STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345350	A. BUILDING _____ B. WING _____	C 06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND TERRACE	2300 ABERDEEN BOULEVARD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/26/23 through 6/28/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #7BF911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/26/23 through 6/28/23. Event ID# 7BF911. The following intakes were investigated NC00189784, NC00191734, NC00193168, NC00194655, NC00197881, NC00197892. 12 of the 12 complaint allegations did not result in a deficiency.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		7/20/23

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

Electronically Signed | 07/21/2023

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F 609	Continued From page 1 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record reviews, the facility failed to submit the 5-day investigation report to the state survey Agency for 1 of 3 sampled residents (Resident #119) reviewed for abuse. The Findings included: Review of the facility policy revised on 10/22 read as: B. Report must be made on all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. C. Complete investigation in 5 working days. Fax 5-Day report from and result of investigation to NCDHHD. (North Carolina Department of Health and Human Division). Review of the Facility 24-Hour Initial Report dated 9/30/22 documented the facility reported to the State Agency that Resident #119 reported she had been abused. There was no documentation to indicate the facility reported the 5-day investigation report to the State Agency.	F 609	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taker or will take the actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be completed by the dates indicated. The facility maintains a Quality Assurance and Performance Improvement Committee that meets monthly to identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action to correct identified quality deficiencies. 1.Corrective actions for resident(s) affected by the alleged practice. Once identified an investigation was completed. A 5- day report was submitted based on available information for resident 119 on 07/19/2023 to NCDHHS. 2.Corrective Action for the residents with	

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F 609	Continued From page 2 An interview with the Administrator on 6/27/23 at 4:11 pm, revealed that he was not the Administrator at the time and was not aware Resident #119 had reported abuse. He indicated they had looked and could not find the 5-day investigative report. An interview with the Social Worker on 6/28/23 at 4:17 pm, she revealed she was not aware Resident #119, reported she had been abused. She revealed staff were trained to report any incident or resident concern related to abuse to the administrative staff. She indicated a 5-day investigation report should have been sent to the State agency.	F 609	potential to be affected by the alleged practice. Corporate Review Audit completed for all previous concerns/grievances during past six months on 05/25/2023 to ensure all reporting requirements were in compliance. On 6/28/2023 Reviewed all other 24-hour reports from the previous 12 months to ensure completion of a 5-day report with each case. All reports found to be in compliance. 3.Meaures/Systemic changes to prevent reoccurrence of alleged deficient practice. Standard work developed 03/01/2023 and updated 7/19/2023 to ensure all elements of reporting are completed including the 24 hour and 5-day report by NHA and/or DON. NHA and/or DON responsible for all 24 hour and 5 day report submissions. Abuse log developed 07/19/2023 to document and track all reportable events to NCDHHS to ensure completion of 24-hour and 5-day reporting. Staff Trained on Updated Process 07/20/2023. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. NHA in collaboration with DON to complete audit on all reportable investigations until 100% of compliance is sustained for four consecutive weeks. Audits to start July 20, 2023. The results of the audit will be reported at monthly QAPI meeting for compliance trends. Expected completion of audits to note substantiable compliance by 08/17/2023.	

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F 609	Continued From page 3	F 609	Once compliance sustained quarterly audits completed and reported at QAPI. POC fully completed 7/20/2023	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be 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;	F 623		7/18/23

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F 623	Continued From page 4	F 623		

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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F 623	Continued From page 5 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide written notice of reason for discharge to hospital to the resident and/or resident representatives and to provide the Ombudsman with a copy of the written notice for 2 of 2 residents reviewed for hospitalization. (Resident #9, Resident #39) The findings included: 1. Resident #9 was readmitted to the facility on 4/11/23. A review of the 5 Day Medicare Minimum Data Set (MDS) dated 4/11/23 revealed Resident #9	F 623	1. Corrective actions for resident(s) affected by the alleged practice. Once identified Resident 9 and 39 were provided discharge notices on 07/18/2023. In addition, a notification was sent to the Ombudsman on 07/18/2023. 2. Corrective Action for the residents with potential to be affected by the alleged practice. From the time of discovery, social workers reviewed all current residents that could be affected by the current practice. Discharge notices were sent to 5 affected residents on 07/18/2023. In addition, notification was	

