STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(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
E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted on 9/25/23 through 9/29/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# NE0L11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 9/25/23 through 9/29/23. Event ID# NEOL11. The following intakes were investigated: NC00207425, NC00207398, NC00207811 NC00203316, NC207435, NC00207508. 16 of 16 allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		10/31/23

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

Electronically Signed | 10/20/2023

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F 553	Continued From page 1 right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to invite the resident to participate in the care planning process for 2 of 19 residents whose care plans were reviewed (Resident #45 and 42). Findings included: 1. Resident #45 was admitted on 6/29/23. Review of the admission Minimum Data Set (MDS) assessment dated 7/6/23 revealed Resident #45 had been assessed as cognitively intact. Review of Resident #45's care plan revealed it had been completed on 7/6/23, but there was no indication that the resident had participated in the care plan meeting or in development of the care plan. During an interview on 9/25/23 at 9:45 AM, Resident #45 stated the facility had not invited her to her care plan meeting.	F 553	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F553 RIGHT TO PARTICIPATE IN PLANNING CARE Corrective Action: Resident #45 Care plan meeting scheduled for Resident to be invited to care planning meeting by Roxboro Healthcare on 9/25/2023 via verbal invitation. Resident #45 care plan meeting was completed on 9/28/2023 with the interdisciplinary team. Resident #42 Care plan meeting scheduled for Resident to be invited to care planning meeting by	

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F 553	Continued From page 2 During an interview on 9/26/23 at 3:20 PM, the Social Worker (SW) indicated she was responsible for invitations to the care plan meeting. Care plan meetings were held after admission for comprehensive care plan and later every 3 months for quarterly assessment. The SW further indicated if the residents were alert and oriented, they would be involved in the care plan meeting. The SW stated based on the MDS completion an invitation letter for the care plan meeting would be mailed to the resident's RP a week before the meeting. SW was unsure why the resident was not invited to her care plan meeting. SW stated the resident was alert and oriented and could participate in her care plan decisions. She should be invited to the meeting. SW further stated there was no documentation related to the comprehensive care plan meeting and the meeting was not conducted with the resident. 2. Resident #42 was readmitted on 6/29/23. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/6/23 revealed Resident #42 was initially admitted on 4/13/21 and had been assessed as cognitively intact. Resident #42's care plan was reviewed on 7/6/23, but there was no indication that the resident or a resident representative had participated in the care plan meeting or in development of the care plan. During an interview on 9/25/23 at 9:45 AM, Resident #42 stated she never had a care plan meeting and would like to have one so that she could participate in her care and treatment	F 553	Roxboro Healthcare on 10/13/2023 via verbal invitation. Resident #42 care plan meeting was completed on 10/13/2023 with the interdisciplinary team. Identification of other residents who may be affected by alleged deficient practice: All current cognitively intact residents, have the potential to be affected by the alleged practice. A 100% audit of all current residents who are cognitively intact residents (BIMS score 13-15) will be completed in order to validate whether they have been invited to participate in the planning of their care during the past 90 days. This audit will be completed by the facility Social Worker and Administrator by October 24, 2023. All residents identified as not having been invited to participate in their care planning conference will receive an invitation to a scheduled care conference. This will be completed for all affected residents no later than October 31, 2023. Systemic Changes: On 10/17/2023 The Minimum Data Set (MDS) Coordinator and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the Administrator. The education focused on: The resident has the right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and	

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F 553	Continued From page 3 decision process. During an interview on 9/26/23 at 3:20 PM, the Social Worker (SW) stated the resident had quarterly MDS assessments completed on 7/6/23, on 6/7/23 prior to her hospitalization and on 4/18/23. The SW stated the resident's RP had not responded to the invitation letters that were sent on 4/25/23 for care plan meeting on 5/4/23 and on 6/6/23 for a care plan meeting on 6/15/23. The SW indicated there were no care plan meetings conducted with the resident for these care plans. The SW stated if the resident was alert and oriented then a care plan meeting could be conducted with the resident even in the absence of the resident's RP. She indicated she was unsure why the resident was not invited to participate in the care plan meeting. There was no documentation indicating the care plan meeting was conducted. The interdisciplinary team did not meet to discuss the care plan with the resident. She added that going forward the resident would be invited to participate in her care plan meeting. During an interview on 9/27/23 at 10:22 AM, the Administrator stated residents and/or resident representatives should be involved in the care plan meeting and make decisions about their care. The Administrator indicated documentation related to the care plan attendance and meeting should be completed in a timely manner.	F 553	the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care,and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Assistant Director of Nursing will interview 5 cognitively intact residents to ensure that they have been invited to participate in the planning of their care. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be	

