STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING ______ B. WING ______	C 10/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted on 10/23/23 through 10/24/23. Event ID #GGUU11. The following intake was investigated NC00207536. 2 of 2 allegations did not result in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure a resident had been assessed to self-administer over the counter medications located in a residen'st room. This occurred for 1 out of 3 residents reviewed for medication administration (Resident #3). The findings included: Resident #3 was admitted to the facility on 06/16/22 with diagnoses which included type 2 diabetes and vascular dementia. Resident #3's self-administration of medication evaluation dated 09/15/23 completed by Director of Nursing (DON) revealed approval for self-administration of a pain ointment and pain relief topical 4% cream. Resident #3's quarterly Minimum Data Set (MDS) dated 10/11/23 revealed he was cognitively intact requiring extensive assistance of one staff	F 554	F554 Resident Self-Administration of Medications On 10/24/2023 Resident #3 was in agreement to allow nursing to remove Peroxide. Voltaren was from bedside upon agreement by 11/6/23. On 11/02/2023 and ongoing, rooms are monitored by Leadership Team to ensure that medications are not at bedside by a specific morning rounds sheet for all patients indicating any medications present at bedside. Round sheet also indicates to alert nursing of any questions from patients/ family members. On 10/28/2023 to 11/06/2023 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding medications at bedside prior to beginning next shift. Newly hired staff will be educated upon	11/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/14/2023

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 554	Continued From page 1 member for most activities of daily living (ADL). On 10/23/23 at 11:19 AM an observation was conducted of Resident #3's room revealed an open 32-ounce bottle half-full of hydrogen peroxide located on bedside dresser. During interview with Resident #3 he stated that he used the hydrogen peroxide for whatever he wanted to whether that was putting it on his hair or on a cut. He revealed he was not aware if he had an order to administer the hydrogen peroxide himself or not. Resident #3 stated he was not aware if staff knew about him using the hydrogen peroxide but that he always kept it on his bedside dresser or bedside tray and staff had never asked him about it. Resident #3 opened the top drawer to his bedside dresser and revealed a partially full tube of arthritis pain gel 1% gel that he stated he had been using for pain in his shoulders and knees. Resident #3 revealed he was not aware if he had an order to self-administer the arthriti pain gel 1% or not and was not aware if staff knew that he was self-administering it. He stated that he had purchased these items and had them delivered to the facility. Resident #3 stated that he had been assessed to be able to self-administer his over the counter pain ointment for shoulder pain which had been provided to him by the facility but he did not feel that it helped with his pain so he had given it away to another resident but could not recall which resident he had given it to. On 10/24/23 at 11:30 AM an observation conducted of Resident #3 room revealed the open Hydrogen Peroxide bottle still located on top of Resident #3 bedside dresser and the partially full tube of arthritis pain gel 1% still located in the top drawer of the bedside dresser.	F 554	hire. Family members will be educated at admission of standard regarding medications at bedside. Current alert and oriented patients are educated by administrative staff on morning rounds of standard involving medications at bedside and indicated on AM Round Sheet, and if any questions from patients arise, they are directed to nurse staff for clarification/ questions. Starting on 11/06/2023 the Director of Nursing and/or designee will conduct Quality improvement monitoring of medications at bedside of all patients two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/09/2023. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance	

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F 554	Continued From page 2 An interview conducted on 10/24/23 at 11:49 AM with Nurse #1 revealed she was familiar with Resident #3 and was responsible for administering him his medications and treatments. She stated Resident #3 was allowed to keep his over the counter pain ointment and topical pain relief cream inside a locked drawer in his bedroom and self-administer as needed. She revealed Resident #3 had no order for Hydrogen Peroxide and his arthritis pain gel 1% was to be administered twice a day by nursing staff and initialed on the treatment administration record (TAR). Nurse #1 stated she was not aware Resident #3 had those items in his possession. She revealed Resident #3 had ordered over the counter medications online before and had them delivered to the facility and was told then that all medications including over the counter medications had to have an order for him to be able to use them. An interview conducted on 10/24/23 at 1:13 PM with the Director of Nursing (DON) revealed she was familiar with Resident #3. She stated she was not aware that he had an open bottle of Hydrogen Peroxide or a tube of arthritis pain gel 1% gel in his possession that he was self-administering. She stated back in September 2023 she had been made aware that Resident #3 had ordered over the counter medications online and she had spoken with him and his family about all medications including over the counter medication had to have a physician order before being administered and she completed a self-administration medication evaluation with Resident #3 for over the counter pain ointment and topical pain relief cream for him to be able to administer on his own for shoulder pain. The DON revealed Resident #3 did not have an order	F 554	Performance Improvement Committee meets monthly and quarterly at a minimum. AOC Date: 11/20/2023	

