| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345296 | A. BUILDING _____ B. WING _____ | C 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARGATE HEALTH AND REHAB CENTER | 540 WAUGH STREET JEFFERSON, NC 28640 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 6/11/23 through 6/15/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #C1CN11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 6/11/23 through 6/15/23. Event ID# C1CN11. The following intakes were investigated: NC00194835 and NC00183883.<br><br>2 of the 2 complaint allegations did not result in deficiency. | F 000 | | |
| F 623 SS=B | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and | F 623 | | 7/7/23 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/30/2023 |

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| F 623 | Continued From page 1 | F 623 | | |

(c)(8) of this section, the notice of transfer or discharge required under this section must be 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;

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| F 623 | Continued From page 2<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related 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<br>(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.<br><br>§483.15(c)(6) Changes to the notice.<br>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.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and Ombudsman interview, the facility failed to provide written notice of discharge to the | F 623 | 1. Notice of discharges/transfers was sent and received by Stevie John, LTC Ombudsman, on 6/14/2023 for effective | |

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| F 623 | Continued From page 3<br>ombudsman for 1 of 4 residents reviewed for discharge to the hospital (Resident #73).<br><br>The findings included:<br><br>Resident #73 was admitted to the facility on 4/16/2023.<br><br>Nursing documentation on 4/29/2023 indicated after notification of the physician, Resident #73 was discharged from the facility to the hospital for an evaluation due to experiencing an unresponsive episode and urine with bright red blood.<br><br>A notice of transfer for Resident #73 dated 4/29/2023 was located in his medical record.<br><br>Hospital emergency room records dated 4/29/2023 indicated Resident #75 was discharged from the emergency room at 1:41 a.m. on 4/30/2023 to return to the nursing home facility.<br><br>Nursing documentation also indicated on 5/4/2023 Resident #73 was discharged from the facility to the hospital due to complaining of numbness and tingling to both upper extremities.<br><br>A notice of transfer for Resident #73 dated 5/4/2023 was located in his medical record.<br><br>There was a discharge Minimum Data Set (MDS) assessment dated 5/4/2023 completed. The 5 -day admission Minimum Data Set (MDS) assessment dated 5/15/2023 indicated Resident #73 was re-admitted to the facility on 5/8/2023 and he was cognitively intact. | F 623 | dates of 5/14/2023 through 6/14/2023.<br>2. Communication with Stevie determined a list of appropriate transfers/discharges is approved to be sent to her via secured email every 30 days.<br>3. 100 percent audit of transfers and discharges to be conducted to ensure notification has been included in 30-day list. To be completed 7/7/2023.<br>4. Monitoring for emergency transfers, resident initiated transfers will include posting in HIPAA compliant electronic communication group. All discharges will be reviewed monthly to determine if notification to ombudsman is appropriate.<br>5. Monitoring of plan of correction will be conducted through monthly auditing<br>6. Compliance to be reviewed and maintained by facility administrator or designee. | |

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| F 623 | Continued From page 4<br>On 6/14/2023 at 10:11 a.m. in an interview with the Administrator, he said beds were available at the facility for residents to return to after a transfer or discharge to the hospital, and the facility considered it a leave of absence; therefore, the Ombudsman was not notified of the transfers and discharges to the hospital.<br><br>On 6/14/2023 at 10:12 a.m. in an interview with Social Worker #1, she stated she did not send notification of transfers and discharges to the hospital to the Ombudsman. She said she only sent the Ombudsman information of bed holds that were activated and residents who were discharged from the facility to the community or another facility.<br><br>On 6/14/2023 at 10:52 a.m. in a phone interview with the designated Ombudsman for the facility, she stated she had never received any notifications of any type of discharges from the facility.<br><br>On 6/14/2023 at 12:20 p.m. in a follow up interview with the Administrator, he provided a printed list of discharges from the facility printed on 6/14/2023 at 10:44 a.m. and stated the list of discharges had been sent to the Ombudsman on 6/14/2023. The list of discharges included Resident #73's discharge on 5/4/2023, but not the transfer for 4/29/2023. He stated after speaking with the Ombudsman earlier, the facility planned to send out written notices of discharges to the Ombudsman every thirty days. He further stated written notices of discharge/transfer from the facility were not being sent to the Ombudsman before 6/14/2023. | F 623 | | |
| F 641 SS=E | Accuracy of Assessments | F 641 | | 7/26/23 |

