STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345162	A. BUILDING ______ B. WING ______	C 10/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GASTONIA	**416 N HIGHLAND STREET GASTONIA, NC 28052**

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E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted 10/02/23 through 10/06/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PWVJ11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 10/02/23 through 10/06/23. Event ID #PWJV11. The following intakes were investigated: NC00207288, NC00207043, NC00206556, NC00206214, NC00205490, NC00205116, NC00204400, NC00200958, NC00199700, NC00199126, and NC00199323. 4 of the 24 complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2023

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 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated dietary concerns voiced by residents during Resident Council meetings for 4 of 9 months reviewed (January 2023, April 2023, May 2023, and July 2023). Findings included: The Resident Council minutes for the period January 2023 through September 2023 were reviewed and revealed the following: Resident Council minutes dated 01/23/23 noted in part, residents voiced dietary concerns that food portions were small, not fully cooked, food was cold, bread was hard, and juice was served hot. Resident Council minutes dated 02/16/23 noted the dietary concerns voiced during the previous month's meeting were reviewed and reported as	F 565	1. By 11/3/23 the Administrator and Director of Nursing have met with the Resident Council, reviewed and acknowledged the ongoing dietary concerns voiced during previous resident council meetings and agreed on a plan to discuss food related issues during the weekly Food Committee Meeting led by the Dietary Manager. 2. By 11/3/23 the Dietary Manager and the Administrator began a weekly food committee. This was re-established to ensure residents have an opportunity for input on food related concerns. 3. The Administrator or designee will monitor a test tray weekly for 12 weeks to provide feedback to the dietary staff related to timely meal service, temperature, seasoning and overall taste. The Administrator will follow up with the Resident Council President weekly and	

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F 565	Continued From page 2 resolved. There were no new dietary concerns voiced during the meeting. Resident Council minutes dated 04/20/23 noted residents voiced concerns about call light response timing, laundry and food but did not specify what the concerns were. Resident Council minutes dated 05/18/23 revealed no documentation that resolution was provided or discussed regarding the concerns voiced during the previous month's meeting. New dietary concerns were voiced regarding cold food and meal trays not being delivered in a timely manner. Resident Council minutes dated 07/20/23 revealed no documentation that resolution was provided to the residents regarding the dietary concerns voiced during the previous month's meeting. New concerns were voiced regarding the food was too spicy, served late, and staff would not warm up the cold food when requested. Resident Council minutes dated 08/17/23 revealed the dietary concerns addressed during the previous month's meeting were discussed but did not indicate if the issues were resolved or ongoing. The facility's grievance logs for the period January 2023 through September 2023 were reviewed. The only grievances filed on behalf of the members of the Resident Council regarding dietary concerns were dated 01/25/23, 05/18/23 and 07/20/23. The concerns were all noted as resolved. A Resident Council group interview was conducted on 10/04/23 at 3:04 PM with Resident #1, Resident #7, Resident #35, Resident #40, Resident #51, and Resident #77 in attendance. The residents all reported ongoing dietary	F 565	the Resident Council monthly for 12 weeks to ensure resolution of food concerns. 4. The Administrator will report results of these audit during the monthly Quality Assurance meeting. Completion date 11/3/23.	

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concerns, specifically with meals being served cold. The residents voiced it took staff a long time to deliver their meal trays once the meal cart arrived on the hall. When the meal tray was served to them, the food was cold and if ice cream was on the tray, it was usually defrosted. The residents all stated they had voiced these concerns during previous meetings and the only follow-up they received regarding administrative efforts to address their dietary concerns was "they are trying and still working on it."

During an interview on 10/05/23 at 2:11 PM, the Dietary Manager (DM) revealed she was aware of the repeated dietary concerns voiced at the Resident Council meetings such as food being cold when served to the residents. The DM explained in an effort to address the concerns, they had received a quote on a new pellet warmer system (keeps hot foods at safe temperatures for a longer period of time), completed test tray audits one to two times a week to check the temperature and taste of the food, and provided in-service training to staff on delivering the meal trays more quickly as well as keeping the doors shut on the meal carts in-between delivering meal trays. The DM stated she felt the reason cold food was still a concern for the residents was due to new agency staff that might not have received the in-service training.

During an interview on 10/06/23 at 11:21 AM, the Activity Director revealed when concerns were brought up during Resident Council meetings, she wrote them on a concern form for the appropriate Department Manager to address. The Activity Director stated for at least half of this year, residents had brought up repeated dietary concerns, such as cold food, and felt the majority

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F 565	Continued From page 4 of the time their concerns were addressed. The Activity Director explained once the resolution to the concern was provided to her, she reviewed it with the Resident Council at the next scheduled meeting but did not always document in the Resident Council minutes if the concerns were resolved or improving. During an interview on 10/06/23 at 5:02 PM, the Administrator stated she was aware there had been repeated dietary concerns voiced during Resident Council meetings. She explained they have requested new menus, an increase in the PPD (per patient day) food cost and more training and support for dietary staff in an effort to address the residents' food concerns. The Administrator stated instead of just informing the residents they were working on addressing the issue, she realized they could do better at explaining the process of what they were actually doing to try and resolve their food concerns.	F 565		
F 584 SS=E	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	F 584		11/3/23

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F 584	Continued From page 5 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, 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 observations and staff interviews, the facility failed to maintain residents' wardrobe closets in good repair by not replacing knobs on the drawers which left exposed screws sticking out from the drawer that had the potential to cut residents when entering and exiting their rooms (rooms 107, 204, 206, 208, 209, 212, 217, 232, 234, 236, and 237); failed to maintain the floors, walls and baseboards of residents' rooms clean and in good repair (rooms 104, 230, 231, 232, 233, 234, 236, and 237); failed to ensure resident bathrooms were clean and sanitary that had	F 584	1. By 11/3/23 the Maintenance Director and designee replaced broken knobs in rooms 107, 204, 206, 208, 209, 212, 217, 232, 234, 236, and 237. By 11/3/23 the Maintenance Director and Housekeeping Supervisor cleaned and repaired the floors, walls and baseboards of resident rooms 104, 230, 231, 232, 233, 234, 236, and 237. By 11/3/23 The Housekeeping Director and designee cleaned and removed debris from bathroom floors in bathrooms 106, 230, 232, 234, and 236.	

