STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345221	A. BUILDING _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT WEAVERVILLE	78 WEAVER BOULEVARD WEAVERVILLE, NC 28787

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E 000	Initial Comments An unannounced recertification survey was conducted on 04/03/23 through 04/06/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 984Q11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/03/23 through 04/06/23. Event ID #984Q11. The following intakes were investigated: NC00190135, NC00199795, NC00197221, NC00199397, NC00189452, NC00191381, NC00200899, and NC00192434. 8 of the 26 complaint allegations resulted in deficiency.	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	F 550		4/29/23

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

Electronically Signed | 04/28/2023

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all 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 record review and resident and staff interviews, the facility failed to treat a resident in a dignified and respectful manner when Nurse Aide #1 spoke and acted in a manner that made a resident feel uncomfortable for 1 of 7 residents reviewed for dignity (Resident #21). Findings included: Resident #21 was admitted to the facility on 09/12/22 with diagnoses that included left tibia (larger bone in the lower leg) and fibula (smaller bone in the lower leg) fractures. The quarterly Minimum Data Set (MDS) dated 03/27/23 assessed Resident #21 with intact	F 550	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice that occurred when facility staff failed to treat a resident in a dignified and respectful manner. Address how corrective action will be	

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F 550	Continued From page 2	F 550		

cognition. Resident #21 required physical assistance of one to two staff members with transfers, bed mobility and toileting.

During an interview on 04/03/23 at 10:43 AM, Resident #21 revealed on Saturday 04/01/23, NA #1 had just finished cleaning her up after an incontinence episode when "within minutes" she had another incontinent episode where urine leaked out from her brief onto the bed. Resident #21 stated that while NA #1 was cleaning her up the second time, NA #1 started walking back and forth around her bed telling Resident #21 that she (NA #1) was "praying the devil out of her." Resident #1 stated NA #1's behavior made her feel very uncomfortable as if NA #1 thought she (Resident #21) was the devil. Resident #21 stated she reported the incident to the Administrator this morning.

During a telephone interview on 04/05/23 at 12:31 PM, NA #1 stated on Saturday (04/01/23) after changing Resident #1, she started assisting her roommate with care when Resident #21 told her she had another incontinent episode. NA #1 explained she didn't realize the brief she had placed on Resident #21 was too big which caused urine to leak out onto the bed. NA #1 recalled Resident #21 was being argumentative and accusing NA #1 of not believing she had an incontinent episode even after NA #1 told her she could see the bed was wet. NA #1 stated it was possible she said to herself, "Lord help me" as she was providing care to Resident #21 but never told Resident #21 she was "praying the devil out of her."

During a follow-up telephone interview on 04/05/23 at 8:09 PM, NA #1 stated she had

accomplished for those residents found to have been affected by the deficient practice:
On 4/3/23, CNA #1 was suspended by the Administrator, resident #21 was notified by the Administrator that CNA #1 would not be caring for her, Initial investigation report was submitted to Department of Health and Human Services (DHHS), Division of Health Service Regulation (DHSR) by the Administrator, Department of Social Services was notified by Social Worker, resident #21□s physician was notified of allegation, resident #21 was referred to Psychiatric services by Director of Nursing (DON), and Care Plan for resident #21 was updated by DON/designee.
On 4/3/23, 4/4/23, and 4/5/23, DON completed psychosocial monitoring after the incident.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

All other residents are at risk of suffering from the deficient practice.

On 4/3/23-4/10/23, an audit of all residents with a Brief Interview for Mental Status (BIMS) of 10 or greater was completed by the DON/designee to determine if any other incidents had occurred that made them feel disrespected and to ensure they felt safe.
On 4/3/23-4/10/23, all staff were interviewed by DON/designee to determine if they had knowledge of abuse or any other incidents that were

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F 550	Continued From page 3	F 550		

thought further about the incident with Resident #21 on 04/01/23 and felt Resident #21 may have misunderstood her. NA #1 explained when dealing with difficult situations, she drew on her faith and would say to herself, "devil, I rebuke you" in an effort to bring herself peace and not react negatively to a situation. NA #1 stated it was possible Resident #21 heard NA #1 make the comment to herself and thought it was directed at her (Resident #21).