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F 623	Continued From page 6 was cognitively intact. Review of a physician ' s order dated 4/1/23 revealed an order to send to hospital for follow up of abnormal critical lab and abnormal computed tomography (CT) imaging. The medical record included no evidence that Resident #9 or her resident representative were provided with written notice that included the reason for discharge to the hospital on 4/1/23. During an interview with Resident #9 on 6/26/23 at 9:18 AM. the resident indicated she had no recollection of receiving written notice that explained the reason for his discharge to the hospital that occurred on 4/1/23. A phone interview was attempted with the Ombudsman on 6/27/23 at 3:18 PM An interview was conducted with the Social Worker (SW) on 6/27/23 at 4:40 PM. The Social Worker stated she was not aware that she was supposed to send out a written notice of discharge to the resident or resident representative and the Ombudsman. The SW stated she had been documenting the follow up phone call in the electronic medical record. During an interview with the Administrator and Senior Director of Patient Care on 6/28/23 at 8:44 AM. The Administrator indicated the Social Worker was responsible for providing the written notice of transfer/discharge to the hospital and notifying the Ombudsman. He revealed that during this survey he realized the Social Worker had not been completing this responsibility and that written notice of discharge/transfer had not	F 623	sent to the Ombudsman on 07/18/2023. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. Standard work developed, and training completed with responsible staff on discharge notices and notification to ombudsman for all discharges. Training completed on 06/28/2023. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. NHA to complete weekly audits for on all discharges until 100% of compliance sustained for four consecutive weeks. Audits started July 1, 2023. The results of the audit will be reviewed at the monthly QAPI meeting for compliance trends. Expected completion audits expected by 07/29/2023 to note substantial compliance. Once compliance sustained quarterly audits completed and reported at QAPI. POC fully completed by 7/18/2023	

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F 623	Continued From page 7	F 623		

been provided to the resident, resident representative, or the Ombudsman for any transfer/discharge to the hospital. The Administrator was unsure of how long the facility had not been providing these notices. Immediate education was provided to the Social Worker on discharge notices.

2. Resident #39 was readmitted to the facility on 5/24/23.

A review of the 5 Day Medicare Minimum Data Set (MDS) Assessment revealed the Resident #39 had severe cognitive impairment.

Review of a physician ' s order dated 5/18/23 revealed an order to send to hospital for evaluation and treatment of lethargy and decreased blood pressure.

The medical record included no evidence that Resident #39 ' s resident representative was provided with written notice that included the reason for discharge to the hospital on 5/18/23.

A phone interview was attempted with the Ombudsman on 6/27/23 at 3:18 PM

An interview was conducted with the Social Worker (SW) on 6/27/23 at 4:40 PM. The Social Worker stated she was not aware that she was supposed to send out a written notice of discharge to the resident or resident representative and the Ombudsman. The SW stated she had been documenting the follow up phone call in the electronic medical record.

During an interview with the Administrator and

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F 623	Continued From page 8 Senior Director of Patient Care on 6/28/23 at 8:44 AM. The Administrator indicated the Social Worker was responsible for providing the written notice of transfer/discharge to the hospital and notifying the Ombudsman. He revealed that during this survey he realized the Social Worker had not been completing this responsibility and that written notice of discharge/transfer had not been provided to the resident, resident representative, or the Ombudsman for any transfer/discharge to the hospital. The Administrator was unsure of how long the facility had not been providing these notices. Immediate education was provided to the Social Worker on discharge notices.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §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 - (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 (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 under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		7/20/23

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F 656	Continued From page 9 (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. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop care plans in the areas of suprapubic catheter (Resident #45) and pressure ulcers (Residents #4, #9, and #5) for 4 of 4 residents reviewed for care planning. The findings included: 1. Resident #45 was admitted to the facility on 11/2/22 with diagnoses that included benign prostatic hyperplasia (BPH) obstructive uropathy. A physician note dated 11/3/22 indicated an	F 656	1. Corrective actions for resident(s) affected by the alleged practice. Once identified care plans updated for residents 45, 9, 5, and 4 on 07/20/2023. 2. Corrective Action for the residents with potential to be affected by the alleged practice. DON along with MDS will audit all residents with catheters and/or pressure ulcers to validate that the care plan is person centered and consistent with resident status by 07/20/2023.	

