STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING ______ B. WING ______	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	230 NC HWY 141 MURPHY, NC 28906

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted 07/23/2022 through 07/27/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # Y45P11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted 07/23/2023 through 07/27/2023. Event ID #Y45P11. The following intake was investigated NC00203238. 2 of the 2 complaint allegations did not result in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		7/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 08/20/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 1 resident reviewed for a safe, comfortable, homelike environment (Resident #86). The findings included: Resident #86 was admitted to the facility on 05/27/22. Review of weekly skin assessment from 05/06/23 through 07/22/23 revealed Resident #86 did not have any skin issues. Review of the admission Minimum Data Set (MDS) dated 06/03/23 assessed Resident #86 with moderately impaired cognition and her primary mobility device was a wheelchair.	F 584	" How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/24/23, wheelchair with tear to arm was identified and removed from service by Maintenance Director. On 7/24/23, the wheelchair arm was replaced by the Maintenance Director. On 7/24/23, the resident with the identified wheelchair was immediately assessed with no skin integrity concerns identified by Director of Nursing. No current residents were identified as being affected by the deficient practice. " How will the facility identify other residents having the potential to be	

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F 584 Continued From page 2

During an observation conducted on 07/24/23 at 09:12 AM, Resident #86 was seen sitting in her wheelchair in the hallway outside of her room. The left armrest of Resident #86's wheelchair was in disrepair with a torn spot approximately 2 by 0.5 inches along with multiple cracked and ripped lines. The right arm rest had multiple cracked and ripped lines as well. Resident #86 was wearing short sleeves sitting in the wheelchair and both of her arms were in contact with the torn, cracked armrests during the observation.

An interview was conducted with Resident #86 on 07/24/23 at 9:14 AM. She could not recall how long the armrests of her wheelchair had been torn. She reported she wore short sleeve most of the time and the torn armrests had irritated her skin at times. She added one of the maintenance staff was aware of her torn armrest but had not done anything to fix it so far. Per observation, the skin for Resident #86's bilateral arms were intact without redness or rashes.

Interview with Nurse Aide #1 on 07/24/23 at 9:33 AM revealed she had provided care for Resident #86 frequently. She explained she did not notice the armrests of Resident #86's wheelchair was torn. She acknowledged that the wheelchair needed to be fixed and she would submit a work order immediately.

During an interview conducted on 07/24/23 at 9:34 AM with Nurse #1, she stated she had seen the torn spot and cracked armrests for Resident #86's wheelchair when providing care or passing medications. However, she had forgotten to notify the maintenance staff to address the issue.

F 584

affected by the same deficient practice?

On 7/26/2023, 100% audit was completed by Maintenance Director relative to Preventative Maintenance of Wheelchairs. Any wheelchairs identified with maintenance concerns were removed from service or repaired immediately by Maintenance Director.

On 7/27/22, 100% Education was completed by Administrator with Maintenance Personnel regarding policy for Preventative Maintenance.

" What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?
On 7/27/23, Maintenance Director or Designee will audit 100% of all wheelchairs to ensure proper working condition and no identified rips/tears. If any wheelchairs are identified with a concern, they will be immediately removed from service and repaired by Maintenance.
On 7/27/23, Maintenance Director or designee will add a monthly monitor check to the TELS preventative maintenance system regarding wheelchair audit for preventative maintenance to include rips/tears to WC arms. This electronic preventative maintenance system will alert Maintenance Director and identify cleaning due dates.
On 7/23/23, 100% staff were educated by SDC regarding completion of Maintenance Work Orders and timely completion.