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F 553	Continued From page 4	F 553	reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		10/31/23

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F 732	Continued From page 5 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing for 13 days of 91 days reviewed for April 2023, May 2023, and June 2023. Findings included: Review of the daily posted nurse staffing revealed documentation of no RN Supervisor and zero ("0") RN hours for each of three shifts covering 7 am to 3 pm, 3 pm to 11 pm, and 11 pm to 7 am on the following days: 1. 4/3/23 2. 4/11/23 3. 4/17/23 4. 4/28/23 5. 5/8/23 6. 5/9/23	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10/16/2023, The Director of Nurses (DON) and the Support Care Nurse reviewed and corrected the daily nurse	

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F 732	Continued From page 6 7. 5/10/23 8. 5/15/23 9. 5/19/23 10. 5/22/23 11. 5/23/23 12. 5/24/23 13. 6/7/23 An interview on 9/27/23 at 8:42 am with the Administrator revealed that Payroll Based Journal (PBJ) reporting for RN coverage was based on the electronic time clock data that she reviewed. During April, May, and June 2023, on the days when zero RN staffing was posted in the facility meant either the RN positions of Unit Manager, Assistant Director of Nursing (ADON)/Staff Development Coordinator (SDC), Wound Care Nurse or Minimum Data Set (MDS) Nurse would serve as the RN support for the day. Review of the electronic time clock software on the Administrator's laptop for each of those days revealed the former ADON/SDC worked eight hours or more on 4/11/23 and 5/10/23, and the former RN Wound Care Nurse worked eight hours or more during the other days when no RN was posted. An interview on 9/27/23 at 3:00 pm with the Director of Nursing (DON) revealed that the posted nurse staffing sheet for the facility was created by the Scheduler. An interview on 9/27/23 at 3:05 pm with the Scheduler revealed she would fill out the nurse staffing form titled "Report of Nursing Staff Directly Responsible for Resident Care of Skilled Halls" and a night shift nurse would post the form on the bulletin board near the nursing station at the front of the facility. She continued the facility	F 732	staff postings from (2 weeks) October 1, 2023 through October 15, 2023 to reflect the assigned staff including Registered Nurses (RN), Licensed Practical Nurses (LPN□s) and Unlicensed staff that worked each day. This was completed on 10/17/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: There were no residents affected by this deficient practice. On 10/16/2023, The Director of Nurses (DON) and the Support Care Nurse reviewed and corrected the daily nurse staff postings from (2 weeks) October 1, 2023 through October 15, 2023 to reflect the assigned staff including Registered Nurses (RN), Licensed Practical Nurses (LPN□s) and Unlicensed staff that worked each day. This was completed on 10/17/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The DON or designee will be responsible for ensuring a daily nurse staff posting was completed and that it was accurate to reflect the assigned staff who work each day. The daily posting will be reviewed daily Monday through Friday x 2 weeks then weekly x 2 weeks then monthly x 2 months for accuracy.	