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F 584	Continued From page 6 strong odors resembling urine and/or buildup of debris on the floor (bathrooms 106, 230, 232, 234, and 236); and failed to place a cover over an outlet leaving the cutout in the wall exposed through the adjoining room (room #133) for 17 of 60 rooms on 2 of 2 resident halls reviewed for environment. The findings included: 1. a. Observations of room #203 on 10/03/23 at 9:45 AM, 10/04/23 at 12:33 PM, and 10/05/23 at 9:00 AM revealed the corner of the wall next to the shared bathroom had a section of missing baseboard exposing the sheetrock. The left side of the of door to the wardrobe closet was missing a doorknob. b. Observations of room #204 on 10/03/23 at 9:48 AM, 10/04/23 at 12:34 PM, and 10/05/23 at 9:01 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor. There was an open, square shaped hole, approximately 2 inches by 2 inches, in the middle of the wooden bathroom door. c. Observations of room #205 on 10/03/23 at 9:52 AM, 10/04/23 at 12:35 PM, and 10/05/23 at 9:02 AM revealed on the wall behind the headboard of the A bed were linear and circular scrapes with exposed sheetrock from the top of the headboard and halfway to the floor. d. Observations of room #206 on 10/03/23 at 9:55 AM, 10/04/23 at 12:36 PM, and 10/05/23 at 9:03 AM revealed a wardrobe closet located just	F 584	By 11/3/23 the Maintenance Director replaced the outlet cover in room 133. 2. By 11/3/23 The Maintenance Director and Housekeeping Director completed an audit of occupied resident rooms to identify and repair any broken or missing knobs on wardrobes and drawers, created a prioritized maintenance list to include needed repairs to floors and baseboards, missing or broken outlet covers. On 11/3/23 the Housekeeping Director or designee audited resident bathrooms to ensure bathrooms are clean and free from debris. 3. The Administrator will round 2 times per week for 12 weeks to ensure the prioritized Maintenance and Cleaning list is progressing with completion and is updated with opportunities as observed. 4. The Maintenance Director will report the results of thee audits to the Quality Assurance committee for further recommendations. Completion date is 11/3/23	

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inside the room door. The bottom drawer on the right side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.

e. Observations of room #207 on 10/03/23 at 10:00 AM, 10/04/23 at 12:37 PM, and 10/05/23 at 9:04 AM revealed on the wall behind the headboard of the B bed were linear and circular scrapes with exposed sheetrock from the top of the headboard and halfway to the floor.

f. Observations of room #208 on 10/03/23 at 10:04 AM, 10/04/23 at 12:38 PM, and 10/05/23 at 9:05 AM revealed a wardrobe closet located just inside the room door. The top drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The top drawer was approximately 2 feet from the floor.

g. Observations of room #209 on 10/03/23 at 10:07 AM, 10/04/23 at 12:39 PM, and 10/05/23 at 9:06 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.

h. Observations of room #212 on 10/03/23 at 10:23 AM, 10/04/23 at 12:40 PM, and 10/05/23 at 9:07 AM revealed a wardrobe closet located just inside the room door. The top drawers on both the left and right sides of the wardrobe closet were missing knobs and the end of the screws were sticking out approximately one inch. The top drawers were approximately 2 feet from the

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floor.

i. Observations of room #217 on 10/03/23 at 10:27 AM, 10/04/23 at 12:41 PM, and 10/05/23 at 9:08 AM revealed a wardrobe closet located just inside the room door. The bottom drawer on the left side of the wardrobe closet was missing a knob and the end of the screw was sticking out approximately one inch. The bottom drawer was approximately 1 foot from the floor.

An environmental tour and interview was conducted on 10/06/23 at 3:36 PM with the Administrator, Maintenance Director, and Environmental Services Director which revealed the conditions of rooms 203, 204, 205, 206, 207, 208, 209, 212, and 217 remained unchanged. The Maintenance Director stated he was unaware of the issues identified with the walls, missing baseboard and exposed screws on the wardrobe closets in residents' rooms. He explained since starting his position in July 2023, he had been trying to train staff to enter work orders into the TELS system instead of on paper so there would be a record of the work order. Both the Maintenance Director and Administrator voiced the exposed screws on the wardrobe closets were potential safety hazards and needed to be repaired. The Administrator explained it was an older building and the Maintenance Director's primary focus had been addressing the plumbing issues within the facility. She stated it was her expectation that residents would have clean rooms that were well-taken care of to live in and the issues identified with the walls, baseboards and wardrobe closets would be addressed.

2. a. Observations of room #232 on 10/02/23 at 3:31 PM, 10/03/23 at 9:22 AM, 10/04/23 at 9:13 AM, 10/05/23 at 8:52 AM, and 10/06/23 at 12:04

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PM revealed a wardrobe closet located just inside the room door. Three of the four drawers of the wardrobe closet were missing a knob leaving the end of the screws sticking out approximately one-half inch.

b. Observations of room #236 on 10/02/23 at 3:45 PM, 10/03/23 at 9:37 AM, 10/04/23 at 9:20 AM, 10/05/23 at 9:10 AM, and 10/06/23 at 12:05 PM revealed a wardrobe closet located just inside the room door. One of the four drawers of the wardrobe closet was missing a knob leaving the end of the screw sticking out approximately one-half inch.

c. Observations of room #237 on 10/02/23 at 3:52 PM, 10/03/23 at 9:41 AM, 10/04/23 at 9:24 AM, 10/05/23 at 9:13 AM and 10/06/23 at 12:06 PM revealed a wardrobe closet located just inside the room door. Two of the four drawers of the wardrobe closet were missing a knob leaving the end of the screws sticking out approximately one-half inch.

d. Observations of room #107 on 10/03/23 at 9:02 AM, 10/03/23 at 9:06 AM, 10/05/23 at 8:36 AM, and 10/06/23 at 12:06 PM revealed a wardrobe closet located just inside the room door. One of the four knobs of the wardrobe closet was missing a knob leaving the end of a screw sticking out approximately one-half inch.

e. Observations of room #234 on 10/03/23 at 9:31 AM, 10/05/23 at 9:08 AM, and 10/06/23 at 12:08 PM revealed a wardrobe closet located just inside the room door. One of the four knobs of the wardrobe closet was missing a knob leaving the end of a screw sticking out approximately one-half inch.