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F 584	Continued From page 3 An interview was conducted with the Maintenance Assistant on 07/24/23 at 9:49 AM. He stated he was not aware that the armrests for Resident #86's wheelchair were torn. He explained the maintenance department depended heavily on staff reporting for repair needs and added he was going to fix the wheelchair immediately. An interview was conducted on 07/26/23 at 12:09 PM with the Director of Nursing. She expected all the staff to report repair needs to the maintenance department in timely manner. It was her expectation for all the wheelchairs to be in good repair all the time. During an interview conducted on 07/26//23 at 2:27 PM, the Maintenance Director stated that he did not know Resident #86's wheelchair armrests were in disrepair and explained he had not received any work orders for wheelchair repairs recently. He used a work order system to identify repair needs on regular basis. In addition, he checked the facility routinely at least twice daily or as needed during his workdays. He stated nursing staff generally would report repair needs either verbally or via work order system. An interview was conducted with the Administrator on 07/27/23 at 10:50 AM. She expected the staff to be more attentive to resident's mobility devices and report repair needs to the maintenance department in timely manner. It was her expectation for all the mobility devices to be in good repair all the time.	F 584	On 7/27/23, all new employees will be educated by the Maintenance Director regarding completion of a Maintenance Work Order for any identified repair needs. " How does the facility plan to monitor its performance to make sure that solutions are sustained? On 7/27/23, Administrator or designee, will perform random audits of five wheelchairs per resident hall weekly times 3 months, then monthly times 9 months to ensure that any wheelchairs identified with maintenance issue will be removed from service and repaired. Frequency and duration of auditing will be extended as needed until substantial compliance is achieved. Any non-compliance will be addressed, and the plan modified if needed. On 7/27/23, Audit will be analyzed by Administrator or designee. Any identified issues will be brought to daily morning meeting as needed by Administrator. Results of monitoring will be brought to QA Committee by the Maintenance Director or designee, quarterly in QAPI meetings times 4 quarters,	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		8/20/23

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F 812	Continued From page 4 §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 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 in 1 of 2 kitchen refrigerators. The facility failed to clean and maintain 1 of 4 ice machines. This practice had the potential to affect food and beverages served to residents. Findings Included: On 7/24/23 at 08:22 AM an observation of the walk-in refrigerator with the Dietary Manager (DM) was conducted. The observation revealed one 4-quart container closed with a lid labeled tuna salad with the dates 7/16 use by 7/19 located on the second shelf of the walk-in refrigerator. The container was 1/4 full, and was immediately removed by the DM.	F 812	• How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/24/23 an expired food product (tuna) was removed from kitchen and disposed of by the Dietary Manager. On 7/26/23 Maintenance Director was placed the ice machine out of service. On 7/26/23 The ice machine on Maple Unit was cleaned and ice disposed of by Maintenance. No current residents were identified as being affected by the deficient practice. • How will the facility identify other residents having the potential to be	

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F 812	Continued From page 5 The DM stated on 7/24/23 at 8:36 AM the tuna salad should not have been in the walk-in refrigerator. The DM stated the evening cook checked for expired foods daily and he (DM) checked for expired food in the morning when working. The DM said the tuna salad was overlooked. On 7/26/23 at 11:00 AM an observation of the Maple Unit nourishment room ice machine with the DM was conducted. The observation revealed the inside roof of the ice machine to contain grey matter and clumpy grey debris that spanned the roof of the ice machine around a seam. The DM stated during the observation that the maintenance department was responsible for cleaning and maintaining the ice machines. The Maintenance Supervisor stated on 7/26/23 at 2:23 PM the ice machines were cleaned and sanitized every 3 months. He stated the ice machine was last cleaned and sanitized around the end of May or first of June. The Maintenance Supervisor said the ice machine debris might have been an oversight when last cleaned. The Administrator stated on 7/27/23 at 11:30 AM the process for the kitchen is the check for any expired food and throw it out. She stated the ice machines are cleaned and sanitized quarterly. The ice machine could have been overlooked when it was being cleaned or the maintenance worker could have been distracted and pulled away from the ice machine during that time.	F 812	affected by the same deficient practice? On 7/24/2023, 100% audit was completed by the dietary manager on food storage, refrigerators and nourishment rooms on all service halls and emergency food storage supply. On 7/24/23, Any expired food containers were removed and immediately disposed of by Dietary Manager. On 7/27/23, 100% audit was completed by the Maintenance Director of all ice machines in facility. No issues identified. • What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 7/27/23, Dietary Manager or designee will audit 100% nourishment rooms to ensure there are no expired food items, three times a week, beginning 7/27/23. If any items are expired they will be immediately discarded. On 7/27/23, Maintenance Director or designee will add a monthly monitor check to the TELS preventative maintenance system regarding cleaning of 100% of ice machines. This electronic preventative maintenance system will alert Maintenance Director and identify cleaning due dates. On 7/27/23, 100% Education was completed by Staff Development Coordinator (SDC) with staff to include dietary staff, maintenance directors, and direct care hall staff regarding review of expiration labels and disposal of any expired product to include policy Date for Food Safety.	