During a follow-up interview on 04/06/23 at 2:29 PM, Resident #21 clarified she had not misunderstood the situation with NA #1. Resident #21 stated when NA #1 was providing her care, NA #1 did not make the comment "devil I rebuke you" softly to herself but instead used a loud tone while walking around the bed and made the comment directly to Resident #21. Resident #21 stated she was never fearful of NA #1 but was bothered by NA #1's behavior because she (Resident #21) was unable to walk or get out of bed on her own to leave the room. Resident #21 restated the incident just made her feel very uncomfortable.

During an interview on 04/05/23, the Administrator stated he spoke with Resident #21 the morning of 04/03/23 regarding the alleged incident with NA #1. The Administrator stated NA #1 had worked at the facility through a staffing agency for about a month and there had been no reported issues with her performance. The Administrator stated he notified the staffing agency NA #1 was suspended from working at the facility while he finished conducting an investigation. The Administrator stated disrespectful behavior, whether actual or perceived, was never acceptable. He stated disrespectful to residents.

Address what measure will be put into place or systemic changes made to ensure the deficient practice will not recur:
On 4/10/23, it was determined by Administrator that CNA#1 would not return to work in the facility.

Beginning on 4/3/23, education on the facility abuse policy and customer service was provided to all staff by the DON/designee. Education included the definitions of the various types of abuse and appropriate reporting to facility Administrator, the need to treat residents with respect and dignity at all times, treating residents as one would wish to be treated, and considering residents feelings during all interactions. The education also discussed the facility policy for zero tolerance of abuse, the expectations for excellent customer service, including the need to ensure that staff/resident interactions do not make a resident feel uncomfortable or disrespected. All current staff will be educated prior to working any shift, and new staff will receive this education prior to working in the facility.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Five random residents will be interviewed by DON/designee to ensure they have not had any incidents with staff that made them feel uncomfortable. These audits will occur 3x week for 2 weeks and 1 x week

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F 550	Continued From page 4 residents should always be treated with respect and never made to feel otherwise.	F 550	for 6 weeks. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until such time that substantial compliance is achieved. Audits will continue thereafter at the discretion of the QAPI committee. The Director of Nursing will be responsible for implementing the corrective action. Include dates when the corrective action will be completed: The facility will be in full compliance with this Plan of Correction no later than 4/29/23.	
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to assess the ability of residents to self-administer medications for 3 of 3 residents reviewed for self-administration of medication (Resident #35, Resident #39, and Resident #7). Findings included: 1. Resident #35 was admitted to the facility 06/17/22 with multiple diagnoses including spinal stenosis (when the spaces in the spine narrow	F 554	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements. Corrective action was accomplished for the alleged deficient practice that occurred when facility failed	4/29/23

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F 554	Continued From page 5 and cause pressure on the spinal cord and nerve roots). The quarterly Minimum Data Set (MDS) dated 01/30/23 revealed Resident #35 was cognitively intact. Review of the medical record revealed no documentation that Resident #35 had been assessed for self-administration of medication. An observation of Resident #35's room on 04/03/23 at 11:32 AM revealed the following: a. a 15 milliliter (ml) bottle of carboxymethylcellulose sodium 0.5% eye drops (eye drops that help with dry eyes) sitting on the overbed table b. a 1.76 ounce (oz) tube of diclofenac sodium topical gel 1% (a topical anti-inflammatory pain-relieving gel) in a bath basin sitting on the floor by Resident #35's bed c. a box of 4% lidocaine patches (patches that help with pain relief) sitting on top of Resident #35's chest of drawers beside her bed An interview with Resident #35 on 04/03/23 at 11:32 AM revealed she put the eye drops in her eyes when she felt like she needed them, she put the diclofenac gel on her knees once a day, and placed the lidocaine patches on her lower back daily. She stated her daughter brought her the medications from home. Observations of Resident #35's room on 04/04/23 at 2:44 PM, 04/05/23 at 11:50 AM, and 04/06/23 at 4:19 PM revealed the eye drops, diclofenac gel, and lidocaine patches remained in the same locations.	F 554	to assess the ability of residents to self-administer medication. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/4/23, residents #7, #35, and #39 were assessed for self-administration of medications by the Director of Nursing (DON)/designee, all medications were removed from the residents' room by DON, and residents/responsible parties were notified by DON that medication cannot be stored at bedside without a Medication Self-Administration Assessment and that if deemed capable of self-administering medications, a physician's order must be obtained, and the medications must be safely stored in a locked box or drawer. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 04/28/23, an audit was completed to ensure that all residents have Medication Self-Administration Assessments. On 04/28/23, an audit was completed by DON/designee to ensure that 1.) If resident is deemed capable of self-administration, a physician's order was present and the medication was properly stored with locked box or drawer, and 2.) There were no medications stored in rooms of residents who were not deemed capable of self-administration.	