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F 732	Continued From page 7 always had eight-hour or more RN coverage for each 24-hour period, but the shift fields had zero RN coverage because she documented the nurses who were working the floor and not assigned other tasks. She could not say why the RN Supervisor field on the form was left blank. A telephone call to the former ADON/SDC was made on 9/27/23 at 3:38 pm requesting a return call. A return telephone call from the former Wound Care Nurse on 9/28/23 at 4:25 pm revealed she worked at the facility September 2022 through the end of June 2023 as the Wound Care Nurse. She continued that she typically clocked in as the Wound Care Nurse and would be identified as the "RN for the day" when only LPNs and Med Aides were scheduled for working the floor and medication carts. On days the facility was short staffed, she would get pulled to the medication cart and the other LPNs would have to do their own wound care. An Interview with the DON on 9/29/23 at 11:08 pm revealed the daily posted nurse staffing did not accurately reflect that either the Wound Care RN or the ADON/SDC RN clocked in on the days when no RN coverage was documented on the form. She continued that the Administrator confirmed there was RN coverage, and that it should be accurately posted.	F 732	On 10/11/2023 the Quality Assurance Clinical Nurse Consultant completed education on Daily Nursing Staff Posting Requirements for the following staff, the DON and the Support Care Nurse. Objectives: " To identify the regulatory requirement of F 732 for Posted Nursing Staff Information " To monitor that the requirement for F732 is met daily and includes the data requirements, posting requirements, Public access to posted nurse staffing data, and Facility data retention requirements. " Posted Nurse Staffing Information F732 CFR(s): 483.35(g)(1)-(4) 483.35(g) Nurse Staffing Information. 483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements. The Director of Nurses or designee will	

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F 732	Continued From page 8	F 732	monitor compliance utilizing the F732 Quality Assurance Tool for daily nursing staff postings. This monitor will be completed daily Monday through Friday x 2 weeks then weekly x 2 weeks then monthly x 2 months for accuracy to ensure the form is being completed and reviewing for accuracy of the daily nursing staff posting. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: _10/31/2023	
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	F 761		10/31/23

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F 761	Continued From page 9 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §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, manufacturer's recommendations, and staff interviews, the facility failed to remove an expired multi-dose vial of insulin and failed to date opened medications in 2 of 5 medication administration carts (200 hall cart and 600 hall cart) reviewed for medication storage. Findings Included: 1. A review of the manufacturer's recommendations indicated to discard Lantus multi-dose vial, Lantus Pen, Aspart Flex Pen 28 days after opening and Tresiba (insulin) Flex Touch Pens 8 weeks after opening. On 9/25/23 at 6:10 AM, an observation of the medication administration for the 200 hall cart with Nurse #1 revealed one opened and undated multi-dose vial of Lantus insulin, one opened and undated Aspart Flex Pen (insulin), and two opened and undated Tresiba (insulin) Flex Touch Pens.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: On 09/25/2023, the Director of Nurses (DON) initiated a cart review of 100% of all medication, treatment, and medications rooms removing any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	

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F 761	Continued From page 10 On 9/25/23 at 6:10 AM, during an interview, Nurse #1 indicated the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. She mentioned per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired medication this shift. On 9/25/23 at 11:10 AM, during an interview, the Administrator indicated all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected no expired items to be left in the medication carts. 2. A review of the manufacturer's recommendations indicated to discard Lispro multi-dose pen 28 days after opening. A review of the manufacturer's recommendations indicated to discard Aspart Flex Pen and Glargine Pen 28 days after opening. A review of the manufacturer's recommendations indicated to discard Levemir Flex Pen 42 days after opening. On 9/25/23 at 6:10 AM, during an interview, Nurse #2 indicated the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. She mentioned per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated she had not checked the expiration date and date of opening on insulin vials in her medication administration	F 761	applicable. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 09/25/2023, the DON and Unit Support Nurse audited all medication carts, treatment carts, and medication rooms and removed any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. No resident was found to be affected by the deficient practice. In order to ensure that no resident was affected, a continued daily audit of the facility medication carts, treatment carts, and medication room was conducted by the DON and Unit Support Nurse to ensure there were no drugs and biologicals that were not labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrections were made immediately where indicated. Daily audits continued until 09/29/2023 at which time auditing was transitioned to random monitoring on various shifts, days, including weekends.	