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F 656	Continued From page 10 indwelling urinary catheter had been placed this day. Review of the admission Minimum Data Set dated 11/6/22 revealed Resident #45 had an indwelling urinary catheter. Review of the Resident #45's Comprehensive Care Plan dated 11/8/22 contained no information or interventions regarding suprapubic catheter care. An interview was conducted with the Minimum Data Nurse on 6/28/23 at 4:32 PM. She revealed Resident #45's catheter should have been care planned. An interview was conducted with the Director of Nursing (DON) 6/28/23 at 4:40 PM. The DON stated Resident #45's care plan chould have been updated to the indwelling urinary catheter. 2a. Resident #4 was admitted to the facility on 4/25/22 with diagnoses that included Rheumatoid arthritis. Review of the Annual Minimum Data Set (MDS) Assessment dated 4/30/23 revealed Resident #9 was cognitively intact and had a Stage III pressure ulcer injury. Review of the Wound Evaluation and Management Assessment dated 6/22/23 revealed Resident #4 had a Stage IV pressure ulcer to her coccyx that measured 3.0 centimeters (cm) X 2.7 cm X 1.0 cm. Review of the Dressing Treatment Plan dated 6/22/23 revealed an order to wash wound with Dakins Solution, Apply three times a week for	F 656	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. Standard work developed, and training completed with MDS and DON on responsibility for ensuring comprehensive care plans are person centered and consistent with resident status. DON clarified roles and responsibilities for the completion of the comprehensive care plan with staff on 07/20/2023. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. DON complete weekly audit reviewing comprehensive care plans for all residents with catheters and/or pressure ulcers until four consecutive weeks of 100% compliance is reached. The results of the audit will be reviewed at the monthly QAPI meeting for compliance trends. Audits to start July 24, 2023. Expected completion audits by 08/21/2023 to note substantial compliance. Once compliance sustained quarterly audits completed and reported at QAPI. POC fully completed by 7/20/2023	

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F 656	Continued From page 11	F 656		

sixteen days. Negative Pressure Wound Therapy apply three times per week for sixteen weeks 125mmHG; Continuous. Collagen sheets apply three times per week for thirty days. Skin prep-Apply three time per week for 16 days.

Review of the care plan initiated 10/24/22 revealed a focus of resident was at risk for pressure ulcer related to immobility. There was no entry or reference to the presence of a wound to the coccyx or interventions.

b. Resident #9 was admitted to the facility on 2/28/23.

Review of the 5 Day Minimum Data Set (MDS) Assessment revealed Resident #9 was cognitively intact and at risk for pressure ulcer injuries. There was no documentation of a pressure ulcer.

Review of the Wound Evaluation and Management Assessment dated 6/22/23 revealed Resident #9 had a Stage III pressure ulcer of the left posterior heel that measured 0.2 centimeters (cm) X 0.2 cm X 0.1 cm.

Review of the Dressing Treatment Plan dated 6/22/23 revealed a dressing order for calcium alginate with silver apply once daily for nine days. Apply Sterile gauze sponge once daily for thirty days. Apply Foam without boarder to heel once weekly for thirty days. Apply Kerlix dressing once daily for thirty days.

Review of the care plan dated 3/4/23 revealed a focus of resident was at risk for pressure ulcer related to immobility. There was no entry or reference to the presence of a wound to the left

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F 656	Continued From page 12	F 656		

heel or interventions.
c. Resident #5 was admitted to the facility on 4/20/23 with diagnoses that included peripheral vascular disease and osteomyelitis (infection of bone) of the lumbar (lower back) region.

An admission assessment dated 4/20/23 revealed Resident #5 was admitted with a stage 3 pressure ulcer to the lumbar region.

