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	345240	A. BUILDING _____ B. WING _____	C 09/14/2023

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WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/11/2023 through 9/14/2023. The facility was found in complaince withthe requirement CFR 483.73, Emergency Preparedness. Event ID# YTZ011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigationnnn survey was conducted on 9/11/2023 through 9/14/2023. Event ID# YTZ011. The following intakes were investigated NC00198613, NC00204743, NC00194852, NC00196763, NC00205702, and NC00206952. 1 of 9 complaint allegations resulted in a deficiency.	F 000		
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	F 656		9/27/23

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

Electronically Signed | 09/29/2023

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (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 observation, record review, and staff interviews the facility failed to develop a written individualized person-centered care plan in the area of pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident #58). The findings included: Resident #58 was admitted to the facility on 8/24/23.	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be	

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F 656	Continued From page 2 The nursing admission skin check dated 8/24/23 revealed Resident #58 had an open area to the right heel. Review of Resident #58's care plan developed on 8/24/23 revealed no care plan for the right heel pressure ulcer. The Weekly Skin Check dated 8/25/23 revealed Resident #58 had a stage 3 pressure ulcer to her right heel which was present upon admission. A physician order dated 8/25/23 to clean wound with wound cleanser, apply [non-adhering wound treatment], and wrap with gauze daily. The Minimum Data Set (MDS) admission assessment dated 8/31/23 revealed Resident #58 was coded for a stage 3 pressure ulcer which was present upon admission. An interview was conducted on 9/14/23 at 8:45 am with the MDS Nurse who revealed she was responsible to develop a written care plan for Resident #58's pressure ulcer but she stated she was not aware of Resident #58's pressure ulcer until this week. The MDS Nurse was unable to state how she coded Resident #58 for a pressure ulcer on her assessment on 8/31/23 but did not develop a written care plan. During an interview on 9/14/23 at 10:11 am the Wound Treatment Nurse revealed she documented Resident #58's right heel pressure ulcer information in her medical record with treatment orders upon admission to the facility. She stated the MDS Nurse was able to review the information from the medical record to develop a written care plan for Resident #58's right heel	F 656	corrected by the dates indicated. F656 Comprehensive Care Plan 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/13/2023 a corrective action was obtained for Resident #58 when the written individualized person-centered care plan was updated to include pressure ulcers. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 09/14/2023, the Administrator began identification of residents that were potentially impacted by this practice. This audit consisted of a review of wound documentation for 100% of current residents who were identified as having pressure ulcers and ensuring that the pressure ulcers were included on the individualized person-centered care plan within the resident□s record. This audit was completed on 9/14/2023. Results included: 10 out of 10 residents who had pressure ulcers had an appropriate individualized person-centered care plan to include pressure ulcers. No additional corrective action needed at that time. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 656	Continued From page 3 pressure ulcer. An interview with the Director of Nursing (DON) on 9/14/23 at 10:24 am revealed the MDS Nurse was responsible for implementing resident care plans. The DON stated the MDS Nurse was able to review the information in the medical record and develop a written care plan for Resident #58's right heel pressure ulcer. During an interview on 9/14/23 at 10:46 am the Administrator revealed the MDS Nurse was responsible to develop the written care plans. The Administrator stated pressure ulcers were typically communicated to the MDS Nurse by the weekly wound report and review of admissions when pressure ulcers were present.	F 656	On 9/18/2023, the MDS Nurse Consultant began reeducating to the members of the Interdisciplinary team who participate in resident care planning (See Education) This training will be incorporated in the new hire orientation for all new hires of Interdisciplinary team who participate in resident care planning. " Regulation: 483.21 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F656 Quality Assurance Tool. This monitoring consists of monitoring 100% of residents who had pressure ulcers to ensure that an appropriate individualized person-centered care plan was implemented, to include pressure ulcers, to assure compliance. Monitoring will be completed weekly x 5 weeks, then monthly x 2 months. Reports will be presented to the weekly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Monitoring will be completed weekly x 5 weeks, then monthly x 2 months. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator,	

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F 656	Continued From page 4	F 656	Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 9/27/2023	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, staff interviews, and Medical Director interview, the facility failed to obtain a physician order for supplemental oxygen for 2 of 3 residents reviewed for oxygen (Resident #26 and Resident #45). Findings included: 1. Resident #26 was admitted to the facility on 7/21/23 with diagnoses which included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and dependence on supplemental oxygen. Review of the Nursing Admission Assessment	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 1. Corrective action for resident(s) affected by the alleged deficient practice:	9/29/23