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| F 641 | Continued From page 5<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of behaviors, antipsychotic medication use, Pre-Admission Screening and Resident Review, diagnoses, and discharge destination for 5 of 29 resident MDS assessments reviewed (Residents #47, #88, #18, #40 and #122).<br><br>Findings included:<br><br>1. Resident #47 was admitted to the facility on 6/9/22 with Alzheimer's disease and anxiety.<br><br>Resident #47's Behavior Monitoring Sheet revealed incidents of biting, hitting, and wandering occurring during the assessment period of 5/2/23 through 5/8/23.<br><br>An annual Minimum Data Set (MDS) assessment dated 5/8/23 indicated Resident #47 had not exhibit any behaviors during the assessment period.<br><br>During an interview on 6/14/23 at 3:15 PM the MDS nurse stated the behavioral section of the MDS assessment was the responsibility of the Social Worker.<br><br>An interview was conducted with Social Worker #2 on 6/14/23 at 3:15 PM who stated Resident #47 should have been coded for behaviors, and | F 641 | 1. 100 percent audit of assessments of all residents to be conducted to ensure assessments accurately reflect resident status. To be completed by MDS nurses.<br>2. Assessments for all residents current status will be reviewed once monthly x 3 months and then once quarterly for 6 months<br>3. Findings will be discussed during QAPI meetings. | |

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| F 641 | Continued From page 6 | F 641 | | |

that was an error.

During an interview on 6/15/23 at 11:35 AM, the Administrator stated Minimum Data Set assessments should be completed accurately.

2. Resident #88 was admitted to the facility on 10/12/21 with diagnoses that included dementia and schizophrenia.

Resident #88's Behavior Monitoring Sheet revealed incidents of yelling and screaming occurring during the assessment period of 5/17/23 through 5/23/23.

A quarterly Minimum Data Set (MDS) assessment dated 5/23/23 indicated Resident #88 had not exhibit any behaviors during the assessment period.

During an interview on 6/14/23 at 3:15 PM the MDS nurse stated the behavioral section of the MDS assessment was the responsibility of the Social Worker.

An interview was conducted with Social Worker #2 on 6/15/23 at 11:05 AM who stated Resident #88 should have been coded for behaviors, and that was an error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Minimum Data Set assessments should be completed accurately.

3. Resident #18 was admitted to the facility on 2/13/23 with diagnoses that included bipolar disorder.

Review of Resident #18's Medication

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| F 641 | Continued From page 7 | F 641 | | |

Administration Record for May 2023 revealed she received antipsychotic medication during the assessment period of 5/13/23 through 5/19/23.

A Minimum Data Set (MDS) assessment dated 5/19/23 revealed Resident #18 received antipsychotic medication daily during the assessment period. The Antipsychotic Medication Review section, a separate section of the MDS, indicated no antipsychotic medication had been received.

During an interview on 6/14/23 at 3:15 PM the MDS nurse stated Resident #18 had received antipsychotic medications daily. She explained the assessment was coded in error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Minimum Data Set assessments should be completed accurately.

4. Resident #40 was admitted to the facility on 2/23/2017 with diagnoses including bipolar disorder.

Resident #40 had a Level II Pre-Admission Screening and Resident Review (PASRR) determination notification letter for a mental illness dated 8/29/2018.

The comprehensive annual Minimum Data Set (MDS) assessment dated 4/8/2023 indicated Resident #40 was not currently considered by the state Level II PASRR process to have a serious mental illness. A diagnosis of bipolar disorder was included on the assessment.

A psychiatric physician note dated 5/12/2023 indicated Resident #40 was followed for

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| F 641 | Continued From page 8 | F 641 | | |

established problems of stable chronic bipolar disorder.

In an interview on 6/14/2023 at 11:13 a.m. with MDS Nurse #1 she stated Resident #40 had a Level II PASRR determination for bipolar disorder and should have been coded for a serious mental illness on the annual MDS assessment.

