STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(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 000	INITIAL COMMENTS An onsite revisit was conducted 02/26/24 to 02/27/24. Tag(s) F578, F607, F656, F689, F740, F756, F758, F760, F791, F809, F835 and F949 were corrected as of 02/27/24. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time of the revisit. The facility is still out of compliance. The following intakes were investigated: NC00213198, NC00213483, NC00212598, NC00213728, NC00212430, and NC00213309. 3 of 23 complaint allegations resulted in deficiency.	F 000		
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		3/12/24

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

Electronically Signed | 03/21/2024

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Responsible Party (RP), and Medical Director interviews the facility failed to notify the Responsible Party of a new diagnosis of pneumonia for 1 of 1 resident reviewed for notification of change (Resident #1). Findings included: Resident #1 was admitted to the facility 09/27/23 with diagnoses including hypertension (high blood	F 580	F-580 1. Resident #1 phone meeting was held with the Responsible Party by the Unit Manager to provide an update of the current events with Resident #1. No other concerns voiced at that time. 2. A quality review was completed by the Director of Nursing and/or designee of	

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F 580	Continued From page 2	F 580		

pressure) and non-Alzheimer's dementia.

Review of Resident #1's Physician orders revealed an order dated 01/25/24 for a chest x-ray due to cough.

Resident #1's chest x-ray result dated 01/28/24 revealed Resident #1 had left lower lobe airspace disease (when air spaces are filled with fluid or pus) which could be related to pneumonia or atelectasis (collapse of an area of the lung).

A review of Resident #1's medical record revealed there was no documentation that the Responsible Party (RP) was notified of her diagnosis of pneumonia on 01/28/24.

An interview with the Unit Manager on 02/26/24 at 5:46 PM revealed she often worked as a floor nurse, and she cared for Resident #1 on 01/28/24 (she could not recall the exact time she cared for Resident #1). She stated Resident #1's RP called the facility frequently for updates and she probably answered the telephone when Resident #1's RP called to check on her and mentioned the chest x-ray results in conversation. She stated she did not have any memory of calling Resident #1's RP to notify her of the chest x-ray results and confirmed there was no documentation in Resident #1's medical record to reflect her RP had been notified of the chest x-ray results on 01/28/24.

A telephone interview with Resident #1's RP on 02/27/24 at 9:10 AM revealed in January 2024 (she was unsure of the specific date) she was notified Resident #1 needed a chest x-ray because she was wheezing. The RP stated she kept calling the facility and was told the chest

resident charts about notification to the Responsible Party related to change in condition to include radiology results and new orders from 2/23/2024 through 3/11/2024 with no additional incidents noted.

3. During the morning clinical meeting, incidents, medication changes and new disagnoses will be reviewed by the clinical team. The team will verifiy that the correct notifications were made to responsible parties. From 3/05/2024 through 3/11/2024, the Director of Nursing and/or designee re-educated licensed nursing staff on all shifts, including part-time and pro re nata (prn), about notification to the responsible party related to change in condition with emphasis on radiology results and new medication orders. New hires and agency will be educated regarding notification of families during orientation and prior to working on the units.

4. Starting on 3/11/2024, the Director of Nursing and/or Designee will conduct random Quality Reviews of resident charts to ensure notification to responsible party related to changes in condition with emphasis on radiology results and new medication orders on 10 random residents 3 times a week for 8 weeks, then weekly for 12 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 3/08/2024. The Director of Nursing is responsible for implementing this plan. The Quality

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F 580	Continued From page 3 x-ray results had not returned, and one day when she called to check on the x-ray results, she was notified Resident #1 had been diagnosed with pneumonia. She stated no staff member from the facility called to notify her of Resident #1's chest x-ray results from 01/28/24. A telephone interview with the Director of Nursing (DON) on 02/27/24 at 11:34 AM revealed she worked as a floor nurse when needed and she cared for Resident #1 for a period of time on 01/28/24 (she could not recall the exact times when she cared for Resident #1). She stated she did not notify Resident #1's family that her chest x-ray that resulted 01/28/24 showed pneumonia. The DON stated Resident #1's RP should have been notified by nursing staff that her chest x-ray on 01/28/24 revealed pneumonia and she was not sure why the RP was not notified. A telephone interview with the Medical Director on 02/27/24 at 12:03 PM revealed he expected nursing staff to notify the resident or their RP any time the resident had a test that showed abnormal findings.	F 580	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 Compliance: 3/12/2024	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and	F 687		3/12/24