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F 554	Continued From page 3 for use of Hydrogen Peroxide and his arthritis pain gel was a treatment to be administered twice daily by nursing staff. She revealed Resident #3 should not have those items in his possession to self-administer and assumed he had purchased those online. The DON stated residents in the facility should not have access to, possession of, or self-administer any medications without a physician order and staff should be more observant of any medications or treatments in resident's rooms. An interview was conducted on 10/24/23 at 2:02 PM with the Administrator revealed he was familiar with Resident #3 and was not aware of him being in possession of and self-administering his own Hydrogen Peroxide and arthritis pain gel 1%. He stated no resident should have possession of or be self-administering any medication or treatments without a physician order.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		11/20/23

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F 561	Continued From page 4 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to honor resident requests for two showers per week for 2 of 4 residents reviewed for choices (Resident #2 and Resident #4). The findings included: 1. Resident #2 was admitted to the facility on 01/21/21. Review of the quarterly Minimum Data Set (MDS) dated 08/07/23 revealed Resident #2 was cognitively intact and required extensive assistance for bathing. Review of the facility's shower schedule revealed Resident #2 was scheduled for a shower on Mondays and Thursdays on second shift. Review of the facility shower documentation from 10/01/23 through 10/23/23 revealed no showers were documented as given to Resident #2. The	F 561	F561 Self-Determination On 10/25/2023 bathing preferences were updated for Resident # 2 and #4 both reflecting their preference to receive a shower. Resident #2, states that she prefers a shower in the evening, no preference noted to days of the week. Resident #4, states that she prefers a shower on 1st shift on Monday and Thursday. Resident #2 refused bathing on 10/26/2023, she was agreeable to shower on 11/02/2023. Resident #4 was provided a shower per her preference on 10/26/2023. On 10/19/2023 to 10/25/2023 current residents/responsible party were questioned regarding bathing preference by the Director of Nursing and/or designee. On 10/31/2023 a shower schedule was developed by the Director	

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F 561	Continued From page 5 documentation revealed Resident #2 was provided a bed bath instead of shower on the scheduled shower dates of: 10/02/23, 10/05/23, 10/09/23, 10/12/23, 10/16/23, 10/19/23, and 10/23/23. An observation and interview were conducted with Resident #2 on 10/24/23 at 11:55 AM. Resident #2 was sitting up in bed, her hair, face, and clothing appeared clean. She stated she was supposed to get two showers a week on Mondays and Thursdays, however staff would not take her to the shower room and would only give her a bed bath. She stated she would rather go to the shower room for a shower, but the staff had told her they did not have time to take her for a shower. Resident #2 stated she had told staff she preferred a shower however they still were giving her a bed bath. The interview revealed during the month of October she had not received a shower on her assigned days, only bed baths. She revealed not receiving a shower made her feel dirty and nasty and she rested better when she was able to have a shower and feel clean. An interview conducted on 10/24/23 at 12:38 PM with Nurse Aide (NA) #9 revealed to her knowledge Resident #2 had only received bed baths over the past month. She stated typically on second shift the staff that were scheduled had to cover two halls apiece and there was not enough time or staff to complete the assigned showers for residents, so most residents received bed baths unless they refused. An interview conducted on 10/24/23 at 12:45 PM with NA #10 revealed she was familiar with Resident #2 and her preference for showers on second shift. She stated over the past month	F 561	of Nursing to reflect the current shower preferences. On 10/28/2023 to 11/06/2023 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding bathing preference to include shower or bed bath, shower schedules and documentation on the daily bathing list/PCC, and the Kardex. Newly hired staff will be educated upon hire. Starting on 11/06/2023 the Director of Nursing and/or designee will conduct Quality improvement monitoring by personal interview of alert and oriented resident bathing per preference two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/09/2023. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance	

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when she had been assigned to Resident #2's hall she had been assigned to another hall as well and did not have time to provide Resident #2 with her assigned showers. NA #10 revealed when she was not able to provide residents with their scheduled showers, she did offer and provide them with a bed bath.