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F 554	Continued From page 6 An interview with the Director of Nursing (DON) on 04/06/23 at 4:59 PM revealed no medications should be left at the bedside unless the resident had been assessed as safe to self-administer medications. She stated if a resident was assessed as safe to self-administer medications, then a physician's order was obtained to leave the medications in the room, including over the counter (OTC) medications. The DON confirmed Resident #35 had not been assessed to self-administer medication and should not have had eye drops, diclofenac gel, or lidocaine patches in her room. She stated she had removed multiple medications from Resident #35's room and her family kept bringing medications to her. 2. Resident #39 was admitted to the facility 11/11/22 with multiple diagnoses including non-Alzheimer's dementia. Review of the quarterly Minimum Data Set (MDS) dated 01/13/23 revealed Resident was moderately cognitively impaired. Review of the medical record revealed no documentation that Resident #39 had been assessed for self-administration of medication. An observation of Resident #39's overbed table on 04/03/23 at 11:42 AM revealed a tube of triamcinolone cream 0.1% (an antifungal cream) and 2 tubes of diclofenac sodium 1% gel (a topical anti-inflammatory pain-relieving gel) sitting on top of the table. Another tube of triamcinolone cream 0.1% cream and diclofenac sodium gel 1% were sitting in a storage basket beside Resident #39's bed.	F 554	Address what measure will be put into place or systemic changes made to ensure the deficient practice will not recur: On 04/28/23, education was provided by DON/designee to all direct care staff that medication may not be stored at the bedside without a Medication Self-Administration Assessment. If a resident is deemed capable of medication self-administration, a physician□s order will be obtained, and the medication will be properly stored in a locked box or drawer. If a resident is not deemed capable of medication self-administration, medication will not be stored at bedside. All current staff will be educated prior to working a shift, and new staff will be educated prior to working in the facility. On 4/28/23, education was provided (via written correspondence) by Administrator to all residents/responsible parties that medication may not be stored at the bedside without a Medication Self-Administration Assessment. If a resident is deemed capable of medication self-administration, a physician's order will be obtained, and the medication will be properly stored in a locked box or drawer. If a resident is not deemed capable of medication self-administration, medication will not be stored at bedside. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Five random residents will be reviewed by DON/designee to ensure they have been assessed for medication self-administration. If a resident is	

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F 554	Continued From page 7 An interview with Resident #39 on 04/03/23 at 11:42 AM revealed he put the triamcinolone cream on his toes for fungus and he put the diclofenac gel on his knees for pain. An observation of the storage basket sitting beside Resident #39's bed on 04/04/23 at 2:18 PM revealed a tube of triamcinolone cream 0.1% and a tube of diclofenac sodium gel 1% were sitting in the basket. An observation of Resident #39's overbed table on 04/05/23 at 11:51 AM revealed 2 tubes of diclofenac sodium gel 1% and 1 tube of triamcinolone cream 0.1% were sitting on top of the table. An observation of the storage basket sitting beside Resident #39's bed revealed a tube of triamcinolone cream 0.1% was sitting in the basket. An interview with the Director of Nursing (DON) on 04/06/23 at 4:59 PM revealed no medications should be left at the bedside unless the resident had been assessed as safe to self-administer medications. She stated if a resident was assessed as safe to self-administer medications, then a physician's order was obtained to leave the medications in the room, including over the counter (OTC) medications. The DON confirmed Resident #39 had not been assessed to self-administer medication and should not have had diclofenac gel and triamcinolone cream in his room. She stated she had removed multiple medications from Resident #39's room and his family kept bringing medications to him. 3. Resident #7 was admitted to the facility 02/15/23 with diagnoses including diabetes and	F 554	deemed capable of medication self-administration, a physician's order will be present, and the medication will be properly stored in a locked box or drawer. If a resident is not deemed capable of medication self-administration, medication will not be stored at bedside. These audits will occur 3x week for 2 weeks and 1 x week for 6 weeks. The results of these audits will be reported monthly to the Quality Assurance Process Improvement (QAPI) committee until such time that substantial compliance is achieved. Audits will continue thereafter at the discretion of the QAPI committee. The Director of Nursing will be responsible for implementing the corrective action. Include dates when the corrective action will be completed: Facility will be in full compliance with this Plan of Correction no later than 4/29/23.	