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F 687	Continued From page 4 arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to ensure a resident's toenails were trimmed for 1 of 3 sampled residents (Resident #1). Findings included: Resident #1 was admitted to the facility on 09/27/23 with diagnoses that included end-stage renal disease and edema. A physician's order dated 09/27/23 for Resident #1 read, Podiatry as needed. A review of Resident #1's Activities of Daily Living (ADL) care plan, last revised on 12/04/23, addressed an ADL self-care performance deficit related to dementia. Interventions included: requires partial to moderate staff assistance with personal hygiene, staff to check nail length, trim and clean on bath day and as necessary, and report any changes to the nurse. The quarterly Minimum Data Set (MDS) dated 01/30/24 revealed Resident #1 had severe cognitive impairment. Resident #1 required partial to moderate staff assistance with bathing and personal hygiene and displayed no rejection of care during the MDS assessment period. During an interview on 02/26/24 at 10:54 AM, the Social Worker (SW) revealed Podiatry services typically maintained their own schedule for facility clinics and she received an email letting her know the date of the upcoming clinic and which	F 687	F-687 1, Resident #1 received nail care including toenails trimmed on 2/27/2024. 2. A quality review was completed by the department managers on current resident□s toenails on 2/28/2024. Identified residents were provided nail care by nursing staff to include cleaning and trimming on 3/08-3/11 with Podiatry referrals initiated as needed. 3. Resident toenail status will be observed during scheduled weekly scheduled shower/bath and/or weekly skin assessments, with cleaning and trimming provided, or a podiatry referral made as appropriate. The Unit Manager/designee will review shower/bath and skin assessments and report variances to the Director of Nursing as indicated. The monitoring process will be reviewed by the clinical team. From 3/05/2024 through 3/11/2024, the Director of Nursing and/or designee re-educated nursing staff prior to their next shift, including part-time and pro re nata (prn), on activities of daily living (ADL) care specific to toenail care. New hires and agency will receive the education during orientation and prior to working on the units. 4. Starting on 3/11/2024, the Director of Nursing and/or Designee will conduct	

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F 687	Continued From page 5 residents would be seen. The SW stated she added residents to the list when nursing staff informed her a resident needed to be seen; however, no one had mentioned anything to her that Resident #1 needed to be seen by the Podiatrist. During an interview on 02/27/24 at 12:46 AM, Nurse Aide (NA) #1 stated she had provided care to Resident #1 on occasion but she was usually dressed and wearing socks by the time she started her shift. NA #1 stated she did not recall observing Resident #1's toenails but when she did notice a resident with long toenails, she informed the nurse. NA #1 stated she would trim a resident's fingernails but did not trim a resident's toenails especially when the toenails were thick. During an interview on 02/27/24 at 1:24 PM, NA #2 explained she didn't trim resident's toenails and when she noticed a resident's toenails were long, she informed the nurse. NA #2 confirmed she was assigned to provide Resident #1's care on 02/27/24 but did not recall observing her toenails. An interview and observation of Resident #1's toenails was conducted with Nurse #1 on 02/27/24 at 2:10 PM. Nurse #1 stated the NAs had not mentioned anything to her about Resident #1's toenails needing trimmed. Nurse #1 explained typically the NAs would let her know when a resident's toenails were too long and if needed, she would inform the SW for the resident to be placed on the list to be seen by Podiatry. Nurse #1 removed Resident #1's socks off both feet and confirmed the toenails on both of Resident #1's big toes extended approximately ½	F 687	random Quality Reviews of residents to ensure residents are provided toenail care with Activities of Daily Living (ADL) care on 10 random residents 3 times a week for 4 weeks, then weekly for 8 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 3/11/2024. 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 Compliance: 3/12/2024	