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F 584	Continued From page 10 3. a. Observations of room #104 on 10/02/23 at 2:32 PM, 10/04/23 at 9:55 AM, 10/05/23 at 8:33 AM, 10/06/23 at 12:03 PM revealed linear scrapes with exposed sheetrock behind the headboards of A and B beds and a dried black substance on the floor between A and B bed. b. Observations of room #230 on 10/02/23 at 3:30 PM, 10/03/23 at 9:15 AM, 10/04/23 at 8:27 AM, 10/05/23 at 8:46 AM, 10/06/23 at 12:04 PM revealed food particles and other debris scattered throughout the floor of both sides of the room. c. Observations of room #230 on 10/03/23 at 9:13 AM, 10/04/23 at 8:27 AM, 10/05/23 at 8:46 AM, and 10/06/23 at 12:04 PM revealed an approximately 4-inch by 4-inch area of exposed sheetrock to the wall beside B bed and food particles and other debris scattered throughout the floor of both sides of the room. d. Observations of room #232 on 10/02/23 at 3:31 PM, 10/03/23 at 9:22 AM, 10/04/23 at 9:13 AM, 10/05/23 at 8:52 AM, and 10/06/23 at 12:04 PM revealed food particles and other debris scattered throughout the floor on both sides of the room. e. Observations of room #236 on 10/02/23 at 3:46 PM, 10/03/23 at 9:37 AM, 10/04/23 at 9:20 AM, 10/05/23 at 9:10 AM, and 10/06/23 at 12:05 PM revealed the baseboard along the wall behind both beds was peeling away from the wall and food particles and other debris were scattered throughout the floor of both sides of the room. f. Observations of room #233 on 10/02/23 at 3:36 PM, 10/04/23 at 9:17 AM, 10/05/23 at 8:59	F 584		

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AM, and 10/06/23 at 12:07 PM revealed multiple linear scratches with exposed sheetrock behind B bed, the baseboard peeling away from the wall behind the room entrance door, and food particles and other debris scattered throughout the floor on both sides of the room.

g. Observations of room #231 on 10/03/23 at 9:18 AM, 10/05/23 at 8:50 AM, and 10/06/23 at 12:07 PM revealed a missing baseboard to the wall beside A bed and the corner of the wall beside A bed had exposed sheetrock.

h. Observations of room #234 on 10/03/23 at 9:31 AM, 10/05/23 at 9:08 AM, and 10/06/23 at 12:08 PM revealed the corner of the wall beside A bed had exposed sheetrock and food particles and debris scattered throughout the floor on both sides of the room.

i. Observations of room #237 on 10/02/23 at 3:52 PM, 10/04/23 at 9:24 AM, 10/05/23 at 9:13 AM, and 10/06/23 at 12:06 PM revealed food particles and other debris scattered throughout the floor on both sides of the room.

4. a. Observations of room #106's shared bathroom on 10/02/23 at 2:37 PM, 10/04/23 at 9:57 AM, 10/05/23 at 8:35 AM, and 10/06/23 at 12:03 PM revealed multiple circular areas of a dried brown substance on the floor beside the toilet.

b. Observations of room #230's shared bathroom on 10/03/23 at 9:31 AM, 10/03/23 at 9:15 AM, 10/04/23 at 8:27 AM, 10/05/23 at 8:46 AM, and 10/06/23 at 12:04 AM revealed scattered debris throughout the floor and a strong odor of urine was noted.

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c. Observations of room #234's shared bathroom on 10/02/23 at 3:39 PM, 10/03/23 at 9:29 AM, and 10/04/23 at 9:18 AM, 10/05/23 at 9:08 AM, and 10/06/23 at 12:08 PM revealed circular dried brown stains on the floor beside the toilet and scattered debris throughout the floor.

d. Observations of room #232's shared bathroom on 10/02/23 at 3:31 PM, 10/03/23 at 9:22 AM, 10/04/23 at 9:13 AM, 10/05/23 at 8:52 AM, and 10/06/23 at 12:04 PM revealed scattered debris throughout the floor.

e. Observations of room #236's shared bathroom on 10/02/23 at 3:46 PM, 10/03/23 at 9:37 AM, 10/04/23 at 9:20 AM, and 10/06/23 at 12:05 PM revealed scattered debris throughout the floor.

An environmental tour and interview was conducted on 10/06/23 at 3:36 PM with the Administrator, Maintenance Director, and Environmental Services Director which revealed the conditions of rooms 104, 107, 230, 231,232, 234, 236, and 237. The Maintenance Director stated he was unaware of the issues identified with the walls, missing baseboard and exposed screws on the wardrobe closets in residents' rooms. He explained since starting his position in July 2023, he had been trying to train staff to enter work orders into the TELS system instead of on paper so there would be a record of the work order. Both the Maintenance Director and Administrator voiced the exposed screws on the wardrobe closets were potential safety hazards and needed to be repaired. The Administrator explained it was an older building and the Maintenance Director's primary focus had been addressing the plumbing issues within the facility.

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F 584	Continued From page 13 She stated it was her expectation that residents would have clean rooms that were well-taken care of to live in and the issues identified with the walls, baseboards and wardrobe closets would be addressed. The Environmental Services Director stated housekeeping staff were not mopping or sweeping rooms daily. She further stated resident rooms should be clean and free of odors and she was going to provide education to staff regarding her expectations. The Administrator stated she expected resident rooms to be clean and free of odors. 5. An in-room observation conducted on 10/03/23 at 10:00 AM of room #133 revealed an outlet cover was missing leaving the cutout in the wall exposed through the adjoining room (room #133) with male resident. On 10/5/23 at 9:56 AM an observation of room #133 revealed the cutout in the wall to be unchanged. Resident #73 was interviewed during the observation. She stated the cutout in the wall had been there since she moved into the room. On 10/05/23 at 4:15 PM the Maintenance Manager and the Administrator reported they were not aware of the missing outlet cover for room #133, and it would be repaired.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data	F 641	1. Based on observation, record review and staff interviews, the facility failed to	11/3/23

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F 641	Continued From page 14 Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), activities of daily living, diagnoses, and skin conditions for 7 of 27 sampled residents reviewed (Residents #8, #55, #72, #3, #15, #18 and #237). Findings included: 1. Resident #8 was admitted to the facility on 12/08/17. Her diagnoses included Parkinson's disease, anxiety, depression, and bipolar disorder. A care plan initiated on 12/04/18 revealed Resident #8 had a mood problem related to disease process and had a Levell II PASRR. Interventions included: administer medications as ordered, behavioral health consults as needed, and has a Level II PASRR. The annual MDS assessment dated 09/20/23 indicated Resident #8 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document dated 10/05/23 revealed Resident #8 had a Level II PASSR with no expiration date. There was no effective date listed on the NC MUST inquiry. During an interview 10/06/23 at 9:30 AM, the MDS Coordinator explained Resident #8's MDS assessment dated 09/20/23 was completed by another MDS Coordinator who was no longer employed at the facility. The MDS Coordinator confirmed Resident #8 had a Level II PASRR that	F 641	accurately code the Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), activities of daily living, seizure diagnoses, and skin conditions for 7 of 27 sampled residents reviewed (Residents #8, #55, #72, #3, #15, #18 and #237). Inaccurately coded assessments were modified appropriately and submitted by the MDS Coordinator by 11/3/2023. 2. Audits were completed by 11/3/2023 by the MDS Coordinator and Director of Clinical Reimbursement on all residents with a level II PASRR to ensure MDS item A1500 was accurately coded, residents with a seizure diagnosis were accurately coded at I5400, and all residents most recent MDS assessment was accurately coded for MDS items G0110H eating and M1200C turning and repositioning program. Any issues identified were corrected and submitted by 11/3/2023. 3. Re-education to MDS Coordinator was completed on 10/26/2023 by the Director of Clinical Reimbursement regarding Resident Assessment Instrument (RAI) guidelines for correct coding of items in sections A, G, I and M. 4. Random audits of MDS items A1500, G0100H, I5400 and M1200C will be conducted by the Director of Nursing/Nurse Management/Designee 2x/week for 12 weeks to ensure appropriate coding of MDS items. Results of observations will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.	