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F 761	Continued From page 11 cart at the beginning of her shift. The nurse did not administer expired medication this shift. On 9/25/23 at 6:30 AM, an observation of the medication administration 600 hall cart with Nurse #2 revealed one Lispro (insulin) Pen, opened on 8/26/23. One opened and undated Levemir Flex (insulin) Pen. One opened and undated Aspart Flex Pen, one opened and undated Glargine (insulin) Pen. On 9/25/23 at 11:10 AM, during an interview, the Administrator indicated all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected no expired items to be left in the medication carts.	F 761	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 09/25/2023, the DON began educating all full time, part time, agency staff, and PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 5pm on 10/31/2023, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tools weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling drugs and biologicals to ensure that they are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the	

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F 761	Continued From page 12	F 761	expiration date when applicable. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/31/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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	F 812		10/31/23

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F 812	Continued From page 13 by: Based on observations and staff interview the facility failed to label food, discard leftover food that had past the use by date and cover dishes that stored food stored in the walk-in refrigerator, reach-in refrigerator, and reach-in freezer. The facility failed to maintain the walk-in freezer floor free from ice. The dietary staff failed to wash hands after handling dirty and before handling clean dishes during the dishwasher observation. These practices had the potential to affect food being served to residents. Findings included: 1a) An observation of the walk-in refrigerator on 9/25/23 at 6:10 AM, revealed the following: food wrapped in aluminum foil with no label, a small stainless-steel bowl wrapped in cling wrap with brown colored food in it. On the cling wrap was written " Beef, 9/18/23; use by 9/21/23. An aluminum pan with food that looked like spaghetti and meat sauce. The pan was not completely covered with cling wrap, the cling wrap was torn around the corners and center, the food in the pan was exposed. An aluminum pan covered with aluminum foil and "Vegetable salad" written on it. The aluminum foil covering the pan was torn in the middle and yellow colored fluid was observed on it. An aluminum pan covered with aluminum foil and "Pasta salad - 9/21/23" written on it. The pan was not properly covered, and the aluminum foil was torn. During an interview with the dietary manager on 9/25/23 at 6:15 AM, she indicated the food wrapped in aluminum foil was sliced turkey. The vegetable salad was three bean salad and had orange juice accidentally spilt on it. She stated all	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 9/25/2023 and 9/26/2023. During initial walk through of the kitchen on 9/25/2023, it was noted dietary services had failed to properly label/date/discard expired food, failed to properly cover/store food in the walk-in refrigerator and freezer, and failed to maintain proper function of the walk-in freezer. On 9/25/2023 the Dietary Manager discarded all improperly stored, unlabeled, and expired food items. On 9/25/2023 the Dietary Manager and Dietitian completed a walk-through of the kitchen to ensure all food items were stored properly. Dietary Manger defrosted and cleaned ice from walk-in freezer 9/25/2023. During 9/26/2023 observation of tray breakdown dietary staff failed to maintain proper sanitary processes when in the dish room. Action was immediately	

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F 812	Continued From page 14 cooks were responsible for labeling all left over foods prior to being placed in the refrigerators. Food should be discarded based on the use by date. The dietary manager stated she usually checks after the cooks in the morning to ensure all foods were properly labeled and expired food discarded. 1 b) An observation of the reach -in refrigerator on 9/25/23 at 6:18 AM, revealed a three fourth filled plastic container with yellowish colored food in it. There was no label on the container. There was another container with cream colored food labeled " Tuna salad -9/15/23 and use by 9/20/23". During an interview with the dietary manager on 9/25 /23 at 6:20 AM, she stated the yellowish colored food was Pimento cheese salad. She stated all food should be labeled by the cooks before placing them in the reach- in refrigerator and needed to be discarded within 7 days of the preparation. During an interview on 9/26/23 at 11:10 AM, the dietary cook #1 stated all leftover foods should be labeled with the preparation date and use by date. She further stated she was unsure who had placed the food without labeling in the refrigerator. Dietary Cook #1 indicated the foods were discarded by the use by date. During an interview on 9/26/23 at 11:20 AM, the dietary cook #2 stated the leftover food was labeled with a prep date and use by date. She indicated she was unsure who had placed the food without labeling the left over in the refrigerator. Dietary Cook #2 indicated all prep food can be stored in the refrigerator for 7 days	F 812	corrected; staff washed hands and re-washed contaminated items. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 9/25/2023, 9/26/2023, and 9/27/2023, the Dietitian Consultant completed a kitchen and nourishment walk through with the Dietary Manager to ensure all food items were stored properly. On 9/25/2023 maintenance director completed a walk-through of the kitchen to check all equipment was in working order. Direct Supply representative assessed freezer on 10/16/2023 for repair recommendations. Plans for repair or replacement to be in place by compliance date of 10/31/2023. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on 9/25/2023 and 9/26/2023. Topics included: " Storage and dating policies and regulations. " Inspections on shifts to observe all food are within their dates and tossed if out of date. " Procedures for alerting PIC/maintenance when equipment out of working order.	