An interview conducted on 10/24/23 at 1:14 PM with the Director of Nursing revealed the facility did not have a shower team but if there were extra staff in the building, she would schedule them to do showers. She stated due to a low census they were sending some of the staff home and there might only be one person completing showers but the Nurse Aides on the hall would also be responsible. She stated she didn't know why Resident #2 had not gotten a shower on her scheduled days. The interview revealed showers should be completed as scheduled and per the resident's preference.

2. Resident #4 was admitted to the facility on 06/13/22 with diagnosis which included Parkinson's, neurogenic bladder, and diabetes mellitus.

Review of the quarterly Minimum Data Set (MDS) dated 10/13/23 revealed Resident #4 was cognitively intact and required maximal assistance for bathing. Resident #4 was documented to weigh 337 pounds during the assessment.

Review of the facility's shower schedule revealed Resident #4 was due a shower on Monday's and Thursdays on first shift.

Review of the facility shower documentation from

F 561

Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

AOC Date: 11/20/2023

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10/01/23 through 10/23/23. The documentation revealed no showers were documented as given to Resident #4. The documentation revealed Resident #4 received a bed bath on 10/2, 10/4, 10/5, 10/9, and 10/11.

An observation and interview were conducted with Resident #4 on 10/23/23 at 11:21 AM. Resident #4 was sitting up in bed dressed in a hospital gown. She stated she was supposed to get two showers a week on Mondays and Thursdays, however staff would not take her to the shower room and would only give her a bed bath. She stated she would rather go to the shower room for a shower, but the staff had told her they could not get her on the shower stretcher. She stated she was unable to use the shower chair because of mobility. Resident #4 stated she had told staff she preferred a shower however they still were giving her a bed bath. The interview revealed during the week of 10/16/23 through 10/19/23 she had not received a shower on her assigned days but finally was given one on 10/20/23. Resident #4 stated the Nurse Aide was able to place her on the shower stretcher and give a shower without difficulty, so she did not understand why other staff continued to tell her they could not take her to the shower room.

A facility invoice dated 10/26/22 revealed an order for a bariatric shower bed with a 900-pound weight capacity.

On 10/23/23 at 10:45 AM an observation was conducted of the facility shower room. A bariatric shower bed was observed in the shower room.

An interview conducted on 10/23/23 at 11:32 AM with Nurse Aide (NA) #7 revealed Resident #4

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only received bed baths. She stated the facility had a shower team and they had told her that the shower stretcher was not large enough to accommodate Resident #4.

An interview conducted on 10/23/23 at 11:40 AM with NA #3 revealed Resident #4 had told her during the week of 10/16/23 through 10/19/23 that she would prefer to have a shower. NA #3 stated she had taken care of Resident #4 during that week and had not given her a shower or bed bath. She stated she thought the facility had a shower team during that week. The interview revealed no staff members from the shower team had told her they were unable to give Resident #4 a shower or bed bath.

An interview conducted on 10/23/23 at 2:07 PM with NA #8 revealed she was assigned to complete showers for the facility on Resident #4's assigned shower days of 10/16/23 and 10/19/23. She stated she was by herself on both days and had up to 20 residents to give a shower to. NA #8 stated she was not able to give Resident #4 a bed bath on her assigned days due to being alone and not having the time during her shift. The interview revealed she thought she told NA #3 that she hadn't given Resident #4 a bed bath but wasn't sure. NA #8 stated she didn't think Resident #4 took showers because she did not fit on the shower stretcher.