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F 695	Continued From page 5 dated 7/21/23 by Nurse #1 revealed Resident #26 had oxygen in place at 2 liters (L) via nasal canula (NC) upon admission to the facility. Record review of the Minimum Data Set (MDS) admission assessment dated 7/28/23 revealed Resident #26 was cognitively intact and was coded for supplemental oxygen use. Observations on 9/11/23 at 9:59 am an 9/12/23 at 12:20 pm Resident #26 was observed with oxygen at 2 liters via NC in use. During an interview on 9/11/23 at 10:05 am Resident #26 stated he used oxygen at home prior to admission and had used the oxygen since he arrived at the facility. Record review of Resident #26's physician orders revealed no order for supplemental oxygen. An interview was conducted with Nurse #1 on 9/12/23 at 1:22 pm who revealed a physician order was required for Resident #26's oxygen. Nurse #1 was unable to state why Resident #26's oxygen order was missed. An interview was completed on 9/14/23 at 10:31 am with the Director of Nursing (DON) who revealed when Resident #26 admitted to the facility with oxygen in place the admitting nurse should have obtained and entered an order for supplemental oxygen. The DON was unable to state how the supplemental oxygen order for Resident #26 was missed. A telephone interview was conducted on 9/14/23 at 9:35 am with the Medical Director who revealed a physician order was required for	F 695	On 09/13/2023 a corrective action was obtained for Resident #26 and resident #45 when an order as entered for oxygen use. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 09/13/2023, the Director of Nurses (DON) began identification of residents that were potentially impacted by this practice. This audit consisted of a walking round to identify 100% of current residents who were identified as receiving oxygen therapy and ensuring that orders for oxygen were present in the resident□s record. This audit was completed on 9/14/2023. Results included: 11 out of 11 residents who receive oxygen therapy have orders for oxygen. No additional corrective action needed at that time. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 9/21/2023, the SDC began reeducating Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency licensed nurses on oxygen use education. (See Education) " policy and procedures related Oxygen use	

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F 695	Continued From page 6 supplemental oxygen. He stated when Resident #26 admitted to the facility with oxygen in place the order should have been obtained. 2. Resident #45 was admitted to the facility on 4/29/22 with diagnoses which included pneumonia, respiratory failure with hypoxia, and anxiety. Resident #45 was discharged to the hospital on 8/03/23 and returned to the facility on 8/21/23. Review of the hospital discharge record dated 8/21/23 revealed no order for supplemental oxygen for Resident #45. The Nursing Admission Assessment dated 8/21/23 by Nurse #1 revealed Resident #45 had oxygen at 2 liters per nasal canula in place upon admission to the facility. The Minimum Data Set (MDS) significant change assessment dated 8/28/23 revealed Resident #45 was coded for oxygen use during the lookback period. Observations on 9/11/23 at 11:05 am and 9/12/23 at 8:37 am Resident #45 was observed with oxygen at 2 liters via nasal canula in use. Record review of Resident #45's physician orders revealed no order for supplemental oxygen. An interview was conducted with Nurse #1 on 9/12/23 at 1:22 pm who revealed a physician order was required for Resident #45's oxygen but he was unable to state how the oxygen order was missed. An interview was completed on 9/14/23 at 10:31	F 695	" The need for orders for any resident receiving oxygen therapy Additionally, on 9/22/2023, the Nurse Consultant educated the DON and the SDC on the admission order review process. This education included: " Admission order process " Admission checklist 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consists of monitoring 3 random residents who are currently receiving oxygen therapy to ensure that orders for oxygen are present to assure compliance. Monitoring will be completed weekly x 3 weeks and monthly x 2 months on various days and various shifts. Reports will be presented to the weekly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. The DON or designee will complete monitoring of the admission/readmission process and the admission checklist to ensure orders for oxygen have been entered if the resident requires oxygen therapy. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is	

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F 695	Continued From page 7 am with the Director of Nursing (DON) who revealed when Resident #45 readmitted with oxygen in place the admitting nurse should have obtained and entered an order for supplemental oxygen. The DON stated Resident #45 had an oxygen order in place before her discharge to the hospital and it was missed when she returned. A telephone interview was conducted on 9/14/23 at 9:35 am with the Medical Director who revealed a physician order was required for supplemental oxygen. He stated when Resident #45 was admitted to the facility with oxygen in place the order should have been obtained.	F 695	attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 9/27/2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		9/29/23