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F 687	Continued From page 6 inch past the tip of the toe. Nurse #1 stated since the toenails on both big toes were thick, they would need to be trimmed by the Podiatrist and she would inform the SW. During a telephone interview on 02/27/24 at 2:32 PM, the Director of Nursing (DON) explained a resident was referred to Podiatry for a toenail trim when they were diabetic or had thick toenails. The DON stated NAs should be observing resident's feet when providing daily care, shower or bed bath and reporting to the nurse when the resident's toenails needed trimmed. The DON stated she could understand the NA overlooking Resident #1's toenails at first but for them to have grown out a ½ inch past the tip of the toe, she would have expected for the NA to have noticed and informed the nurse, SW or herself so that a podiatry consult could have been made.	F 687		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/12/24

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F 761	Continued From page 7 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff the facility failed to store an unopened insulin pen in the refrigerator until needed for use for 1 of 4 medication carts (200/300 Hall medication cart) and failed to remove medicated mouthwash by the date it was to be discarded from 1 of 1 medication refrigerator reviewed for medication storage. Findings included: 1. Review of manufacturer's package insert recommended to store unused (unopened) insulin aspart in a refrigerator between 36°F to 46°F and in-use (opened) insulin at room temperature for 28 days. An observation of the 200/300 Hall medication cart was conducted with the Unit Manager (UM) on 2/26/24 at 3:54 PM. Stored on the medication cart and available for use was an unopened insulin aspart (fast-acting) pen. There was no date on the insulin pen to indicate when it was placed on the medication cart. During an interview on 2/26/24 at 3:54 PM the UM revealed the insulin aspart pen should be kept in the designated medication refrigerator	F 761	F 761 1. Magic mouth wash was removed from medication room on 2/27/2024. Unlabeled insulin was removed from 100 cart on 2/27/2024. 2. A quality review was completed by the Director of Nursing and/or designee to ensure medication in medication carts was labeled and dated, with emphasis on insulin and any expired medications removed on 2/27/2024. A quality review was completed by the Director of Nursing and/or designee to ensure medication room is free from expired medication on 2/27/2024. Inconsistencies were corrected. 3. The DON/Designee will monitor the medication carts randomly each week to ensure medications are dated approriately and any expired medications are removed/discarded. From 3/5/2024 through 3/11/2024, The Director of Nursing and/or Designee re-educated all Licensed Nursing Staff and Medication Aides prior to beginning their shift,	

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F 761	Continued From page 8 until needed for use. She stated the nurses were expected to label the pen with the date it was removed from refrigerator or put on medication cart and was discarded after being in use for 28 days. The UM stated her, or the Director of Nursing (DON) completed the audit reviews of the medication carts three times a week that included to ensure insulin pens were dated. She revealed the nurses received the medications delivered from the pharmacy and placed insulin in the refrigerator in the medication room or on the med cart if needed. During an interview on 2/27/24 at 2:59 PM the DON revealed her, and the UM checked the for expired medications and she was unsure why an unopened insulin pen with no date was stored on the med cart. 2. An observation of the refrigerator located in the medication storage room was conducted on 2/26/24 at 4:49 PM with the UM. Two bottles of medicated mouthwash were stored in the refrigerator and available for use. The labels on the back of the medicated mouthwash indicated one of the bottles was to be discarded on 1/1/24 and the other on 1/9/24. During an interview on 2/26/24 at 4:49 PM the UM stated the facility had one medication storage room and either her or the DON check the refrigerator for expired medications. The UM stated the medicated mouthwash should be discarded, and she removed both bottles from the refrigerator and placed them in the return to pharmacy bin. The UM stated she did not see the discard date label located on the back of the bottles of mouthwash, and she just checked the front label for the expiration date. The UM	F 761	including those licensed nurses and medication aides on leave or vacation, on labeling and dating all medication in medication carts and expired and/or unlabeled medication in medication carts and in medication room must be removed. Newly hired Licensed Nursing Staff and Medication Aides and agency staff will receive education during orientation and prior to unit assignment. 4. Starting on 3/11/2024 the Director of Nursing and/or designee will conduct random Quality Reviews on medication carts and medication room for expired and/or un-labeled medications 5 times a week for 8 weeks then weekly for 4 weeks, then 3 times a week for 8 weeks the weekly for 8 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 3/11/2024. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, 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/designee will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. The DON/Designee will report findings to the QAPI committee monthly as an ongoing performance improvement plan. The Vice	

