the Pre-admission

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Screening and Resident Review (PASRR) on the comprehensive MDS assessment for 3 of 24 residents reviewed for MDS accuracy.

An interview was conducted with the Administrator on 3/30/2023 at 5:14 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing, Medical Director, executive director, minimum data set nurse, unit managers, nursing assistants, housekeeping supervisor, maintenance director, infection control nurse, human resources, admission coordinator, rehabilitation manager, medical records, activities director, pharmacy consultant, dietary manger, and the Social Worker. She stated the committee reviewed any areas of identified concerns in the mock survey, morning meetings, trends with grievances, staff retention, the admission process, dietary, nursing, vaccinations, wounds, falls, and antibiotic usage. She stated the MDS accuracy had improved according to the plan of correction follow up reviews from the previous survey in 2021. She added the identified concern for the current recertification was due to the new software system being used that might have caused a glitch that led to a coding error.

4. F761 - Based on observation, resident and staff interviews and record review, the facility failed to secure medications for 1 of 1 resident (Resident #40) observed with medications at bedside.

During the recertification and complaint survey, dated 12/2/2021, the facility failed to remove expired medications from 1 of 1 medication room reviewed for medication storage.

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F 867	Continued From page 16 An interview was conducted with the Administrator on 3/30/2023 at 5:14 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing, Medical Director, executive director, minimum data set nurse, unit managers, nursing assistants, housekeeping supervisor, maintenance director, infection control nurse, human resources, admission coordinator, rehabilitation manager, medical records, activities director, pharmacy consultant, dietary manger, and the Social Worker. She stated the committee reviewed any areas of identified concerns in the mock survey, morning meetings, trends with grievances, staff retention, the admission process, dietary, nursing, vaccinations, wounds, falls, and antibiotic usage. She stated the medication storage concern identified in 2021 had been due to the storage room and a plan of correction was put into place.	F 867		