The 5-day Minimum Data Set (MDS) assessment dated 4/24/23 revealed Resident #5 was cognitively intact, required limited assistance from 1 staff member to complete activities of daily living, and was coded as having an unhealed stage 3 pressure ulcer.

A review of the Care Area Assessments (CAA) for the 5-day MDS assessment indicated he had a pressure wound to his lumbar region. The CAA for pressure ulcer indicated he was at risk for developing further ulcers. The CAA worksheet for pressure ulcers contained a checkmark to indicate that pressure ulcers would be addressed in the Resident's care plan.

The care plan for Resident #5 created on 5/1/23 noted the potential for skin breakdown but there was no entry or reference to the presence of a wound to the lumbar region or of any interventions in place.

An interview was completed on 6/28/23 at 11:23am with the MDS Nurse. The Nurse indicated she was responsible for the creation of all care plans but the wound care plan. She stated the Wound Nurse was responsible for creating a resident's wound care plan.

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F 656	Continued From page 13 An interview was completed on 6/28/23 at 11:27am with the Director of Nursing (DON). She revealed there was confusion among management nursing staff who was responsible for creating a resident's wound care plan. The DON stated the MDS Nurse was responsible for creating the initial wound care plan and the Wound Nurse updated the care plan accordingly. An interview was completed on 6/28/23 at 11:32am with the Wound Nurse. The Nurse stated the MDS Nurse creates the intial wound care plan and she updates accordingly. An interview was completed on 6/28/23 at 6:40pm with the facility Administrator. He stated management staff were aware of incomplete comprehensive care plans and were attempting to update all resident's care plans to reflect their current medical diagnoses.	F 656		
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.	F 761		6/28/23

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F 761	Continued From page 14 §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 and staff interview the facility failed to discard an expired medications for 1 of 1 medication room reviewed for medication storage. The findings included: 1.During an observation of the medication room for medication storage on 6/28/23 at 12:02 PM, 1 multidose vial of opened and accessed Tuberculin Purified Diluted (Aplisol) was in the medication refrigerator. The vial had an opened date of 4/15/23. A review of the manufacturer ' s instruction label on the box indicated the medication should be discarded 30 days from the date medication was opened. During an interview with the Director of Nursing on 6/28/23 at 12:10 PM, she stated it was the night shift nurses responsibility to check the refrigerators and medication carts for expired medication. The DON stated the expired medications should have been discarded or returned to the pharmacy.	F 761	1. Corrective actions for resident(s) affected by the alleged practice. At the time of discovery expired medications were destroyed. 2. Corrective Action for the residents with potential to be affected by the alleged practice. At the time of discovery all medication refrigerators checked for expired medications. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. Daily checklist developed for supervisors to ensure medication fridges checked for expired medications. Supervisors educated on checklist on 06/28/2023. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. Staff Development Coordinator to ensure daily checklists are 100% in compliance with refrigerator checks for four consecutive weeks. The results of these audits will be reviewed at	

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F 761	Continued From page 15 2. An observation of the medication storage room conducted on 6/28/23 at 12:02 PM revealed 2 bags of Vancomycin 750 milligrams(mg)/ in 250 milliliters (ml) of normal saline with an expiration date of 6/12/23 was in the medication refrigerator. The instructions read "Infuse intravenously (IV) over 90 minutes at 175ml/hour(hr) every 12 hours until 6/12/23. During an interview with the Director of Nursing on 6/28/23 at 12:10 PM, she stated it was the night shift nurses responsibility to check the refrigerators and medication carts for expired medication. The DON stated the expired medications should have been discarded or returned to the pharmacy. An interview was conducted with the Administrator on 6/28/23 at 8:44 AM. The Administrator indicated that he expected expired medications would be discarded per manufacturer ' s instruction.	F 761	monthly QAPI meeting for compliance trends. Audits started 07/01/2023. Expected completion of audits by 07/29/2023 to note substantial compliance. Once compliance sustained quarterly audits completed and reported at QAPI. POC fully completed by 6/28/2023	
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	F 812		7/18/23