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F 761	Continued From page 9 revealed she was not aware medicated mouthwash had a time limit to be discarded after it was delivered by the pharmacy. An interview conducted on 2/27/24 at 2:59 PM with the DON revealed her and the UM checked the refrigerator in the medication storage room for expired meds. She stated she must have checked the expiration date on the front label of the bottles and did not see the discard date located on the back. The DON revealed she was not aware medicated mouthwash had a time limit to be discarded after it was delivered by the pharmacy. She stated going forward she would know to check medicated mouthwash for a discard date. During an interview on 2/27/24 at 4:49 PM the Administrator stated the monitoring tools did not meet the standards for medication storage if deficiency was found and he was not sure what the breakdown in the process was.	F 761	President of Clinical Services/designee will review the findings each month for effectiveness and make recommendations as needed. Date of Compliance: 3/12/2024	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		3/12/24

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F 812	Continued From page 10 (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: 1) maintain a clean and sanitary kitchen; 2) failed to remove gloves and perform hand hygiene after handling dirty dishes; 3) failed to date opened food items stored in the walk-in refrigerator ready for use; 4) failed to discard thickened juice by the date it could no longer be used; and 5) failed to seal and date an open bag of cereal for 1 of 1 kitchen. These practices had the potential to affect ninety-one (91) residents who resided in the facility. Findings included: The initial walk-through observation of the kitchen was conducted on 2/26/24 from 9:05 AM through 10:06 AM with the Dietary Manager (DM). The observations revealed the following: 1 a. During an observation on 2/26/24 at 9:14 AM a metal table with sliding cabinet doors used to store hot and cold beverage serving containers appeared dirty. The tracks on the metal table used to open and shut the cabinet doors had a thick buildup of black colored debris all along the tracks and the inside of the cabinets had crumb-like and paper debris throughout the cabinet shelves. b. During an observation on 2/26/24 at 9:14 AM a heavy-duty can opener attached to a metal table	F 812	K 812 1. There were no current residents affected. 1)a. The metal table with sliding cabinet door used to store hot and cold beverage containers has been cleaned. 1)b. The heavy-duty can opener attached to a metal table has been cleaned. 1)c. The wall directly above the dishwasher sink has been cleaned. 1)d. The floor of the walk-in cooler, the threshold of the door between the refrigerator and freezer have been cleaned. Debris on the floor has been removed. 1)e. The lower portion of the wall in dry storage has been cleaned; Areas of the floor along the wall molding have been cleaned. 2)a. The dietary aid who did not change gloves before unloading clean dishes was re-educated on 02/27/2024, prior to beginning their shift, regarding the importance of changing soiled gloves and washing hands prior to handling clean dishes to avoid cross contamination. 3) There were no other Residents affected.	

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F 812	Continued From page 11 had a buildup of thick black colored debris on the sharp end used to puncture metal cans of food. c. During an observation on 2/26/24 at 9:28 AM the wall directly above the dishwasher sink where dirty dishes were rinsed had a large black colored stain. d. During an observation on 2/26/24 at 9:46 AM the floor in the walk-in refrigerator and freezer cooler appeared dirty. There was a thick black colored build-up of debris at the threshold of the door between the refrigerator and freezer. There was an empty plastic container and other crumb-like debris on the floor in the freezer underneath the shelving where food was stored. e. During an observation on 2/26/24 at 10:06 AM the dry storage room along the lower portion of wall behind the shelving where food was stored appeared dirty in multiple areas. There were stains that appeared as a liquid substance was spilled on the wall and left to dry. The areas of floor along the wall molding underneath the shelving where food was stored had a thick black colored buildup of debris in multiple areas. An interview with the DM conducted on 2/26/24 at 10:06 AM revealed Dietary Staff were responsible for cleaning kitchen equipment and the Cooks were responsible for the daily sweeping and mopping the floors and he was responsible for checking the cleanliness of the kitchen. The DM revealed he was newly hired and since he took over the kitchen on 2/21/24 he was still getting familiar with things. He revealed since he started several dietary staff did not show up for work and if he did not find someone to cover their shift it was his responsibility and he had worked	F 812	3)a. The cheese, milk, applesauce, and chocolate shake supplement all found to be opened, undated and/or wrapped in plastic were discarded. 4)a. The open 46 oz. container of thickened orange juice with the open date and no use-by date was discarded. 5)a. The open and undated bag of cereal was discarded. 2. The Regional and District Managers for the contracted dietary services group performed a kitchen wide inspection on 02/28/2024 to ensure all foods were correctly labelled with open date and use-by dates; ensured foods were stored correctly and ensured any other areas which needed more detailed cleaning were noted. There were areas noted that needed deep cleaning, however no foods were improperly stored. A deep cleaning schedule was developed and completed by 3/11/2024. 3. The District Manager/Dietitian/designee will perform audits of the kitchen regarding cleanliness; proper food storage/labeling and infection control practices each month. The Sanitation report will be provided to the Executive Director for review. The re-education of contracted dietary services personnel was completed on 3.11.2024 regarding the procedure for correctly labeling food products with the opened date and use-by date; the requirement to keep all food service items such as walls, floors and	