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arthritis.

The admission Minimum Data Set (MDS) dated 02/17/23 revealed Resident #7 was moderately cognitively impaired.

Review of the medical record revealed no documentation that Resident #7 had been assessed for self-administration of medication.

An observation of Resident #7's overbed table on 04/03/23 at 9:30 AM revealed a 10 milliliter (ml) bottle of carboxymethylcellulose sodium 1% gel eye drops (eye drops that help with dry eyes) was sitting on the table.

An interview with Resident #7 on 04/03/23 at 9:30 AM revealed nursing staff put the drops in his eyes because he didn't have the hand strength to open the bottle and apply the drops.

An observation of Resident #7's overbed table on 04/05/23 at 11:48 AM revealed a 10 milliliter (ml) bottle of carboxymethylcellulose sodium 1% gel eye drops (eye drops that help with dry eyes) was sitting on the table.

An interview with the Director of Nursing (DON) on 04/06/23 at 4:59 PM revealed no medications should be left at the bedside unless the resident had been assessed as safe to self-administer medications. She stated if a resident was assessed as safe to self-administer medications, then a physician's order was obtained to leave the medications in the room, including over the counter (OTC) medications. The DON confirmed Resident #7 had not been assessed to self-administer medication and should not have had eye drops in his room. She stated she had

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F 554	Continued From page 9 removed eye drops from Resident #7's room on multiple occasions and his family kept bringing him more eye drops.	F 554		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) for a resident with a new mental health diagnosis for 1 of 1 resident reviewed for PASRR (Resident #44). Findings included: Resident #44 was admitted to the facility on 10/11/22. Her diagnoses included panic disorder, major depressive disorder, and psychotic disorder	F 644	Regarding the alleged deficient practice of failure to request a Pre-Admission Screening and Resident Review (PASRR): a. Resident #44 noted with new mental health diagnosis on January 27, 2023 with no request made for Level II screening at that time. On 04/05/23 an updated PASSR request was submitted for resident #44.	4/29/23

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F 644	Continued From page 10 with delusions due to a known physiological condition. The North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry dated 04/06/23 revealed Resident #44 had a Level I PASRR effective 10/11/22. A Psychiatrist progress note dated 01/26/23 revealed in part, Resident #44 had been having some delusions that her water was poisoned and hearing people talking to her. It was further noted Resident #44 reported feeling restless, anxious, and realized people were not in the room with her but still worried about the voices. The assessment and plan noted a new diagnosis of psychotic disorder with delusions due to known physiological condition with plans to consider medication at a future visit. Review of Resident #44's list of cumulative diagnoses contained in her medical record revealed a new diagnosis of psychotic disorder with delusions due to known physiological condition with an onset date of 01/27/23. The significant change Minimum Data Set (MDS) dated 02/03/23 revealed Resident #44 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During interviews on 04/05/23 at 11:57 AM and 04/06/23 at 10:10 AM, the Social Worker (SW) explained typically the Psychiatrist or nursing staff notified him of residents with a new mental health diagnosis and he would submit a referral to PASRR requesting a Level II evaluation. The SW did not recall being notified Resident #44 was	F 644	All residents with new mental health diagnoses have the potential to be affected. An audit was conducted on 4/7/23 of all residents with mental health diagnoses added in the past 30 days to ensure that all had requests for PASRR reviews with no additional deficiencies identified. On 04/10/2023, the facility administrator initiated education to team members who participate in the PASRR request process for newly identified mental health diagnoses: social services director, minimum data set coordinators, mental health providers, and director of nursing regarding timely notification to facility social services director of new mental health diagnoses, and required requests for PASRR reviews. Newly hired team members who will participate in the PASRR review process will be educated on this process by the administrator or social service director upon hire. Social services director will audit 5 residents per week every week for 4 weeks to ensure requests for PASRR reviews are submitted, then will audit 3 residents with newly assigned mental health diagnoses every week for 4 weeks to ensure requests for PASARR reviews are submitted. Facility administrator will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Facility administrator will review the plan during Quality Assurance committee	