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F 812	Continued From page 15 before they were discarded. 1 c) An observation of the reach in freezer on 9/25/23 at 6:21 AM, revealed 12 cups with ice in a tray. 10 cups of the 12 cups did not have lids on them. During an interview with the dietary manager on 9/25/23 at 6:22 AM, she stated the cups should have lids on them before placing them in the freezer. All food and drinks should be properly covered. 2) An observation of the walk-in freezer on 9/25/23 at 6:25 AM revealed ice blocks on the floor (approximately 3 x 4 inches), and thin sheet of ice on the floor. During an interview on 9/25/23 at 6:27 AM, the Dietary Manager stated the freezer was serviced by the maintenance director. She indicated the equipment was old and needed to be replaced. During an interview on 9/27/23 at 3:17 PM the Maintenance Director stated the walk-in freezer was located inside the walk-in refrigerator and it absorbed moisture resulting in accumulation of ice. He further stated the unit was an old unit and defrosted multiple times during the day. The defrosted moisture refroze as ice on the floor and on the boxes. The maintenance Director stated he had recently replaced the entire door sealing and placed a new rubber seal at the bottom of the door to prevent moisture flow into the freezer. He indicated he was constantly monitoring the unit. He added he had given a few options to the management as the unit was old and needed replacement. The management was looking into it.	F 812	" Sanitation processes in dish room. " Proper hand washing and when hands should be washed. Maintainenace to maintain kitchen equipment by keeping up to day on audits and maintenance request through TELS program. All full time, part time, and as needed dietary staff will complete the Healthcare Academy Courses Safe Food Handling and Kitchen Observation before compliance date of 10/31/2023. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Manager or assignee will monitor procedures for proper food storage and sanitation biweekly x 4 weeks then weekly x 2 months using the Dietary Inspection Tool which will observe that all food is labeled, dated, within proper dates, and stored in clean and working equipment. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 812	Continued From page 16 3) During an observation and interview on 9/26/23 at 1:10 AM, Dietary cook help #1 was observed placing dirty glasses in the dirty dishwasher rack. He was later observed taking clean and dried plates, cups, and plate dooms from the clean air-dried rack to be placed on the tray line. The dietary cook's help indicated he had only placed the dirty glasses in the dirty rack for washing and had not touched other dirty dishes. When dietary helper was informed that hand hygiene was essential between handling of dirty and clean dishes. The staff started wearing gloves instead of washing his hands. The staff was asked to wash hands before he wore the gloves to handle clean dishes. During an observation and interview on 9/26/23 at 1:20 AM, Dietary cook help #2 was observed loading dirty dishes on the rack and placing them near the dishwasher for washing. The staff was observed to be removing a clean dishes rack from the dish washer without washing hands. The Dietary cook help #2 stated she had not touched the clean dishes, just pulled the rack out of the dishwasher so that the next load of dishes could be placed in the dishwasher for washing. All the dishes observed to be handled by staff without washing hands were rewashed in the dishwasher. During an interview on 9/28/23 at 8:51 AM -the Administrator stated that the leftover food should be covered to ensure there was no cross contamination and labeled to ensure the food was used or discarded prior to the use by date. Regarding the walk-in freezer, the Administrator indicated there have been few options that have	F 812	weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	