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F 812	Continued From page 6	F 812		

On 7/31/23, 100% Education was completed by SDC with staff to include dietary staff, maintenance directors and direct care hall staff regarding Preventative Maintenance policy to include ice machine cleaning.
On 7/27/23 all new Dietary employees will be educated by the Dietary Manager regarding dating disposal of expired food items upon new hire process.
On 7/27/23 all new employees will be educated on preventative maintenance and reporting any cleaning or preventative maintenance concerns timely to Maintenance Director utilizing the Maintenance request form.

- How does the facility plan to monitor its performance to make sure that solutions are sustained?

On 7/27/23 Administrator or designee will perform audits of all food storage areas to include refrigerators weekly times 3 months, then monthly times 9 months to ensure that any expired food is immediately discarded. Frequency and duration of auditing will be extended as needed until substantial compliance is achieved. Any non-compliance will be addressed, and plan modified if needed.

On 7/27/23 Administrator or designee will perform preventative maintenance audits of all ice machines. Frequency and duration of auditing will be extended as needed until substantial compliance is achieved. Any non-compliance will be addressed, and plan modified if needed.

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F 812	Continued From page 7	F 812	On 7/27/23, Audit results will be analyzed by Administrator and designee. Any identified issues will be presented during daily mo rning meeting as needed by the Administrator. Results of monitoring will be brought to QA Committee by the Dietary Manager or designee, quarterly in QAPI meetings times 4 quarters.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		8/20/23

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F 867	Continued From page 8 §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.	F 867		

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F 867	Continued From page 9	F 867		

§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 10 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 observation and staff interviews the facility's Quality Assurance Activity (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 1/28/22 recertification survey. The failure was related to one deficiency that was originally cited during the 1/28/22 recertification survey and was cited on the current recertification and complaint survey of 7/27/23. The recited deficiency was in the area of food safety requirements to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program. The Findings included: This tag is cross referenced to: F 812 Based on observations and staff interviews the facility failed to remove expired food in 1 of 2 kitchen refrigerators. The facility failed to clean and maintain 1 of 4 ice machines. This practice	F 867	• How will corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by this deficient practice. • How will the facility identify other residents having the potential to be affected by the same deficient practice? On 8/17/23, 100% audit of all closed and open QA/QAPI initiatives was completed to ensure substantial compliance. On 8/18/23, any QA/QAPI initiatives that were found to be out of compliance were reopened by the QA Committee. • What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 8/17/23, QA/QAPI team initiated an additional process review of all open initiatives to reflect confirmation of compliance by Administrator On 8/18/23 QA/QAPI team will document and discuss outcomes prior to closing/completing any QAPI initiative by	

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F 867	Continued From page 11 had the potential to affect food and beverages served to residents. During the recertification survey of 1/28/22 the facility was cited failing to discard opened and undated food items stored in 2 of 2 nourishment room refrigerators (Nourishment room that serviced 100-300 halls and nourishment room that serviced all other halls). This practice had the potential for affecting food served to residents. The Administrator stated on 7/27/23 at 11:30 AM that the facility had been doing audits of the kitchen areas to check for expired food. The Administrator said the kitchens process for removing expired food would be reviewed to correct the process.	F 867	Administrator. On 8/17/23 Closed/completed QAPI initiatives will be reviewed and substantial compliance verified at next scheduled meeting by Administrator. Discussion will be documented in QAPI minutes by Administrator. On 8/18/23 QAPI team educated regarding the process of closing initiatives by Administrator. • How does the facility plan to monitor its performance to make sure that solutions are sustained? On 8/18/23, QA/QAPI team discussed the updated initiatives implemented and document the completion by Administrator. On 8/18/23, Administrator will schedule QA/QAPI meetings. QA/QAPI will be completed quarterly times quarterly times 4 quarters and documented by Administrator. On 8/18/23, Administrator hosted QA/QAPI meeting with QA/QAPI committee to document quality improvement plans.	