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F 812	Continued From page 12 extended hours on multiple occasions. 2) During an observation of the dishwasher in use on 2/26/24 at 9:28 AM Dietary Aide (DA) #1 was washing and rinsing off dirty dishes that she loaded onto racks and sent through the dishwasher. DA #1 was wearing gloves while she washed and rinsed three racks of dirty dishes. After the dishware completed the wash and rinse cycles DA #1 moved from dirty side to the clean side and began to unload the clean dishes. DA #1 did not wash her hands after handling dirty dishes and wore the same gloves she used to wash and rinse dirty dishware to unload the clean dishes. An interview was conducted on 2/26/24 at 9:36 AM with DA #1. DA #1 stated typically she would remove her gloves and wash her hands after handling dirty dishes. DA #1 stated hand hygiene was done to prevent cross contamination from dirty dishes to clean. During an interview on 2/26/24 at 2:34 PM the Regional Dietary Manager stated when washing dishes dietary staff were supposed to remove their gloves and wash their hands before going to the clean side of the dishwasher and receive training about cross contamination. 3. During an observation of the walk-in refrigerator on 2/26/24 at 9:46 AM opened food and beverage items did not have visible dates to determine when it was open, or how long it should be served to residents included the following: a. Half a block of Swiss cheese slices opened and wrapped in plastic. b. One-fourth of block of American cheese slices	F 812	baseboards clean at all times; the importance of changing soiled gloves and washing hands prior to handling clean dishes to avoid cross contamination. New hires for the dietary department will receive the education during orientation. 4. Beginning 3/11/2024, the Executive Director/Designee will monitor the food storage areas to ensure correct policy is followed with regards to correctly dating opened food items; inspect the kitchen areas for cleanliness and monitor the dietary services staff to ensure proper gloving and handwashing procedures are followed. The monitoring will be documented 5 X/week for 4 weeks then 1X/week for 8 weeks. The plan was introduced to the QAPI Committee on 3/11/2024. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. 5.Date of Compliance: 3.12.2024	

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opened and wrapped in plastic.
c. One open 8-ounce carton of milk.
d. A small bowl of apple sauce wrapped in plastic.
e. A thawed 4-ounce chocolate shake supplement.

During an interview on 2/26/24 at 9:46 AM the DM stated when food items were open dietary staff were to write the date it was opened and use by date on the item. He revealed it depended on the product how long it could be in use and served to residents. He stated the use by date for cheese was 7 days and supplement shakes were used 14 days after thawed. He was unsure why a small bowl of applesauce and one open 8-ounce carton of milk were in the refrigerator and stated those should have been dated.

4. During an observation of the walk-in refrigerator on 2/26/24 at 9:46 AM an opened 46 fluid ounce container of thickened orange juice was available for use with an open date 2/7/24 but no use by date.

During an interview on 2/26/24 at 9:46 AM the DM stated thickened orange juice should be discarded after being in use for 14 days and should have been removed from the refrigerator on 2/21/24.

5. An observation of the dry storage room revealed on 2/26/24 at 10:06 AM a large bag of rice crispy cereal was not sealed and left open to air with no date.

During an interview on 2/26/24 at 10:06 AM the DM stated when cereal was opened it was put in plastic container and label with the date it was open and the date it should be use by.