An observation and interview were conducted on 10/24/23 at 8:30 AM with Resident #4. She was observed sitting up in the bed dressed in a hospital gown. She stated she felt so good because NA #3 had put her on the shower stretcher on 10/23/23 and gave her a shower. She stated, "that was what I wanted all along".

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F 561	Continued From page 9 An interview conducted on 10/23/23 at 9:26 AM with NA #3 revealed she had given Resident #4 a shower on 10/23/23. She stated the shower team had thought Resident #4 was over the weight limit for the shower stretcher and were scared to take her to shower room. The interview revealed she had no issues while giving the resident a shower. An interview conducted on 10/24/23 at 1:14 PM with the Director of Nursing revealed the facility did not have a shower team but if there were extra staff in the building, she would schedule them to do showers. She stated due to a low census they were sending some of the staff home and there might only be one person completing showers but the Nurse Aides on the hall would also be responsible. She stated she didn't know why Resident #4 had not gotten a shower on her scheduled days and was not aware the resident had told NA #3 that she wanted a shower last week. The interview revealed showers should be completed as scheduled and per the resident's preference.	F 561		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide hair care to a dependent resident for 1 of 3 residents reviewed for activities of daily living (Resident #1). Resident #1 was observed with	F 677	F677 ADL Care Provided for Dependent Residents On 10/25/2023 resident #1 was asked about her preferences for hair brushing.	11/20/23

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matted hair while waiting to go for an outside Physician appointment. Resident #1 stated the matted hair was painful and she felt like the staff did not care.

The findings included:

Resident #1 was admitted to the facility on 09/08/22 with diagnoses that included cancer.

An annual Minimum Data Set (MDS) assessment dated 08/08/23 indicated Resident #1 was cognitively intact and required extensive assistance of two staff members for personal hygiene and was dependent for bathing. It further indicated no rejection of care or behaviors.

Review of the nurse's progress notes from 09/08/23 through 10/24/23 revealed no notes regarding Resident #1 refusing showers or personal hygiene care. Review of the Nurse Aide (NA's) documentation of the same period revealed no indication Resident #1 refused hair care.

An observation and interview with Resident #1 on 10/24/23 at 10:40 AM revealed Resident #1 sitting in her wheelchair at the nurse's station. Resident #1 stated she was ready and waiting to go to her cancer treatment appointment. The back of Resident #1's hair was matted and protruding over the back of the resident's wheelchair. She was observed to have long, thick hair. Resident #1 stated the last time her hair had been washed was 3-4 weeks prior. She stated she knew her hair was matted because she could not brush it herself due to not being able to lift her arms above her head. Resident #1 stated her matted hair caused her scalp and head to hurt all

F 677

Resident #1 states that her preference for hair brushing was by her request. On 11/07/2023 hair care was provided to include haircut and detangled per her choice.

On 10/19/2023 to 10/25/2023 current residents/responsible party were questioned regarding hair care preferences by the Director of Nursing and/or designee.

On 10/28/2023 to 11/06/2023 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistant regarding providing ADL care to dependent residents that includes hair brushing. Newly hired staff will be educated upon hire.

Starting on 11/06/2023 the Director of Nursing and/or designee will conduct Quality improvement monitoring of resident getting hair care per their preference two times a week for four weeks, then one time a week for eight weeks, and then one time monthly for three months.

The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/09/2023. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance

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the time on a pain level of 4 on a 0-10 scale. She stated staff had tried to brush it today, but it hurt too bad. The interview revealed she had told staff her hair was matted, and they were aware of it. She stated her husband had even offered to pay to have her hair cut but the facility did not have a hairdresser. Resident #1 stated, "I feel like the staff don't care". Resident #1 then went on to say that it really wasn't the staff's fault because she had thick hair that needed to be cut and the facility did not have a hairdresser.

An interview conducted with Resident #1's Family Member #1 on 10/24/23 at 10:48 AM revealed he had wanted Resident #1's hair cut for several months. He stated he had talked with the former Administrator of the facility. The interview revealed the former Administrator had told him they did not have anyone to cut her hair but if he wanted to, they would make an area in the beauty shop for him to wash and cut her hair. The family member stated he had medical conditions himself and he was not able to wash Resident #1's hair or cut it.