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F 641	Continued From page 15 should have been reflected on the MDS assessment and it was likely an oversight. During an interview on 10/06/23 at 5:02 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. 2. Resident #55 was admitted to the facility on 07/25/22. Her diagnoses included depression and bipolar disorder. A PASRR Level II Determination Notification letter dated 08/19/22 revealed Resident #55 had a Level II PASRR with no expiration date. The annual MDS assessment dated 06/26/23 indicated Resident #55 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. During an interview on 10/06/23 at 9:30 AM, the MDS Coordinator revealed she was not always informed when a resident had a Level II PASRR and due to changes in staff, she was not sure who was responsible for keeping track to let her know. The MDS Coordinator explained she was not informed Resident #55 had a Level II PASRR which is why the MDS assessment dated 06/26/23 did not accurately reflect her PASRR status. During an interview on 10/06/23 at 5:02 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. 3. Resident #72 was admitted to the facility on 08/04/23. Her diagnoses included anxiety and depression.	F 641	Completion date 11/3/23.	

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The annual MDS assessment dated 08/08/23 indicated Resident #72 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions.

Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document dated 10/06/23 revealed Resident #72 had a 30-day Level II PASSR effective 07/31/23 with an expiration date of 08/30/23.

During an interview on 10/06/23 at 9:30 AM, the MDS Coordinator revealed she was not always informed when a resident had a Level II PASRR and due to changes in staff, she was not sure who was responsible for keeping track to let her know. The MDS Coordinator stated she was not informed Resident #72 had a Level II PASRR which is why the MDS assessment dated 08/08/23 did not accurately reflect her PASRR status.

During an interview on 10/06/23 at 5:02 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately.

4. Resident #40 was admitted to the facility 08/08/20 with diagnoses including anemia and muscle weakness.

The quarterly Minimum Data Set (MDS) dated 08/12/23 reflected Resident #40 was cognitively intact, required extensive assistance with bed mobility, and was on a turning and repositioning program.

An interview with the MDS Coordinator on

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10/06/23 at 9:35 AM revealed she received assistance with coding some parts of the MDS from a staff member who worked remotely. She explained the staff member who worked remotely coded the quarterly MDS incorrectly because the facility did not have a turning and repositioning program and the coding error was an oversight.

An interview with the Director of Nursing (DON) on 10/06/23 at 4:50 PM revealed she expected the MDS to be coded correctly.

5. Resident #237 was admitted to the facility 12/05/22 with diagnoses including anemia and diabetes.

The nutrition care plan initiated 04/26/23 revealed Resident #237 had significant weight loss due to refusing meals and was at risk for malnutrition. Interventions included monitoring Resident #237 for signs or symptoms of malnutrition and providing his diet as ordered.

The significant change Minimum Data Set (MDS) dated 05/01/23 revealed Resident #237 was cognitively intact and did not eat or drink during the look back period.

An interview with the MDS Coordinator on 10/06/23 at 9:46 AM revealed she received assistance with coding some parts of the MDS from a staff member who worked remotely. She explained the staff member who worked remotely coded the quarterly MDS incorrectly because even though Resident #237 had a poor appetite, he did eat and drink during the look back and the coding error was an oversight.

An interview with the Director of Nursing (DON)

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on 10/06/23 at 4:50 PM revealed she expected the MDS to be coded correctly.

6. Resident #18 was admitted to the facility 05/04/20 with diagnoses including non-Alzheimer's dementia and diabetes.

Review of Resident #18's Physician orders revealed an order dated 02/22/22 for valproic acid (used to treat seizures) oral solution 250 milligrams per 5 milliliters(ml) give 2.5 ml twice a day for seizures.

Review of Resident #18's Medication Administration Record (MAR) from June 2022 through October 2023 revealed she received valproic acid as ordered.

The quarterly Minimum Data Set (MDS) dated 08/04/23 revealed Resident #18 was severely cognitively impaired and did not list seizures as a diagnosis.

An interview with the MDS Coordinator on 10/06/23 at 9:44 AM revealed the quarterly MDS should have reflected Resident #18 had a diagnosis of seizures and it was an oversight that it was not coded correctly.

An interview with the Director of Nursing (DON) on 10/06/23 at 4:50 PM revealed she expected the MDS to be coded correctly.

7. Resident #3 was admitted to the facility 08/01/19 with diagnoses including Alzheimer's disease and hypertension (high blood pressure).

Review of the quarterly Minimum Data Set (MDS) dated 08/10/23 revealed Resident #3 was

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F 641	Continued From page 19 severely cognitively impaired, required extensive assistance with bed mobility, and was on a turn and reposition program. An interview with the MDS Coordinator on 10/06/23 at 9:32 AM revealed she received assistance with coding some parts of the MDS from a staff member who worked remotely. She explained the staff member who worked remotely coded the quarterly MDS incorrectly because the facility did not have a turning and repositioning program and the coding error was an oversight. An interview with the Director of Nursing (DON) on 10/06/23 at 4:50 PM revealed she expected the MDS to be coded correctly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		11/3/23

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) Level II evaluation for a resident with a history of mental health diagnoses for 1 of 5 sampled residents reviewed for PASRR (Resident #53).

Findings included:

Review of hospital records dated 12/28/22 noted Resident #53 had a diagnosis of bipolar disorder with an effective date of 04/09/21.

Resident #53 was admitted to the facility on 01/02/23 with diagnoses that included manic depression (bipolar disease).

The admission Minimum Data Set (MDS) dated 01/06/23 revealed Resident #53 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

Review of Resident #53's list of cumulative diagnoses contained in her medical record revealed the following diagnoses: bipolar disorder with a date of 01/02/23, anxiety disorder with a date of 04/05/23, persistent mood disorder with a date of 04/13/23, and schizophrenia with a date of 04/13/23.

A hospital psychiatric consult progress note dated 03/29/23 revealed Resident #53 had a psychiatric history of bipolar disorder and anxiety. It further noted a diagnosis of schizoaffective disorder.