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F 812	Continued From page 14 During an observation and interview on 2/26/24 at 2:34 PM the Regional Dietary Manager observed the areas identified for cleanliness. She stated the stain on the wall by dishwasher was an ongoing issue and maintenance would be informed. She stated dietary staff were expected to clean as needed and the metal storage cabinet tracking should be cleaned once a week to prevent buildup of debris and the can opener daily after each use. She stated the floors should be swept and mopped daily and deep cleaned once a week to prevent debris buildup. She revealed the kitchen cleaning schedule included daily tasks to complete and stated she was going to update the schedule to ensure tasks were specifically assigned to a dietary staff member. During an interview on 2/27/24 at 4:49 PM the Administrator revealed he officially started his position on 2/10/24. He stated after the last survey (01/16/24) there were no citations related to dietary or the kitchen and was not his focus. He stated cleanliness and the other issues discussed should be addressed as part of the daily routine of maintaining the kitchen.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		3/12/24

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F 867	Continued From page 15 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and 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.	F 867		

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F 867	Continued From page 16 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §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).	F 867		

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F 867	Continued From page 17 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 01/16/24. This was for a repeat deficiency in the area of label/store drugs and biologicals that was originally cited during the recertification survey completed on 01/16/24 and subsequently recited during the revisit and complaint investigation completed on 02/27/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program.	F 867	F867 1. The Executive Director, Director of Nursing, Staff Development (Scheduler), Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set (MDS) nurse, Business Office Manager, Human Resources Director, Director for Sales and Marketing, Medical Records Director, Director of Therapy were inserviced as to the principles of Quality Assurance/Performance Improvement (QAPI) and its relationship to effective	

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F 867	Continued From page 18 The findings included: This tag is cross referenced to: F761: Based on record review, observations, and interviews with staff the facility failed to store an unopened insulin pen in the refrigerator until needed for use for 1 of 4 medication carts (200/300 Hall medication cart) and failed to remove medicated mouthwash by the date it was to be discarded from 1 of 1 medication refrigerator reviewed for medication storage. During the recertification survey of 01/16/24, the facility failed to secure an opened tube of antifungal cream, label insulin pens stored in the medication cart with the date they were opened and remove expired over-the-counter medications in accordance with the manufacturer's expiration date. During an interview on 02/27/24 at 4:50 PM, the Administrator explained since starting at the facility on 02/10/24, his focus had been on the processes put into place to correct the concerns identified from the recertification survey and he wasn't sure where the breakdown occurred regarding the repeat deficiency. The Administrator stated they did not meet their standards as identified previously by QAPI. He stated the QA committee would be reviewing and discussing the repeat concern and his goal going forward was to make sure they had effective processes in place that met regulatory guidance.	F 867	care, processes, and State inspections by Vice President of Clinical Services on 2/27/24. 2. A Quality review was completed on 2/28/24 related to the root causes for the failure of revisit and the additional tags related to the complaint. The root cause was deemed to be an ineffective QAPI process which did not identify and/or address the ongoing issues previously cited. The Committee failed to continue to monitor the citations monthly and adapt the process improvement plan accordingly. As a result, the Quality Assurance/Performance Improvement Committee will review all citations each month until recertification occcurs and any monitor variances will result in a new monitoring plan to be implemented. . 3. The Executive Director/designee will provide an agenda for the Quality Assurance Performance Improvement Committee which specifically reviews the deficient practices after the monitoring period has closed. The topics will be reviewed each month and updates provided by the DON/Designee. From 3/4/24 to present, the Interdisciplinary Team (IDT) has practiced QAPI by reviewing areas cited in survey with their associated Plans of Correction and follow-up tools. The Interdisciplinary Team (IDT) also discussed areas for performance improvement. The Vice President of Clinical Services/designee will 1) attend the QAPI meetings each month and/or 2) review the minutes	

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F 867	Continued From page 19	F 867	generated from the meeting and make recommendations. This monitor will be in effect until the next recertification survey is complete. 4. Starting on 3/12/24, monthly QAPI meeting minutes and quality monitoring tools will be presented to and reviewed by the VP of Clinical Services/Designee to ensure that QAPI practices are being effectively utilized and the plan of correction is serving to make the necessary changes. Date of Compliance: 3/12/24	