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F 812	Continued From page 16 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to maintain the kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the undershelf of one of one steamtables. The findings included: Review of the "Equipment Cleaning Log" week of June 18th there was no mention of the steamtable under splash area to be cleaned. An observation of the steamtable undershelf on 6/27/23 at 10:04 AM revealed the steamtable to have splatters of dark black dried food particles covering the under-splash area of the top shelf directly above the food wells. During the meal temperature observation on 6/28/23 at 8:28 AM revealed the 5 well steamtable was observed on and pans of food were in the steamtable ready to serve. The steamtable was observed to have splatters of dark black dried food particles covering the under-splash area of the top shelf directly above the steaming food wells. In an interview on 6/28/23 at 8:39 AM the Operations Manager stated the steamtable	F 812	1. Corrective actions for resident(s) affected by the alleged practice. At the time of discovery, the steam table undershelf was cleaned. 2. Corrective Action for the residents with potential to be affected by the alleged practice. At the time of discovery, the standard work for cleaning the steam table undershelf was updated on 06/28/2023 and current staff training completed on new standard work 07/18/2023. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. Standard work added to training checklist and job responsibility sheet for all new kitchen staff. Steam Table undershelf added to Equipment Cleaning Log 06/30/2023. The kitchen supervisor added to monthly QAPI meeting to ensure ongoing regulatory compliance 07/18/2023. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 812	Continued From page 17 should have been cleaned. In an interview on 6/28/23 at 8:45 AM the kitchen manager revealed staff should have cleaned the splash area and they would clean the area immediately.	F 812	compliance. Kitchen Supervisor to ensure weekly cleaning logs are 100% in compliance for four consecutive weeks which includes visualization of steamtable undershelf. The results of these audits will be reviewed at QAPI meeting for compliance trends. Audits to start 07/24/2023. Expected Completion by of audits 08/21/2023 for sustained compliance. Once compliance sustained quarterly audits completed and reported at QAPI. POC fully completed by 7/18/2023	
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	F 867		7/18/23

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§483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such 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.

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§483.75(e) Program activities.

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

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F 867	Continued From page 20 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including 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 record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 7/9/21. This was for a recited deficiency on the current recertification and complaint survey in the area of development and implementation of comprehensive care plans. The continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F656: Based on record review and staff interviews the facility failed to develop care plans in the areas of suprapubic catheter (Resident #45) and pressure ulcers (Residents #4, #9, and #5) for 4 of 4 residents reviewed for care planning. During the recertification survey on 7/9/21 the facility was cited for failing to develop a comprehensive care plan in the areas of indwelling catheter usage and anticoagulant,	F 867	1. Corrective actions for resident(s) affected by the alleged practice. Updated current MDS PIP to include comprehensive care plans 07/12/2023. 2. Corrective Action for the residents with potential to be affected by the alleged practice. Reviewed all open PIPs at QAPI on 07/12/2023 including MDS PIP for timeliness and accuracy of assessments with the addition of comprehensive care plans. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. Education provided to Interdisciplinary Team on PIP tools and expectations to submit to QAPI monthly results while PIP open on 07/18/2023. QAPI team to determine close of PIPs. 4. Monitoring procedure to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory compliance. DON to complete weekly audit reviewing comprehensive care plans	

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F 867	Continued From page 21 diuretic, and opioid medication usage. An interview was complete on 6/28/23 at 6:23pm with the Administrator, Director of Nursing (DON), and Director of Patient Care. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The DON indicated there were no current monitoring plans for the development and implementation of comprehensive care plans.	F 867	for 10 residents per week until four consecutive weeks of 100% of compliance is reached. The results of the audit will be reviewed at the monthly QAPI meeting for compliance trends. Audits to start 07/24/2023. Expected completion of audits expected by 08/21/2023 for sustained compliance. Once compliance is sustained each MDS nurse will audit five of their peer□s comprehensive care plans monthly to ensure person centered and consistent with resident status. The results of these audits will be reported at the monthly QAPI meeting. POC fully completed by 7/18/2023	