5. Resident #122 was admitted to the facility on 03/23/23.

A Family Guide for Home Care of Patient document dated 04/09/23 was completed by Social Worker #1. Recommendations were for Resident #122 to follow up with his physician in two weeks. Home health care and home food service delivery had been arranged.

The Patient Discharge Instructions dated 04/09/23 documented Nurse #2 reviewed the resident's list of medications with him prior to his discharge to home.

Review of a Minimum Data Set (MDS) assessment for Resident #122 dated 04/14/23 documented he was discharged to an acute hospital on 04/09/23.

Review of a Discharge Summary dated 04/14/23 for Resident #122 documented: "Resident admitted for short term rehab following hospitalization for pneumonia. He tested positive for COVID 72 hours after admission. He was placed on precautions per protocol and received antiviral medication per MD order as well as vitamins per standing order. He was able to transition home with a recommendation for home health services."

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| F 641 | Continued From page 9<br><br>In an interview with Nurse #3 on 06/15/23 at 9:30 AM she stated Resident #122 was discharged to home on 04/09/23 with his family. She commented he originally came to the facility for therapy after a hospitalization for pneumonia and was able to be discharged to home.<br><br>In an interview with MDS Nurse #1 on 06/15/23 at 10:30 AM she stated the MDS Discharge assessment for Resident #122 should have reflected the resident was discharged to home, not to a hospital. She concluded she probably was thinking about where he came from when she coded the discharge section, not where he went. She noted she had known he went home with his family. | F 641 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights | F 656 | | 7/26/23 |

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| F 656 | Continued From page 10<br>under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop and implement an individualized person-centered care plan in the areas of behaviors (Resident #65 and #7), dementia (Resident #88), Pre-Admission Screening and Resident Review (Resident #18) and bipolar disorder behaviors (Resident #48) for 5 of 29 residents reviewed for comprehensive care plans.<br><br>Findings included: | F 656 | 1. 100 percent audit of comprehensive care-plans to be conducted to ensure comprehensive care-plans are accurately in place. To be completed by MDS nurses or Social Workers.<br>2. Comprehensive care-plans will be reviewed once monthly x 3 months and then once quarterly for 6 months<br>3. Findings will be discussed during QAPI meetings. | |

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| F 656 | Continued From page 11 | F 656 | | |

1. Resident #65 was admitted to the facility on 8/23/22 with diagnoses that included schizophrenia and dementia.

Resident #65's Minimum Data Set (MDS) assessment dated 2/1/23 revealed she was assessed as being severely cognitively impaired. She was coded for physical and verbal behaviors 1-3 days of the 7-day lookback period.

Review of Resident #65's care plan last updated 5/19/23 revealed she was not care planned for schizophrenia.

During an interview on 6/14/23 at 3:15 PM the MDS Nurse stated the behavioral section of the care plan was the responsibility of social work.

An interview was conducted with Social Worker #2 on 6/15/23 at 11:05 AM who stated Resident #65 should have been care planned for schizophrenia and it was an error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Resident #65's care plan should have accurately reflected her diagnoses.

2. Resident #7 was admitted to the facility on 4/11/13 with diagnoses that included psychosis not otherwise specified.

An interview on 6/15/23 at 9:50 AM with Resident #7's responsible party revealed Resident #7 had a diagnosis of psychosis not otherwise specified prior to admission.

Review of Resident #7's care plan updated 3/27/23 revealed she was not care planned for

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| MARGATE HEALTH AND REHAB CENTER | 540 WAUGH STREET JEFFERSON, NC 28640 |

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psychosis not otherwise specified.

During an interview on 6/14/23 at 3:15 PM the MDS Nurse stated the behavioral section of the care plan was the responsibility of social work.

An interview was conducted with Social Worker #2 on 6/15/23 at 11:05 AM who stated Resident #7 should have been care planned for psychosis and it was an error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Resident #7's care plan should have accurately reflected her diagnoses.

3. Resident # 88 was admitted to the facility on 10/12/21 with diagnoses that included delusional disorder and dementia.

Resident #88's behavior monitoring sheet for May 2023 revealed incidents of yelling and screaming.

Review of Resident #88's care plan updated 5/22/23 revealed she was not care planned for delusional disorder or dementia.