A psychiatric progress note dated 04/21/23

1. Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) Level II evaluation for a resident with a history of mental health diagnoses for 1 of 5 sampled residents reviewed for PASRR (Resident #53). Resident was reviewed and updates were sent for new Level 2 PASRR determination by the Social Services Director by 11/3/2023.
2. Audit was completed by 11/3/2023 by the Director of Nursing/Director of Social Work/designee to ensure accuracy of PASRR on all current residents with a mental health diagnosis. Any issues identified were addressed as indicated.
3. Education to Social Worker was completed by 11/3/2023 by the Director of Clinical Reimbursement on the components of this regulation with emphasis on ensuring accuracy of resident□s PASRR.
4. Random audits will be conducted by the Director of Social Services/Designee 2x/week for 12 weeks to ensure accuracy of resident□s PASRR□s. Results of observations will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.
Completion date is 11/3/23.

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revealed in part, Resident #53 was seen to evaluate severe mood swings and behaviors. It was also noted Resident #53 had informed a previous provider she was diagnosed with schizophrenia and has had auditory hallucinations.

A physician's order dated 04/26/23 for Resident #53 read, Venlafaxine (antidepressant medication) 75 mg one time a day for bipolar depression related to persistent mood disorder.

A physician's order dated 06/21/23 for Resident #53 read, Risperidone (antipsychotic medication) 1 mg/milliliter (ml) mouth two times a day for delusions related to schizophrenia.

Review of a North Carolina Medicaid Uniform Screening Tool (NC MUST) document dated 10/03/23 revealed Resident #53 had a Level 1 PASRR effective 03/09/21. There were no requests for reevaluation after 03/09/21.

During interviews on 10/05/23 at 9:02 AM and 10/06/23 at 10:52 AM the Admissions Director revealed when she started her position in August 2023, no one was keeping up with Level II PASRR's so she started submitting the PASRR requests for reevaluations of time-limited PASRR via NC MUST. The Admissions Director explained as part of the admission process, she checked NC MUST to ensure resident's had a PASRR number prior to their admission but she did not submit requests for PASRR reevaluations if they had mental health diagnoses. The Admissions Director stated going forward the SW would be responsible for managing Level II PASRRs.

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F 644	Continued From page 22 During an interview on 10/06/23 at 3:30 PM the SW revealed she started her position at the facility in June 2023 and had not yet been trained on the process for requesting Level II PASRR reevaluations. During an interview on 10/06/23 at 5:02 PM, the Administrator stated she expected Level II PASRR requests to be requested per regulatory guidelines. She explained the SW would be the staff member responsible for requesting PASRR reevaluations going forward and corporate would be coming next week to train the SW on the process.	F 644		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide supporting documentation for a resident with a new diagnosis of schizophrenia for 1 of 5 residents reviewed for unnecessary medications (Resident #18). Findings included: Resident #18 was admitted to the facility 05/04/20 with diagnoses including non-Alzheimer's dementia, depression, and anxiety. Review of the care plan for psychotropic medication use (medication that affects mental	F 658	1. 10/7/23 the Director of Nursing notified the Physician and revised the diagnosis list for Resident #18 to remove the diagnosis of Psychosis related to Schizophrenia, due to lack of supporting documentation. 2. By 11/3/23 the Director of Nursing completed an audit of all residents with a current diagnosis of Psychosis related to Schizophrenia and validated supporting documentation is in place. The physician was notified of any opportunities identified and diagnoses revised as needed. Completion date is 11/3/23.	11/3/23

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F 658	Continued From page 23 functions and behaviors) last updated 07/04/23 revealed Resident #18 received medications related to dementia, depression, and anxiety. Interventions included administering Resident #18's medications as ordered and monitoring her for any adverse reaction. Resident #18 had a Physician order dated 12/20/22 for Seroquel (an antipsychotic) 25 milligrams (mg) twice a day for psychosis related to schizophrenia. On 05/05/23 the Physician order for Seroquel 25 mg twice a day was changed to Seroquel 50 mg at bedtime for sleep related to schizophrenia. A summary of Physician #1's progress note dated 02/27/23 is as follows: Resident #13 was seen at the request of staff to evaluate whether she had a diagnosis to justify the use of Seroquel. The note stated Resident #18 was doing reasonably well with some underlying confusion but was not floridly (severely) delusional (beliefs not based in reality). The note further stated Resident #18 had a diagnosis of schizophrenia and dementia, but the delusional disorder predated the onset of her dementia and attempts to wean Seroquel were not successful due to florid psychosis. The quarterly Minimum Data Set (MDS) dated 08/04/23 revealed Resident #18 was severely cognitively impaired, had no behaviors during the look back period, had a diagnosis of schizophrenia, and received antipsychotic medications 7 out of 7 days during the look back period. Review of Resident #18's medical record revealed there was no further documentation of what specific behaviors she exhibited that	F 658	3. By 11/3/23 The Director of Nursing and Nurse Managers will begin reviewing new admissions with a diagnosis of Psychosis related to Schizophrenia to ensure there is documentation available to support this diagnosis, 2 times per week for 12 weeks. 4. The Director of Nursing will report the results of these audits to the Quality Assurance Committee for further recommendations. Completion date is 11/3/23/	

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F 658	Continued From page 24 resulted in a new diagnosis of schizophrenia on 02/27/23. No orders for a psychiatry consult were observed in Resident #18's medical record. An interview with the Director of Nursing (DON) on 10/06/23 at 8:22 AM revealed she was unable to locate any further documentation for why Resident #18 was given a diagnosis of schizophrenia on 02/27/23. She stated psychiatric services had been offered to Resident #18's family in the past and they declined those services. Physician #1 was unavailable for interview during the investigation. A telephone interview with the Medical Director on 10/06/23 at 12:32 PM revealed any resident with a new diagnosis of schizophrenia should have documentation to support the diagnosis. A joint interview with the DON and Administrator on 10/06/23 at 4:50 PM revealed any resident with a new diagnosis of schizophrenia should have a Physician assessment and documentation to support the diagnosis.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660		11/3/23

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F 660	Continued From page 25 rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.	F 660		

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F 660	Continued From page 26 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge care plan that addressed the resident's discharge goals and post-discharge needs for a resident who wished to discharge to the community for 1 of 2 sampled residents (Resident #236). Findings included: Resident #236 was admitted to the facility on 02/01/23 with diagnoses that included cellulitis of	F 660	1. Based on record review, resident and staff interviews, the facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge care plan that addressed the resident's discharge goals and post-discharge needs for a resident who wished to discharge to the community for 1 of 2 sampled residents (Resident #236). 2. Audit was completed by 11/3/2023 by the Social Worker/designee to ensure all resident care plans appropriately	

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Continued From page 27

left lower limb, obsessive-compulsive personality disorder, major depressive disorder, and anxiety.