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F 644	Continued From page 11 diagnosed with a new mental health condition on 01/27/23 and confirmed he had not requested a Level II PASRR evaluation for Resident #44 until 04/05/23. During an interview on 04/06/23 at 5:16 PM, the Administrator stated the SW should have been made aware when Resident #44 was diagnosed with a new mental health condition so that he could have requested a Level II PASRR evaluation.	F 644	meetings and continue audits at the discretion of the committee. Facility will be in full compliance with this Plan of Correction no later than 4/29/23	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to correctly enter an order to obtain a speech therapy (ST) evaluation as ordered by a Nurse Practitioner (NP) for 1 of 4 residents (Resident #76) reviewed for therapy services. Findings included: Resident #76 was admitted to the facility 02/08/23 with multiple diagnoses including dysphagia (difficulty swallowing). Resident #76 had a Physician order dated 02/10/23 to receive a mechanical soft diet (a diet consisting of foods that could be swallowed safely).	F 658	Regarding the alleged deficient practice of failure to ensure services provided meet professional standards: a. Facility failed to enter an order to obtain a Speech Therapy evaluation for resident #76 as ordered by Nurse Practitioner. On 04/05/23, Speech Therapy evaluation for Resident #76 was conducted by the Rehab Program Manager. On 4/28/23, the Director of Nursing audited all orders for therapy evaluations in the last 30 days to ensure all were performed/implemented with no additional deficiencies identified. On 4/28/23, the Director of Nursing educated all licensed nurses to the	4/29/23

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F 658	Continued From page 12 The admission Minimum Data Set (MDS) dated 02/14/23 revealed Resident #76 was cognitively intact and received a mechanically altered diet. The nutrition care plan initiated 02/15/23 revealed Resident #76 had a nutritional problem related in part to a diagnosis of dysphagia and interventions included providing her diet as ordered and monitoring her meal intakes. NP #1's progress note revealed Resident #76 was seen for diet/swallowing on 03/07/23. The note further stated Resident #76 verbalized concern with her dietary restrictions, was requesting speech-language therapy re-evaluate her for aspiration (inhaling food or fluid into the airway), and denied difficulty chewing or swallowing food. Resident #76's orders revealed an order dated 3/08/23 for speech-language therapy to evaluate her to increase her diet consistency. Review of Resident #76's medical record did not contain any documentation that a ST evaluation was completed on or after 03/08/23. An interview with Resident #76 on 04/03/23 at 10:07 AM revealed she received a chopped meat diet and she did not have a chewing or swallowing problem and refused to eat chopped meat. She stated she had requested to have her diet changed to a regular diet but no one had changed it. An interview with the Director of Rehab on 04/05/23 at 8:18 AM revealed Resident #76 was placed on the ST case load on 02/9/23 and was	F 658	process to correctly enter therapy evaluation orders to ensure implementation. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to entering and therapy evaluation orders. The Director of Nursing and/or Rehab Program Manager will audit and reconcile all orders for therapy evaluations twice a week for four weeks to ensure they are entered correctly and conducted for the resident, then once weekly for four weeks to ensure they are entered correctly and conducted for the resident. Facility administrator or Director of Nursing will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Facility administrator or Director of Nursing will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Facility will be in compliance with this Plan of Correction by 4/29/23	