During an interview on 6/14/23 at 3:15 PM the MDS nurse stated the behavioral section of the care plan was the responsibility of social work.

An interview was conducted with Social Worker #2 on 6/15/23 at 11:05 AM who stated Resident #88 should have been care planned for delusional disorder and dementia. She stated it was an error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Resident #88's care plan should have accurately reflected her diagnoses.

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4. Resident #18 was admitted to the facility on 2/13/23 with diagnoses that included bipolar disorder.

Review of Resident #18's medical record revealed she had a Level II Preadmission Screening Resident Review (PASSR) effective 10/20/21.

Review of Resident #18's care plan last updated 5/19/23 revealed she was not care planned for a Level II PASSR.

During an interview on 6/14/23 at 3:15 PM the MDS nurse stated the behavioral section of the care plan was the responsibility of social work.

An interview was conducted with Social Worker #2 on 6/15/23 at 11:05 AM who stated Resident #18 should have been care planned for a Level II PASSR. She stated it was an error.

During an interview on 6/15/23 at 11:35 AM the Administrator stated Resident #88's care plan should have accurately reflected her Level II PASSR.

5. Resident #48 was admitted to the facility on 4/27/2018 with a diagnosis of bipolar.

Physician orders included an order written on 10/15/2019 for Lithium Carbonate (a medication used to treat manic-depressive disorders, bipolar disorder, to stabilize the mood and reduce extremes in behaviors) 150 milligram (mg) capsule twice a day and Zyprexa (an antipsychotic medication that treats mental health conditions like bipolar disorders) 1 mg at bedtime

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for bipolar.

The annual Minimum Data Set (MDS) assessment dated 1/2/2023 indicated Resident #48 was moderately cognitively impaired, displayed no behaviors toward others, diagnoses included bipolar disorder and received antipsychotic medications for seven days of the seven-day look back period. The quarterly MDS assessment dated 4/6/2023 indicated Resident #48 continued to receive antipsychotics for the for seven days of the seven-day look back period.

A review of Resident #48's care plan dated 1/2/2023 included Resident #48 had a potential for drug injury related to taking medications that included Zyprexa and Lithium. There was not a care plan focus that addressed Resident #48's bipolar disorder behaviors.

Physician note dated 4/22/2023 stated Resident #48's bipolar was currently stable with current medication regimen.

Psychiatric note dated 5/12/2023 stated Resident #48 had a history of paranoia related to fear of others stealing from him and stayed dressed in a gown all day fearful if sent to the laundry department, he will never get the gown back.

In an interview with the MDS Nurse #1 on 6/15/2023 at 11:01 a.m., she stated Resident #48 was care planned for medications ordered and received for his bipolar disorder. She said she did not know why a bipolar disorder focus was not included in Resident #48's care plan except if no behaviors were triggered in the last quarterly assessment dated 4/6/2023.

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| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever | F 732 | | 7/7/23 |

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| F 732 | Continued From page 16<br>is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 22 of 43 posted census daily staffing forms reviewed.<br><br>A review of posted census daily staffing forms from 5/1/2023 to 6/11/2023 indicated the following posted census daily staffing forms contain incomplete and/or inaccurate number of staff working compared to the daily assignment sheets:<br><br>a. On 5/12/2023, the posted census daily staffing form indicated 7 licensed staff for the 3p.m to 11p.m. shift, and there were 6 licensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet. On the 11p.m. to 7a.m. shift, the posted census daily staffing form indicated 5 licensed staff and 7.5 unlicensed staff, and there were 4 licensed staff and 6.5 unlicensed staff scheduled on the 11p.m. to 7a.m daily assignment sheet.<br><br>b. On 5/13/2023, the posted census daily staffing form indicated 14 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 16 licensed staff scheduled on the 7a.m. to 3p.m daily assignment sheet. On the 3p.m to 11p.m. shift, the posted census daily staffing form indicated 16.5 unlicensed staff, and there were 16 unlicensed staff scheduled on the 3p.m to 11p.m. daily assignment sheet.<br><br>c. On 5/14/2023, the posted census daily staffing form indicated 9 unlicensed staff for the 11p.m to 7a.m. shift, and there were 8.5 unlicensed staff | F 732 | 1. Education to be completed with all supervisors/team leaders on accuracy of posting of daily staffing form<br>2. Posting of daily staffing form to be reviewed daily by DON or designee for accuracy for 2 weeks then weekly for 4 weeks then monthly X 90 days.<br>3. Findings will be reviewed in QAPI meetings. | |