The baseline care plan initiated on 02/01/23 noted Resident #236's discharge goal was to return to the community.

The admission Minimum Data Set (MDS) dated 02/06/23 revealed Resident #236 had intact cognition. The MDS noted an active discharge plan was in place for Resident #236 to discharge to the community.

A physician progress note dated 03/06/23 read in part, Resident #236 was seen for coordination of care in preparation for discharge. Resident #236's level of function improved while at the facility and received maximum inpatient therapy benefit. Decision was made for her to discharge to home with supervision and assistance, therapy and ongoing medical treatment. After review of the discharge plan with the social worker, the Director of Nursing (DON), and Administrator it was uncovered Resident #236 did not have a safe place in which to go to and decision was made to suspend her discharge to try and arrange a safe location.

Review of Resident #236's comprehensive care plan, last reviewed/revised 08/24/23, revealed no discharge care plan.

A physician's order dated 09/08/23 for Resident #236 read in part, discharge home with home health services. A walker will be needed.

Resident #236 discharged to the community on 09/08/23.

F 660

addressed preferences for discharge goals and post discharge needs. Modifications were also completed as needed.
3. Education to Social Worker was completed by 11/3/2023 by the Director of Clinical Reimbursement on regulations regarding appropriate and timely care plan interventions to include development of a discharge care plan that addresses the resident's discharge goals and any post-discharge needs.
4. Random audits of resident discharge care plans will be conducted by the Director of Nursing/Nurse Management/Designee 2x/week for 12 weeks to ensure resident care plans are updated timely and accurately to reflect the resident's discharge goals and post-discharge needs. Results of observations will be discussed at the monthly Quality Assurance meeting for three (3) months to sustain substantial compliance.
Completion date is 11/3/23.

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F 660	Continued From page 28 During an interview on 10/05/23 at 11:09 AM, the Social Worker (SW) revealed she did not develop a discharge care plan for Resident #236 as she was admitted to the facility prior to the SW starting her employment in June 2023. The SW stated prior to Resident #236 discharging from the facility, they had a care plan meeting with Resident #236 and her family member. The SW recalled Resident #236 voicing she wanted to return home and was agreeable to a discharge date of 09/08/23. During an interview on 10/06/23 at 9:55 AM, the MDS Coordinator revealed it depended on the SW as to whether or not a discharge care plan was developed. The MDS Coordinator stated she was not sure of the reason why the previous SW did not develop a discharge care plan for Resident #236 as they had multiple meetings throughout Resident #236's stay regarding her discharge plans. The previous SW was no longer employed at the facility and unable to be interviewed. During an interview on 10/06/23 at 5:02 PM, the Administrator stated it was her expectation for care plans to be developed that reflected a resident's discharge goals and needs. The Administrator explained the discharge planning process initially started during the 72-hour care plan meeting conducted after the resident's admission. The discharge plan was then reviewed and discussed during discharge plan of care meetings and updated accordingly as the discharge plans progressed.	F 660		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		11/3/23

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F 730	Continued From page 29 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure performance reviews were completed every 12 months for 4 of 4 Nurse Aides (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #1, NA #2, NA #3, and NA #4). The findings included: 1. a. On 10/06/23 at 10:59 AM, a review of NA #1's employee file revealed NA #1 had been employed at the facility for at least 12 months and there was no evidence a performance review was completed in 2022 or 2023. b. On 10/06/23 at 10:59 AM, a review of NA #2's employee file revealed the NA had been employed at the facility for at least 12 months and there was no evidence a performance review was completed in 2022 or 2023. c. On 10/06/23 at 10:59 AM, a review of NA #3's employee file revealed the NA had been employed at the facility for at least 12 months and there was no evidence a performance review was completed in 2022 or 2023. d. On 10/06/23 at 10:59 AM, a review of NA #4's	F 730	1. The Director of Nursing provided performance reviews for (NA #1, NA #2, NA #3, and NA #4) by 11/3/23. 2. By 11/3/23 the Director of Nursing and Nurse Managers completed an audit of all current Nursing staff employed greater than 12 months to identify NAs due for performance appraisals. A master list of NAs was developed from this audit and used as tracking for completion of performance appraisals. 3. By 11/3/23 the Director of Nursing and Nurse Managers completed performance appraisals for current NAs past due for an annual appraisal according to their month and year of hire. The Director of Nursing developed a twelve month plan to provide performance appraisals during the month of the NAs employment anniversary for 2024 to ensure ongoing compliance. Performance appraisals will be completed by the Director of Nursing or designee. The Director of Nursing will audit weekly for 12 weeks to ensure performance appraisals are completed for NAs. 4. The Director of Nursing will report on	

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F 730	Continued From page 30 employee file revealed the NA had been employed at the facility for at least 12 months and there was no evidence a performance review was completed in 2022 or 2023. A joint interview on 10/6/23 at 5:21 PM with the Director of Nursing (DON) and the Administrator revealed they were unable to locate any documentation that performance reviews had been completed and stated they were overlooked. They both stated their expectation was for performance reviews to be completed annually with the staff's weaknesses incorporated into the required staff training. The DON stated she was responsible for completing performance reviews.	F 730	the results of the monthly performance appraisals during the monthly Quality Assurance meeting for recommendations. The completion date is 11/3/23.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical	F 756		11/3/23

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F 756	Continued From page 31 director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Consultant Pharmacist, and Medical Director interviews the Consultant Pharmacist failed to provide recommendations for laboratory tests for drug monitoring for 1 of 5 residents reviewed for unnecessary medications (Resident #3). Findings included: Resident #3 was admitted to the facility 08/01/19 with diagnoses including hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), thyroid disorder, and vitamin D deficiency. The quarterly Minimum Data Set (MDS) dated 08/10/23 revealed Resident #3 was severely cognitively impaired and received a diuretic 7 out of 7 days during the look back period.	F 756	1. By 10/6/23 The Director of Nursing ensured the physician was notified of the delayed lab monitoring and an order was received and executed for Resident #2. 2. By 11/3/23 An audit of all residents taking Digoxin, Thyroid replacement drugs and Magnesium, was conducted by the Consulting Pharmacist to ensure further lab monitoring was ordered or requested as recommended. 3. By 11/3/23 the Director of Nursing provided education to the Consulting Pharmacist regarding the facility policy for monitoring medications including recommendations from the pharmacist to the provider. The Director of Nursing will continue to monitor residents receiving	