A review of the undated shower schedule revealed Resident #1 was to receive bathing and personal hygiene twice weekly on Monday and Thursdays during day shift (7AM- 3PM).

An interview with Nurse Aide (NA) #1 on 10/24/23 at 10:22 AM revealed he had been assigned to Resident #1 on 10/23/23 on day shift (7A-3P) and had not provided hair care. He stated the hall Resident #1 is on had 12 dependent residents requiring a mechanical lift for transfers including Resident #1. He stated he often had to give the residents bed baths because he could not get them up for a shower due to staffing and bed

F 677

Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

AOC Date: 11/20/2023

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baths did not always include washing the resident's hair. NA #1 stated Resident #1's hair was matted because nobody was brushing it and with the number of residents on the hall the staff didn't have time. He stated Resident #1 had told him for several months she wanted her hair cut, so he stated he told the nurses, but nothing had been done. The interview revealed Resident #1's hair was matted to the point the staff could not brush it out.

An interview with Nurse Aide (NA) #2 on 10/24/23 at 11:05 AM revealed she had been assigned to Resident #1 on the week prior to 10/24/23. She stated she had to get Resident #1 ready for a cancer treatment appointment and had noticed her hair was matted. NA #2 stated Resident #1 was screaming and stated it hurt when she tried to brush the hair because it was matted. She stated, "her hair is matted because staff aren't brushing it". The interview revealed she had seen Resident #1's hair matted for the last several months. NA #2 stated she had not told the Nurse on duty about the resident's hair condition.

An interview with Nurse #1 on 10/24/23 at 11:38 AM revealed she had been assigned to Resident #1 in the past. She stated she knew Resident #1's hair was matted in the back, but it was to the point the Nurse Aides could not brush it out without hurting the resident. Nurse #1 stated Resident #1 was getting up daily to go out for cancer treatments and staff were brushing the hair over the matted hair to make it less obvious. Nurse #1 stated she had not told the Director of Nursing about Resident #1's hair because she thought everyone knew.

An interview with Nurse #2 on 10/24/23 at 12:09

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F 677	Continued From page 13 AM revealed she had been assigned to Resident #1 on 10/24/23. Nurse #2 stated Resident #1 had matted hair for several months. She stated she got Resident #1 up on the morning of 10/24/23 for her appointment and tried to brush her hair but it was hurting the resident so she just put what she could in a ponytail. Nurse #2 stated, "I did the best I could". The interview revealed Resident #1 had asked Nurse #2 to cut her hair the week prior. She stated she told the Director of Nursing on 10/24/23 after she got her up for the appointment that the resident had matted hair. Nurse #2 stated she did not cut the resident's hair because she did not feel comfortable doing so. An interview with the Director of Nursing on 10/24/23 at 1:24 PM revealed she expected all residents to receive hair care on bath days and when needed by nurse aides. She stated Nurse #2 told her about the matted hair on 10/24/23. The DON stated no staff members had come to her and told her about the matted hair prior to 10/24/23. An interview with the Administrator on 10/24/23 at 2:01 PM revealed that he had only been in the facility 3 weeks. He stated each resident should receive hair care on their shower day and no resident's hair should be in a matted condition. The interview revealed the facility would have someone come in to cut Resident #1's hair and staff would wash the resident's hair.	F 677		
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 -	F 812		11/20/23

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F 812

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§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to date opened items stored in the dry storage area located in the main kitchen. These practices had the potential to affect food served to residents.

Findings included:

A tour of the facility's dietary department on 10/23/23 beginning at 9:30 AM revealed the following items:

Dry storage area:

- A 35 ounce (oz) opened and undated bag of cereal

- A large bag of opened and undated cake mix

An interview with Cook #1 on 10/23/23 at 9:45 AM revealed they had been educated all items

F 812

F 812
On 10/23/2023 food items were discarded by HSG Cook.

On 10/23/20203 the HSG Dietary Manager performed A Quality Improvement Monitoring of current food storage. No additional were noted.

Starting on 11/06/2023 to 11/10/2023 current dietary staff were educated by the HSG Dietary Manager on the policy related to food storage. Newly hired staff will be educated upon hire.