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scheduled on the 11p.m. to 7a.m. daily assignment sheet.

d. On 5/15/2023, the number of unlicensed staff and the number of hours worked were not recorded on the posted census daily staffing form for the 7a.m. to 3p.m., and the daily assignment sheet indicated 17 unlicensed staff were scheduled assignments on the 7a.m. to 3p.m. shift.

e. On 5/16/2023, the posted census daily staffing form indicated 18 unlicensed staff for the 3p.m to 11p.m. shift, and there were 17 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet. On the 11p.m. to 7a.m. shift, the posted census daily staffing form indicated 2 licensed staff and 8 unlicensed staff, and there were 3 licensed staff and 7 unlicensed staff scheduled on the 11p.m. to 7a.m daily assignment sheet.

f. On 5/17/2023, the posted census daily staffing form indicated 20 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 21 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 17 unlicensed staff, and there were 19 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

g. On 5/19/2023, the posted census daily staffing form indicated 22 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 15 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 13 unlicensed staff, and there were 12 unlicensed staff

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scheduled on the 3p.m. to 11p.m. daily assignment sheet.

h. On 5/20/2023, the posted census daily staffing form indicated 16 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 13.5 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 16 unlicensed staff, and there were 14.5 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

i. On 5/22/2023, the posted census daily staffing form indicated 20 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 19 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 18 unlicensed staff, and there were 15.5 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

j. On 5/23/2023, the posted census daily staffing form indicated 26 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 25 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 6 licensed staff, and there were 4.5 licensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet

k. On 5/24/2023, the posted census daily staffing form indicated 7 unlicensed staff on the 11p.m. to 7a.m. shift, and there were 6.5 unlicensed staff scheduled on the 11p.m. to 7a.m daily assignment sheet.

l. On 5/23/2023, the posted census daily staffing

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form indicated 23 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 21.5 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet.

m. On 5/26/2023, the posted census daily staffing form indicated 6 licensed staff and 19 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 7 licensed staff and 21 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 15 unlicensed staff, and there were 13 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

n. On 5/27/2023, the posted census daily staffing form indicated 14 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 14.5 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet.

o. On 5/31/2023, the posted census daily staffing form indicated 6 licensed staff for the 3p.m. to 11p.m. shift, and there were 5.5 licensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

p. On 6/2/2023, the posted census daily staffing form indicated 21 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 21.5 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 6 licensed staff and 13 unlicensed staff, and there were 5.5 licensed staff and 16 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

q. On 6/3/2023, the posted census daily staffing form indicated 14 unlicensed staff for the 7a.m. to

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3p.m. shift, and there were 15 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 5.5 licensed staff, and there were 5 licensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

r. On 6/5/2023, the posted census daily staffing form indicated 16 unlicensed staff on the 3p.m. to 11p.m. shift, and there were 13 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

s. On 6/6/2023, the posted census daily staffing form indicated 20 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 22.5 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 15 unlicensed staff, and there were 17 licensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

t. On 6/8/2023, the posted census daily staffing form indicated 5.5 licensed staff for the 7a.m. to 3p.m. shift, and there were 6 licensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet.

u. On 6/9/2023, the posted census daily staffing form indicated 22 unlicensed staff for the 7a.m. to 3p.m. shift, and there were 21 unlicensed staff scheduled on the 7a.m. to 3p.m. daily assignment sheet. On the 3p.m. to 11p.m. shift, the posted census daily staffing form indicated 16 unlicensed staff, and there were 15 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet.

v. On 6/11/2023, the posted census daily staffing

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form indicated 16 unlicensed staff for the 3p.m to 11p.m. shift, and there were 17.5 unlicensed staff scheduled on the 3p.m. to 11p.m. daily assignment sheet. On the 11p.m. to 7a.m. shift, the posted census daily staffing form indicated 8 unlicensed staff, and there were 7.5 unlicensed staff scheduled on the 11p.m. to 7a.m daily assignment sheet.