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F 758	Continued From page 8 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Physician interviews, Hospice Administrator interview, and Pharmacy Consultant interview, the facility failed to ensure Physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 5 residents reviewed for unnecessary medication (Resident #45). The findings included: Resident #45 was admitted to the facility on	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 758	Continued From page 9 4/29/22 with diagnoses which included anxiety and major depressive disorder. Resident #45 was discharged to the hospital on 8/03/23 and returned to the facility on 8/21/23 under hospice services. A physician order dated 8/21/23 for lorazepam (an anxiety medication) 0.5 milligram (mg) every 4 hours as needed (PRN) for anxiety without a stop date. The Note to Attending Physician/Prescriber dated 8/21/23 revealed the facility was notified by the Pharmacy Consultant that Resident #45's PRN lorazepam medication did not have a stop date. The Minimum Data Set (MDS) significant change assessment dated 8/28/23 revealed Resident #45 was not coded for behaviors and had not received medication for anxiety during the lookback period. Review of the Medication Administration Record for August 2023 and September 2023 revealed Resident #45 had not been administered the PRN lorazepam. During an interview on 9/13/23 at 2:30 pm the Director of Nursing (DON) revealed when a resident was on hospice services and a pharmacy recommendation was received, she would forward the information to hospice for review and wait to hear from them. She stated she was not sure if she had received a response for Resident #45's PRN lorazepam order. The DON stated she was ultimately responsible for the pharmacy recommendations and was to ensure they were addressed and completed when received.	F 758	F758 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/13/2023 the Director of Nursing (DON) obtained a corrective action for R# 45 when the provider was notified of the prn order for Ativan when the Ativan order was discontinued. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take PRN psychotropic medications have the potential to be affected. On 09/18/2023, the SDC identified residents that were potentially impacted by this practice by completing a 100% audit on all current residents with orders for prn psychotropic medications. This audit was completed on 09/18/2023. The audit results included: 2 residents with PRN psychotropic medications ordered within 14 days of the audit that didn□t have stop dates in place. On 9/18/2023 the Support Nurse implemented corrective action for those residents which included: Obtaining stop dates from the MD for PRN psychotropic medication for both residents on 9/18/2023. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 09/27/2023, the SDC in-serviced all licensed nurses Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency nurses on: PRN Orders for Psychotropic and Antipsychotic Medications. This training	

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F 758	Continued From page 10 A telephone interview was conducted on 9/13/23 at 3:04 pm with the Pharmacy Consultant who revealed when a PRN psychotropic medication was noted to not have a stop date the facility would be notified, and a response was requested from the prescriber to add a stop date. The Pharmacy Consultant stated if the facility had not responded to the pharmacy recommendation before the next monthly review a second notification would be sent to the facility. The Pharmacy Consultant stated the expectation was that the facility would follow-up and complete the recommendation for Resident #45's PRN lorazepam prior to the next monthly visit. A telephone interview was conducted on 9/13/23 at 6:15 pm with the Hospice Administrator who revealed she did not recall receiving any recommendations from the facility pharmacy to add a stop date to the PRN lorazepam, but stated the orders were written by the facility physician so the facility was responsible to adjust Resident #45's PRN lorazepam order if required. A telephone interview was conducted on 9/14/23 at 9:01 am with the Nurse Practitioner who revealed she was aware of the 14-day stop date requirement for PRN psychotropic medication, and she stated she normally would order for 14 days and re-evaluate if the medication was still needed. The Nurse Practitioner stated she must have missed the stop date for Resident #45's PRN lorazepam order. A telephone interview on 9/14/23 at 9:40 am with the Medical Director revealed the facility was responsible to notify him when a response was not received from another provider regarding the	F 758	will include all current staff including agency. This training included: " Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record " PRN orders for psychotropic drugs are limited to 14 days. Except as provided in, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident□s medical record and indicate the duration for the PRN order. " PRN orders for anti-psychotic drugs are LIMITED to 14 days and CANNOT be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. As of 09/27/2023, the DON will ensure that any of the above identified staff who does not complete the in-service training by _the Staff Development Coordinator_ will not be allowed to work until the training is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F758 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor for compliance to	

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F 758	Continued From page 11 pharmacy recommendation for a 14-day stop date for Resident #45's PRN lorazepam and he would address the pharmacy recommendation. An interview was conducted with the Administrator on 9/14/23 at 10:49 am who revealed the DON should have reached out to the Medical Director to obtain a stop date for Resident #45's PRN lorazepam.	F 758	ensure with prn psychotropic medications are limited to 14 days, except as provided in, if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. Reports will be presented to the Quality Assurance committee by the DON or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing monitoring program reviewed at the Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/29/2023	
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 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.	F 812		10/3/23