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F 658	Continued From page 13 discharged from ST on 03/03/23. She confirmed Resident #76 had not received any additional ST services since 03/03/23 and was not aware of any orders for a ST evaluation after 03/03/23. An interview with the Director of Nursing (DON) on 04/06/23 at 4:59 PM revealed the order for ST to evaluate Resident #76 dated 03/08/23 was placed in the computer by nursing staff as a one time order and one time orders fell off the active order list at midnight each night. She stated if the order had been entered into the computer as a routine order it would have remained on Resident #76's active orders and would have notified the therapy department Resident #76 had a new order for ST evaluation. The DON stated since the order was not entered into the computer correctly ST was not aware of the order and that is why Resident #76 did not receive a ST evaluation as ordered on 03/08/23. She stated residents should receive therapy consults as ordered.	F 658		
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	F 761		4/29/23

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F 761	Continued From page 14 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 observations, staff and resident interviews, and record review the facility failed to secure medication for 1 of 1 resident (Resident #10) observed with medication at bedside. The findings included: Resident #10 was admitted to the facility on 8/25/22 with diagnoses including a stage 3 pressure ulcer. A review of Resident #10's physician's orders revealed an order dated 12/16/22 to clean wound with wound cleaner and apply zinc with collagen every shift and as needed. The annual Minimum Data Set (MDS) dated 3/1/23 revealed she was cognitively intact. On 11/25/22 Resident #10's self-administration of medication assessment documented Resident #10 was not able to self-administer medications. An observation of Resident #10's room and interview were conducted on 4/3/23 at 10:09 AM.	F 761	Regarding the alleged deficient practice of failure to store all drugs labeled in accordance with currently accepted professional principles, including expiration date when applicable, as evidenced by: a) Zinc oxide with collagen paste was stored on overbed table of resident #10 Zinc oxide with collagen paste was secured in medication cart on 04/07/2023. All resident rooms and overbed tables were audited on 04/10/2023 by the Director of Nursing with any improperly stored medications removed and properly secured. On 4/28/23, the Director of Nursing (DON) provided in-service education to licensed nurses regarding requirements for storing of medication. with education to continue upon return to work for all licensed nurses. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to accepting a resident assignment.	

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F 761	Continued From page 15 The Resident was alert and lying in bed. A container labeled zinc oxide with collagen paste was on the overbed table. The Resident stated the zinc oxide with collagen paste was left on her overbed table a lot of the time. Nurse # 1 stated in an interview on 4/3/23 at 10:45 AM the zinc oxide with collagen paste was left on the overbed table after application earlier in the morning. She said it should have been locked up in the treatment cart after use and the paste contained 25% zinc concentration. The Director of Nursing (DON) stated on 4/6/23 at 3:13 PM that zinc oxide is labeled with the resident's name and date and should be stored in the treatment cart when not in use. It was not standard protocol to leave it in a resident's room.	F 761	The DON and/or Unit Coordinators will audit 8 resident rooms weekly for 4 weeks, then 4 resident rooms weekly for eight weeks to ensure there are no improperly stored medications. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. The facility will be in compliance with the Plan of Correction by 4/29/23	
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	F 812		4/29/23

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F 812	Continued From page 16 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired food, and to date and label opened food in 1 of 3 kitchen refrigerators. The facility failed to remove expired resident food in 1 of 2 nourishment refrigerators (nourishment room #1). Additionally, the facility failed to maintain a clean wall behind the dish machine free of black matter and maintain and repair a leaking dish machine pipe. This practice had the potential to affect food served to residents. The findings included 1. On 4/03/23 at 8:15 AM an observation of the walk-in refrigerator in the kitchen revealed multiple stored food items that were expired or stored without a use by date. The Dietary Manager was not present at the time of the observation. The second shelf of the walk-in refrigerator contained as followed: 1 opened bag of French toast not dated. 2-quart plastic container of lettuce dated 3-27 and use by 3-30. 2-quart container of chicken broth dated 3-26 and use by 4-2. 1 plastic bag with Swiss written on it and dated 2-25 use by 3-15. 1 plastic bag containing sliced cheese not dated. 1 opened plastic bag containing shredded cheese not dated. 1 plastic bag containing ham not dated. 3-quart container of cooked rice half full dated 3-22 to 3-30.	F 812	Regarding the alleged deficient practice of failure to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidenced by: a) Failure to discard stored food prior to or on the expiration date b) Failure to date and label open food containers c) Failure to maintain a clean wall behind the dish machine d) Failure to repair a leaking dish machine pipe On 04/10/2023, the expired and unlabeled, undated foods were discarded by Dietary Manager. On 04/10/2023, the wall behind the dish machine was cleaned by the Dietary Manager. On 4/27/23, the dish machine pipe was repaired by facility maintenance director and EcoLab repairman. On 4/26/23, the facility administrator (NHA) provided inservice education to the Dietary Manager and dietary staff regarding requirements for discarding stored food on or before expiration dates, as well as dating and labeling of open food containers, and maintaining clean walls. Newly hired dietary staff and those contracted through agencies will be educated upon hire. Current employees will be educated prior to working a shift. Dietary manager or facility administrator will audit foods stored in all kitchen and	