Starting on 11/06/2023 the Administrator and/or designee to perform Quality Improvement Monitoring on food storage three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months.

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F 812	Continued From page 15 should be labeled and dated with an open/discard date. He stated the opened bag of cereal should have been sealed and labeled with the date it was opened. An interview with the Regional Dietary Manager on 10/24/23 at 1:38 PM revealed she was made aware of items that were unlabeled and dated in the dry storage area stated all items should be labeled and dated with an open and discard date.	F 812	The HSG Manager introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 11/09/2023. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Alleged Compliance is 11/20/2023	
F 867 SS=G	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	F 867		11/20/23

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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 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

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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.

§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

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F 867	Continued From page 18 (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 interviews, 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 dated 9/08/23. This was for two repeat deficiencies that were cited in the areas of self-determination, activities of daily living care provided for dependent residents that were originally cited during a recertification and complaint survey dated 03/21/23, 09/08/23 and subsequently recited during the onsite revisit and complaint survey dated 10/24/23. The area of food procurement was originally cited during a recertification and complaint survey dated 09/08/23 and subsequently recited during the onsite revisit and complaint survey dated 10/24/23. The continued failure of the facility	F 867	F867 -- QAPI 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 11/09/2023 with the Interdisciplinary Team including the Director of Nursing, Dietary Manager, Minimum Data Set Nurse, Social Services Director, Medical Records Director and Business Office Manager focusing on the areas of F561Choices pertaining to Bathing Preferences, F677 ADL Care to Dependent Resident (hair care), F812 Food Labeling and Dating. The facility Quality Assurance committee reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 11/09/2023	

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during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

The tag is cross referenced to:

F561- Based on observations, record review, resident and staff interview the facility failed to honor resident requests for two showers per week (Resident #2 and Resident #4) for 2 of 4 residents reviewed for choices.

During the recertification and complaint survey dated 9/08/22, the facility failed to honor resident request for two showers per week and the facility also failed to honor a resident's request to get out of bed this affected 4 of 6 residents reviewed for choices.

During the recertification and complaint survey dated 3/21/22 the facility failed to honor a resident's bathing preferences for 3 of 7 residents reviewed for choices.

F677- Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide hair care to a dependent resident for 1 of 3 residents reviewed for activities of daily living (Resident #1). Resident #1 was observed with matted hair while waiting to go for an outside Physician appointment. Resident #1 stated the matted hair was painful and she felt like the staff did not care.

During the recertification and complaint survey dated 9/08/23, the facility failed to provide nail care to a dependent resident for 1 of 2 residents

F 867

the Vice President of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained.

3. The Vice President of Clinical Services will attend the facility Quality Assurance Performance Improvement Committee meeting at a minimum of quarterly to evaluate the effectiveness of the program, the compliance of ongoing monitoring and the revision to the plan of correction for citations as appropriate to maintain compliance.

4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for three months. The QAPI Committee will evaluate the effectiveness and amend as needed.

Alleged Date of Compliance: 11/20/2023

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reviewed for providing activities of daily living.

During the recertification and complaint survey dated 3/21/22 the facility failed to provide facial grooming for 1 of 4 dependent residents reviewed for activities of daily living.

F812- Based on observations and staff interviews, the facility failed to date opened items stored in the dry storage area located in the main kitchen. These practices had the potential to affect food served to residents.

During the recertification and complaint survey dated 9/08/22 the facility failed to label and date leftover food items available for resident consumption stored in 1 of 1 reach in refrigerator and failed to date pre-filled bowls of cereal stored in the dry storage area located in the main kitchen. These practices had the potential to affect food served to residents.

An interview with the Director of Nursing (DON) and Administrator on 10/24/23 at 4:00 PM revealed monthly Quality Assurance (QA) meetings were held to review measures put in place and discussed with the Medical Director and other departments for their response and feedback to issues identified. When issues were identified a review and corrective action plan was implemented and if there was no improvement, the QA committee revisited it. The DON and Administrator felt interventions put into place were beginning to aid in preventing repeat deficiencies but need to be revisited by the QA committee to ensure ongoing compliance in all areas.