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F 812	Continued From page 17 been talked about with the corporation. The maintenance director had resealed the area around the door, and this had been helping to ensure no moisture leaked from the refrigerator to freezer. The walk-in refrigerator and freezer were a combined unit. Due to the age of the unit other options have been discussed. The Administrator stated dietary staff should ensure that their hands were washed between dirty and clean dishes, when hands become dirty or when change of the work assignment in the kitchen.	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 will be used to develop and monitor performance indicators.	F 867		10/31/23

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F 867	Continued From page 18 §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. §483.75(e) Program activities.	F 867		

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F 867	Continued From page 19 §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 program required under paragraphs (a) through (e) of this section. The committee must:	F 867		

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F 867	Continued From page 20 (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, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint surveys dated 8/3/22 and 6/10/21 to achieve and sustain compliance. The deficiencies were in the areas of accuracy of assessment and food procurement, store/prepare/serve- Sanitary. The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: F641 - Based on record review and staff interviews, the facility failed to code the discharge Minimum Data Set (MDS) assessment to reflect accurately the discharge status for 1 of 4 discharged residents, reviewed for assessment accuracy (Resident #100). During the previous recertification and complaint survey on 8/3/22, the facility failed to code the quarterly Minimum Data Set (MDS) assessment to accurately reflect the dialysis status for 1 of 1 resident, reviewed for assessment accuracy.	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10.11.2023, the Clinical Nurse Consultant educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Accuracy of Assessments (MDS) (F641). These deficiencies were cited again on the current recertification survey completed on 9.29.2023.	

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F 867	Continued From page 21 F812 - Based on observations and staff interview the facility failed to label food, discard leftover food that had past the use by date and cover dishes that stored food stored in the walk-in refrigerator, reach-in refrigerator, and reach-in freezer. The facility failed to maintain the walk-in freezer floor free from ice. The dietary staff failed to wash hands after handling dirty and before handling clean dishes during the dishwasher observation. These practices had the potential to affect food being served to residents. During the previous recertification and complaint survey on 8/3/22, the facility failed to: maintain the oven clean; maintain the reach-in freezer #1, walk-in refrigerator and walk in freezer clean; label and discard expired food from the reach-in refrigerator; place lids on cups filled with ice in the reach-in freezer #2. The roof of the reach-in freezer #2 had icicles that were touching the ice in the cups. Facility failed to discard a dented can in the dry storage area. Facility failed to label and date food and nutritional supplements 2 of 2 nourishment refrigerators (station 1 and station 2 nourishment refrigerators). During the previous recertification and complaint survey on 6/10/21, the facility failed to label and date food and nutrition supplements in 2 of 2 nourishment refrigerators reviewed for food storage (station 1 and station 2 nourishment refrigerators). During an interview on 09/28/23 at 11:26 AM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Storage/Prepare/Serve-Sanitary (F812). Corrective action has been taken for the identified concerns in the areas of: Accuracy of Assessments (MDS) (F641). The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 10.16.2023 to review the deficiencies from the September 25 □ September 29, 2023 annual recertification survey and reviewed the citations. On 10.11.2023, the Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Accuracy of Assessments (MDS) (F641). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10.20.2023, the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 09/29/2023

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F 867	Continued From page 22 would be put in place as needed to resolve the issue. Regarding the repeated citations the Administrator stated the dietary staff should date and label opened foods prior to placing them in the refrigerator and should wash their hands between tasks. The Administrator further stated the dietary staff needed some education as some dietary staff were recently employed. As for the inaccuracy of assessment, the administrator indicated it was a technical error from staff. The staff from now on will closely be looking into discharge and other assessments. The Administrator stated the old plan would be revisited and analyzed to see where the failures and breakdown happened. The root cause would be revisited and new interventions, and monitoring tools would be put in place. Audit and education would be completed as needed. The team would continuously monitor until the deficient areas of concerns have been resolved.	F 867	committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Food Procurement, Storage/Prepare/Serve-Sanitary (F812) and Accuracy of Assessments (MDS) (F641).The administrator will continue monthly QAPI meetings to review compliance with F812 and F641 as well as any new areas of non-compliance. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 10.20.2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the	

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F 867	Continued From page 23	F 867	weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 10/31/2023	