In an interview with Nurse #1 on 6/13/2023 at 10:30 a.m. she explained posted census daily staffing forms were completed by each team leader at the beginning of each shift, and the forms represented the number of licensed and unlicensed staff were in the facility at the beginning of the shift and hours worked. She stated posted census daily staffing forms were placed in the Director of Nursing's (DON) mailbox each morning, and the DON checked the forms for accuracy.

In an interview with the Administrative Assistant on 6/15/2023 at 11:31 a.m., she stated she obtained posted census daily staffing forms from the DON's mailbox outside her office door daily. She explained she was responsible for filing posted census daily staffing forms and did not verify forms for accurate information. She explained if she noticed information on posted census daily staffing form was incomplete, she returned the forms to the DON for completion. She stated she didn't know why posted census daily staffing form dated 5/15/2023 was filed incomplete.

In an interview with the Director of Nursing on 6/15/2023 at 10:29 a.m., she stated completed posted census daily staffing forms were placed in her mailbox outside her office door every morning

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| F 732 | Continued From page 22<br>and the Administrative Assistant collected the forms for filing. She said the posted census daily staffing forms reflected the actual staff in the facility at the beginning of each shift daily. She stated she had not reviewed the posted census daily staffing forms for accuracy in a while and could not recall the last time she reviewed a posted census daily staffing form. In a follow-up interview on 6/15/2023 at 11:36 a.m., she explained there were inaccuracies in the number of nursing staff on the posted census daily staffing forms because nurses were counting 4-hour shifts as a whole person, and nursing staff were not counting agency staff. She further stated she did not know if new nursing staff had been trained on how to complete the posted census daily staffing forms accurately. | F 732 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional | F 812 | | 7/7/23 |

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| F 812 | Continued From page 23<br>standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to discard outdated leftover cooked food and failed to label leftover cooked food stored in the main walk-in refrigerator. This practice had the potential to affect food served to the residents.<br><br>Findings included:<br><br>An observation of the facility's walk-in refrigerator was conducted at 1:21 PM on 6/11/23 with the Kitchen Manager in Training. This observation revealed the following concerns:<br><br>a. Five metal serving pans containing food were observed to be covered by clear plastic wrap with the expiration date written on the wrap in marker. The pans were observed to not be labeled with what foods they contained.<br><br>b. A clear food storage container with leftover food inside labeled as "oatmeal" was dated 6/4/23 - 6/10/23.<br><br>On 6/11/23 at 1:54 PM an observation and interview were conducted with the Kitchen Manger in Training. The Kitchen Manager in Training identified the unlabeled food items in the walk-in refrigerator as left-over foods that included 2 pans of mashed potatoes, 1 pan Italian sausages, 1 pan ground pepper steak, and 1 pan "sloppy joe" meat. The Kitchen Manager in Training observed the expired oatmeal and removed it from the walk-in and stated she would dispose of it immediately. She stated the oatmeal should have been removed and that the | F 812 | 1. Education on food storage, labeling and dating, disposal of expired foods to be provided to all dietary department staff by district dietary manager or designee<br>2. Audit of all stored and labeled items completed 6/14/2023 and any items failing audit were removed and either corrected or discarded.<br>3. Dietary manager or designee will audit storage areas of food for proper storing, labeling and dating, and expirations weekly x 4 weeks, monthly x 3 months, quarterly x 6 months.<br>4. Results of the audits will be given to the Quality Assurance Performance Committee monthly for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345296 | A. BUILDING _____ B. WING _____ | C 06/15/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MARGATE HEALTH AND REHAB CENTER | 540 WAUGH STREET JEFFERSON, NC 28640 |

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| F 812 | Continued From page 24<br>unlabeled pans should have been labeled. She explained that labeling, dating, and discarding food items was the responsibility of the entire kitchen staff, but that she should have checked to make sure it was done properly.<br><br>In an interview with the District Dietary Manager #1 on 6/14/23 at 4:46 PM, she stated her expectation was that all foods stored in the walk-in refrigerator be labeled with what each item is as well as the date. Additionally, it was her expectation that all left-over foods would be disposed of after 7 days. | F 812 | | |