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F 756	Continued From page 32 Review of Resident #3's Physician orders included the following medications: Digoxin (medication for irregular heartbeat and high blood pressure) 125 micrograms (mcg) every other day ordered 08/03/19 Levothyroxine 125 mcg once a day for low thyroid hormone ordered 08/02/19 Magnesium Oxide 400 milligrams (mg) for low magnesium ordered 07/14/22 Vitamin D 2000 units once a day as a supplement ordered 08/02/19 Potassium 20 milliequivalents (mEq) twice a day ordered 08/01/19 Lasix (a diuretic) 20 mg twice a day ordered 08/01/19 Review of Resident #3's Medication Administration Records (MAR) from April 2023 through October 2023 revealed she received Digoxin, Levothyroxine, Magnesium Oxide, Vitamin D, Potassium, and Lasix as ordered with few noted exceptions. Review of Resident #3's medical record revealed the Consultant Pharmacist had conducted medication regimen reviews (MRRs) monthly from April 2023 through September 2023. No recommendations regarding obtaining a Digoxin level, magnesium level, Vitamin D level, thyroid stimulating hormone (TSH) level (a laboratory test that checks thyroid function), or a potassium level had been made to the Physician. A telephone interview with the Consultant Pharmacist on 10/04/23 at 3:34 PM revealed she conducted MRRs for Resident #3 from April 2023 through September 2023. She stated laboratory tests for a Digoxin level, magnesium level,	F 756	Digoxin, Thyroid replacement drugs and Magnesium supplements to ensure lab monitoring is ordered as required. This monitoring will occur twice weekly for 12 weeks during the clinical meeting. The Director of Nursing will report the results of these to the Quality Assurance committee monthly for recommendations. 4. Completion date is 11/3/23	

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F 756	Continued From page 33 Vitamin D level, potassium level, and TSH should be obtained annually unless the resident was having symptoms. The Consultant Pharmacist explained she did not provide a recommendation to the Physician to obtain routine laboratory tests because it was overlooked. In an interview with the Director of Nursing (DON) on 10/04/23 at 4:45 PM she confirmed the last Digoxin level, magnesium level, TSH level, and comprehensive metabolic panel (a laboratory test for electrolytes including potassium) for Resident #3 were obtained 07/07/22. An interview with the Medical Director on 10/06/23 at 12:32 PM revealed he expected pharmacy to prompt providers to order laboratory work as indicated by established guidelines. During a joint interview with the DON and Administrator on 10/06/23 at 4:50 PM they stated they expected pharmacy to make recommendations for laboratory work as appropriate.	F 756		
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		11/3/23

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F 812	Continued From page 34 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 record review, observations and staff interviews the facility failed to repair the walk-in refrigerator door seal and remove expired milk stored for use in the walk-in refrigerator. Additionally, the facility failed to maintain a clean and maintain a heating, ventilation, and air conditioning unit (HVAC) located in the kitchen, a vertical pole adjacent to food production, a conduit pipe located above the tray line, and the ceiling area of the dish room free of peeling paint. The practice had the potential to affect the food served to the residents. Findings Included: a. On 10/2/23 at 10:42 AM an observation with the Dietary Manager (DM) of the walk-in refrigerator door seal was observed to be peeling away from the bottom right side door jam and sticking out from the closed refrigerator door. Inside the walk-in refrigerator revealed 2 unopened cases (50 count) pint milk on the bottom shelf of food rack with expiration rack 9/28/23. b. On 10/2/23 at 10:42 AM A heating, ventilation, and air conditioning (HVAC) unit located directly in front of the walk-in refrigerator was observed with a buildup of thick, crumbly to touch debris	F 812	1. The Regional Manager will provide Re-education of Culinary Services Manager (CSM) on Next Level Policies & Procedures for Sanitation & Storage by 11/3/23. The CSM discarded the milk immediately. The Maintenance Director repaired the broken door seal on the walk-in, removed the peeling paint on the pipes and ceiling near the tray line by 11/3/23. The Maintenance Director removed the thick debris from the length of the HVAC unit and repaired the same HVAC unit by 11/3/23. 2. The CSM will Re-educate the Culinary Staff on Next Level Policies & Procedures for Sanitation & Storage by 11/3/23 3. Beginning 11/3/23 Sanitation audits will be completed with a Next Level regional manager and the facility administrator one (1) time a week x 12 weeks on weekly sanitation audit form. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The Quality Assurance committee may modify	

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(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

F 812 Continued From page 35

that spanned the length of the HVAC unit.

On 10/2/23 at 10:45 AM The Dietary Manager stated during the observation that the milk had arrived the previous week and had not been used.

The District Dietary Manager stated on 10/5/23 at 1:55 PM that he had noted the broken door seal on his inspections for the previous 3 months. The inspection report was sent to the Administrator each month.

c. On 10/04/23 at 11:48 AM a vertical pole located directly adjacent to the tray line was observed with brown and sticky to touch debris.

d. On 10/4/23 at 12:03 AM an observation in the kitchen of the ceiling area above the tray line revealed a conduit pipe observed with thick clumpy grayish debris. An air vent was blowing directly onto the conduit pipe with the potential to blow debris onto the tray line. During this observation, the dish machine area was also observed and noted to have peeling paint 2-3 inches in length hanging down from the ceiling.

The DM and stated on 10/05/23 at 1:49 PM that she posted daily cleaning assignments for dietary staff to complete. She stated the pole next to the tray line, HVAC unit and conduit pipe on the ceiling was not assigned to dietary staff.

The Administrator stated on 10/05/23 at 4:15 PM that expired food should have been removed from the walk-in refrigerator and that the peeling paint in the kitchen was an issue and would be repainted. The kitchen should be cleaned as needed and on a cleaning schedule and repairs

F 812

this plan to ensure the facility remains in compliance *(Sanitation tool will be used on next level app as seen below and monitored for increase/decrease in score)

4.The CSM will complete the manager checklist daily five (5) times a week x 12 weeks to ensure proper food storage and sanitation practices and report findings to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance. Completion date is 11/3/23.