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F 812	Continued From page 17 3.5-quart container of salsa dated 3-23 use by 3-29. 3.5-quart container half full of ketchup dated 3-24 use by 3-3. 2-quart container of lime gelatin dated 3-17 use by 3-24. 3.5- quart chicken salad dated 3-23 use by 3-30. 1 plastic bag containing turkey dated 3-25 and use by 4-2. On 4/3/23 at 8:40 AM a dietary aide reported there were new staff that worked the previous weekend and overlooked the items in the walk-in refrigerator. She stated that all dietary staff normally dated items and checked expiration dates of food in the refrigerators. On 4/5/23 at 10:32AM the District Dietary Manager stated that all food in the walk-in refrigerator should have been dated and removed if expired. The manager should have checked for dates and expired food, but also any dietary staff should have checked for dates when in the walk-in refrigerator. 2. A follow-up visit to the kitchen on 4/05/23 at 10:19 AM revealed the wall area directly behind the dish machine contained an approximately 24 by 12 inch splotchy blackish matter that was crumbly to touch in some areas. On 4/05/23 at 10:32 AM the District Dietary Manager in training stated the dish machine area was assigned to be cleaned every Tuesday night by the dietary staff. She said the dietary staff assigned to clean the area the previous day (Tuesday) did not clean it as assigned by the cleaning schedule.	F 812	nourishment room refrigerators for expiration dates and proper labeling five times per week for four weeks, then two times per week for 4 weeks. Dietary manager or facility administrator will audit kitchen walls and surfaces for cleanliness 5 times per week for 4 weeks, then 2 times per week for 4 weeks. All kitchen equipment, pipes and drains will be audited by maintenance director twice weekly for 4 weeks to ensure no repairs are needed; then weekly for four weeks to ensure no repairs are needed. Facility administrator will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Facility administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. The facility will be in compliance with this Plan of Correction by 4/29/23.	

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F 812	Continued From page 18	F 812		

3. On 4/5/23 at 10:19AM an observation in the kitchen with the District Dietary Manager revealed a leaking hot water pipe with a steady drip on the top of the dish machine. The dish machine was identified as a high temperature machine that used hot water to sanitize the dishes. The dish machine water temperature gauge revealed a wash temperature of 170 degrees Fahrenheit and a rinse temperature of 195 degrees Fahrenheit with both exceeding the minimum temperature requirements (150 and 180 degrees respectively).

On 4/5/23 at 10:32 AM the District Dietary Manager stated she was unaware of the leaking pipe and did not know how long it had been leaking. The District Dietary Manager was covering for the Dietary Manager who was on vacation.

The Maintenance Director was interviewed on 4/5/23 at 4:10 PM and stated he was unaware of the leaking pipe on the dish machine. He made rounds in the kitchen daily to check for any maintenance issues and the kitchen staff would inform him of any maintenance issue they had.

4. On 4/5/23 at 11:00 AM an observation of nourishment room #1 with the District Dietary Manager revealed a resident's container of watermelon was dated use by 3/31/23. The container of watermelon was removed and disposed of by the District Dietary Manager. The District Dietary Manager stated the dietary aides check the nourishment rooms 3 times daily for expired items and to restock any needed items. The container of watermelon should have been removed by a dietary aide.

The Administrator stated on 4/6/23 at 5:13 PM

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F 812	Continued From page 19 that any expired food in refrigerators should have been thrown out by the kitchen staff and food should have been dated and labeled. The dish machine area should have been cleaned by the kitchen staff and the dish machine should have been maintained and repaired when leaking.	F 812		