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F 812	Continued From page 12 §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, record review and staff interviews the facility failed to maintain food service equipment without a build up of debris on 3 of 4 pieces of cookline equipment (top/bottom convection oven, gas range oven) observed for cleanliness, and failed to remove excessive ice buildup and clean 2 of 2 nourishment refrigerators observed for cleanliness. These practices had the potential to affect facility residents. The findings included: During the initial tour of the kitchen on 9/11/23 at 9:52AM observation of the double stacked convection oven revealed a buildup of dark charred food debris on the bottom of both the top and bottom stacked convection ovens. The bottom convection oven door had a buildup of grease on the inside of the doors and lower inside rim of the oven. The gas range oven had a buildup of dark black food debris on the bottom of the oven. A second observation of the convection ovens and gas range oven on 9/14/23 at 8:55 AM revealed the ovens to be in the same condition. Observation of the 600-hall nourishment refrigerator on 9/11/23 at 11:25 AM revealed a 2-inch buildup of ice on the top, bottom, and left sides of the freezer. Inside the front ice debris was a 2-inch by 3-inch pink stain.	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 9/14/2023. During initial walk through of the kitchen, it was noted dietary services had failed to keep equipment in sanitary condition and prevent cross contamination. 3 of 4 pieces of cookline equipment (top/bottom convection oven, gas range oven) were noted with debris. 2 of 2 nourishment refrigerators observed were noted to be unclean with excessive ice buildup. The Dietary Service Director ensured both the convection oven and gas range oven were clean, which was corrected on 9/14/2023. The nourishment refrigerators were also defrosted to remove excessive ice buildup and cleaned out by Environmental Service Director on 9/14/2023. 2. Corrective action for residents with	

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F 812	Continued From page 13 During observation on 9/14/23 at 8:29 AM the 300-hall nourishment refrigerator was observed. The freezer top shelf had frozen paper debris stuck and the shelf was sticky to touch. On 9/14/23 at 8:32 AM observation of the 600-hall nourishment refrigerator revealed a 2-inch buildup of ice on the top, bottom and left sides of the freezer. Inside the front ice debris was a 2-inch by 3-inch pink stain. During an interview on 9/14/23 at 9:03 AM the Dietary Manager revealed the convection ovens were scheduled to be cleaned and on the scheduled day staff called out and had not been cleaned. He indicated environmental services were responsible for cleaning the nourishment refrigerators. During an interview on 9/14/23 at 10:12 AM the Director of Nursing stated the Environmental Service should have a cleaning list and follow it.	F 812	the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 9/18/2023, the Dietary Service Director updated the cleaning schedule with assigned specific staff roles to include a weekly deep cleaning of the top and bottom ovens and gas range oven as well as review cleanliness and ice buildup of nourishment refrigerators twice daily. 3. Systemic changes In-service education was provided to all full time, part time, initiated on 9/18/2023 and completed on 9/22/2023 by facility Dietary Manager and as needed staff on updated the cleaning schedule with assigned specific staff roles to include a weekly deep cleaning of the top and bottom ovens and gas range oven as well as review cleanliness and ice buildup of nourishment refrigerators twice daily with weekly reviews for completion by the Dietary Manager. Topics included: " Sanitation and cross contamination prevention policies. " Inspections on shifts to observe convection ovens and gas range ovens to ensure that they are without debris or food particles. " Inspections on shifts to observe that nourishment refrigerators are in clean condition and without ice buildup " Assigned roles responsible for at least weekly cleaning of the convection ovens	

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F 812	Continued From page 14	F 812	and gas range ovens added to cleaning schedule. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or assignee will monitor procedures for proper sanitation and prevention of cross contamination weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that equipment is in sanitary condition. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 10/2/2023	
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	F 867		9/27/23

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F 867	Continued From page 15	F 867		

monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, 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

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F 867	Continued From page 16 systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; 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.	F 867		

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F 867	Continued From page 17 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following a recertification and complaint survey of 4/8/2022. This was for one recited deficiency on the current	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	

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F 867	Continued From page 18 recertification and complaint survey in the area of Food and Nutrition Services (F812). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F812: Based on observations, record review, and staff interviews the facility failed to maintain food service equipment without a buildup of debris on 3 of 4 pieces of cookline equipment (top/bottom convection oven, gas range oven) observed for cleanliness, and failed to remove excessive ice buildup and clean 2 of 2 nourishment refrigerators observed for cleanliness. These practices had the potential to affect all residents. During the recertification and complaint survey of 4/8/2022 the facility was cited for failing to maintain kitchen equipment in a clean and sanitary condition to prevent cross contamination. An interview was completed on 9/14/2023 at 10:56am with the Administrator. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator stated there was a current monitoring plan in place related to the identified F812 deficient practice. The Administrator explained the monitoring plan included the use of a cleaning schedule and cleaning list that must be followed. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor identified issues within the facility to sustain complaince.	F 867	or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/21/2023, the Regional Director of Operations (RDO) educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Food Procurement, Storage/Prepare/Serve-Sanitary (F812). This deficiency was cited again on the current recertification survey completed on 9/14/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Storage/Prepare/Serve-Sanitary (F812). The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 9/14/2023 to review the deficiencies from the 9/11/2023-9/14/2023 annual recertification survey and reviewed the citations. On 9/21/2023, the RDO in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include	

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F 867	Continued From page 19	F 867	identifying issues and correcting repeat deficiencies related to the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On _9/22/2023__, the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812). This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 9/22/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor	

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F 867	Continued From page 20	F 867	compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 09/27/2023	