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	345162	A. BUILDING ______ B. WING ______	C 10/06/2023

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F 812	Continued From page 36 should be made in the kitchen as soon as possible. On 10/06/23 at 1:01 PM the Maintenance Supervisor stated he was made aware of the peeling paint on the ceiling in the kitchen earlier in the day and had replaced the door seal on the walk-in refrigerator. The walk-in refrigerator door seal had been replaced repaired previously but was not aware it was currently needing to be replaced. He stated the HVAC unit could be cleaned by the dietary staff, and that he would clean the conduit pipe above the tray line.	F 812		
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 §483.70(e) and including how such information	F 867		11/3/23

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F 867	Continued From page 37	F 867		

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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F 867	Continued From page 38	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 activities, including implementation of the QAPI

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F 867	Continued From page 39 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 interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification and complaint investigation survey that occurred 10/06/23 and the recertification and complaint investigation survey that occurred 05/20/22. This failure was for 3 deficiencies that were originally cited in the areas of Food Procurement, Store/Prepare/Serve-Sanitary (F-812), Accuracy of Assessments (F-641), and Safe/Clean/Comfortable/Homelike Environment (F-584) and were subsequently recited on the current recertification and complaint investigation survey of 10/06/23. 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 QAA program. Findings included: This tag is cross referenced to: F812: Based on record review, observations and staff interviews the facility failed to repair the walk-in refrigerator door seal and remove expired milk stored for use in the walk-in refrigerator.	F 867	1. By 11/3/23, the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding 3 deficiencies that were cited in the areas of Food Procurement, Store/Prepare/Serve-Sanitary (F-812), Accuracy of Assessments (F-641), and Safe/Clean/Comfortable/Homelike Environment (F-584). 2. By 11/3/23 the Director of Operations and Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to the areas of Food Procurement, Store/Prepare/Serve-Sanitary (F-812), Accuracy of Assessments (F-641), and Safe/Clean/Comfortable/Homelike Environment (F-584) Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care	

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F 867	Continued From page 40 Additionally, the facility failed to maintain a clean heating, ventilation, and air conditioning unit (HVAC) located in the kitchen, a vertical pole adjacent to food production, a conduit pipe located above the tray line, and the ceiling area of the dish room free of peeling paint. The practice had the potential to affect the food served to the residents. Based on the recertification and complaint investigation survey conducted 05/20/22 the facility failed to discard spoiled and expired food, date milkshakes to identify their use-by date, and label food and drink items in one nourishment room. F641: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), activities of daily living, diagnoses, and skin conditions for 7 of 27 sampled residents reviewed (Residents #8, #55, #72, #3, #15, #18 and #237). During the recertification and complaint investigation survey conducted 05/20/22 the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of medications, oral and dental status, and catheter for 3 residents. F584: Based on observations and staff interviews, the facility failed to maintain residents' wardrobe closets in good repair by not replacing knobs on the drawers which left exposed screws sticking out from the drawer that had the potential to cut residents when entering and exiting their rooms (rooms 107, 204, 206, 208, 209, 212, 217,	F 867	documentation, and observation during leadership rounds. 3.By 11/3/23 the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Nurse Managers, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. The QAPI committee will continue to meet monthly. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. 4. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. Completion date is 11/3/23.	

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F 867	Continued From page 41 232, 234, 236, and 237); failed to maintain the floors, walls and baseboards of residents' rooms clean and in good repair (rooms 104, 230, 231, 232, 233, 234, 236, and 237); failed to ensure resident bathrooms were clean and sanitary that had strong odors resembling urine and/or buildup of debris on the floor (bathrooms 106, 230, 232, 234, and 236); and failed to place a cover over an outlet leaving the cutout in the wall exposed through the adjoining room (room #133) for 17 of 60 rooms on 2 of 2 resident halls reviewed for environment. During the recertification and complaint investigation survey conducted 05/20/22 the facility failed to ensure a denture cup was stored properly, ensure a raised toilet seat was clean, clean an interior bathroom door, and maintain clean walls in 5 resident rooms. An interview with the Administrator on 10/06/23 at 6:00 PM revealed the quality assurance team met monthly since she began employment and included the Medical Director, administrative staff, unit managers, Social Worker, MDS Coordinator, therapy, and pharmacy staff. She stated part of the root cause of repeat citations was due to a lack of consistent staff, lack of training, and not having QAA meetings monthly. The Administrator stated she felt she had currently assembled a strong team of employees and once everyone was trained the facility could move forward to achieve and maintain compliance long term.	F 867		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides.	F 947		11/3/23

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F 947	Continued From page 42 In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure Nurse Aides (NA) received at least 12 hours of in-service training yearly and maintain documentation of the in-service training hours provided for 4 of 4 NA employee records reviewed for staffing (NA #1, NA #2, NA #3, and NA #4). The findings included: 1. a. On 10/06/23 at 10:59 AM, a review of NA #1's employee file revealed the NA had been employed at the facility for at least 12 months and there was no evidence of educational hours being completed in 2022 or 2023. b. On 10/06/23 at 10:59 AM, a review of NA #2's employee file revealed the NA had been employed at the facility for at least 12 months and	F 947	1. The Director of Nursing and Nurse Managers immediately provided inservice and education for Abuse and Dementia for (NA #1, NA #2, NA #3, and NA #4) on 10/6/23. 2. By 11/3/23 the Director of Nursing and Nurse Managers completed an audit of all current Nursing staff to identify NAs who need 12 hours of training. A master list of NAs was developed from this audit and used as tracking for completion of training. 3. By 11/3/23 the Director of Nursing and Nurse Managers developed a plan and completed training of all current NAs that included Abuse and Dementia. The Administrator and Director of Nursing have developed a twelve month plan for required Nurse Aide training for 2024 to	

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F 947	Continued From page 43 there no evidence of educational hours being completed in 2022 or 2023. c. On 10/06/23 at 10:59 AM, a review of NA #3's employee file revealed the NA had been employed at the facility for at least 12 months and there was no evidence of educational hours being completed in 2022 or 2023. d. On 10/06/23 at 10:59 AM, a review of NA #4's employee file revealed the NA had been employed at the facility for at least 12 months and no evidence of educational hours being completed in 2022 or 2023. An interview on 10/6/23 at 2:48 PM with the Director of Nursing (DON) revealed she was also the Staffing Development Coordinator (SDC) since 6/12/23. The DON explained she was unable to locate documentation of individual NA training hours. In addition, the DON stated she was unaware that NA were still required to receive 12-hours of annual in-service training. She stated going forward they planned to utilize a computer training program to track educational training requirements for staff. A follow-up interview on 10/6/23 at 3:46 PM with the DON revealed there should be 12 hours per year of documented education provided to NAs that included dementia training. She explained the documentation from the previous corporation was very disorganized and she was unable to locate all the training that was provided to NAs by the previous corporation. The DON explained she was used to using a computer training program that tracked the hours of employee education; however, the previous corporation did not utilize a computer training program and the	F 947	ensure ongoing compliance. The Director of Nursing will ensure nurse aide training is completed by current staff monthly. 4. The Director of Nursing will report on the results of the monthly inservices during the monthly Quality Assurance meeting for recommendations. Completion date is 11/3/23.	

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F 947	Continued From page 44 required NA training hours were overlooked. An interview on 10/6/23 at 4:50 PM with the Administrator revealed she expected staff to have the required 12 hours or more of in-service education that included dementia and resident abuse training.	F 947		